

Name	Mrs KARUNA	UHID	HNH-00011649
Father/Guardian	Mr ANKUSH BHATI	Age/Gender	23 Y 4 M 14 D/ Female
Address	Kattedan le, Hyderabad, Telangana, INDIA, 500077		
IP No	IP26-00006456	Admission Date	29-05-2026
Ref Doctor	Self.		
Discharge Date	30.05.2026		

DISCHARGE SUMMARY

Consultant:

Dr. P Priyadarshini,
MBBS, MS OBGY
63596

Diagnosis: PRIMIGRAVIDA AT 27 WEEKS WITH ? GESTATIONAL HYPERTENSION FOR OBSERVATION

History:

LMP: 21.11.2025
EDD: 28.08.2026

Obstetric formula: PRIMI
Gestation at admission: 27 weeks

Obstetric History:

G1 - Present pregnancy, Spontaneous conception.

Medical History: Nil

Name	Mrs KARUNA	UHID	HNH-00011649
IP No	IP26-00006456	Admission Date	29-05-2026

Surgical History: Nil

Family History: Father- HTN + DM

Allergies: Nil

Antenatal Details:

Mrs KARUNA was booked to Rainbow hospital at 6 weeks of gestation. She had regular antenatal checkups and investigations as advised. NT scan was normal, FTS was low risk MTAS was normal. Scan at 6 weeks showed subchorionic hemorrhage measuring 24* 6*27mm which was resolved. She was admitted at 24⁺³ weeks with complaints of lower abdominal pain, managed conservatively. Scan done on 12.05.2025 showed single live intrauterine fetus at 24⁺⁴ weeks of gestation with breech presentation, EFW: 741gm, AC: 32%, AFI: 14.9cm, placenta: posterior, high with normal dopplers. She was admitted at 27 weeks with complaints of High BP recordings at home.

Investigations: Enclosed

Blood Group : "B" positive

Management: On admission her vitals were stable, uterus was relax. PE profile sent and traced to be normal. Strict BP monitoring was done. BP recordings were within normal limits. There were no further episodes of High BP since admission. AFI/ Doppler scan was done on 30.05.2026 showed single live intrauterine fetus at 27⁺¹ weeks of gestation with cephalic presentation, AFI: 14.7cm, placenta: posterior, high with normal dopplers. Patient was hemodynamically stable and found fit for discharge.

Advice:

1. Cap. Pan-40 once daily (7am) till 06.06.2026 before breakfast.
2. Continue Antenatal medication till further advice

Name	Mrs KARUNA	UHID	HNH-00011649
IP No	IP26-00006456	Admission Date	29-05-2026

3. Tab. Zofer 4mg SOS.
4. Plenty of oral fluids.
5. Strict fetal kick count.
6. Ophthalmic Opinion

Strict BP monitoring at Home, if BP >140/90 mmHg or any complain of headache, nausea, vomiting, epigastric pain, blurring of vision, bleeding or leaking per vagina, reduced fetal movements- Report immediately to 4th floor

Review with **Dr. P PRIYADARSHINI** after 1 **week** on **06.06.2026** at Rainbow Children's Hospital with prior appointment (**Review consultation will be charged**).

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

Patient/ Attender

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

Name	Mrs KARUNA	UHID	HNH-00011649
IP No	IP26-00006456	Admission Date	29-05-2026

Manish
Registrar/Resident/C.M.O



Consultant:

Dr. P Priyadarshini,
MBBS, MS OBGY
63596

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006456 Admit Date : 29-May-2026 Admit Time : 09:25 PM UHID : HNH-00011649

Patient Details :

Patient Name	: Mrs KARUNA	Age	: 23 Y 4 M 13 D
Guardian	: Mr ANKUSH BHATI	DOB	: 16-01-2003
Gender	: Female	Religion	:
Occupation	:	Martial Status	:
Address (H)	: Kattedan le Hyderabad Telangana INDIA 500077	Phone No	: 9652470701/ 8074826148
		E-mail	: na@gmail.com

Admission Details :

Bed Type : TWIN SHARING Bed No : PPO-418 Ward Name : 4F -OT
Room No : PPO-418 Admission Type : First Visit

Contact Details :

Name : Mr ANKUSH BHATI Relationship : W/O
Contact Address : Kattedan le Hyderabad Telangana INDIA 500077 Phone No : 9652470701


Signature

Doctor Details :

Doctor Name : Dr. P PRIYADARSHINI Specialisation : OBSTETRICS AND GYNECOLOGY
Referral Doctor : Self. Phone No :
Co-Consultant :

Payment Details :

Payment Mode : DC/CC Card Deposit Amount : 20000.00
Payor Name : SELFPAY

2 2 3

2 2

2



Fetal Medicine Report

RAINBOW HOSPITAL FOR WOMEN AND CHILDREN
 3/6/234, Old MLA Quarters Rd.
 Himayatnagar, Hyderabad -500029
 T- 040-48873000
 Reg No (Under PC & PNDT Act 1994): 0116A1466/2023



SP

FetalMedicine ID:
 HNR2900086
 ViewPoint ID: 2900086
 Date 30-05-2026

Fetal Wellbeing Assessment

RAINBOW HOSP
 3/6/234, Old MLA
 Himayatnagar, Hyderabad
 Patient: Karuna Bhati DOB: 16-01-2003
 T - 040-48873000
 Exam date: 30-05-2026

Indication AFI/Doppler scan

History
 General Smoking: no. Height 154 cm, 5 ft 1 in
 History
 OB History Gravida 1

Method Transabdominal ultrasound examination, Voluson E8. View: Suboptimal view: limited by late gestational age

Pregnancy Singleton pregnancy. Number of fetuses: 1

Dating	Date	Details	Gest. age	EDD
LMP	21-11-2025		27 w + 1 d	28-08-2026
Agreed dating	based on the LMP		27 w + 1 d	28-08-2026

General Evaluation Cardiac activity present. FHR 149 bpm. Fetal movements: visualised. Presentation: cephalic
 Placenta: posterior high

Amniotic Fluid Assessment Amount of AF: normal
 AFI 14.7 cm

Fetal Doppler

Umbilical Artery:					
PI	1.17		75%	RI	0.71
Mid Cerebral Artery:					
PI	2.52		95%	PS	1.18 MoM
PS	42.00 cm/s			CPR PI	2.15
Ductus Venosus:					
A-wave		positive flow		PIV	0.73

Maternal Doppler

Right uterine artery:					
PI	0.98		74%	RI	0.58
Left uterine artery:					
PI	0.69		18%	RI	0.47
Mean PI	0.84		50%		

Comment

Rainbow Children's Medicare Limited

Please note: Detailed evaluation of fetus is difficult due to advanced gestational age and fetal position. All fetal anomalies cannot be detected by ultrasound alone. The pick up rate of abnormalities depend on gestational age of the fetus, fetal position, maternal habitus, tissue penetration of ultrasound waves and machine resolution. The results of the today's scan have been discussed with the parents. They were aware that ultrasound examination alone cannot exclude all genetic syndromes or chromosomal abnormalities. This report is not for medicolegal purposes

Impression

There is a single viable intrauterine pregnancy.

The fetus is in cephalic presentation today.

Amniotic fluid (AFI - 14.7) is normal.

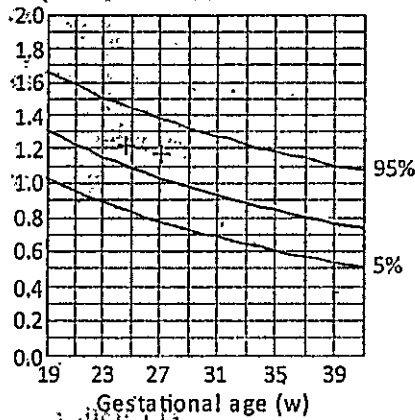
Fetal Doppler and Uterine artery Doppler are normal.

I, Dr. Mythreyi. K declare that while conducting ultrasonography / image scanning on Mrs. Karuna Bhati, I have neither detected nor disclosed the sex of her fetus to any body in any manner.

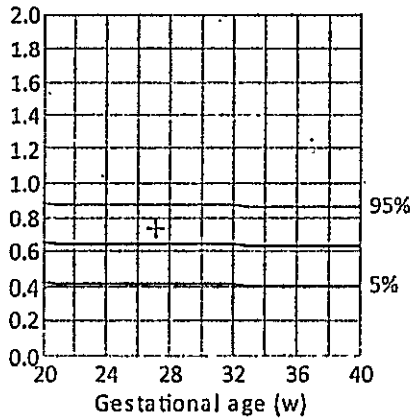
Follow-up

Follow up clinically indicated

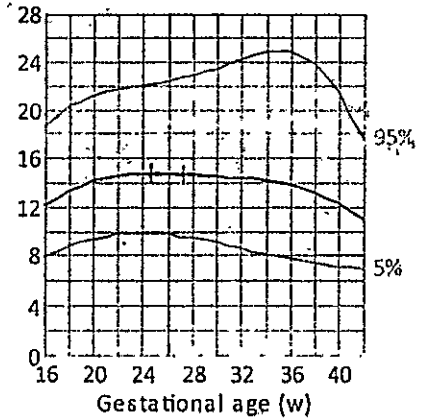
Umbilical artery pulsatility Index



Ductus ven. PIV

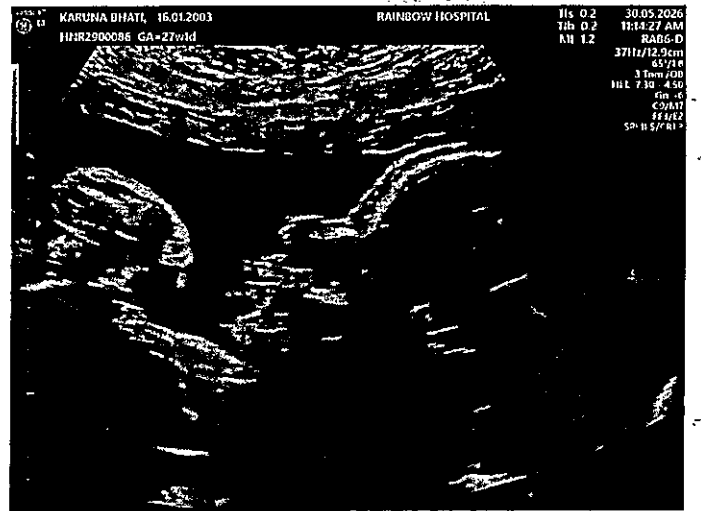
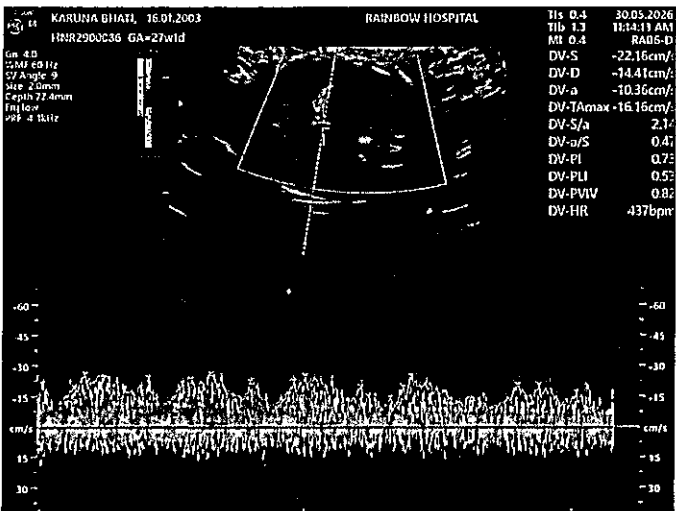
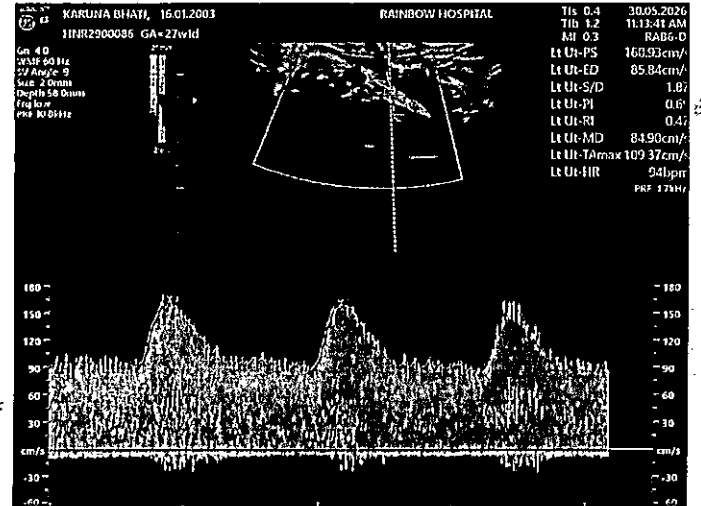
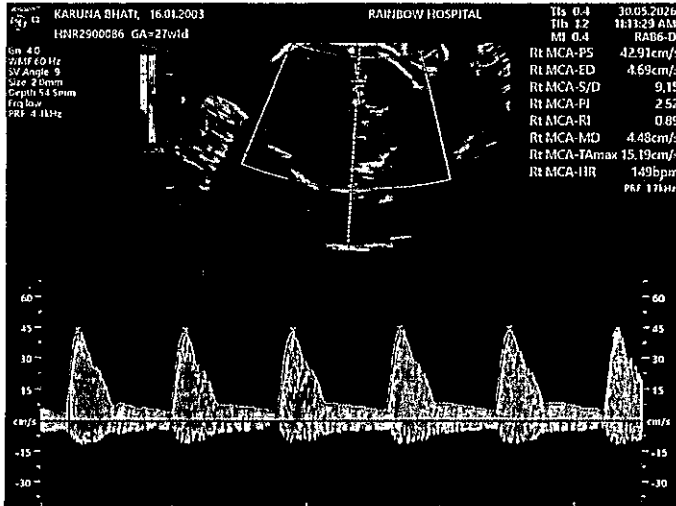


Amniotic Fluid Index (cm)



Dr. Priyadarshini P
 Referring Consultant

Dr Mythreyi K
 Performing Physician




ACTIVITY RECORD FOR BILLING

Name: -----

UHID No : ----- IP No **HNH-00011649** **IP26-00006456** t : ----- Dept : -----

Date of Admission : ----- **Mrs KARUNA** **18-01-2003** **23 Y 4 M 13 D (F)** : of Discharge : ----- Time: -----

Room / Bed No : ----- **Dr. P. PRIYADARSHINI** Suggested Billable bed type : -----



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	urine albumin	29/5/26	203015	Anhep
2.	dipstick @lurs			cross checked by AKWls
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

PROCEEDURE

Date	Procedure	Quantity	Order No.	Signature
29/5	TV placement	①	202978	R. Smith CNS check below AKC/19

ANY OTHER INFORMATION

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
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IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

clb Headache, Generalised weakness, Blurring of vision

Obstetric Formula: nausea, vomiting
 Primi ML-1-Sys - yesterday

Obstetric History: NCM
 1st - PP, Spontaneous Conception.

Present Pregnancy Record:
 NT - normal, FTS - low risk
 TIFFA - normal.

RISK FACTORS:

h/o high BP, headache, nausea & vomiting.

Height: 152 cm
 Weight: 91.4 kg
 Allergies: Nil
 Breast: Normal Abnormal
 General Examination:
 Consciousness: clc Pallor: no
 Icterus: no Edema: no
 Temp: Afebrile PR: 91bpm
 BP: 122/85mmHg DTR: (N)
 CVS: S₁, S₂ (+), normal murmurs B/L NUBS (+)
 Liver/Spleen: (N) Urine Output: adequate

LMP: 21/11/2025 EDD:
 Corrected EDD: 28/8/2026 GA: 27 wks

Menstrual History: Regular: Yes No

Obstetric Examination

Fundal Height: 26-28 wks
 Ut. Activity: Relaxed Mild Mod Severe
 Liquor: Adequate Oligo Poly
 PP: Cephalic Breech Others _____
 Head Fifths Palpable: _____
 FHS: Normal Tachy Brady Absent

Per Speculum Examination not done

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

Vaginal Examination not done

Cervix: Long Partially effaced Effaced
 Os: Closed _____ 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

Primigravida with 27 wks POG with high BP recordings for observation @ home

HNH-00011849

Mrs KARUNA

18-01-2003

Dr. P. PRIYADARSHINI

IP26-00006456

23 Y 4 M 13 D

(F)



<p>Family History:</p> <p>Father - HTN, DM</p>	<p>Surgical History:</p> <p>Nil.</p>
<p>Medical History:</p> <p>Nil</p>	<p>Medication History:</p> <p>T. IRON T. CALCIUM.</p>
<p>Plan of Care:</p> <p>Admission.</p> <p>CBP.</p> <p>LFT</p> <p>RFT</p> <p>Se-electrolytes.</p> <p>LDH</p> <p>Coagulation profile</p> <p>Urine Spot protein/ Creatinine</p> <p>CUE:</p> <p>strict FHR monitoring 4th hrly</p> <p>strict BP monitoring 2hrly</p> <p>Monitor Vitals</p> <p>Inform SOS.</p>	<p>Investigations: <u>BGT 'B Positive'</u></p> <p><u>CBP</u></p> <p>Wb - 9.3 Ht - 4.26 Hb - 13.64</p> <p>HIV HbsAg HCU VDRL } NR</p> <p><u>USG (12/05/2026)</u></p> <p>SLIUF</p> <p>Breech</p> <p>placenta - post-high</p> <p>AFI - 14.9 cm.</p> <p>AC - 32%</p> <p>EFW - 741 gm.</p>

Doctor Name: Dr. Naveena

Signature: [Signature]

Date & Time: 29/05/2026 @ 9:45 pm

Dr. P. PRIYADARSHINI
Reg. No: 63596

Consultant Name: Dr. Priyadarshini

Signature: [Signature]

Date & Time: 9:45 pm, 29/5/26



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/5/2006	CS16 @ Mornike	
9:30 AM	Priini 27+1 / 89/77W /	for observation
	Qc - For Afebrile	Adv
	BP - 108/70	- Rest in left lateral position
	PR - BS	- Daily fetal kick counts
	PIA ut 28w	- W/F vitals & FHS
	FHS ⊕	- BP monitoring q ⁴ hourly
	U/E NAD	- AF2 + Doppler scan Today
PPM ⊕		- Inform SVS
		my Armani
30/5/2006 10 AM	Priini 27+1 WMS 2 G. HTN for observation	
	O/E	6
	pt cu	
	Genfu	1. Rest in UP
	afebrile	2. DEICE
	9° / 10°	3. Monitor BP q ⁴ hourly
	P.R - 80/mt	4. follow drug chart
	B.P - 110/90	5. Inform SVS
	H/E NAD	
	PIA - ut 28w	
	FP ⊕	
	FHS ⊕ 140/mt	
	lig ⊕ locally	
	- DFR good.	
	- No S/S ⊕	
	SE.	
	Adv	
	AFI Doppler scan	
		Dr. P. PRIYADARSHINI Reg. No: 6355 30/5/2006

HNH-00011649 IP26-00006456
 Mrs KARUNA
 18-01-2003 23 Y 4 M 13 D (F)
 Dr. P PRIYADARSHINI



...GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/1/2022	Clots in Menses	
12:30 pm		
	CC For Afibrosis	Can be discharge
	Vitals Stable	Send file for Procyon
		By
		Dmanohar

HNH-00011649

Mrs KARUNA

18-01-2003

Dr. P PRIYADARSHINI

IP26-00006456

23 Y 4 M 13 D

(F)



RESULT SHEET

Date	(IP) 29/5/26				
Time					
Hb	9.3				
PCV	27.2				
RBC	3.91				
WBC	13.64				
N/L					
Platelets	426				
CRP					
ESR					
PCT					
RBS					
Na	136				
K	3.7				
Cl	106				
Ca/Mg					
Phosphate					
Urea	7				
Creatinine	0.4				
ALP	167				
SGPT	14				
SGOT	16				
T.Bill/Conj	0.3 < (C-0.1) 0.02				
T.Protein	6.5				
S.Albumin	3.3				
S.Globulin	3.2				
A/G Ratio	1				
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR	14 / 1.0				
APTT	38				
CSF Protein / Sugar					
Cells LDH	191				
N/L					

Spot protein / Creatinine Ratio

→ spot protein = 3.5
 → spot creatinine = 89.6
 → Ratio = 0.05

Date					
Time					
CUE - Alb	.				
CUE - Sugar	Nil				
CUE - Ketones	Present +++				
CUE - PUS Cells	4-6				
CUE - RBC Cells	Nil				
CUE Epithelial cells	3-5				
pH	7.0				
Specific Gravity	1.015				
PROTEIN	Nil				
Stool Pus Cell					
OVA / Cyst					
Occult Blood					
blood group	B ⁺ positive				

Culture and Sensitivities :

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Radiology : USG :

X-Ray :

ECHO :

CT :

MRI :

Others (ECG, Contrast Studies etc.,) :

HNH-00011849
 Mrs KARUNA
 18-01-2003 23 Y 4 M 13 D (F)
 Dr. P PRIYADARSHINI



MEDICATION RECONCILIATION FORM

Drug Allergies: Nil Not known any Drug Allergies

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

Shifting From: Shifted to:

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T. IRON	7TAB	PO	OD	29/5	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
2	T. CALCIUM	1TAB	PO	OD	29/5	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Naveena @
 Date & Time: 29/5/2026 @ 9:55pm
 Nurse Name & Signature: Sujatha fj
 Date & Time: 29/5/26 @ 10pm



DRUG CHART

Date of Admission: 20/5/20 Drug Allergies: None 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 Sign

REGULAR PRESCRIPTIONS

Weight. Ward.



				Date Time																
Dose	Route	Frequency	Start Date																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : T-PANTOPRAZOLE				Date Time	30/5															
Dose	Route	Frequency	Start Date																	
40mg	PO	BD	30/5	6AM																
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date Time																
Dose	Route	Frequency	Start Date																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date Time																
Dose	Route	Frequency	Start Date																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

HNH-00011849 IP26-00008456
 Mrs KARUNA
 18-01-2003 23 Y 4 M 13 D (F)
 Dr. P PRIYADARSHINI



Sheet No:

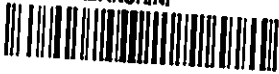
REGULAR PRESCRIPTIONS

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																					

Signature
 Name
 VERIFIED BY

HNH-00011649 IP26-00008456
 Mrs KARUNA
 18-01-2003 23 Y 4 M 13 D (F)
 Dr. P PRIYADARSHINI



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																			
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																			

VE DRY 117

HNH-00011649
 Mrs KARUNA
 18-01-2003
 Dr. P PRIYADARSHINI
 IP26-00006456
 23 Y 4 M 13 D (F)

Weight. Ward.

Date Time	Dose	Dr. Sign.	Dose	Dr. Sign.	Dose	Dr. Sign.	Dose	Dr. Sign.
DRUG :								
Route	Start Date							
Name & Signature of the Doctor								
Additional Instructions:								

Date Time	Dose	Dr. Sign.	Dose	Dr. Sign.	Dose	Dr. Sign.	Dose	Dr. Sign.
VARIABLE DOSE								
Route	Start Date							
Name & Signature of the Doctor								
Additional Instructions:								

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
29/5	9PM	T. PARACETAMOL	1000mg	PO	@	Anusha's Sujatha
29/5	9PM	INSJ. PANTOPRAZOLE	40mg	IV	@	Sujatha Anusha's
29/5	9PM	INSJ-ONDENSETRON	4mg	IV	@	Sujatha Anusha's

VERIFIED BY Name Signature

HNH-00011649

Mrs KARUNA

18-01-2003

Dr. P PRIYADARSHINI

IP26-00006456

23 Y 4 M 13 D

(F)



Warning Observation Score Chart - Obstetrics

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

Date																												
		8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7			
29/5																												
RESP (write rate in corresp. box)	> 30																											
	21 - 30																											
	11 - 20																											
	0 - 10																											
Saturations	94 - 100 %																											
	< 94 %																											
Administered O ₂ (L/min.)																												
Temp °C	40																											
	39																											
	38																											
	37																											
	36																											
	35																											
	< 35																											
Heart Rate	170																											
	160																											
	150																											
	140																											
	130																											
	120																											
	110																											
	100																											
	90																											
	80																											
	70																											
	60																											
	50																											
40																												
Systolic Blood Pressure	190																											
	180																											
	170																											
	160																											
	150																											
	140																											
	130																											
	120																											
	110																											
	100																											
	90																											
	80																											
	70																											
60																												
50																												
Diastolic Blood Pressure	130																											
	120																											
	110																											
	100																											
	90																											
	80																											
	70																											
	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																												
TOTAL ORANGE SCORES																												
Nurse Initial																												

29/5/26

4th hourly FHR

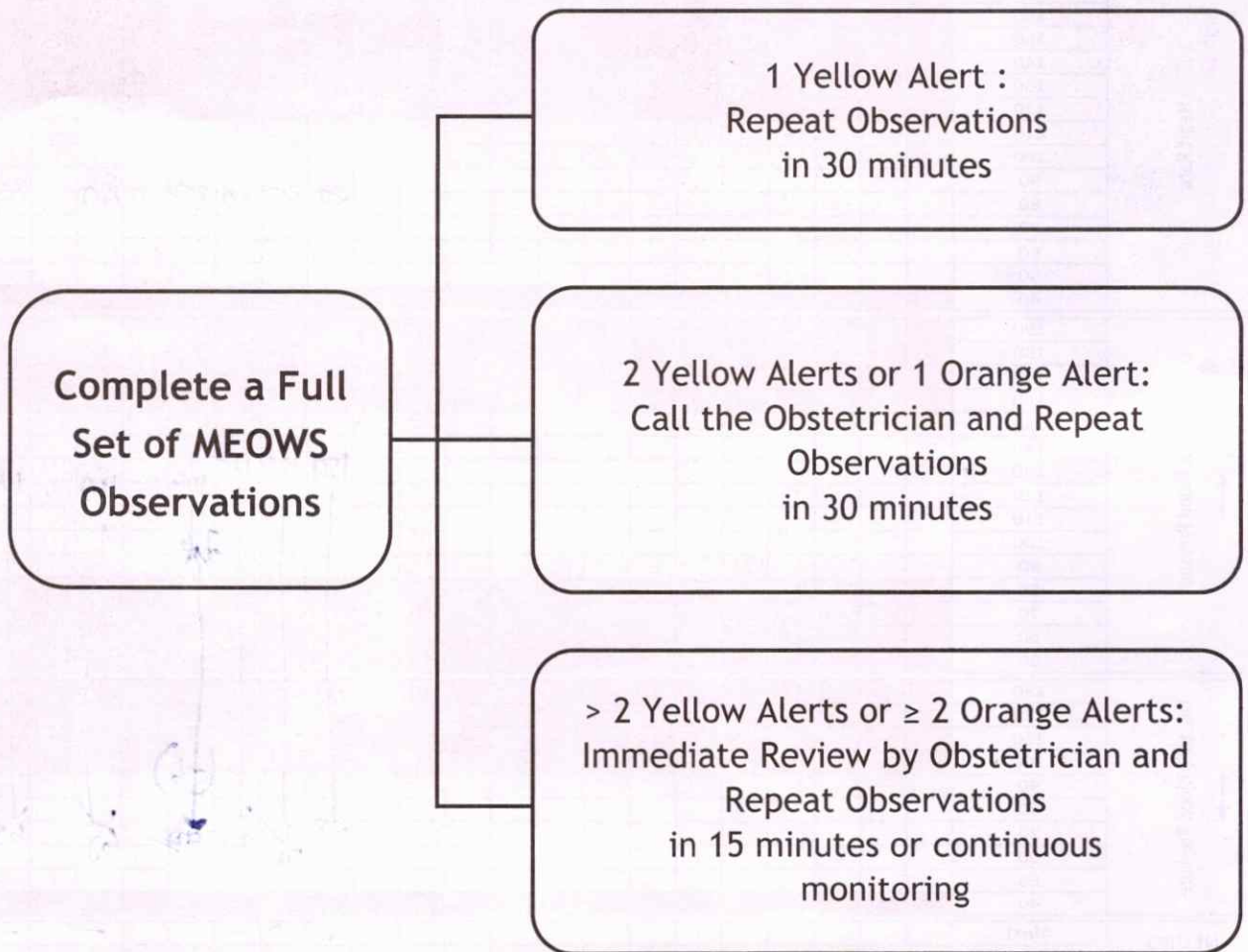
10 PM - 147 - 149

015 | 12 AM - 149 - 147

2 AM - 149 - 150

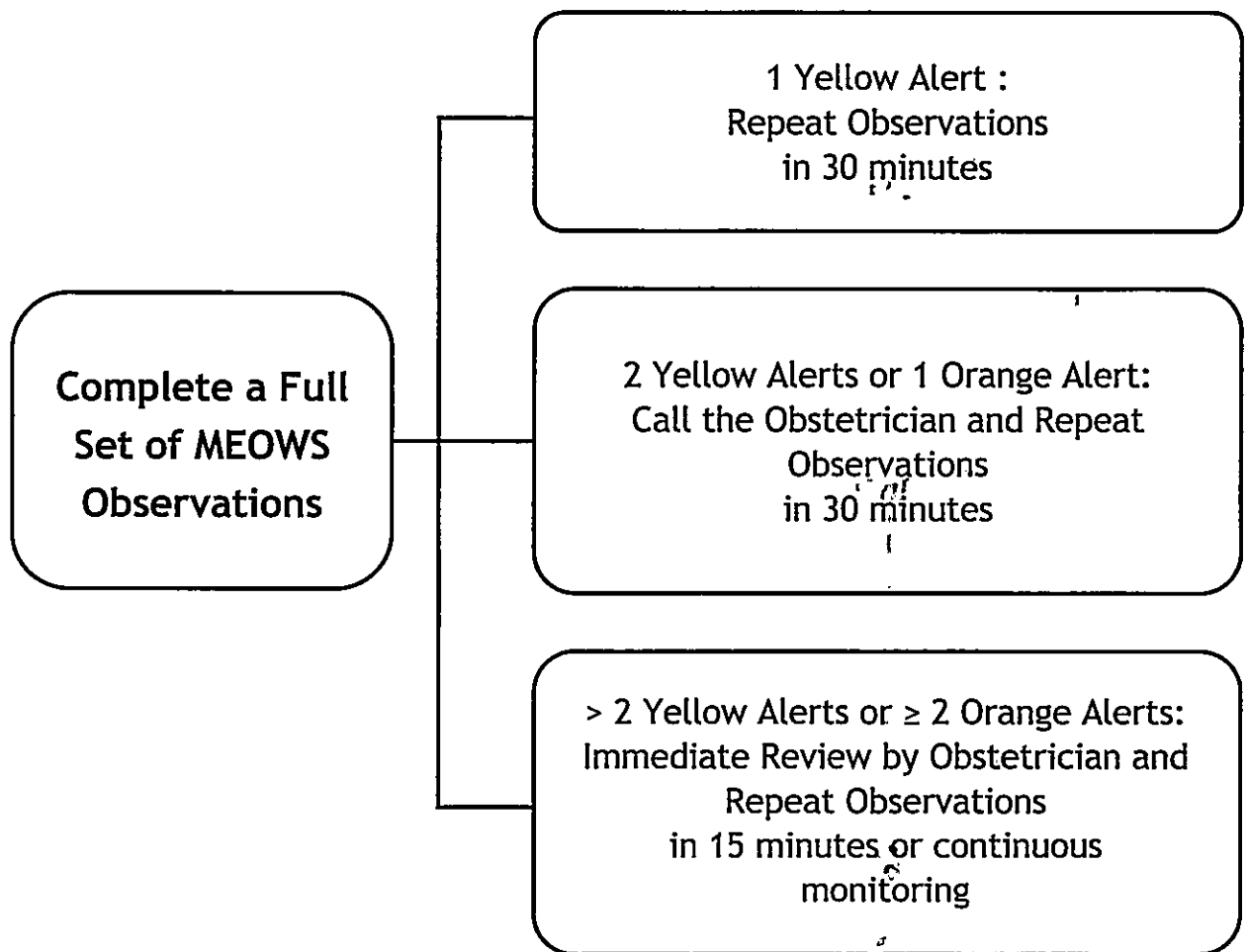
6 AM - 147 - 148

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			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	RL		100ml								
	09:00 pm	RL	Ho	100ml					✓			
	10:00 pm	RL		100ml					✓			
	11:00 pm	RL	Ho	100ml								
	12:00 am	RL		100ml								
	01:00 am	RL		100ml								
Total Intake : taken						Total Output : passed						
	02:00 am											
	03:00 am		Ho						✓			
	04:00 am											
	05:00 am		Ho						✓			
	06:00 am								✓			
	07:00 am											
Total Intake : taken						Total Output : Passed						
Total 24 hrs. Intake						Total 24 hrs. Output						

HNH-00011649 IP26-00006456
 Mrs KARUNA
 18-01-2003 23 Y 4 M 13 D (F)
 Dr. P PRIYADARSHINI



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
30/5/26 Balrak													
	08:00 am	- Blyg	-										
	09:00 am	-	-										
	10:00 am	- H2O	-										
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake : Taken						Total Output : passed							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							

HNH-00011649 IP26-00006456
 Mrs KARUNA
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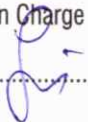
CHECKLIST FOR THROMBOPHLEBITIS

30/1

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	29/5 DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			NA	0						
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			NA	-						
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			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	-						
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	-						
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			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 : Sejatha

Signature of Ward In Charge :

Signature :  Name : Kaflmani

HNH-00011649 IP26-00006456
 Mrs KARUNA
 18-01-2003 23 Y 4 M 13 D (F)
 Dr. P PRIYADARSHINI



BRADEN 'Q' SCALE



Date : 29/5/2015
 Time : 8 PM 16

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

TOTAL SCORE

28 28

Evaluator's Name

R S Q

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

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

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Use same protocol as for "High Risk" Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors. 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

HNH-00011849
 Mrs KARUNA
 18-01-2003 23 Y 4 M 13 D (F)
 Dr. P PRIYADARSHINI

IP26-00006456



Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	29/3	30/3/26	Fall Risk Grading		
		Score	8pm	16	Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25			Low Risk	0 - 24	Standard Fall Precaution
	No	0					
Secondary Diagnosis (more than one diagnosis)	Yes	15			Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0	0	0			
Ambulatory Aid	Furniture	30			High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Crutches, Cane(S), Walker	15					
	None /Bed Rest /Nurse Assist	0	0				
IV / Heparin Lock or Saline	Yes	20	20	20	Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0					
GAIT / Transferring	Impaired	20			High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10					
	Normal /On Bed Rest /Immobile	0	0	0			
Mental Status	Forgets limitations	15			High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0					
Total Morse Fall Scale Score:			20	20			
		Signature	Pi	A			

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

HNH-00011649
 Mrs KARUNA
 18-01-2003
 Dr. P PRIYADARSHINI
 IP26-00006456
 23 Y 4 M 13 D (F)



PAIN ASSESSMENT FORM



Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
29/5	10PM	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	Lj'
29/5	2AM	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	Lj'
30/5	7AM	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	Lj'
30/5	4PM	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	@
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Re-assessment Frequency:

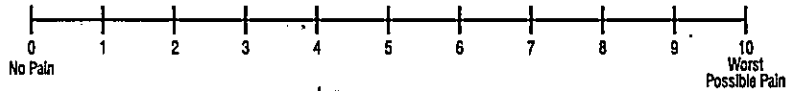
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 - a) At least every 2 hours for the first 24 hours
 - b) Then every 4 hours.
 - c) Prior to pain relieving intervention.
 - d) Within 30 – 60 minutes after pain relief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

PAIN ASSESSMENT TOOLS

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 drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, 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

Numerical Pain Scale (Obstetric and Gynecology)



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, SaO₂	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

Wong - Baker (Pediatrics) Above 7 Years



HNH-00011649 IP26-00006456
 Mrs KARUNA
 18-01-2003 23 Y 4 M 13 D (F)
 Dr. P PRIYADARSHINI



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <i>observation</i>	Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:						
	Surgery / Procedure:	Post OP Day:						
BACKGROUND	Date	<i>29/5</i>	<i>30/5/26</i>					
	Shift	<i>8PM</i>	<i>16</i>					
	Medical Condition (Any special condition to be noted):	<i>NA</i>	<i>NA</i>					
ASSESSMENT	Diet:	<i>NA</i>	<i>NA</i>					
	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	<i>NA</i>	<i>NA</i>					
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:	<i>97.8</i>	<i>98.4</i>				
		Res:	<i>20</i>	<i>20 bmt</i>				
		SpO ₂ :	<i>99.1</i>	<i>99.1</i>				
		Pulse:	<i>85</i>	<i>87 bmt</i>				
		BP:	<i>129/88</i>	<i>117/70</i>				
		LOC:	<i>-</i>	<i>-</i>				
Fall Risk Score:	<i>-</i>	<i>-</i>						
Pain Score:	<i>-</i>	<i>0/10</i>						
Skin Integrity	<i>good</i>	<i>good</i>						
Recommendations	Safety Needs:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:	<i>NA</i>	<i>-</i>					
	Others Specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Special Diet:	<i>NA</i>	<i>-</i>					
	Critical Lab Test / Values:		<i>-</i>					
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
ADL (Dependent / Non Dependent):	<i>NA</i>	<i>NA</i>						
Post Operative Procedure Special Orders:		<i>NA</i>	<i>NA</i>					
Handed Over By Name :		<i>Sujatha</i>	<i>Akhil</i>					
Signature / ID :		<i>[Signature]</i>	<i>[Signature]</i>					
Date:		<i>29/5/26</i>	<i>30/5/26</i>					
Time:		<i>8AM</i>	<i>2PM</i>					
Taken Over By Name :		<i>Akhil</i>						
Signature / ID :		<i>[Signature]</i>						
Date:		<i>30/5/26</i>						
Time:		<i>5AM</i>						

HNH-00011649
 Mrs KARUNA IP26-00006456
 18-01-2003 23 Y 4 M 13 D (F)
 Dr. P PRIYADARSHINI



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:					
	Surgery / Procedure:	Post OP Day:					
BACKGROUND	Date	/	/				
	Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Vital Signs:	Temp:					
		Res:					
		SpO ₂ :					
		Pulse:					
		BP:					
		LOC:					
		Fall Risk Score:					
	Pain Score:						
	Skin Integrity						
Recommendations	Safety Needs:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Physiotherapy:						
	Others Specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	PU Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
DVT Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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-00011649 IP26-00006456
 Mrs KARUNA
 18-01-2003 23 Y 4 M 13 D (F)
 Dr. P PRIYADARSHINI



NURSING CARE RECORD



Date: 29/5/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night	8pm To 8AM	→ Assess the pt condition → plan for vitals → plan for I/O chart → plan for medication	8pm To 8AM	→ Assessed the pt condition → vital are checked & recorded → all medication as per doctor's order	I/O chart maintained	patient is stable	Lu Sulath



NURSING CARE RECORD



Date: 30/5/20

- 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	8pm	→ Assess the pt condition → plan for vital → plan for D/Chart → plan for IV placement	8pm	→ Assessed the pt condition → vital are checked & released → IV placement done	D/Chart maintained	patient is stable	Ri Sujatha
	To 8AM		To 8AM				
Afternoon				D/C			Akw
Night							

HNH-00011649

Mrs KARUNA

16-01-2003

Dr. P PRIYADARSHINI

IP26-00006456

23 Y 4 M 13 D (F)



GENERAL CONSENT FOR TREATMENT

Patient Name: Mrs KARUNA Age : 23 Y 4 M 13 D
 IP No: IP26-00006456 Sex: Female
 Consultant: Dr. P PRIYADARSHINI Ward/Bed No: 4F -OT/PPO-418

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

Patient, be deemed advisable or necessary.

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

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

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

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

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

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

Signature of Patient/Relative:

[Signature]

Name: *Ayush Telt*

Relationship: *Bhai*

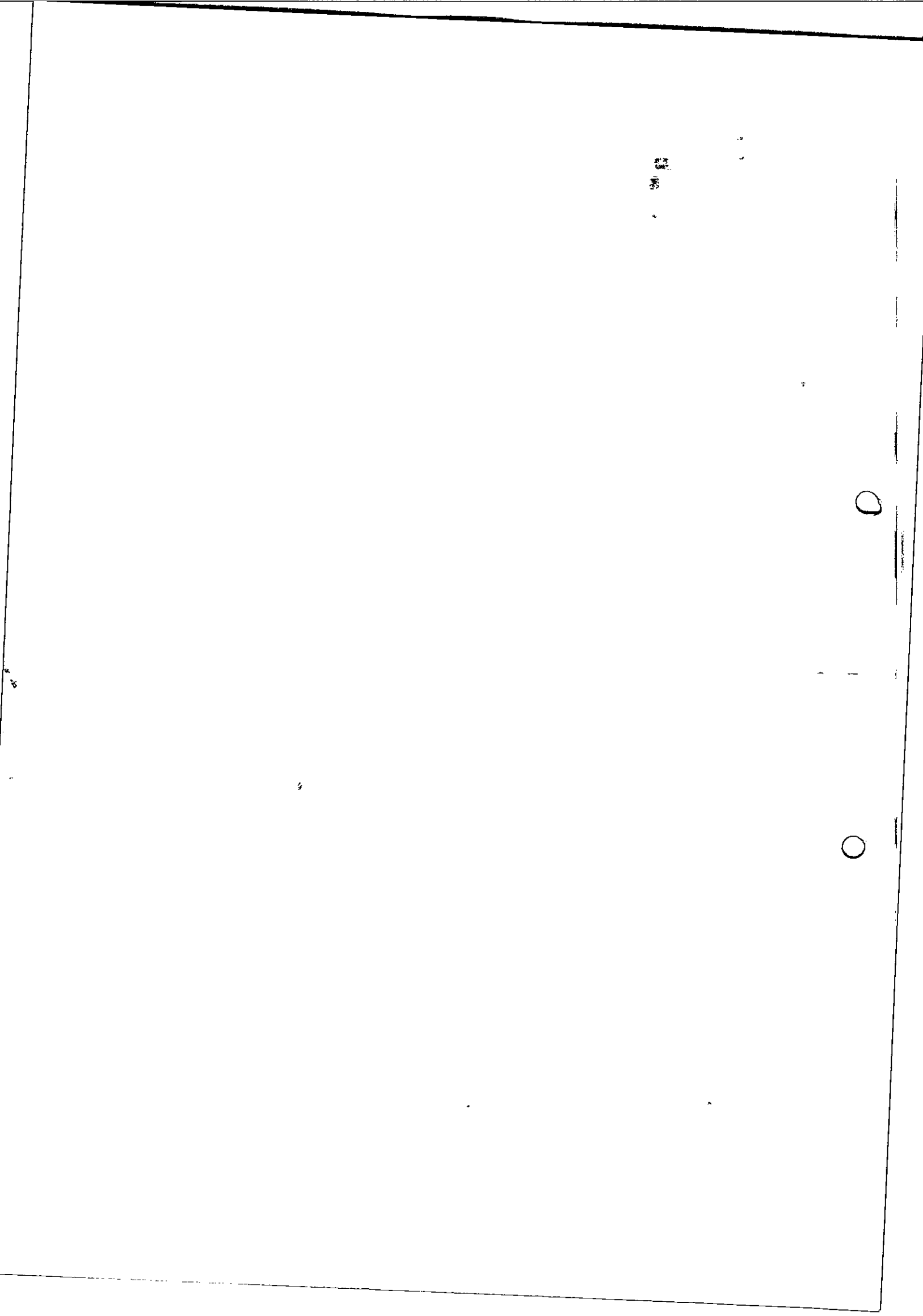
Date: *29/5/20*

Witness Name: *[Signature]*

Witness Signature: *[Signature]*

Patient Address:
 Kattedan le Hyderabad Telangana
 INDIA 500077

Time: *21:30*



HNM-00011649
Mrs KARUNA
16-01-2003
Dr. P PRIYADARSHINI
IP26-00006456
23 Y 4 M 13 D (F)

BILLING POLICY

Billing cycle: - With effective from 1st January 2020, Our billing cycle to be start from 12 PM to 12 PM, Settlement post 12 PM, room rent will be charge for half day extra & post 6 pm, it will be charge for full day. Less than 24 hours stay will be considered as one day.

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

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

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

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

MODE OF PAYMENT & REFUNDS

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

Ayush Tale
Name & signature of Patient/Attendant

RS
(Signature of Admission Desk executive)

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

RAINBOW CHILDREN'S MEDICARE PRIVATE LIMITED

Registered Office: Road No.2, Banjara hills, Near Hotel Park Hyatt, Hyderabad - 500 034, T: +91 40 2233 4455.

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

Branches : BANJARA HILLS - T: 2233 4455 | VIKRAMPURI - T: 4246 2200 | KONDAPUR - T: 4246 2400 | MADHAPUR - T: 6464 2020 | KUKATPALLY - T: 4246 2300 | L B NAGAR - T: 7111 1333 | MARATHAHALLI, BENGALURU - T: +91 80 7111 2345 | BANNERGHATTA ROAD, BENGALURU - T: +91 80 2551 2345, HIMAYATNAGAR- T:- 40 48873000

