Dr. Swapna / Dr. Rajani

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

ESTIMATION SLIP

1503

Date : 5/5/25 UHID / IP No. : HNH-00011462 Sl No.

Name of Patient : Mrs. Revathi Age: 28Y Gender: F

Father's / Husband's Name : Mr. Varun Corporate / Occupation :

Address : Mallatunde Phone : 9018335434 Email : 9140692531

Procedure / Plan : ND/LSCS EDD/Dos: June-26

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

TARIFF INFORMATION :

Particulars	Package Amounts (Rs.)	
Room Category	Normal Delivery	LSCS
Multi Shared Ward		
Shared Ward		
Twin Shared Ward →	90k	1.10c
Private Room →	1.07k	1.17k
Super Deluxe Room		
Suite Room	+ Non Payables Extra 15k to 20k	
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/-
CBP, NST ←	Investigations up to 2,500/-	Investigations up to 3,000/-
Others	Well baby Care	25k to 35k

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

Initial Minimum Deposit : 20,000/- Advance time of Admission

REMARKS : Vaccination, Neonatal, SBR, BIG

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

Name	Mrs PERALI REVATHI	**UHID**	HNH-00011462
Father/Guardian	Mr M VARUN	**Age/Gender**	28 Y 11 M 21 D/ Female
Address	2-1-565/1/a, Nallakunta, Hyderabad, Telangana, INDIA, 500044		
IP No	IP26-00006398	**Admission Date**	21-05-2026
Ref Doctor	Self.		
Discharge Date	23.05.2026		

DISCHARGE SUMMARY

Consultant:
Dr. SWAPNA SAMUDRALA
OBSTETRICIAN & GYNAECOLOGIST
69924

Diagnosis: PRIMI AT 38 WEEKS IN EARLY LABOUR FOR DELIVERY

SPONTANEOUS VAGINAL DELIVERY DONE ON 22.05.2026

History:
LMP: 28.08.2025
EDD: 04.06.2026
Obstetric formula: PRIMI
Gestation at admission: 38 weeks

Obstetric History:
G1 - Present pregnancy, Spontaneous conception.

Medical History : Nil
Family History : Nil

Name	Mrs PERALI REVATHI	UHID	HNH-00011462
IP No	IP26-00006398	Admission Date	21-05-2026

Surgical History: Nil Allergies : Nil

Antenatal Details:

Mrs PERALI REVATHI was booked to Rainbow hospital at 35^{+5} weeks of gestation. She had regular antenatal checkups and investigations as advised by Dr. Rajani Kumari . NT scan was normal. FTS was low risk. TIFFA was low risk. Fetal growth monitoring was done by serial growth scan. Scan done on 05.05.2026 showed SLIUP at 35^{+5} weeks with cephalic presentation with AFI-15.5 cm with EFW 2.77Kg (52%) with AC 34% with Doppler normal. She was admitted at 38 weeks in view of early labour for delivery.

Investigations: Enclosed
Blood group: "O" Positive

Management: Course in hospital and Delivery Details:

At admission on clinical examination the vitals were stable, uterus was mildly acting, cervix was partially effaced and 2cm dilated. Fetal well being was confirmed by an admission NST which was found to be reactive. Partographic monitoring of labour was done. Patient opted for epidural analgesia at 4cm dilatation for pain relief. The same was sited by an anesthetist after informed consent. She progressed to full dilatation at 7:10am. Passive descent of fetal head was allowed. She was put into position for vaginal birth. Parts painted with betadine solution and draped to ensure full asepsis. She was encouraged to bear down. At crowning of head episiotomy was given under local anesthesia (10 ml of 2 % xylocaine solution). Baby was delivered by spontaneous vaginal delivery. Cord clamped and cut and baby handed over to pediatrician. Cord blood collected for blood grouping and Rh typing. Placenta and membranes delivered completely with controlled cord traction. Prophylactic syntocinon given. Episiotomy inspected. Left lateral vaginal wall friable and diffuse ooze noted. Episiotomy sutured in layers and haemostasis

Name	Mrs PERALI REVATHI	**UHID**	HNH-00011462
IP No	IP26-00006398	**Admission Date**	21-05-2026

achieved. Instrument and swab count checked. 600 mcg of misoprostol given per rectally as prophylaxis against post partum hemorrhage. Vaginal pack kept in-situ and later removed after 3 hours and cleaned with betadine solution.

Delivery Details:

Date : 22.05.2026
Time of Delivery: 7:32 AM
Type of Labour : Spontaneous vaginal delivery
Type of Delivery: Spontaneous vaginal delivery
Analgesia : Epidural

Baby Details:

Date : 22.05.2026
Time : 7:32AM
Sex : Male
Weight : 3.1kg
Apgar : 8,10
Gestational Age: 38 weeks
NICU Admission: No

Post-Partum Notes: She was closely monitored for post partum hemorrhage. Breast feeding initiated. Vitals were stable; patient ambulated and was shifted to room. Patient was encouraged for spontaneous voiding. Dietary advice given. Her postpartum period following that was uneventful. On first postpartum day episiotomy wound was healthy and intact. Her general condition was satisfactory and she was found to be fit for discharge. Wound care and medications were explained to patient supplemented by written information. She was given the postpartum book for further reference.

Name	Mrs PERALI REVATHI	UHID	HNH-00011462
IP No	IP26-00006398	Admission Date	21-05-2026

Advice:

1. Tab. Taxim-O 200mg (Cefixime 200mg) twice daily till 26.05.2026 (9am-9pm) after food.
2. Tab. Calpol 500mg (Paracetamol 500mg) (2tabs) thrice daily till 24.05.2026 (8am-2pm-10pm) after food.
3. Tab. Pantodac (Pantoprazole - 40mg) 1 tablet twice daily till 26.05.2026 (7am-7pm) before food.
4. Tab. Voveran 50 mg (Diclofenac 50mg) thrice daily till 24.05.2026 (9am-3pm-11pm) after food.
5. Tab. Livogen (Elemental iron - 50mg, folic acid 1.5mg) once daily (7am) for three months before breakfast.
6. Tab. Shelcal (Elemental Calcium 500 mg, vitamin D3 250 IU) once daily (2pm) till breast feeding after food.
7. Tab chymoral forte 1 tab thrice daily for 7 days .
8. Metro-p ointment for local applocation.
9. Syp. Duphalac 15 ml (Lactulose 3.33gm/5ml) at bed time for one week.

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

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

Review with **Dr. SWAPNA SAMUDRALA** after 2 weeks on 06.06.2026 at Rainbow children's hospital OP with prior appointment **(Review consultation will be charged).**

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Name	Mrs PERALI REVATHI	**UHID**	HNH-00011462
IP No	IP26-00006398	**Admission Date**	21-05-2026

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 Himayatnagar or 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

Dr. SWAPNA SAMUDRALA
OBSTETRICIAN & GYNAECOLOGIST
69924

HNH-00011462
Mrs P REVATHI
01-06-1997 28 Y 11 M 20 D (F)
Dr. SWAPNA SAMUDRALA
IP26-00006398

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SURGERY DETAILS

Date : 22/1/2025

Patient Name: mrs. pendli revathi Date of Birth: 1-6-1997 Age: 28Y/F

Gender: Female Ward : LDR UHID No.: HNH-000011462

LDR-I.

Date of Surgery: ☐ OT-1 ☐ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Normal delivery & Epidural

Time in : 7AM Time Out : 8AM

		NAME	AMOUNT
1.	Surgeon	: DR. Swapna Samudrala	
2.	Anaesthetist	: DR. Subramenyam	
3.	Assistant Surgeon	: DR H Swathi HV	
4.	OT Technician	: —	
5.	Circulating Nurse	: madumitha	
6.	Assistant Nurse	: Chandrakala	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 26-000020130.1 Order by: Sujatha

Rainbow Children's Hospital

BirthRight by Rainbow

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 : IP26-00006398 **Admit Date** : 21-May-2026 **Admit Time** : 11:27 PM **UHID** : HNH-00011462

Patient Details :

Patient Name	: Mrs PERALI REVATHI	**Age**	: 28 Y 11 M 20 D
Guardian	: Mr M VARUN	**DOB**	: 01-06-1997
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 2-1-565/1/a Nallakunta Hyderabad Telangana INDIA 500044	**Phone No**	: 9440692531/ 9948335434
		E-mail	: revathi.perhi@gmail.com

Admission Details :

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

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

Contact Details :

Name : Mr M VARUN **Relationship** : W/O

Contact Address : 2-1-565/1/a Nallakunta Hyderabad Telangana INDIA 500044 **Phone No** : 9440692531

Signature

Doctor Details :

Doctor Name : Dr. SWAPNA SAMUDRALA **Specialisation** : OBSTETRICS AND GYNECOLOGY

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

Co-Consultant :

Payment Details :

Payment Mode : DC/CC Card **Deposit Amount** : 20000.00

Payor Name : BAJAJ ALLIANZ GENERAL INSURANCE CO LTD.

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00011462 IP26-00006398 Mrs P REVATHI 01-06-1997 28 Y 11 M 20 D (F) Dr. SWAPNA SAMUDRALA	21/5/26 @ 11:27PM	22/5/26 @
	Transfer Ordered by DR. Naveena	Reason for Transfer Observation
From Unit ~~LDR~~ LDR	To Unit Room	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 30	Number of Imaging Films -4-	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. Sujatha	DR. Naveena
Patient & Clinical Records Received by : Mounika	
Date & Time of Patient Received : @2pM 22/5/26	

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

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ACTIVITY RECORD FOR BILLING

Name: ---------- HNH-00011462 IP26-00006398 ----------
Mrs PERALI REVATHI
UHID No : ---------- 01-06-1997 28 Y 11 M 20 D (F) nsultant : ---------- Dept : ----------
Dr. SWAPNA SAMUDRALA
Date of Admission : -- --- Date of Discharge : ---------- Time: ----------
Room / Bed No : ---------- Ward : ---------- Suggested Billable bed type : ----------

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
22/5/26		LDR	Room	

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
21/5	CBP	8610	
21/5	NST - (1)	62007	
22/5	NST - (2)	62007	
22/5	NST - (3)	62007	
22/5	NST - (4)	2626-06205	
			cross checked by
	Cross checked done by Sunanda		

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
22/5	cardiac monitor	5:30Am	9AM	201277	[illegible]
22/5	infusion pump	5:30Am	9Am		[illegible]
22/5	Epidural pump	5:30Am	9Am		[illegible]

Cross checked by [illegible]

Cross checked done by Sunanda

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
21/5	IV Placement	(1)	1242	
22/5	Catharization	(1)	201275	
22/5	PAC (OP)	(1)	201276	
				Cross checked by Latha
22/5/26	NHA	(1)	1504	
				Cross checkout done by Sananda

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00011462 IP26-00006398
Mrs PERALI REVATHI
01-06-1997 28 Y 11 M 20 D (F)
Dr. SWAPNA SAMUDRALA

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IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints primigravida @38wks c/o pain Abd :: 6hrs

Obstetric Formula:

Obstetric Hostory: + spontaneous conception, CRTS low risk, NIPT ®

Present Pregnancy Record:
- TIFFA @ study
- wart @ vagina - HPV DNA test

RISK FACTORS:

* warts in vagina.

Height: 157 cm
Weight: 67.8 kg
Allergies: ....
Breast: ☑ Normal ☐ Abnormal

General Examination:

Consciousness:	Pallor:
Icterus:	Edema:
Temp:	PR: -88/m
BP: -100/80	DTR: } NAD
CVS:	RS } NAD
Liver/Spleen:	Urine Output:

LMP: 28/08/2025 EDD: 4/6/2026.
Corrected EDD: 4/6/2026 GA: 38wks.
Menstrual History: Regular : ☑ Yes ☐ No

Obstetric Examination

Fundal Height: 36 cms
Ut. Activity: ☐ Relaxed ☑ Mild ☐ Mod ☐ Severe
Liquor: ☑ Adequate ☐ Oligo ☐ Poly
PP: ☑ Cephalic ☐ Breech Others ______
Head Fifths Palpable: 3/5th.
FHS: ☑ Normal ☐ Tachy ☐ Brady ☐ Absent

Per Speculum Examination

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

Vaginal Examination

Cervix: ☐ Long ☑ Partially effaced ☐ Effaced
Os: Closed 2cm. Dilated ______
Membranes: ☑ Present ☐ Absent
Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained
Presenting Part: ☑ Vertex ☐ Breech ☐ Others
Sutton: ☐ -3 ☐ -2 ☑ -1 ☐ 0 ☐ +1 ☐ +2
Pelvis: ☑ Adequate ☐ Doubtful

DIAGNOSIS

Primi @38wks in early labor

HNH-00011462 IP26-00006398
Mrs PERALI REVATHI
01-06-1997 28 Y 11 M 21 D (F)
Dr. SWAPNA SAMUDRALA

Family History:	Surgical History:
nil	nil
Medical History:	**Medication History:**
nil	-
Plan of Care:	**Investigations:**
- Admission - Inj POL - CTG - 3rd hrly - Trend CBP → w/f ↑ pain/leak pv / bleed pv - Explained.	21/05 Hb => 10 g. BGT - O+ve. plt → 1.84 lac HIV. HbsAg } NR HCV Last scan: 5/5/2026 - SLIUF @ 35wk5d AFI - 15.57 EBW - 2771g. (52%) AC - 34%. Doppler (N)

Doctor Name: Dr. Swathi. H
Signature: [signature]
Date & Time: 21/05/2026 @ 11:30pm.

Consultant Name: Dr SWAPNA
Signature: [signature]
Date & Time: 21/5/26

HNH-00011462 IP26-00006398
Mrs PERALI REVATHI
01-06-1997 28 Y 11 M 20 D (F)
Dr. SWAPNA SAMUDRALA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/08/2024	S/B [illegible]	
4AM	→ [illegible] @ 38wks, → 40 [illegible] pain Abd	→ [illegible] Early labor
	O/E - [illegible]	Advice:
	PR - 88 bpm	→ [illegible] POL
	BP → 100/80	→ [illegible] @ 100ml/hr
	[illegible]	→ Epidural Analgesia
	PA: [illegible]	Inform [illegible]
	cephal 2/5	→ Inform [illegible]
	FHR ⊕ 130bpm	
	2-3/10'/20"	
	PV: OS 3-4cm, Vx [illegible] I-II	
	[illegible] 70% effaced	
	pelvis adequate	Dr. Swapna Samudrala, Consultant Obstetrics and Gynecology, Reg. No: 69924
	S/B [illegible]	
5:30AM	- P+ [illegible] CA.	Adv:
	O/E: [illegible] @	- [illegible] POL
	PA: [illegible]	
	cephal 2/5	→ CTG now [illegible]
	FHR ⊕ Reg.	- FHR [illegible]
	2-3/10/20-25'	→ [illegible] for Oxytocin Augmentation
	PV: OS 4-5cm, Vx [illegible] I-II	→ Inform [illegible]
	[illegible], ARM done, clear liquor noted, no post ARM drops	

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

HNH-00011462 IP26-00006398
Mrs P REVATHI
01-06-1997 28 Y 11 M 20 D (F)
Dr. SWAPNA SAMUDRALA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/5/26 8:30 AM	PND - 0 (P1L1 / SVD)	
	A/O Conc	
	PR - 100 bpm	Adv
	BP - 103/62	- Regular / Bgt Diet
Baby well.	O2 Sat. 99% RA	- Oral hydration
	P/A - Ut well retracted	- Drugs as charted
	L/E - MAB	- Monitor vitals ½ hrly
Foley ⊕	P/A - Ut well retracted	- w/f excessive P/V
	L/E - MAB	bleeding.
	pads ⊕	- Inform SOS
	Dr. Swapna Samudrala Consultant Obstetrics and Gynecology Reg. No: 69924	[signature] Dr. Swapna S.
	c/s/B Dr. Veena	
22/5/26 12pm	PND-0 / P1L1	
	Pt is stable, No c/o	
	O/E GC fair	Adv
	BP - 100/70mmHg	- Reg Soft diet
Baby @ms	PR - 78bpm	- Vital monitoring
	SpO2 - 99% on RA	- Drugs as charted
Foleys ⊕	P/A - Ut well retracted	- w/f excessive bleeding P/V
	L/E - BWNL.	- I/O charting
	U/O - 80ml/hr, clear	- Inform SOS
	Vaginal in-situ ⊕	[signature]

HNH-00011462 IP26-00006398
Mrs PERALI REVATHI
01-06-1997 28 Y 11 M 21 D (F)
Dr. SWAPNA SAMUDRALA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/5/26 1:30pm	c/s/B Dr. Swathi / Dr. Veena c/D/H Dr. Swapna	
	PND-O / P1L1	
	Pt is stable, No c/o	
	O/E GC fair, Afebrile	Adv
	Vitals - stable.	- Soft diet
	P/A - Ut well retracted	- Foley's till evening @6pm
	BS ⊕	- Adequate hydration
	L/E - BWNL.	- Ambulation
	P/V. - Pack removed - Soaked	- w/f excessive bleeding P/v
	Episiotomy intact.	- T/O charting
	No active bleeding P/v.	- Inform SOS
	NB Ankeh	- Shift to Room
22/5/26 8:30pm	PND - O	
	No comp	Adv
	O/E - GC fair	- Regular Diet
	Afebrile	- Oral hydration
	O. Sat - 99% RA	- Drugs as charted
Baby - well	Vitals - ⓝ	- Monitor vitals
	P/A - Ut well retracted	- Ambulation
	L/E - NAD	- w/f excessive P/v bleeding
		- Inform SOS
		- Remove Foley's @6pm
		- IV Abx today
		Oral Abx tomorrow

Dr. Swapna Samudrala
Consultant Obstetrics and Gynecology
Reg. No: 69324

NB. Maheshwari

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

(P.T.O)

HNH-00011462 IP26-00006398
Mrs P REVATHI
01-06-1997 28 Y 11 M 20 D (F)
Dr. SWAPNA SAMUDRALA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/5/26	Cls/b	Amarula
7:30pm	PND 0	
		Ad
	CC - Fav Afebrile	- Regular Diet
	Vitals : Stable	- Adeq Hydration
	P/A ut well retracted	- Drugs as charted
	PV Bleeding WNL	- Encourage to void
BMS		Inform SOS
U - yet to void		
		N B maheshwari
		Amarula
23/5/26	Cls/b	Amarula
4Am	PND 1	
		Ad
	CC - Fav Afebrile	Regular Diet
	Vitals stable	Adequate Hydration
BM✓	P/A ut well retracted	Drugs as charted
	BS⊕	Ambulation
U✓	LE - NAD	Inform SOS
F✓	PV- Episiotomy intact	
Sq		
		Amarula
		NB Sunanda

HNH-00011462 IP26-00006398
Mrs P REVATHI 28 Y 11 M 20 D (F)
01-06-1997
Pati Dr. SWAPNA SAMUDRALA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/5/26 11:00 AM	POD - 2	
	N/O comp	Adv
	O/E: G.C fair	- Regular Diet
	Afebrile	- Oral hydration
Baby - well	Vitals - (N)	- Drugs as charted
	P/A - UV well retracted	- Monitor vitals
urine ✓	L/E - MAR.	- Ambulation
flatus ✓		- Inj pain SOS.
stools ×		
V/E / SE 32 wound care	patient can be discharged	(Dr. Swapna.S)

Dr. Swapna Samudrala
Consultant Obstetrics and Gynecology
Reg. No: 69924

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

HNH-00011462 IP26-00006398
Mrs PERALI REVATHI
01-06-1997 28 Y 11 M 21 D (F)
Dr. SWAPNA SAMUDRALA

Rainbow® Children's Hospital
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BirthRight™ BY RAINBOW HOSPITALS
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00011462
Mrs P REVATHI
01-06-1997 28 Y 11 M 20 D (F)
Dr. SWAPNA SAMUDRALA
IP26-00006398

307

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RESULT SHEET

Date	2115					
Time						
Hb	10.9					
PCV	31.3					
RBC	4.21					
WBC	9.25					
N/L	68@26.4					
Platelets	184					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Blood Grouping O +ve						
HCV HBsAg } NR HeV						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

HNH-00011482
Mrs PERALI REVATHI IP26-00006398
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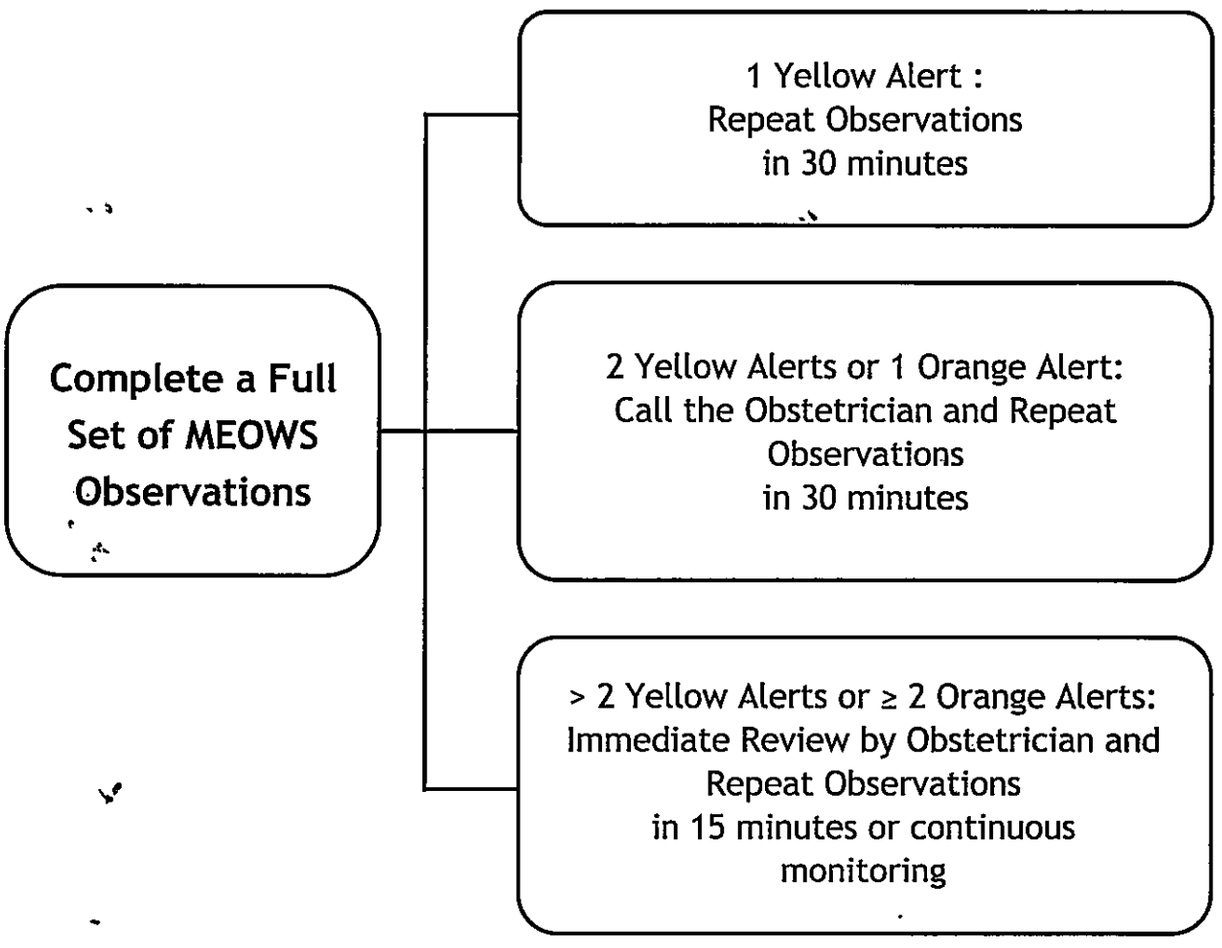
Early Warning Observation Score Chart - Obstetrics

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

21/5/26

		Date																							
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20																	20			20			20		
	0 - 10																									
Saturations	94 - 100 %																	100			99			99		
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°C	40																									
	39																									
	38																									
	37																									
	36																	36.4			36.4			36.6		
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80																	86			87			99		
	70																									
	60																									
	50																									
	40																									
↑ Systolic Blood Pressue	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																	110			116			112		
	90																									
	80																									
	70																									
	60																									
	50																									
↓ Diastolic Blood Pressure	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																	70			81			89		
	60																									
	50																									
	40																									
NEURO RESPONSE [✓]	Alert																	✓			-			-		
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30																	✓			-			-		
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal																	✓								
	Heavy / Foul																									
Liquor	Clear / Pink																	✓								
	Green																									
TOTAL YELLOW SCORES																		2			2			2		
TOTAL ORANGE SCORES																		0			0			0		
Nurse Initial																										

Obstetrics and Gynaecology Early Warning Signs



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

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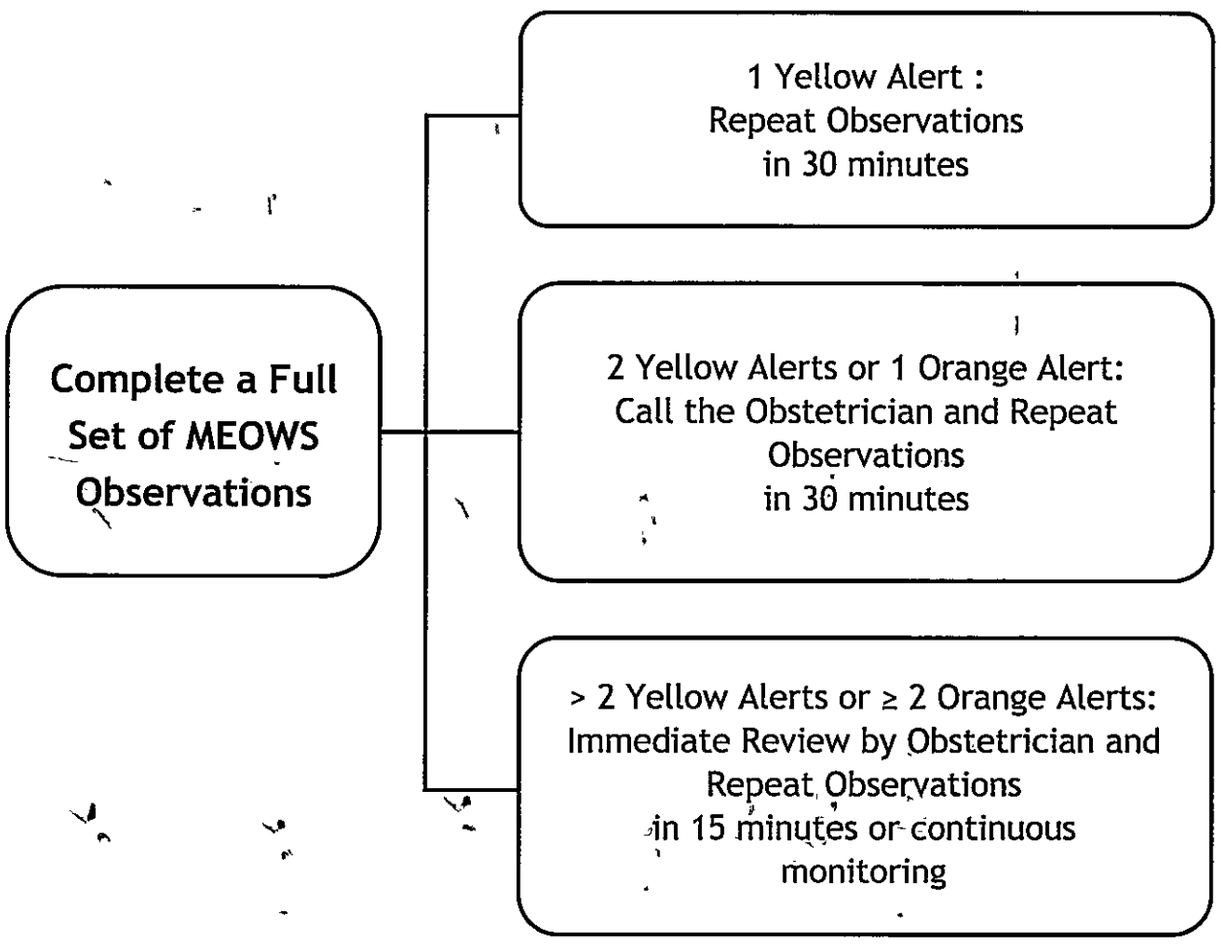
Early Warning Observation Score Chart - Obstetrics

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

27/5/26	Date																							
	Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																								
	21 - 30																								
	11 - 20	20	20	20	20	20		20				20				20				20				20	
	0 - 10																								
Saturations	94 - 100 %	99%	99%	99%	99%	99%		99%				98%				99%				99%				99%	
	< 94 %																								
Administered O_2 (L/min.)																									
Temp°c	40																								
	39																								
	38																								
	37																								
	36	97°F	97°F	98°F	98°F							98.3°F				98°F				98.3°F				98.1°F	
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80	80	85	80	91							76				85				72				80	
	70																								
	60																								
	50																								
	40																								
↑ Systolic Blood Pressue	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120	115	118	110				120				110				100				115				104	
	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
↓ Diastolic Blood Pressure	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70	65	62	65				78				65				68				65				76	
	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	1		0				0				0				0				0	
TOTAL ORANGE SCORES		0	0	0	0	0		0				0				0				0				0	
Nurse Initial																									

Obstetrics and Gynaecology Early Warning Signs



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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

28/5

		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																						
	0 - 10																									
Saturations	94 - 100 %			aa																						
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37																									
	36			98.4°F																						
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
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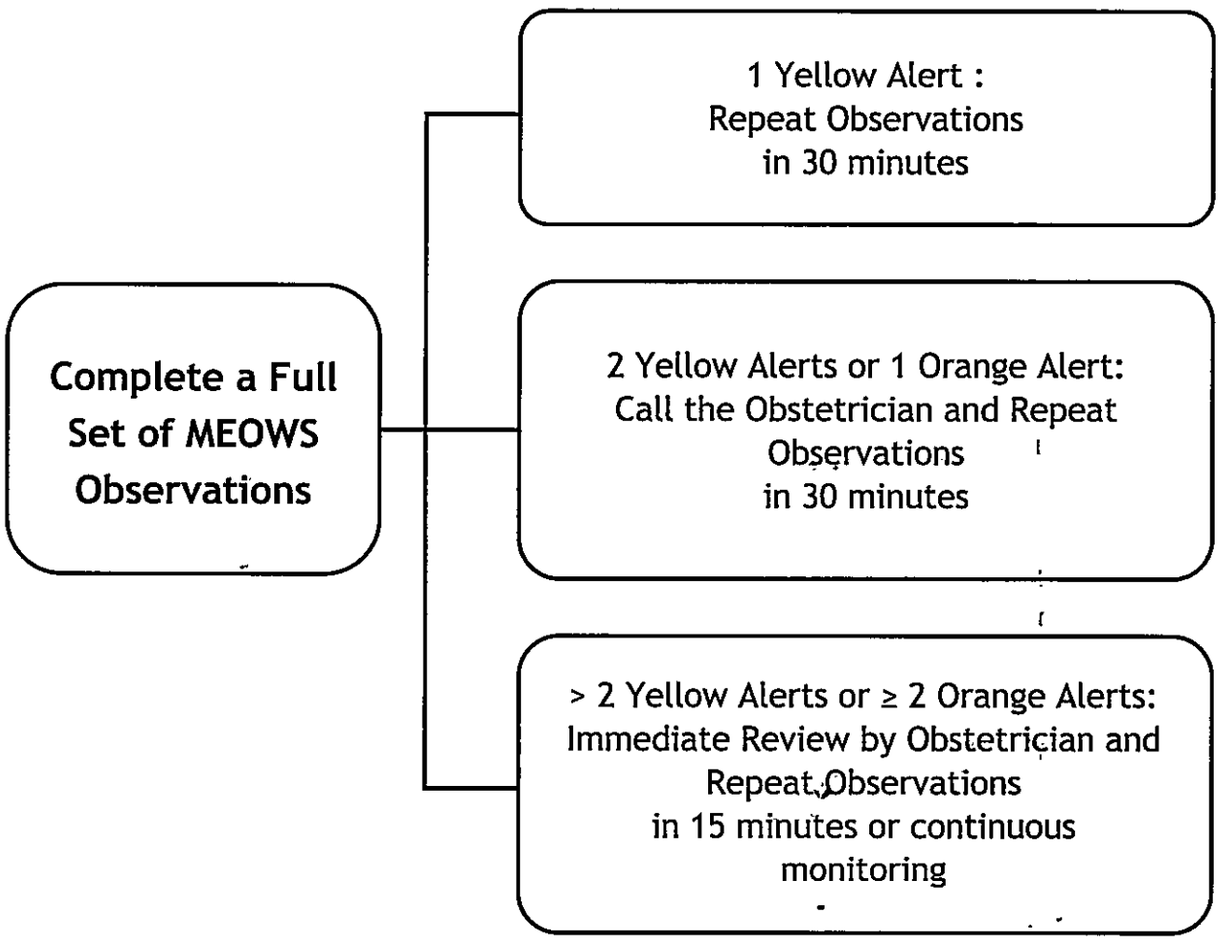
	110																									
	100																									
	90																									
	80			81																						
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120			115																						
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70			73																						
	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																						
TOTAL ORANGE SCORES				0																						
Nurse Initial				SS																						

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					NA						
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											
21/5/20	11:00 pm		H2O				✓			✓	0	
	12:00 am											
	01:00 am											
Total Intake :		Taken				**Total Output :**	✓			✓	0	
	02:00 am											
	03:00 am											
	04:00 am	RL		10ml								
	05:00 am	R2	H2O	100ml							0	
	06:00 am	R2		10ml								
	07:00 am	RL		100ml								
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.

22/5/26		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
22/5	08:00 am	RL		100ml								
	09:00 am	RL	idly	100ml								
	10:00 am	RL	H2O	100ml								
	11:00 am	stop		stop						200ml		
	12:00 pm		H2O									
	01:00 pm									200ml		
Total Intake : taken						Total Output : U M —						
22/5	02:00 pm											
	03:00 pm											
	04:00 pm		kichidi									
	05:00 pm		+									
	06:00 pm		H2O									
	07:00 pm											
Total Intake :						Total Output :						
22/5	08:00 pm											
	09:00 pm		idly									
	10:00 pm		+									
	11:00 pm		H2O									
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
23/5	02:00 am											
	03:00 am											
	04:00 am		H2O									
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : .....

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

23/5/26		Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am									✓		
	09:00 am		Idly									
	10:00 am	0	T							✓	0	
23/5/26	11:00 am		H_2O		NA			NA				
	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	

Patient Sticker

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

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FLUID CHART

Sheet No. : .....

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

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

Total 24 hrs. Intake		Total 24 hrs. Output	

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NURSING CARE RECORD

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

Date: 21/5/26

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				NA			
Afternoon							
Night	8pm to 8pm	=> Assess the patient condition => maintain vitals => pt on bed & discharge	8pm to 8pm	=> Assessed the pt condition => maintain vitals allowed => maintain I/O Chart	patient is stable	vitals is normal	Co

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NURSING CARE RECORD

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BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: 22/5/26

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 to 2PM	→ Assess the pt condition → vital are checked → plan for vital → plan for medi	8AM to 2PM	→ Assessed the pt condition → vital are checked & recorded → I/o chart maintained	I/o chart maintained	Patient is stable	Sujatha
Afternoon	2pm to 8pm	→ Assess the pt condition. → monitor the vitals. → maintain I/o chart. → drugs give as per. drug chart.	2pm to 8pm.	→ Assessed the pt condition. → monitored the vitals. → maintained I/o chart. → drugs give as per drug chart.	→ pt is stable. Now.	→ Re assessed the I/o chart.	Mahi
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	— Now pt is stable	— Rechecked the v/s	

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Date: 27/5/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am 2pm	→ Assess the pt condition. → monitor the the vitals. → maintaine I/o chart. → drugs give as per drug chart.	8Am. 2pm	→ Assessed the pt condition. → monitored the vitals. → maintained I/o chart. → drugs given as per drug chart.	→ pt is stable now	→ Reassessed the vitals	
Afternoon							
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

SITUATION

Diagnosis: NVD

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

Surgery / Procedure:

Post OP Day:

BACKGROUND / ASSESSMENT / Recommendations

Date / Shift	21/5 N1	22/5 8AM	22/5 G	22/5 N1	23/5 MC	
Medical Condition (Any special condition to be noted):	–	–	–	–	–	
Diet:	NA	NA	NA	NA	Soft diet	
Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Ventilation (RA, NP, NIV, VENTI):	NA	NA	–	–	–	
Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Vital Signs: Temp:	97°F	97F	97.9°F	97.3°F	97.9°F	
Res:	20	20	20b/m	22b/m	20b/m	
SpO_2:	100	99%	99%	99%	99%	
Pulse:	80	85	81b/m	82b/m	86b/m	
BP:	110/70	115/75	110/70	112/73	115/78	
LOC:	–	–	–	–	–	
Fall Risk Score:	–	–	–	–	–	
Pain Score:	–	–	–	–	–	
Skin Integrity	–	–	Good	Good	Good	
Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Physiotherapy:	–	NA	–	–	–	
Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Special Diet:	–	NA	–	–	–	
Critical Lab Test / Values:	–	NA	–	–	Soft	
Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
ADL (Dependent / Non Dependent):	–	NA	–	–	–	
Post Operative Procedure Special Orders:	–	NA	–	–	–	
Handed Over By Name :	Cluvd	Sijith	mahi	Sunanda	mahi	
Signature / ID :						
Date:	22/5/26	22/5/26	22/5/26	23/5/26	23/5/26	
Time:		8PM	8PM.	8am	8PM	
Taken Over By Name :	Sujith	mahi	Sunanda	mahi		
Signature / ID :						
Date:	22/5/26	22/5/26	22/5/26	23/5/26		
Time:	8AM	2PM	8pm	8am		

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NURSING SHIFT HAND OVER FORM

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

HNH-00011462 IP26-00006398
Mrs P REVATHI
01-06-1997 28 Y 11 M 20 D (F)
Dr. SWAPNA SAMUDRALA

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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	22/5 DAY-1			23/5 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	NA	NA	NA	NA						
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	NA	NA	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						
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						
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						
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						
			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 : Suvatha

Signature of Ward In Charge :

Signature : ..... Name : kasthuri

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

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BRADEN 'Q' SCALE

					Date : 21/5	22/5	22/5	22/5
					Time : MN	8AM	5	M1
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	20	28
				Evaluator's Name	CT	PJ	[illegible]	[illegible]

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

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

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	21/5/26	22/5	22/5
		Score	N/	6AM	6
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0			
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0	0	0	0
IV / Heparin Lock or Saline	Yes	20	20	20	20
	No	0			
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0			
Mental Status	Forgets limitations	15			
	Oriented to own ability	0	0	0	0
Total Morse Fall Scale Score:			20	20	20
		Signature	CR	Ri	[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				Fall Risk Grading		
		Score						
History of Falling (immediately or w/in 3 months)	Yes	25				Risk Level	Morse Fall Score (MFS)	Action
	No	0						
Secondary Diagnosis (more than one diagnosis)	Yes	15						
	No	0				Low Risk	0 - 24	Standard Fall Precaution
Ambulatory Aid	Furniture	30						
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0						
IV / Heparin Lock or Saline	Yes	20				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20						
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
Mental Status	Forgets limitations	15						
	Oriented to own ability	0						
Total Morse Fall Scale Score:								
		Signature						

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
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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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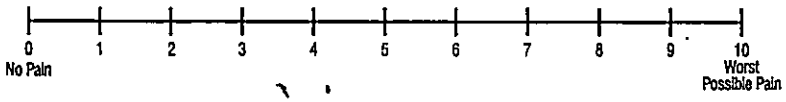
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
21/5/26	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
21/5/26	11.59pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
22/5	2Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
22/5	6Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
22/5	12Pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
22/5	6pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
22/5	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
23/5	2am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
23/5	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
23/5	12pm	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

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URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 22/5 Date of Removal: .....

Parameters	Date / Shift Time	22/5 MG	22/5 E					
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 Removed	☐ 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		Maddy	mahi					
Signature of the Nurse								

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DRUG CHART

Date of Admission: 21/05/2024 Drug Allergies: nel ☐ 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 ..... Sig ..... e .....

HNH-00011462 IP26-00006398
Mrs P REVATHI
01-06-1997 28 Y 11 M 20 D (F)
Dr. SWAPNA SAMUDRALA

REGULAR PRESCRIPTIONS Weight. ..... Ward. .....

DRUG : T. CEFIXIME

Dose	Route	Frequency	Start Date
200mg	PO	BD	22/5

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

Additional Instructions: AFTER FOOD

Date / Time	22/5
6AM	X
6PM	5:30 PM inj

STOP 22/5/26.

Daily Doctor's Endorsement by a Sign

DRUG : T. PANTOPRAZOLE

Dose	Route	Frequency	Start Date
40mg	PO	BD	22/5

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

Additional Instructions: BEFORE FOOD.

Date / Time	22/5	23/5
6AM	X	
6PM		

Daily Doctor's Endorsement by a Sign

DRUG : T. PARACETAMOL

Dose	Route	Frequency	Start Date
500mg	PO	BD	22/5

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

Additional Instructions: AFTER FOOD

Date / Time	22/5	23/5
6AM		
6PM		

Daily Doctor's Endorsement by a Sign

DRUG : T. DICLOFENAC

Dose	Route	Frequency	Start Date
50mg	PO	TID	22/5

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

Additional Instructions: AFTER FOOD

Date / Time	22/5	23/5
6AM		
2PM		
10PM		

Daily Doctor's Endorsement by a Sign

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Sheet No: .....

REGULAR PRESCRIPTIONS

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

DRUG : SYP. DUPHALAC

Dose	Route	Frequency	Start Dt.
15ml	PO	OD	22/5

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	22/5															
Time	10PM															

DRUG : OINT. METRONIDAZOLE

Dose	Route	Frequency	Start Dt.
	L/A	BID	22/5

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	22/5	23/5														
Time	6AM		8PM	10PM												

DRUG : T. CEFEXIME

Dose	Route	Frequency	Start Dt.
200mg	P/O	BD	23/5/26

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	23/5															
Time	8AM		8PM													

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date																
Time																

VERIFIED BY : Name : Signature

(P.T.O.)

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

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

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

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

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

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

DRUG :	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
22/05	12:30AM	Procelysis enema	1 pack	P/R		Madhu
22/05	5:30AM	Inj CEFOTAXIM	1g	IV		Madhu
22/5	5:45 AM	Inj DROTAVERINE	40mg	IV		Madhu
22/5	8:30AM	T. MISOPROSTOL	600mcg	P/R		Sujatha Anusha.D
22/5	8:30AM	JUSTIN (DICLOFENAC) SUPPOSITORY	1 tab	P/R		Anusha.D Sujatha
22/5	8:30AM	INJ. OXYTOCIN	100	IM		Anusha.D Sujatha
22/5	8:32AM	INJ. METHYL ERGOMETRINE	0.2mg	IM		Anusha.D Sujatha
22/5	8:40AM	INJ. TRANEXAMIC ACID	1g	IV		Anusha.D Sujatha
22/5	4:00 pm	INJ TRANEXAMIC ACID	1gm	IV		Rahuthumi

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

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I.V. FLUIDS CHART

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

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
22/5 4 PM	RINGER LACTATE	IV	100ml/hr			22/5		
22/5 6:30 PM	~~Syndo + RL~~ RINGER LACTATE + INJ. OXYTOCIN 15U	IV	100ml/hr			22/5		
	STOP In Amount							

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

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Mrs. Revathi

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STAT / ONCE ONLY DRUGS

Name: ..... Weight: ..... kgs

Sheet No: .....

DATE	TIME	MEDICATION	DOSAGE & OTHER INSTRUCTIONS	ROUTE	SIGNATURE		
					Doctor	Nurse-1	Nurse-2
22/6/26	5:30PM	INJ-CEFOTAXIME	1g	IV			

P. Revathi

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307.

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NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 22/5/26 Time: 3:45 pm

Origin: Indian Height: 157cm Weight: 67.2 kg BMI: ☐ ~ 26 kg/m² ☐ ~ 28 kg/m² ☐ ~ 30 kg/m²

Food Allergies: NO FA

Diagnosis: NVD

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

Diet Advised:

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

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

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

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

Patient's / Attendant's

Signature: Revathi Perali

Name:

Date & Time: 22/5/26 3:45 pm

Dietician's

Signature: Sabiya

Name: Syeda Sabiya Zahee

Date & Time: 22/5/26 3:45 pm

DIETARY NOTES

Date	Time	Notes	Sign

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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	Iron, Ca.	1tsp	P/O	OD.	21/05	☑ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr Swathi. HV

Date & Time : 21/05/2026 @ 11:30pm

Nurse Name & Signature: Madhumita @ Madhu

Date & Time : 21/5/26 @ 11:30Pm

PARTOGRAPH

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LABOUR

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

Indications for IOL-Accel: ☐ None ☑ Oxytocin

Memb. Repture Type: ☐ SROM ☐ PROM ☑ ARM

Presentation: ☑ Vertex ☐ Breech ☐ Others

INTRA PARTUM COMPLICATION

Maternal: ☑ Nome ☐ Pyrexia ☐ HTN ☐ Others

Liquor: ☑ Adequate ☐ Oligo ☐ Poly ☐ Clear

☐ Blood ☐ Meconium ☐ Cord: -Ⓥ...........

Shoulder Dystocia: ☐ Yes ☑ No

DELIVERY DETAILS

Anesthesia: ☑ None ☑ Epidural

Non-epi: ☐ Local ☐ Spinal ☐ General

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

AVD: – ☐ Outlet ☐ Low Forceps ☐ Ventouse ☐ Trails of Forceps

Indications: –

Application, Locking & Traction: –

Duration of Instrumentation: –

No. of Pulls: –

Catherised : ☑ Yes ☐ No

Type: ☑ Fileys ☐ Plain

Perineum : ☐ Intact ☑ Episiotomy ☐ Tear

Suture Material Used: Rapid vicryl NO-1

STAGE III

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

PPH : ☐ Atomic ☐ Traumatic ☑ None

Lacerations: nil

Cervical: nil

Perineal: nil Ⓛ lateral vaginal wall friable c diffuse ooze ⊕

Others:

Prophylaxis: Synocinon (marked) Prostodin

Blood Loss: 500 ml

Blood Transfusion:

Other Details (if any):

Ractal Examination: Mucosa Intact.
- Mops & instrument count found correct
- vaginal pack placed insitu

DURATION OF LABOUR

1st Stage: 2.5 hrs

2nd Stage: 10 min

3rd Stage: 10 min

Duration of Active Pushing: 5 min

No. of VE'S: 3

BABY DETAILS

Gender: Male

Weight: 3.1 kg

APGAR: 8/10

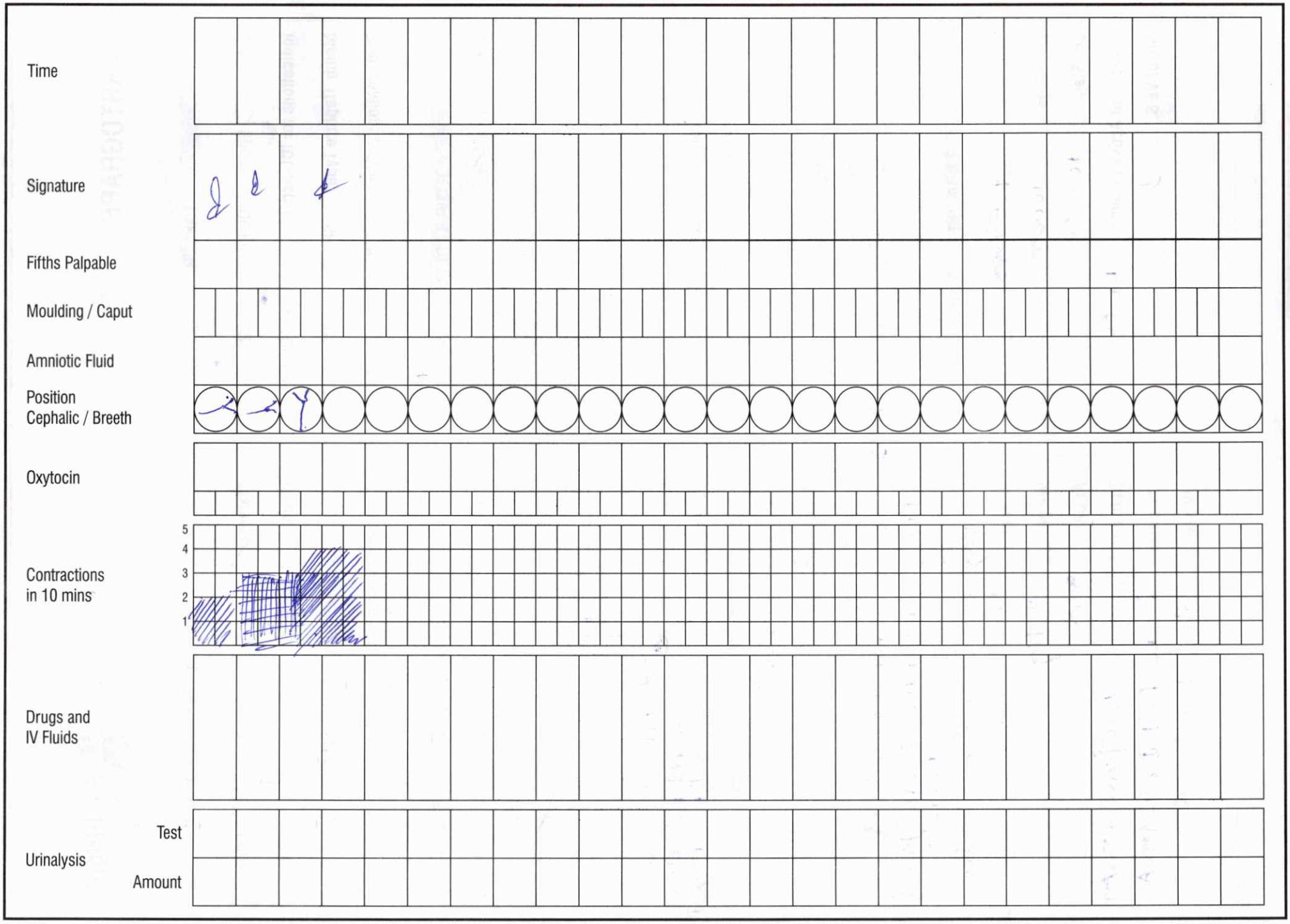
Date and Time of Delivery: 22/5/20 @ 7:32AM

LW Doctor: Dr Swathi / Dr SWAPNA

LW Sister: S/N. Chandrakala

Docu. No. : RCH /FRM / CLINICAL / 143

(P.T.O.)


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

PARTOGRAPH

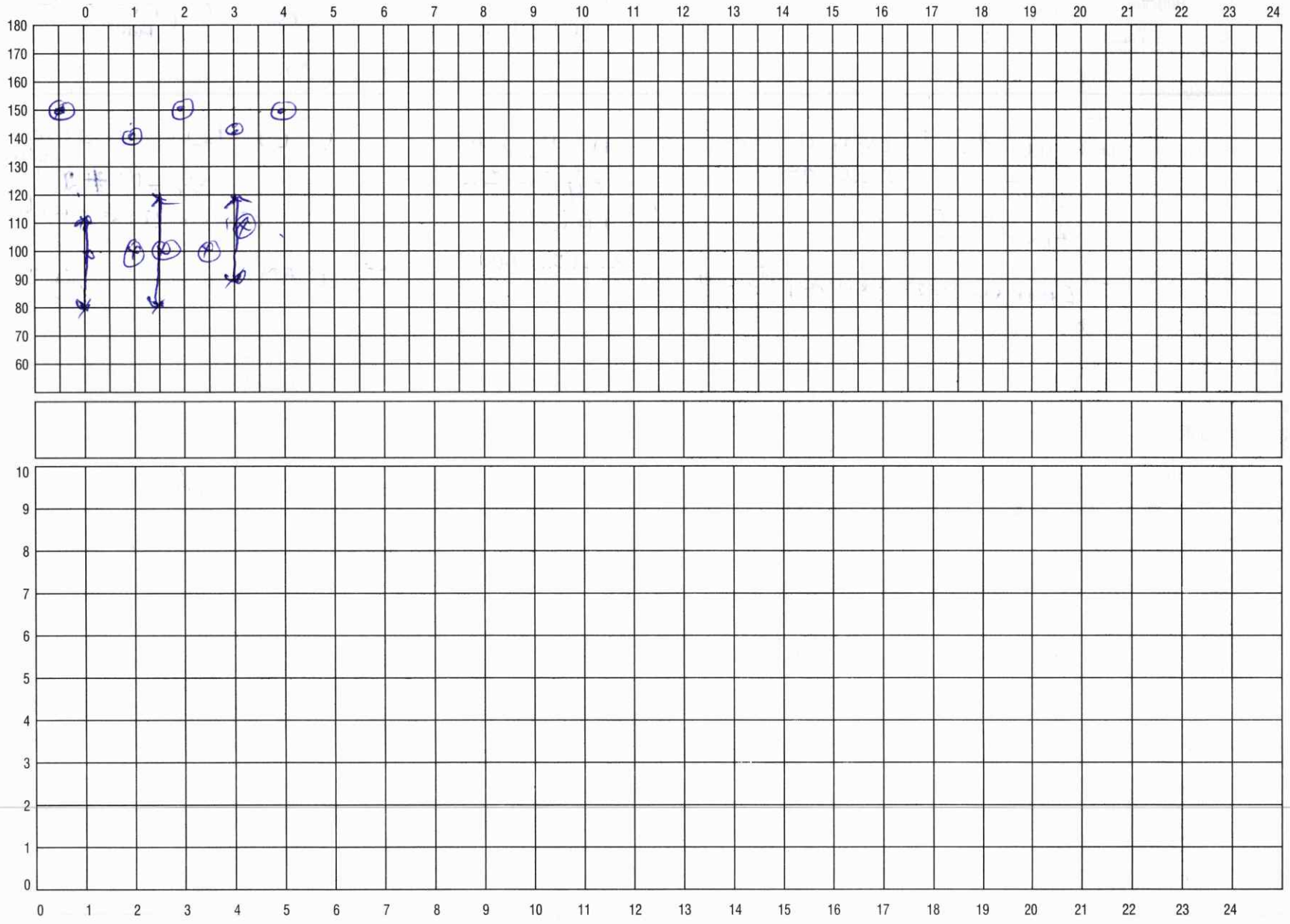
Name: Rosalin. Obstetrics Formula: ..... Blood Group Type: .....

Memb. Ruptured: **SROM** **PROM** **ARM** **Risk Factors:** .....

Fetal Heart ●

Maternal BP ↕

Maternal Pulse ×



Record of Labor:

Maternal Condition: - Good, tachycardia (+)

Fetal Condition: - Good

Progress of Labor: Awaited

Management:

P/A: Ut 36wks, cephal 3/5th, FHS (+) Reg, 2-3/10/20"

PV: Os 5cm, Vx at (-1), memb (+) → ARM done, clear liquor noted.

Time: 5:30 AM Signature: [signature]

Maternal Condition: - Good, tachycardia (+) P=100 bpm

Fetal Condition: - Good

Progress of Labor: - Awaited.

Management: → Encourage bearing down →.

PA: Ut 36wks, cephal 0/5th, FHS (+) Reg. 3/10/30-40"

PV: Os. fully dilated & effaced, Vx at #2. clear liquor noted.

Time: 7:10 AM Signature: [signature]

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

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

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

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

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

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

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OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 21/5/26 Time of Arrival: 8:pm Time Seen by Nurse: 11:10am

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°F Pulse: 86 RR: 20 SpO_2: 100 BP: ..... Weight: .....

4) **Gestational Criteria:**

Gravida:	G 1	P	L	A

LMP: 28/8/25 EDD: 4/6/26 Gestational Age: 38 wks

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: Paracetamol .....
- Frequency: .....
- Interventions: .....

.....

6) **Past History:**

a) Surgeries: .....

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: 11.15pm

Nurse Name : Madhumita Nurse Signature: Madhu

Date: 21/5 Time: 11.10Am

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LABOUR AND DELIVERY NURSING ASSESSMENT

Date of Admission: 21/5/26

Baseline Information:

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

Primary Language: ☑ Telugu ☐ English ☐ Hindi ☐ Others

Do you require an interpreter? ☐ Yes ☐ No

Source of Information: ☐ Patient ☑ Family ☐ Others

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

handed over to .....

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

If yes , identify .....

Chief Complaints: ..... Doctor Notified on Admission: ☐ Yes ☐ No

..... painful Name of the Doctor: Dr Sreelekha

..... Time Notified: 11 pm

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

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

Blood Group: O+VE LMP: ..... EDD: ..... Gestational age during admission: .....

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

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

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

Temp: 97.0 F HR: 86 RR: 20 BP: 110/70 SpO_2 100

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

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

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Family History: ☑ No Abnormalities Detected

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

☐ Liver disease ☐ Other .....

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

Fall Assessment: ☐ Yes ☐ No Score ..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:

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

☐ Under Weight ☐ Diabetes Mellitus ☑ No Abnormality Detected

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

☐ Others .....

Inform consultant for positive criteria

SOCIAL SCREENING:

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

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

Social History: Lives With .....

Orientation has been given regarding the following aspects:

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

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

Above information given to ..patient..

Name of Person Orientation was given to: ..self Revathi..

Orientation not given Reason: ..self..

Nurse Signature: ..Madhu..

Nurse Name: ..Madhumitha..

Date & Time: ..2/1/26 @ 10AM..

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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: NO
   - ☐ a. Mother needs to stimulate her breast for 2 min every 2 hours

9. Additional notes: .....

Continuity of Care: Date: 22/5/24

→ Assess the pt condition
→ vital are checked & recorded
→ I/O chart maintained
→ 2nd hourly DBP given

Handover given by ..... Sujatha

Signature ..... Suj

Date & Time: 22/5/24 @ 9AM

Handover taken by .....

Signature .....

Date & Time: .....

CONSENT FOR SPECIAL PROCEDURES

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Patient Name : Mrs. Perali Renathi .... Gender: ☐ Male ☐ Female

UHID No : 4NH - 11462 .... Department : labour .... Date : 22/5

I Mrs. Perali Renathi .... S/D/W/O Mr. M Varun

Here by give consent for procedure of : labour Epidural Analgesia

For my patient, Named : - self -

The doctors have clearly explained to me that the procedure has following possible complications:

headache / hypotension / bradycardia / partial effect - epidural failure need for redo - resite

....

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :

IV analgesics / Entonox.

....

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure: Dr Sanni Vinayak

Patient Attendant :

Signature : Revathi Perali

Name : Revathi

Relationship with Patient: - self -

Date & Time : 22/5 at 445 am

Witness :

Signature : [signature]

Name : Varun

Date & Time : 22/5 at 445 am

Doctor (who is taking the consent) :

Signature : [signature]

Name : Dr Sanni Vinayak

Date & Time : 22/5 at 4am

Docu. No. : RCH /FRM / CLINICAL / 019

INFORMED CONSENT FOR VAGINAL BIRTH

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Patient Name : P. Revathi UHID No : HNH-0001162

Gender: ☐ Male ☑ Female Date : 22/05/2026 Time : .....

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. SWAPNA S

Consentee :

Signature : Revathi

Name : .....

Date & Time : 22/5/26 @ 12 Am

Patient Attendant :

Signature : Varun

Name : Varun

Relationship with Patient: Husband

Date & Time : 22/5/26 @ 12 Am

Witness :

Signature : Madhu

Name : Madhumitha

Date & Time : 22/5/26 @ 12 Am

Doctor (who is taking the consent) :

Signature : .....

Name : PRASANTHI - HV.

Date & Time : 22/05/2026 @ 12 Am

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: Mrs Perah Kenath Age: 28 Sex: female UHID.No : MNH-11462

Date: 22/5 Time: 4:15 am Proposed Operation: Epidural Analgesia

Diagnosis: Primi c̄ 38 weeks.

B.P / CRT: 103/72 H.R: 97 Weight: 67 kg. ASA Physical Status: ☐ 1 ☑ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 10.9	Glucose:	Protein:	HIV: Nil	X-Ray:
PCV: 31.3	Urea:	Alb:	HBS Ag: Nil	ECG:
WBC: 9250	Creat:	Total Bil:	HCV: Nil	2D Echo:
Plate: 1.84	Na:	Dir. Bil:	Blood group: O pos	Stress/Anglo:
PT:	K:	LDH:	T3	Other:
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH	
	Cl -:	SGOT/SGPT:		

Allergies: nknda

Medical History: CVS : /

RESP : No prior significant med. history Diabetes :

CNS : Regular ANCs done - uneventful.

Renal : /

Hepatic / GE : /

Physical Activity: good active

Others : /

Past Anaesthetic History: nil

Physical Exam: c/c

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

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

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

CURRENT MEDICATIONS	DOSAGE
Fe/Ca	

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:

Signature: [signature] Name: Dr Sami Venayak

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

Patient Sticker

ANAESTHESIA CHART

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Pre Induction Assessment:

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

H.R:	B.P / CRT:	SpO_2:	R.R:	Last Feed:

Pre-OP Diagnosis: ..... Operation: ..... Date : .....

Surgeon: ..... Anaesthesiologist: ..... Technician: .....

TIME

N,O /AIR /O, LPM

HALO /SO /SEVO

Drugs:

FIO_2 / SaO_2

$ETCO_2$

ECG

Temperature

Urine Output

Fluids

Blood

Antibiotic

Suppository

Blood Loss

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: .....
☐ Art Site: .....
☐ EKG 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: .....
OP Start: .....
OP End: .....
Leave OR: .....

Anaesthesia:
☐ GA
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP: .....
☐ ART: .....
☐ IV: .....
☐ 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: .....
☐ Spinal ☐ Epidural ☐ Caudal
Others: .....
Position: .....
Site: .....
Needle Size: ..... Depth: .....
Parasthesia ☐ Yes ☐ No
Catheter at skin ..... cm
Drug Name & Conc: .....
Bolus: .....
Infusion: .....
Block Level: .....
Comments: .....

Transportation to
☐ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☐ NA

Name of the Doctor :.....

Signature of the Doctor :.....

Patient Sticker

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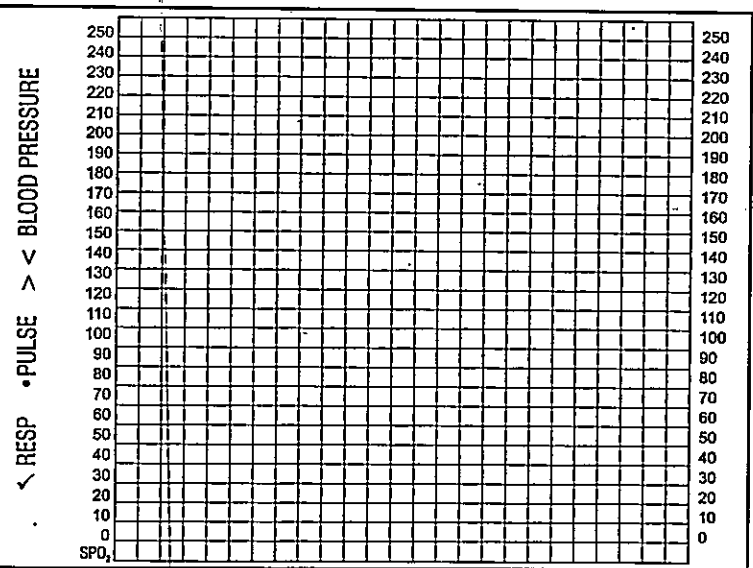
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : ..... Time Received : ..... Time Discharged : .....



IV Cannula Site : .....

☐ 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 Orat ☐ Yes ☐ No

IV Fluids: .....
Oral Feeds: .....

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature

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 : .....

Anaesthesiologist Signature: .....

Date & Time: .....

PACU Nurse Name : .....

PACU Nurse Signature: .....

Date & Time: .....

Transferred to Unit by (PACU): .....

Date & Time: .....

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: 22/5 Time: 445 am Procedure done by Dr. Ramin Gnayak

CSE /Spinal /Epidural (circled) Position : sitting Space : L3-4 Technique (LOR/LOS) (LOS circled)

Depth: 4cm Catheter at Skin: 10cm Attempts : 01

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

Solution Composition : 0.1% BUPIVACAINE + 2mcg/mL FENTANYL

Any other issues :

a)

b)

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level Left Right	Maternal BP	Maternal Pulse	FHR	Comments
450am	—	8 mL	[illegible]	107/63	93	133	0.8% Loxic ADR Signature

Delivery Details : Time : 7:32AM APGAR: 8/9 SVD (circled) / Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected : Blue Tip Seen

Patient Satisfaction : pt comfortable

Discharge /Shifting ordered by

Doctor Signature: [signature]

Doctor Name: Dr. Brinda

Date and Time : 22/5/26, 2PM

26-00002012 72

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NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name:	MRS. Perali Revathi	Age:	28y	Gender:	Female
UHID No:	HNH-0001462	IP No:	26-00006398	Date:	22.5.26 Time: 4.20 Am
Diagnosis:	NVD				

PRESCRIPTION DETAILS (Tick only one of the following)

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

Doctor Name: Dr Mmiv

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: 26-00006398 Date: 22.5.26

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

1.	Name :	Remarks
2.	Complete postal address (with contact number, if any)	2-1-564/1/a, Nallakanta Hyderabad
3.	Brief description of the illness	NA
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	NA
5.	Details of essential Narcotic drug dispensed	NA

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
22/5	Fentanyl	1		

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

Received by (Name & ID No.): Madhumita (015724) Signature:

Time: 4.3n

Docu. No: RCH / FRM / CLINICAL / 133

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26-00009019772

NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name: MRS. Perali Revathi		Age: 28Y	Gender: female
UHID No: UHI-0004162	IP No: 26-0006398	Date: 22.5.26	Time: 4.20AM
Diagnosis: NVD			

PRESCRIPTION DETAILS (Tick only one of the following)

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

Doctor Name: Dr MM IV Doctor Registration No: 67524

Signature:

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

IP Registration No: 26-0006398 **Date:** 22.5.26

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

1.	**Name :**	**Remarks**
2.	Complete postal address (with contact number, if any)	2-1-464/1Ka, Nallakunta Hyderabad
3.	Brief description of the illness	NA
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	NA
5.	Details of essential Narcotic drug dispensed	NA

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
22/5	Fentanyl	1		

Dispensed by (Name & ID No.): Savia (01844) Signature: .....

Received by (Name & ID No.): Madhumita (016724) Signature: .....

Time: 4:30