Dr. Indira Rani

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ESTIMATION SLIP

Date : 01/7/26 **UHID / IP No. :** HNH.0000001789 **Sl No.** 1651

Name of Patient : Mrs. Soumya Sree **Age:** _____ **Gender:** F

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

Address : Andhra Mahila Sabha **Phone :** 9640918469 **Email :** _____

Procedure / Plan : Diagnostic Hysteroscopy **EDD/Dos:** July 14

MODE OF PAYMENT : ☐ **SELF** ☑ **TPA :** _____ ☐ **GIPSA :** _____ ☐ **OTHER**

TARIFF INFORMATION :

Particulars	Package Amounts (Rs.)	
Room Category	**Normal Delivery**	**LSCS**
Multi Shared Ward		
Shared Ward		
Twin Shared Ward		
Private Room	65k	Package
Super Deluxe Room		
Suite Room	+ Pharmacy & Investigation Extra	
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 :	Length of Stay for :
	Pharmacy up to	Pharmacy up to
	Investigations up to	Investigations up to
Others		

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

Initial Minimum Deposit : 20,000/- Advance Paid

REMARKS :

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.

Mr. Vivek
Signature of the Client

Husband
Signatory Relationship

Signature of the financial Counselor

HNH-00001789 IP26-00006701
Mrs SOWMYA SREE JAKSANI
18-09-1997 28 Y 9 M 15 D (F)
Dr. Y.INDIRA RANI

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SURGERY DETAILS

Date : 01-07-2026

Patient Name: Mrs. Sowmya Sree Jaksani Date of Birth: 18-09-1997 Age: 28 Yr.

Gender: Female Ward : OT UHID No.: .....

Date of Surgery: 01-07-2026 ☐ OT -1 ☑ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Diagnostic Hysteroscopy

Time in : 12:35pm Time Out : 1:10pm.

		NAME	AMOUNT
1.	Surgeon	: Dr. Y. Indira Rani	.....
2.	Anaesthetist	: Dr. Samir, Dr. Ayesha	.....
3.	Assistant Surgeon	:	.....
4.	OT Technician	: Br. Arvind	
5.	Circulating Nurse	: Sr. Natasha	
6.	Assistant Nurse	: Sr. Sandhya	

Mrs SOWMYA SREE JAKSANI (28 Y 9 M 18 D/ F)
NINV01040
HN26010736020

Special Equipment:
☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others Hysteroscopy - 26-00002097529

Signature of the Surgeon

Natasha
Signature of Circulating Nurse

Order No: 26-00002097499 Order by: Sandhya 1/7/26 @ 1:47pm

(OT record saved)

HNH-00001789 IP26-00006701
Mrs SOWMYA SREE JAKSANI
16-09-1997 28 Y 9 M 15 D (F)
Dr. Y.INDIRA RANI

Hysteroscopy

CONSUMABLES OF OT

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Circulating Staff : ..... Technician : ..... Date : 1/7/26 Time : .....

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			~~Major~~ Pack General		01	Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : A / P / N		03				Suction Catheter		
HME filter : A / P / N			TVRP		01	Feeding Tube		
Syringes : 10 cc		01				Vaccum Suction Set		
05 cc		01	Gloves S.9 6½,6	1+1		Surgical Gloves		
02 cc		01	Fr(oil 6	1		Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade			Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL		01	Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml		02	Koochies					
			Ointments					
Ryles tube 10		01	Suction Catheter					
Fentanyl		01	Cap, Mask	10 +10				
Morphine			Gauze Pack 7.5cm		2			
Ketamine			Mop Pack					
Propofol		02	Steristrip					
~~Rocuronium~~ O_2 mask (A)		01	Underpad		2			
Glycopyrolate			Draw sheet					
Myopyrolate			Abgel					
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
			Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg		~~02~~	Vaccum Suction set					
Justin : 12.5 mg / 25mg / 100mg		01	Plastic ~~Bed Sheet~~ Drapes	2				
Tab. Misoprost 200mg			Betadine Solution	1				
Naso Airway 26 Fr		01	Microshield	1				
		01	Cotton Balls	01				
			Latex Gloves	10				
			Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 26 00002097591758 Ordered by : Sandhya 1/7/26 @ 1:55pm

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

Rainbow Childrens Hospital-Himayatnagar

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

ELECTRONIC MEDICINE PRESCRIPTION

MRN	: HNH-00001789	**Name**	: Mrs SOWMYA SREE JAKSANI
Age / Sex	: 28 Y 9 M 15 D / Female	**Doctor**	: Y.INDIRA RANI
Adm/Reg Date/Time	: 01/07/2026 09:52	**Payor**	: MEDI ASSIST INSURANCE TPA PVT LTD
Order Date	: 01/07/2026 13:54	**Ordernumber**	: 26-0000209759
Visit ID	: IP26-00006701	**Ward/Bed No**	: 4F -OT / PDA-414
Patient Address	: Andhra Mahila Sabha, Hyderabad, Telangana, INDIA, 500044		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	NITRILE EXAMINATION GLOVES P F- MEDIUM		1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
2	FACE MASK 3 LAYER - ELASTIC	FACE MASK 3 LAYER	1 Nos	External / Once Daily	1 Days		10 Nos	Ordered
3	SURGEONS CAP	SURGEONS CAP	1 Cap	Oral / Once Daily	1 Days		10 Cap	Ordered

Y.INDIRA RANI

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

Note

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

*** Do not refill medicines.**

Rainbow Childrens Hospital-Himayatnagar

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040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	HNH-00001789	**Name**	. Mrs SOWMYA SREE JAKSANI
Age / Sex	28 Y 9 M 15 D / Female	**Doctor**	. Y.INDIRA RANI
Adm/Reg Date/Time	01/07/2026 09:52	**Payor**	MEDI ASSIST INSURANCE TPA PVT LTD
Order Date	: 01/07/2026 13:54	**Ordernumber**	: 26-0000209758
Visit ID	IP26-00006701	**Ward/Bed No**	: 4F -OT / PDA-414
Patient Address	: Andhra Mahila Sabha, Hyderabad, Telangana, INDIA, 500044		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	BACTOPREP SOLUTIONS 100 ML		1 mL	/ Once Daily	1 Days		1 Nos	Ordered
2	IRRIGATTO(T.U.R SET)	IRRIGATTO(T.U.R SET)	1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
3	GENERAL SURGICAL KIT (MEDITAKE)		1 Nos	/ Once Daily	1 Days		1 Nos	Ordered
4	ENCORE MICROPTIC GLOVES-6 PF		1 Nos	/ Once Daily	1 Days		1 Nos	Ordered
5	DISPOSABLE APRONS STERILE XL	DISPOSABLE APPRON STERILE XL	1 Nos	/ Once Daily	2 Days		2 Nos	Ordered
6	RL 500 ML CLOSED SYSTEM	RINGER LACTATE 500ML CLOSED	1 Bottle	/ Once Daily	1 Days		1 Bottle	Ordered
7	COTTON BALLS 2 GM 5 NOS		1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
8	SGLOVE # 6 (SURGICARE)	SURGICAL GLOVES 6.0	1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
9	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
10	GAUZE 7.5X7.5 12 PLY (5 NOS) NON XRAY	GAUZE 7.5X7.5 12 PLY 5 NOS	1 Nos	External / Once Daily	1 Days		2 Nos	Ordered
11	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
12	MCT-ROF 100MG 10ML		1 Nos	/ Once Daily	1 Days		2 Nos	Ordered
13	DSYRINGE 5ML(NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
14	E.C.G ELECTRODES (ADULT)	ELECTRODES ADULT	1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
15	JUSTIN SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
16	OxygenMask With Tubing - Adult ROMSONS-FC		1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
17	UNDERPADS 60X90 BUTTERFLY		1 Nos	External / 10 AM	1 Days		2 Nos	Ordered

Y.INDIRA RANI

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Note

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*** Do not refill medicines.**

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Name	Mrs SOWMYA SREE JAKSANI	**UHID**	HNH-00001789
Father/Guardian	Mr VIVEK VASGI	**Age/Gender**	28 Y 9 M 15 D/ Female
Address	Andhra Mahila Sabha, Hyderabad, Telangana, INDIA, 500044		
IP No	IP26-00006701	**Admission Date**	01-07-2026
Ref Doctor	Self.		
Discharge Date	01.07.2026		

DISCHARGE SUMMARY

Consultant:
Dr. INDIRA RANI Y
MBBS, DGO, DNB
700113

Diagnosis: PRIMARY INFERTILITY WITH K/C/O HYPOTHYROIDISM FOR DIAGNOSTIC HYSTEROSCOPY

DIAGNOSTIC HYSTEROSCOPY DONE ON 01.07.2026

History: Mrs Sowmya sree jaksani, presented with complain of Primary infertility with married life of 3 years. Infertility Workup showed normal hormonal profile. She underwent SSG (Saline Sonosalpingography) on 12.12.2025 which revealed normal uterine cavity, bilateral free spill with patent both fallopian tubes. Husband's Semen analysis (15.05.25) showed

Name	Mrs SOWMYA SREE JAKSANI	**UHID**	HNH-00001789
IP No	IP26-00006701	**Admission Date**	01-07-2026

Asthenoteratozoospermia. She has history of three failed IVF attempts - last attempt being at June 2026. She was admitted for Diagnostic Hysteroscopy.

Menstrual History:
LMP: 24.06.2026
Previous cycles: Regular

Obstetric History: Nulligravida

Medical History: K/c/o Hypothyroidism since 2 years- On Tab Thyronorm 50mcg OD
Family History: Nil.
Allergies:Nil
Surgical History:Nil

Investigations: Enclosed
Blood Group : " B" Positive

Surgery Notes:
Operation performed: DIAGNOSTIC HYSTEROSCOPY

Operative findings:

- cervical canal normal
- uterine cavity normal
- endometrium thick
- bilateral ostia seen

Name	Mrs SOWMYA SREE JAKSANI	**UHID**	HNH-00001789
IP No	IP26-00006701	**Admission Date**	01-07-2026

Endometrial biopsy sent for TBPCR

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

Advice:

1. Tab. Taxim O 200mg twice daily till 05.07.2026 (9am-9pm) after food.
2. Tab. Dolo 650 mg SOS (for Pain).
3. Tab Combinorm plus Once daily (2pm) x 1 week.
4. Continue Thyroid medication as before.
5. Collect TB-PCR (Endometrial biopsy) report

Review Dr. INDIRA RANI Y with TBPCR report at Gynec OPD.

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 just dial one toll free number - 18002122.You can also take appointments at any time by going online to our website **www.rainbowhospitals.in**

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Name	Mrs SOWMYA SREE JAKSANI	**UHID**	HNH-00001789
IP No	IP26-00006701	**Admission Date**	01-07-2026

Registrar/Resident/C.M.O

Consultant:
Dr. INDIRA RANI Y
MBBS, DGO, DNB
700113

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Childrens Hospital-Himayatnagar

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TEL NO :040-48873000
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006701 **Admit Date** : 01-Jul-2026 **Admit Time** : 09:52 AM **UHID** : HNH-00001789

Patient Details :

Patient Name	: Mrs SOWMYA SREE JAKSANI	**Age**	: 28 Y 9 M 15 D
Guardian	: Mr VIVEK VASGI	**DOB**	: 16-09-1997
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: Andhra Mahila Sabha Hyderabad Telangana INDIA 500044	**Phone No**	: 9640918989/ 9030344440
		E-mail	: Vivekvasgi@gmail.com

Admission Details :

Bed Type : TWIN SHARING **Bed No** : PDA-414 **Ward Name** : 4F -OT

Room No : PDA-414 **Admission Type** : First Visit

Contact Details :

Name : Mr VIVEK VASGI **Relationship** : Husband

Contact Address : **Phone No** : 9030344440

Signature

Doctor Details :

Doctor Name : Dr. Y.INDIRA RANI **Specialisation** : OBSTETRICS AND GYNECOLOGY

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

Co-Consultant :

Payment Details :

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

Payor Name : MEDI ASSIST INSURANCE TPA PVT LTD

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(1)

ACTIVITY RECORD FOR BILLING

Name : _____ HNH-00001789 IP26-00006701 _____
Mrs SOWMYA SREE JAKSANI
16-09-1997 28 Y 9 M 15 D (F)
Dr. Y.INDIRA RANI

UHID No. : _____ Consultant: _____ Dept : _____

Date of Admission: ___ Date of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
1/7/26	12:20 pm	pre-post	OT	Durga.K / Natasha
1/7/26	1.50 pm	post-OT	post-OP	Natasha / Suvatha

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
1/7/26			
1			

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
1/7/26	cardiac monitor	1:50pm	3PM	209760	ds
1/7/26	oxygen	1:50pm	3PM		

Cross checked by Swathi 1/7/26 @ 3PM

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
1/07/26	I.V placement	-1	9699	
1/07/26	PAC (OP Bays)		96-00021958	

cross checked by swintha 1/7/26 @ 3 PM

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00001789 IP26-00006701
Mrs SOWMYA SREE JAKSANI
18-09-1997 28 Y 9 M 15 D (F)
Dr. Y.INDIRA RANI

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...SION SHEET FOR GYNECOLOGY

Date of Admission : ..... Time of Admission : .....

Allergies: ..... NK ..... ☐ Not know any drug allergies

PRESENTING COMPLAINTS :

Primary Infertility

15/8/25 Hysto - Asthenoteratozoospermia (HSA)

SSG done (12/12/2015) - Ut cavity (N) ; B/L spill (+) - Tubes patent
Free flow in POS

IUI - 3 times - last attempt - June/2026

MENSTRUAL HISTORY		OBSTETRIC HISTORY	
Year of Marriage :	3yr	Parity :	NL
Previous Periods :	MM- 2-3d 28d. (Regular)	Mode of Delivery :	
LMP :	24/6/2026	Last Child Birth :	
Contraception :	(N) Flow		

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
H/o Hypothyroid : 2yr	NL

HNH-00001789 IP26-00006701
Mrs SOWMYA SREE JAKSANI
18-09-1997 28 Y 9 M 15 D (F)
Dr. Y.INDIRA RANI

NM

MEDICATION HISTORY:

T. thyronorm 50mcg od

INITIAL ASSESSMENT :

Date 1/7/2026

Ht. _____ Wt. _____

BMI (N) WNL

B.P 110/70 70/min

Pallor (-)

CVR NAD

Respiratory System BAE

Thyroid NAD

Breasts

(N)

Abdominal Examination

Soft

Local/Speculum Examination

not done

Bimanual Pelvic Examination

not done

PROVISIONAL DIAGNOSIS : Primary Infertility for Diagnostic Hysteroscopy

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT
BGT B (+)ve 24/6/26 Hb 12.2 WBC - 8.100 Plt - 3.38 HIV HBsAg HCV RPR } NR 3/11/2026 AMH - 1.290 ng/ml HbA1c - 5.5%	- NBM - Patho prepare - Informed consent - Drugs as charted - Shift to OT on call

Name of the Doctor : Dr Indira Rani

Signature of Doctor _____

Date & Time : 1/7/2026 @ 10AM

HNH-00001789 IP26-00006701
Mrs SOWMYA SREE JAKSANI
18-09-1997 28 Y 9 M 15 D (F)
Dr. Y.INDIRA RANI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
01/7/2016	C/S lb @	Mansha
1:30pm	POD-0	Diagnostic Hysteroscopy
	Qe for Afebrile	Adv
	BP: 110/68 mmHg -	NBM x 2-4h
	PR: 82 bpm. -	Drips as charted
	P/A Soft -	W/F vitals 1 BPV
	UE NAD -	Encourage to pass urine after
		regain sensation
file can be sent for.	-	Inform SW
R/ can discharge processing		
		M/s Obstetrics

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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

HNH-00001789 IP26-00006701
Mrs SOWMYA SREE JAKSANI
18-09-1997 28 Y 9 M 15 D (F)
Dr. Y.INDIRA RANI

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RESULT SHEET

Date	27/6/26					
Time						
Hb	12.2					
PCV						
RBC						
WBC	8.100					
N/L						
Platelets	3.38					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Blood group	B+ve					
HIV						
HBsAg	neg					
HCV						
VDRL						

OP BMP

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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OPERATION THEATER NOTES

HNH-00001789 IP26-00006701
Mrs SOWMYA SREE JAKSANI
18-09-1997 28 Y 9 M 15 D (F)
Dr. Y.INDIRA RANI

Patient's Name : ..... Age : 28 yrs Gender : Female

UHID.: ..... .No. : ..... Weight : .....

Surgeon : Dr Indira Rani Y	Asst. Surgeon :
Anesthetist : Dr Ayesha	OT Nurse : Sandhya

Surgical Procedure : Diagnostic Hysteroscopy

Indications for Surgery : Primary Infertility

Date : 8/1/2024	Start Time : 12:35 PM	End Time : 1:10 PM

PRE-OPERATIVE PREPARATION :

↓AAP, Parts painted & draped.
IV Antibiotics

OPERATION NOTES:

findings :-
Cervical canal Normal
Uterine Cavity Normal
Endometrium thick
B/L ostia seen

Endometrial Biopsy taken for TB PCR.

POST - OPERATIVE ORDERS :

Adv

Tab Ceftriaxone 200mg PO BD x 5d.

Tab Dolo 650 SOS

Tab Combiflam + PPI OD x 7d.

Review ☐ TBPLR Report

.....

Consultant Surgeon's Name

.....

Consultant Surgeon's Signature

Date : .....Time : .....

HNH-00001789 IP26-00006701
Mrs SOWMYA SREE JAKSANI
18-09-1997 28 Y 9 M 15 D (F)
Dr. Y.INDIRA RANI

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☐ 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						☐ 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. Dna.

Date & Time : .....

Nurse Name & Signature: ..... Karthi. K

Date & Time : 11/02/26 @ 10:00 A.M.

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

HNH-00001789 IP26-00006701
Mrs SOWMYA SREE JAKSANI
16-09-1997 28 Y 9 M 15 D (F)
Dr. Y.INDIRA RANI

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DRUG CHART

Date of Admission: 1/7/2026 Drug Allergies: NKDA ☑ ~~Not~~ known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

NURSES
- Nurses must follow strictly the FIVE RIGHTS before administration of medication.
  1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

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

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REGULAR PRESCRIPTIONS

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

DRUG : T. PARACETAMOL

Dose	Route	Frequency	Start Date
1gm	PO	TID	1/7/26

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG : T. DICLOFENAC

Dose	Route	Frequency	Start Date
50mg	P/O	BD	1/7/26

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG : T. TRAMADOL

Dose	Route	Frequency	Start Date
100mg	PO	BD	1/7/26

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
1/7	11:00AM	INJ PANTOPRAZOLE	40mg	IV		Kavhi
1/7	11:30AM	INJ METOCLOPRAMIDE	10mg	IV		Kavhi
1/7	10:15AM	INJ TT (TETANUS TOXOID)	0.5mg	IM		Kavhi
1/7	10AM	T. MISOPROSTOL	400mg	PV		Kavhi
1/7	12PM	INJ CEFOTAXIME	1g (AST)	IV		Kavhi
1/7	12:55pm	DICLOFENAC Suppository	100mg	PR		Arvind Natasha
1/7	12:55pm	TRANADOL Suppository	100mg	PR		Arvind Natasha
1/7	12:35pm	Inj. PARACETAMOL	1gm	IV		Arvind Natasha

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I.V. FLUIDS CHART

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

		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
1/07	10:10 Am	RINGER. LACTATE.	IV	100ml/hr			1/1/26		
1/7/26	12PM	RINGER LACTATE	IV	100ml/hr			1/7/26		
1/7/26	2PM	RINGER LACTATE	IV	100ml/hr			1/7/26		

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

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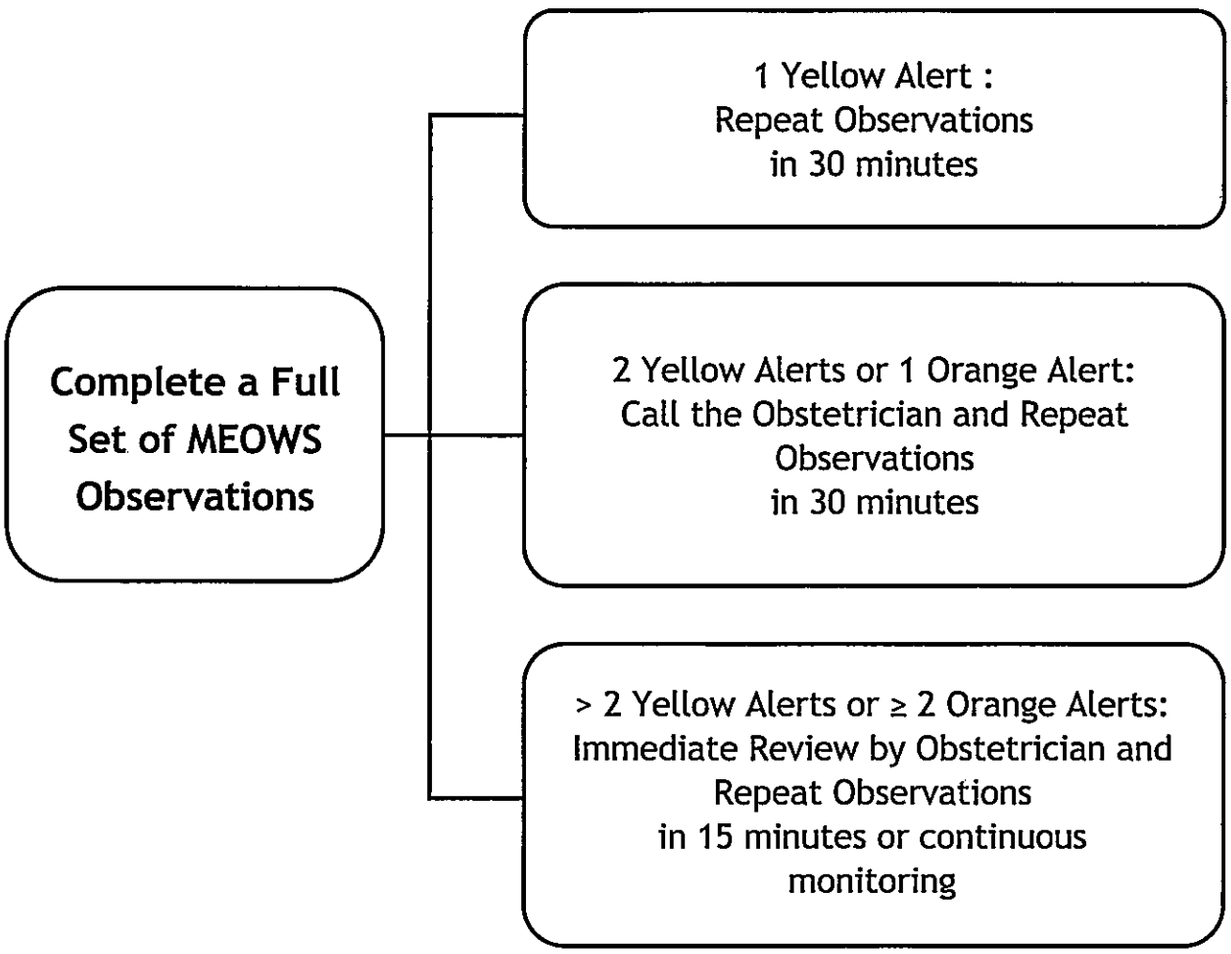
Early Warning Observation Score Chart - Obstetrics

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

11/07/24	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			18		20	20	20	20																
	0 - 10																								
Saturations	94 - 100 %																								
	< 94 %																								
Administered O2 (L/min.)																									
Temp°c	40																								
	39																								
	38																								
	37			98.8		98.6		99																	
	36																								
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80			90		80		82	80																
	70																								
	60																								
	50																								
	40																								
Systolic Blood Pressue ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120		115	120	100	110		110	112																
	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70																								
	60		60		72	67		68	65																
	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																				
TOTAL ORANGE SCORES			0		0																				
Nurse Initial																									

Obstetrics and Gynaecology Early Warning Signs



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

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FLUID CHART

Sheet No. : 1

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
9/09	08:00 am	RL		100ml						✓		
	09:00 am	RL	M	100ml								
	10:00 am	RL	B	100ml							0	
	11:00 am	RL	"	100ml						✓		
	12:00 pm	RL		100ml								
	01:00 pm	RL		100ml								
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	

Patient Sticker

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FLUID CHART

Sheet No. : .....

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

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

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

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OBSTETRICS / GYNECOLOGY
NURSING INITIAL ASSESSMENT FORM

Date of Admission: 1/02/2026

Baseline Information:

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

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

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

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

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

If yes , identify .....

Chief Complaints: .....

.....

.....

Doctor Notified on Admission: ☑ Yes ☐ No

Name of the Doctor: Dr. Durga

Time Notified: 10 AM

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

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

Gynecology Assessment: ☐ Not Applicable

Menstrual History: .....

.....

Onset of Menarche: .....

Menstrual Cycle: ☐ Regular ☐ Irregular

Last Menstrual Period: .....

Gynecology Surgical History:

Caesarean Section: ☐ No ☐ Yes

Cervical Cerclage: ☐ No ☐ Yes

Ectopic Pregnancy: ☐ No ☐ Yes

Myomectomy: ☐ No ☐ Yes

Others: _____

Gynecological History:

Contraceptives: ☐ No ☐ Yes

Vaginal Discharge: ☐ No ☐ Yes

Post-Coital Bleeding: ☐ No ☐ Yes

Infertility: ☐ No ☐ Yes

If Yes Type: ☐ Primary ☐ Secondary

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

Previous LSCS: .....

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

Family History: ☐ No Abnormalities Detected

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

☐ Liver disease ☐ Other .....

Vital Signs / Measurements: Temp: 98.1 HR: 85 RR: 20

BP: 115/75 Weight: ..... Height: ..... BMI: .....

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

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PHYSICAL ASSESSMENT

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

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

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

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

☐ Mobility problem ☐ Walking Problem ☐ No Abnormality Detected

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☐ No Abnormality Detected

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

☐ Under Weight ☐ Diabetes Mellitus ☐ Hyperemesis Gravidarum

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

☐ Others .....

Inform consultant for positive criteria

SOCIAL SCREENING:

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

Social History: Lives With .....

Orientation has been given regarding the following aspects:

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

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

Above information given to ..... Patient .....

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

Orientation not given Reason: .....

Nurse Signature: .....

Nurse Name: .....

Date & Time: ..... 1/1/2026 @ 10AM

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NURSING SHIFT HAND OVER FORM - WARD

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

SITUATION	Diagnosis: Infertility Diagnostic hysteroscopy						Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify: .....
BACKGROUND	Area / Shift Time	1/2/26 M6					
	Medical Condition (Any special condition to be noted):	–					
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.5°C					
	Res:	18bpm					
	SpO_2:	98%					
	Pulse:	72bpm					
	BP:	98/82					
	Fall Risk Score:	–					
	Pain Score:	–					
Recommendations	Safety Needs:	–					
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	–					
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	–					
Post Operative Procedure Special Orders:		–					
Handed Over By Name :		[signature]					
Signature :		[signature]					
Date:		1/2/26					
Time:		2pm					
Taken Over By Name :							
Signature :							
Date:							
Time:							

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NURSING SHIFT HAND OVER FORM - WARD

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

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

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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	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 cordpyrexia	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 : .....

Signature of Ward In Charge :

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

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CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	1/2/20		
		Score			
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		
IV / Heparin Lock or Saline	Yes	20	20		
	No	0			
GAIT / Transferring	Impaired	20	0		
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0			
Mental Status	Forgets limitations	15			
	Oriented to own ability	0			
Total Morse Fall Scale Score:			20		
		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

HNH-00001789 IP26-00006701
Mrs SOWMYA SREE JAKSANI
18-09-1997 28 Y 9 M 15 D (F)
Dr. Y.INDIRA RANI

BRADEN 'Q' SCALE

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

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

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

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16-09-1997 28 Y 9 M 15 D (F)
Dr. Y.INDIRA RANI

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PAIN ASSESSMENT FORM

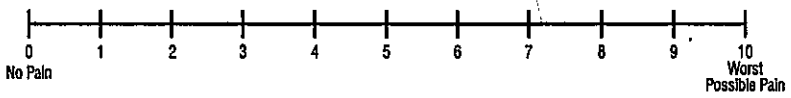
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
1/7/2026	10PM	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

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

HNH-00001789 IP26-00006701
Mrs SOWMYA SREE JAKSANI
16-09-1997 28 Y 9 M 15 D (F)
Dr. Y.INDIRA RANI

NURSING CARE RECORD

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Date: 1/7/2026

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM 2pm	→ Assess the pt condition → Check the vital's → I/O chart Maintain → plan for Pre Medication	8AM 2pm	→ Assessed pt condition → checked vital's if need → Maintained I/O chart → pre Medication done	vital's is Normal	pt is stable	Anusha
Afternoon							
Night							

Patient Sticker

NURSING CARE RECORD

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Date: .....

Goals

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

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

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : Mrs. Soumya ..... Age : 29 ..... Gender : Male ☐ Female ☑

UHID NO: KNH-1789 ..... Surgeon Name: Dr Indira Rani .....

Anaesthesiologist : Dr Sami Chayakh .....

Operative procedure planned : Diagnostic Hysteroscopy .....

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

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

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

☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure

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

☐ Incapacitating Cronic Obstructive Pulmonary Disease

☑ Others : nil specific .....

Comments : .....

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

DECLARATION BY PATIENT / GUARDIAN / PROXY

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

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

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

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

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

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

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

- Pregnant : ☐ Yes ☑ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

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

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

Patient / Patient Attendant :

Signature : Soumya.

Name : soumya

Relationship with Patient: .....

Date & Time : 1/07/26 @ 10:30 AM

Witness :

Signature : .....

Name : V. Vele Vanji

Date & Time : 1/07/26 @ 10:35 PM

Doctor (who is taking the consent) :

Signature : .....

Name : Dr Sanni Vinayak

Date & Time : 1/7 at 1.03 am.

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: Ms. Soumya Age: 29 Sex: female UHID.No :

Date: 29/5 Time: 730 pm Proposed Operation: Diagnostic hysteroscopy

Diagnosis: Primary infertility

B.P / CRT: 110/70 H.R: 70/min Weight: 86 kg ASA Physical Status: ☐1 ☐2 ☐3 ☐4 ☐5

Laboratory Data:

27/6

Hgb:	12.2	Glucose:	89	Protein:	7.1	HIV:	X-Ray:
PCV:	36.5	Urea:	20.1	Alb:	4.4	HBS Ag: NR	ECG: TH V1-V3, SR. VR=10
WBC:	8100	Creat:	0.7	Total Bill:	0.3	HCV:	2D Echo: EF-68% (N) valves.
Plate:	3.38	Na:		Dir. Bill:	0.1	Blood group: B pos.	Stress/Anglo: NO RWMA
PT:	16.5	K:		LDH:		T3	Other:
PTT:	29.6	Ca++:		Alk phos:	109	F T4 1.04	
INR:	1.22	Mg++:		Amylase:		TSH 2.77	
		Cl -:		SGOT/SGPT:			

BT - 02'05"
CT - 4'15"

Allergies: NKDA.

Medical History: CVS : NO Cardio respiratory symptoms.

RESP : pregnent viral URTIs - last episode 5 days back - asymptomatic at present.

CNS : -

Renal : -

Hepatic / GE : -

Physical Activity: NYHA-I, METS=4.

Others : hypothyroid - compliant & medication

Past Anaesthetic History: nil.

Physical Exam: coherent alert

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 : -

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

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

12AM ← 9AM

CURRENT MEDICATIONS	DOSAGE
THYROXORM	50mcg.

Pre-Operative Instructions:

7AM WATER

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: → THYROXORM TO CONTINUE

Signature: Name:

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

HNH-00001789 IP26-00006701
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ANAESTHESIA CHART

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Pre Induction Assessment:

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

H.R: 95/min | B.P / CRT: 100/55 mm Hg | SpO_2: 98/ on RA | R.R: 18/min | Last Feed: >6hrs

Pre-OP Diagnosis: PRIMARY INFERTILITY | Operation: Diagnostic hysteroscopy | Date: 1/7/26

Surgeon: Dr. Y. INDIRA RANI | Anaesthesiologist: Dr. AYESHA | Technician: Aravind

TIME	12:35	12:45	12:55	1:05	1:15
N_2O/AIR /O_2 LPM					
HALO /SO/SEVO	INJ CEFTRIAXONE 1gm IV				
Drugs:					
Inj. MIDAZOLAM 2mg IV					
Inj. FENTANYL 100mcg IV					
Inj. PROPOFOL 170mg IV					
Inj. PARACETAMOL 1gm IV					
FIO, / SaO,	100/	100/	100/	100/	100/
$ETCO_2$	34	35	37	37	37
ECG	SR	SR	SR	SR	SR
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: (Rt) VL
☐ Art Site: .....
☑ EKG Lead 3 lead
☐ Temp Site
☐ FIO_2 Monitor
☑ Agent Monitor
☑ Pulse Oximeter
☑ Capnograph
☑ Ventilator
☐ Nerve Stimulator

Position: .....
☑ Pressure Points Checked

Eye Care:
☐ Oint
☑ Tape
☐ Padding
☐ Awake

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

Times:
Anaes Start: 12:35pm
OP Start: 12:45pm
OP End: 1:05pm
Leave OR: 1:10pm

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☐ Regional

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

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

☐ Mask ☑ SGA Igel 3
☐ 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 : Dr. Ayesha
Signature of the Doctor : .....

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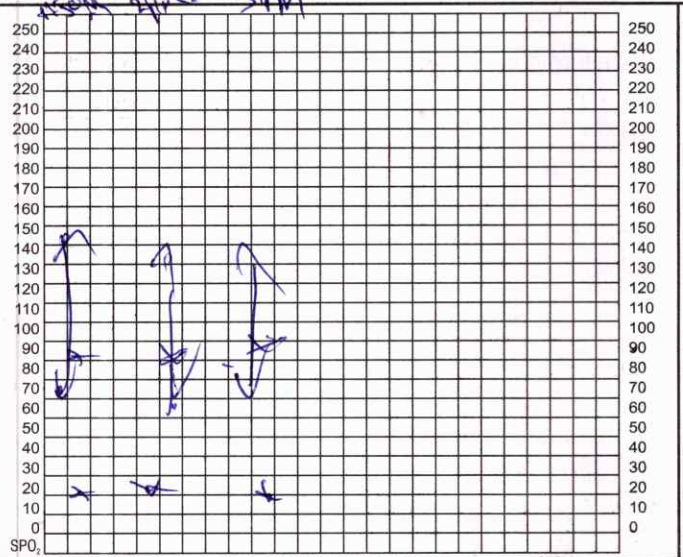
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : ..... Time Received : 1:50 pm Time Discharged : .....



IV Cannula Site : Rt
☐ O_2 Mask ☐ Nasal Prongs
☐ Tracheostomy ☐ T-Piece
☐ Oral Airway ☐ Nasal Airway

Vomiting : ☐ Yes ☑ No Drug: .....
NG Tube : ☐ Yes ☑ No
Drain: ☐ Yes ☑ No
Urinary Catheter: ☐ Yes ☑ No
Chest Tube: ☐ Yes ☑ No
Nil Oral ☐ Yes ☑ No
IV Fluids: Rt RL 80 cc/hr
Oral Feeds: NPO

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		1	2	2		A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to deep breathe & cough freely Dyspnea or limited breathing Apneic	= 2 = 1 = 0	RESPIRATION		2	2	2		
BP ± 20 of Pre Anaesthetic leve BP ± 20-50 of Pre Anaesthetic leve BP ± 50 of Pre Anaesthetic leve	= 2 = 1 = 0	CIRCULATION		2	2	2		
Fully awake Arousable on calling Not responding	= 2 = 1 = 0	CONSCIOUSNESS		2	2	2		
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0	COLOR		2	2	2		
		TOTAL		9	10	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
1/07/26 1:50 pm	1:50pm	04	Patient comfortable	
1/7	3PM	0	NA	
1/7	4PM	0	NA	
1/7	5PM	0	NA	

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

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

Anaesthesiologist Name : .....
Anaesthesiologist Signature: .....
Date & Time: .....

PACU Nurse Name : Karthik
PACU Nurse Signature: .....
Date & Time: 1/07/26 @ 1:50pm

Transferred to Unit by (PACU): .....
Date & Time: 1/7/26 @ 3 PM

HNH-00001789 IP26-00006701
Mrs SOWMYA SREE JAKSANI
16-09-1997 28 Y 9 M 15 D (F)
Dr. Y.INDIRA RANI

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Depar[illegible]ology

EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : .....

Any other issues :

a) .....

b) .....

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

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

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

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : Mrs Sowmya. Gender: ☐ Male ☑ Female Age : .....

UHID No : HNH-00001789 Date : 1/1/2026

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

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

DIAGNOSTIC HYSTEROSCOPY

upon

(Name of the Patient) Mrs Sowmya

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

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

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

Bleeding, infection, inadvertent injury to adjescent organs, failed attempt, need for further intervention

My signature on this form indicates that

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

Name of the Doctor who is performing the Surgery / Procedure: Dr Indira Rani

Consentee :

Signature : Sowmya

Name : Mrs Sowmya

Date & Time : 1/1/2026 @ 10AM

Witness :

Signature :

Name : Karthi

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

Patient Attendant :

Signature :

Name : Vivek Vasoji

Relationship with Patient: Husband

Date & Time : 1/1/2026 @ 10AM

Doctor (who is taking the consent) :

Signature :

Name : Dr Mamba

Date & Time : 1/1/2026 @ 10AM

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Indira
Asst. Surgeon :
Anaesthetist : Dr. Samir
Scrub Nurse : Sr. Sandhya

HNH-00001789 IP26-00006701
Mrs SOWMYA SREE JAKSANI
16-09-1997 28 Y 9 M 15 D (F)
Dr. Y.INDIRA RANI

Age : 28 Gender : F
ry Name :
Date : 01/07/26 In-time : 12.35 Pm Out-time : 1.10 Pm

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 12:32 Pm

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

Site Marked ☐ Yes ☐ No ☐ NA

Anaesthesia Safety Check Completed ☑ Yes ☐ No

Pulse Oximeter on Patient & Functioning ☑ Yes ☐ No

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

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

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

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

Signature : Ayesha
Name : Dr. Ayesha

Before Skin Incision ➤➤

TIME OUT Time: 12:30 Pm

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

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

Anticipated Critical Events

Surgeon Reviews:
- What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? Diagonyl Hy. 20min. 50ml ☑ Yes ☐ No ☐ NA

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

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

Signature : Natalia
Name : Natasha 1/7/26 @ 12:30 Pm

Before Patient Leaves Operating Room

SIGN OUT Time:

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

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

Signature :
Name :

OT

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00001789 IP26-00006701 Mrs SOWMYA SREE JAKSANI 18-09-1997 28 Y 9 M 15 D (F) Dr. Y.INDIRA RANI	1/7/26 @ 9.52 AM	01/07/26 @ 12:30 PM
	Transfer Ordered by: Dr. Samir	Reason for Transfer: Observation
From Unit: OT	To Unit: Pre-Post	Information to Attendant: Yes ☑ No ☐
Number of Sheets in Clinical File: 32	Number of Imaging Films: –	Personal belongings including clinical documents. If any handed over to attendant: Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sr. Natasha	Dr. Samir

Patient & Clinical Records Received by : Kaffiu 1/07/26 @ 1:51

Date & Time of Patient Received :

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

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

PATIENT TRANSFER FORM

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HNH-00001789 IP26-00006701
Mrs SOWMYA SREE JAKSANI
18-09-1997 28 Y 9 M 15 D (F)
Dr. Y.INDIRA RANI

Treating Consultant Name	Date & Time of Admission	Date & Time of Transfer Order
Dr. Indira	1/7/26 @ 9:52	1/7/26 @ 12:20pm
Transfer Ordered by	**Reason for Transfer**	
Dr. Manisha	Diagnostic hysteroscopy	
From Unit	**To Unit**	**Information to Attendant**
pre post	OT	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
3	—	Yes ☑ No ☐
		If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	PL	500ml
2.		
3.		
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
	Dr. Manisha

Patient & Clinical Records Received by : Sushmita

Date & Time of Patient Received : Sushmita 1/7/26 @ 12.20 Pm

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

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

26-0000209700

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NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name:	MRS. SOWMYA SREE JAKSANI	Age:	28Y	Gender:	FEMALE
UHID No:	FINI-00001789	IP No:	26-0000670	Date:	01/07/26 Time: 10.52 AM
Diagnosis:	HYSTUSCOPY		(Ward - OT)		

PRESCRIPTION DETAILS (Tick only one of the following)

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

Doctor Name: DSAMMY

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: 26-0000670 1

Date: 01/07/2026

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

1.	Name : MRS SOWMYASREE JAKSANI	Remarks
2.	Complete postal address (with contact number, if any)	ANDHRA MAHILA SABHA HYDERABAD
3.	Brief description of the illness	HYSTUSCOPY
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	NO
5.	Details of essential Narcotic drug dispensed	FENTANYL

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
01/07	INJ: FENTANYL	01	Sowmya.	

Dispensed by (Name & ID No.): Sania (018442) M ARVIND KUMAR (021257) Signature: Sania

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

Time: .....