

Dr. Sushilre



ESTIMATION SLIP

Date : 23/5/26 UHID / IP No. : HNH-00015573 SI No. **1533**
 Name of Patient : Mrs. Noorain Fatima Age: 27 Gender: F
 Father's / Husband's Name : _____ Corporate / Occupation : _____
 Address : A.G.S office Phone : 9700921493 Email : _____
 Procedure / Plan : _____ EDD/Dos: May-26
 MODE OF PAYMENT : SELF TPA: _____ GIPSA : _____ OTHER

TARIFF INFORMATION :

Particulars	Package Amounts (Rs.)	
	Normal Delivery	LSCS
Room Category		
Multi Shared Ward		
Shared Ward		
Twin Shared Ward <u>-></u>	<u>1.30k</u>	<u>1.40k</u>
Private Room <u>-></u>	<u>1.45k</u>	<u>1.55k</u> <u>1.45k</u>
Super Deluxe Room		
Suite Room		
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 : <u>2 Days</u>	Length of Stay for : <u>3 Days</u>
	Pharmacy up to <u>9,000/-</u>	Pharmacy up to <u>12,000/-</u>
	Investigations up to <u>2,000/-</u>	Investigations up to <u>3,000/-</u>
Others	<u>Well baby care</u>	<u>25k to 35k 15k</u>

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

Initial Minimum Deposit : 80% Advance

REMARKS : Vaccination Neonatal, SBL, BIG Vaccination 9B/1G

- 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.
- 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.
- Total baby charges are extra which include admission, pharmacy, vaccinations, investigations, disposables, consumables, equipments, speciality consultations, etc.
- 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
- 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.
- 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.
- 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
- Tariffs are subject to revision
- Kindly check your billing status on day to day basis at IP Billing Department.
- Additional Charges on package are applicable for Non-working hours and Non-working days (sundays and public holidays)

DECLARATION

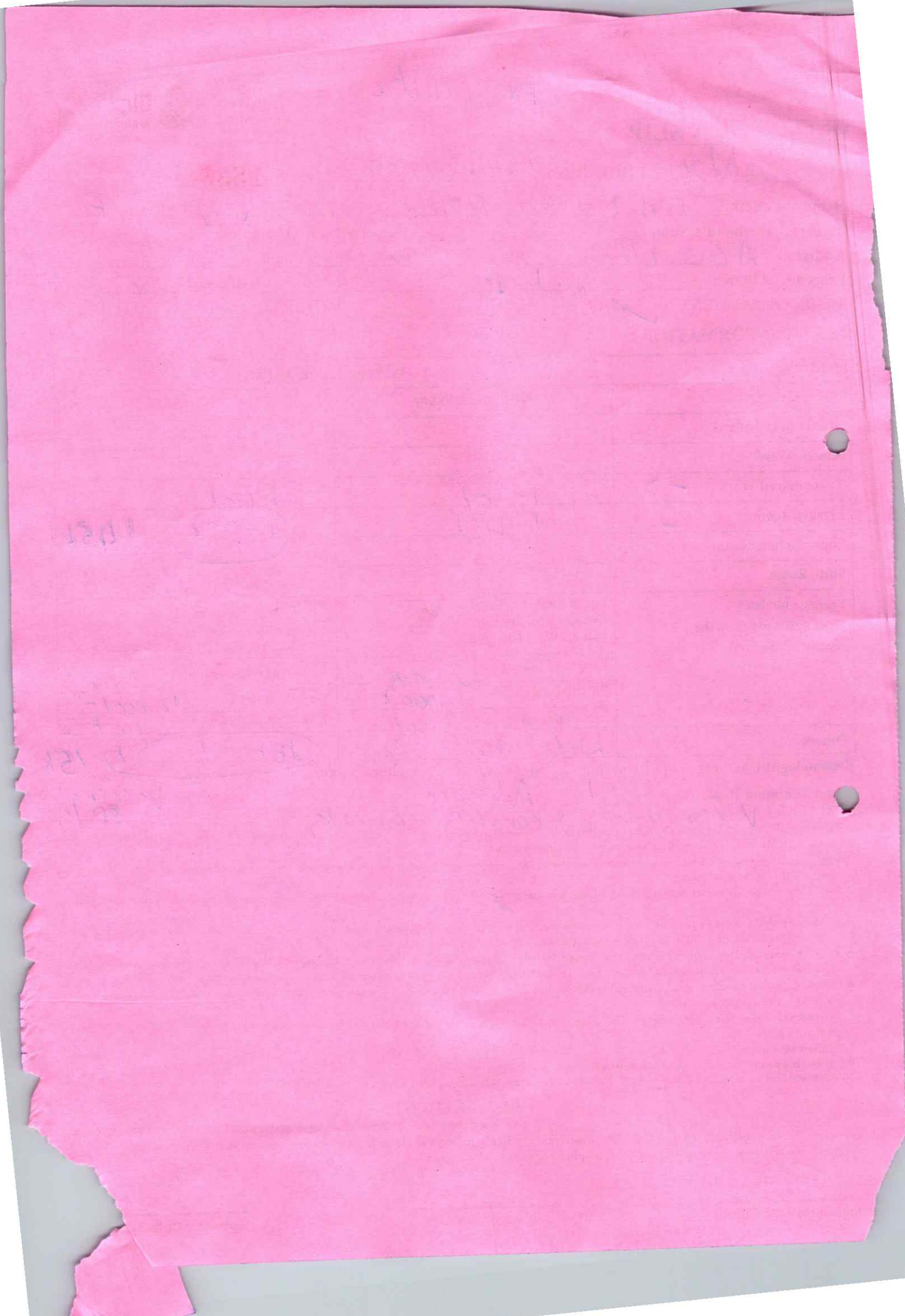
I _____ have attended the Financial counseling desk and understood the expected costs and other conditions applicable. In case the TPA / Insurance Company rejects the claim for whatsoever reasons at any point of time I promise to settle the hospital bill with the hospital without any ambiguity.

Signature of the Client

Signatory Relationship

Signature of the financial Counselor

Counselor



HNH-00015573 IP26-00006411
Mrs NOORAIN FATIMA
29-01-1999 27 Y 3 M 24 D (F)
Dr. SUCHITRA SRIRAMPUR



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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

SURGERY DETAILS

Date: 23/5/26
Patient Name: Mrs Noorain Fatima Date of Birth: 29/1/1999 Age: 27
Gender: Female Ward: OT UHID No.: HNH-00015573
Date of Surgery: 23/5/26 OT-1 OT-2 OT-3 OT-4 OBG OT-1 OBG OT-2
Name of the Surgery: Elective LSCS + BILATERAL TUBECTOMY

Time in: 12:25pm

Time Out: 1:50pm

	NAME	AMOUNT
1. Surgeon	Dr. Suchitra Srirampur	
2. Anaesthetist	Dr. Heena, Dr. S. V. S. V.	
3. Assistant Surgeon	Dr. J. V. Reddy, Dr. Ramya	
4. OT Technician	Sr. Pallavi, Sr. Saraswathi	
5. Circulating Nurse	Sr. Sudipta	
6. Assistant Nurse	Sr. Archana	

Tubectomy charges: - 26-000020657

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

Signature of the Surgeon
Suchitra

Signature of Circulating Nurse
Suchitra

Order No: 26-000020657/

Order by: *Suchitra*

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



*El. 1 set c
 B/L tubectomy*
CONSUMABLES OF OT



Circulating staff : *Sudipta* Technician : *Sr. Saraswathi* Date : *23/5/21* Time :

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube			Major Pack <i>1 set</i>	<i>1</i>	<i>1</i>	Inj Vit.K		<i>01</i>
LMA			Sutures <i>2346, 4242</i>	<i>2</i>	<i>2</i>	Cord Clamp		<i>01</i>
ECG leads <i>A/P/N</i>		<i>03</i>	<i>883, 1326</i>	<i>1</i>	<i>1</i>	Suction Catheter		
HME filter : A/P/N						Feeding Tube <i>6.0</i>		<i>01</i>
Syringes : 10 cc		<i>03</i>	<i>plastic Apron</i>	<i>4</i>	<i>4</i>	Vaccum Suction Set		
05 cc		<i>03</i>	Gloves <i>S.G 6 1/2, 7</i>	<i>3</i>	<i>11</i>	Surgical Gloves <i>7.5, 6.5</i>		<i>11</i>
02 cc		<i>03</i>	<i>encore 6 1/2</i>	<i>2</i>	<i>2</i>	Gauze Pack <i>7.5</i>		<i>02</i>
01 cc		<i>01</i>				Syringe 1ml / 2ml		<i>02</i>
Cautery plate <i>A/P/N</i>		<i>01</i>	Surgical blade <i>22</i>	<i>1</i>	<i>1</i>	Surgical Blade # 20		<i>01</i>
IV set		<i>01</i>	NG tube			Koochies (S)		<i>01</i>
RL		<i>03</i>	Cautery pencil	<i>1</i>	<i>1</i>	<i>DUO Derm</i>		<i>01</i>
NS : 10ml / 100ml / 500ml / 1000ml		<i>01</i>	Koochies <i>xxL</i>	<i>1</i>	<i>1</i>			
<i>oxytocine</i>		<i>02</i>	Ointments <i>wokadine</i>		<i>01</i>			
			Suction Catheter					
Fentanyl		<i>01</i>	Cap, Mask		<i>10+10</i>			
Morphine			Gauze Pack <i>7.5x7.5</i>	<i>3</i>	<i>3</i>			
Ketamine			Mop Pack	<i>2</i>	<i>2</i>			
Propofol			Steristrip					
Rocuronium			Underpad		<i>2</i>			
Glycopyrolate			Draw sheet					
Myopyrolate <i>Methergin</i>		<i>01</i>	Abgel					
Ondansetron		<i>01</i>	Foleys catheter					
Pencan 25g Spinal Needle 22		<i>01</i>	Urobag		<i>1</i>			
Bupivacaine 0.25%			Chest Drainage Catheter <i>(22)</i>		<i>1</i>			
Bupivacaine 0.25%(Heavy)		<i>01</i>	Romodrain bag					
Antibiotics			Bandage					
			Tegaderm					
Suppositories			loban <i>chest drain</i>		<i>2</i>			
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg		<i>01</i>	Vaccum Suction set		<i>1</i>			
Justin : 12.5 mg / 25mg / 100mg		<i>01</i>	Plastic Bed Sheet					
Tab. Misoprost : 200mg		<i>01</i>	Betadine Solution		<i>2</i>			
<i>encore glove 6.5</i>		<i>01</i>	Microshield		<i>2</i>			
<i>Gauze 7.5x7.5</i>		<i>01</i>	Cotton Balls		<i>1</i>			
			Latex Gloves		<i>20</i>			
			Ramdione Scrub					
			Saral					

Surgeon _____ Anaesthesiologist _____ Nurse _____ OT Technician _____
 Order No. : *26-0000201651/1652* Ordered by : *Sargeetha*
 Doc. No. : RCH / FRM / GENERAL / 125



ELECTRONIC MEDICINE PRESCRIPTION

MRN : HNH-00015573 Name : Mrs NOORAIN FATIMA
 Age / Sex : 27 Y 3 M 24 D / Female Doctor : SUCHITRA SRIRAMPUR
 Adm/Reg Date/Time : 23/05/2026 09:13 Payor : SELF PAY
 Order Date : 23/05/2026 14:39 Ordernumber : 26-0000201651
 Visit ID : IP26-00006411 Ward/Bed No : 4F -OT / LDR-415
 Patient Address : H.NO: 10-1-1188, A.C. GUARDS., A GS Office, Hyderabad, Telangana, INDIA, 500004

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	MOPS 30X30 8PLY 6S X-RAY	MOPS 30X308 PLYDATT	1 Nos	/ Once Daily	2 Days		2 Nos	Dispensed
2	SURGEON CAP(FEMALE) (PROTECTCARE)		1 Nos	/ Once Daily	1 Days		20 Nos	Dispensed
3	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
4	SGLOVE # 7.0(SURGICARE)	SURGICAL GLOVES 7.0	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
5	POVRANZ SOLUTION 10% 100 ML		1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
6	PROLENE 1 NW 853	PROLENE 1 NW 853	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
7	WOKADINE 10% OINT 15GM	POVIDONE IODINE 10% 15GM	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
8	VACCUME SUCTION SET	VACCUME SUCTION SET	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
9	PENCAN 25G*3 1 2	PENCAN 25G*3 1 2	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
10	VICRYL 1-0 VP 2346	VICRYL 1-0 VP 2346	1 Nos	/ Once Daily	2 Days		2 Nos	Dispensed
11	BACTOPREP SOLUTIONS 100 ML	CHLORHEXIDINE GLUCONATE2% & ALCOHOL 80% 500	1 mL	/ Once Daily	2 Days		2 Nos	Dispensed
12	CHEST DRAINAGE CATH 240-ROHMONS		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
13	BUPIVACAIN HEAVY 80MG INJ 4ML	BUPIVACAIN 80MG INJ	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
14	Encore Microptic gloves-6.5		1 Nos	/ Once Daily	1 Days		3 Nos	Dispensed
15	DSYRINGE 1ML (NIPRO)	SYRINGE 1ML	1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
16	E.C.G ELECTRODES (ADULT)	ELECTRODES ADULT	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
17	GAUZE 7.5X7.5 12 PLY (5 NOS)	GAUZE 7.5X7.5 12 PLY 5 NOS	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
18	JUSTIN SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
19	DISPOSABLE APRONS STERILE XL	DISPOSABLE APRON STERILE XL	1 Nos	/ Once Daily	4 Days		4 Nos	Dispensed
20	MONOCRYL 3-0 NW 1326	MONOCRYL 1326	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
21	METHERGIN INJ 1 ML		1 Vial	/ Once Daily	1 Days		1 Vial	Dispensed
22	DSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
23	PREGELLED SURGICAL PLATES(ADULT)	PREGELLED PLATED ADULT	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
24	RL 500 ML CLOSED SYSTEM	RINGER LACTATE 500ML CLOSED	1 Bottle	/ Once Daily	3 Days		3 Bottle	Dispensed
25	SURGICAL BLADE 22	SURGICAL BLADE 22	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
26	MISOPROST TAB 200MCG 49		1 Tabs	External / Once Daily	1 Days		4 Tabs	Dispensed
27	FACE MASK 3 LAYER- ELASTIC	FACE MASK 3 LAYER	1 Nos	/ Once Daily	20 Days		20 Nos	Dispensed
28	ONDOKRID INJ 4 MG 2 ML	ONDANSETRON 4MG 2ML INJ	1 Nos	/ Once Daily	1 Days		1 Vial	Dispensed
29	UROBAG (ADULT)- URODYNE		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
30	TRUGUT CHROMIC CATGUT SN4242	TRUGUT CHROMIC CATGUT SN4242	1 Nos	/ Once Daily	2 Days		2 Nos	Dispensed
31	GAUZE 7.5X7.5 12 PLY (5 NOS)	GAUZE 7.5X7.5 12 PLY 5 NOS	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
32	ADULT DIAPERS-XXL		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
33	LSCS DRAPE PACK (PROTECTCARE)		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed

SUCHITRA SRIRAMPUR

Reg No : HMC10563

* 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.



ELECTRONIC MEDICINE PRESCRIPTION

MRN : HNH-00015573 Name : Mrs NOORAIN FATIMA
 Age / Sex : 27 Y 3 M 24 D / Female Doctor : SUCHITRA SRIRAMPUR
 Adm/Reg Date/Time : 23/05/2026 09:13 Payor : SELFPAY
 Order Date : 23/05/2026 14:39 Ordernumber : 26-0000201652
 Visit ID : IP26-00006411 Ward/Bed No : 4F -OT / LDR-415
 Patient Address : H.NO: 10-1-1188, A.C. GUARDS., A G'S Office, Hyderabad, Telangana, INDIA, 500004

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	SUPRIDOL SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
2	BCV-INTRAFIX SAFESET		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
3	CAUTERY PENCIL (ADVANCE)	CAUTERY PENCIL (ADVANCE)	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
4	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
5	DSYRINGE 5ML.(NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
6	EVATOCIN (OXYTOCIN) INJ 5 IU 1 ML		1 Nos	/ Once Daily	7 Days		7 Vial	Dispensed
7	NS 100ML ACCULIFE - EH		1 mL	External / 10 AM	1 Days		1 mL	Dispensed
8	UNDERPADS 60X90 BUTTERFLY		1 Nos	External / 10 AM	1 Days		2 Nos	Dispensed
9	NITRILE EXAMINATION GLOVES P F - MEDIUM	NITRILE GLOVES M	1 Nos	/ Once Daily	20 Days		20 Nos	Dispensed

SUCHITRA SRIRAMPUR

Reg No : HMC10563

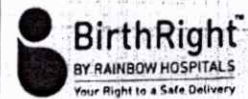
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HNH-00015573 IP26-00006411
 Mrs NOORAIN FATIMA
 29-01-1999 27 Y 3 M 26 D (F)
 Dr. SUCHITRA SRIRAMPUR



DEFICIENCY CHECK LIST OF CASE SHEET

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

305
FE

Name	Mrs NOORAIN FATIMA	UHID	HNH-00015573
Father/Guardian	Mr MIR FAHAD ALI	Age/Gender	27 Y 3 M 24 D/ Female
Address	H.NO: 10-1-1188, A.C. GUARDS., A G'S Office, Hyderabad, Telangana, INDIA, 500004		
IP No	IP26-00006411	Admission Date	23-05-2026
Ref Doctor	SELF		
Discharge Date	26.05.2026		

DISCHARGE SUMMARY

Consultant:

Dr. SUCHITRA SRIRAMPUR,
MBBS, MD (OBS & GYN)
HMC10563

Diagnosis: G4P3L3 WITH 37⁺² WEEKS PERIOD OF GESTATION WITH THREE PREVIOUS CAESAREAN SECTIONS FOR ELECTIVE LOWER SEGMENT CAESAREAN SECTION AND BILATERAL TUBECTOMY

ELECTIVE LOWER SEGMENT CAESAREAN SECTION WITH BILATERAL TUBECTOMY DONE ON 23.05.2026

History:

LMP: 04.09.2026
EDD:11.06.2026

Obstetric formula: G4P3L3

Gestation at admission: 37⁺² weeks

Name	Mrs NOORAIN FATIMA	UHID	HNH-00015573
IP No	IP26-00006411	Admission Date	23-05-2026

Obstetric History:

G1 - 2020, FT/LSCS, Female, 2.7 kg, A & H.

G2 - 2021, FT/LSCS (Indi.: Previous LSCS), Female, 4 kg, A & H,

G3 - 2024, FT/LSCS (Indi.: Previous 2 LSCS), Female, 3.5 kg, A & H.

G4- Present pregnancy, Spontaneous conception.

Medical History: Nil

Surgical History: 3 LSCS (2020,2021,2024)

Family History : Nil

Allergies : Nil

Antenatal Details:

Mrs NOORAIN FATIMA was booked to Rainbow hospital at 37⁺² weeks of gestation. She had regular antenatal checkups and investigations as advised.

NT scan was normal. FTS not done. TIFFA was normal.. Fetal growth monitoring done by serial growth scan. Growth scan done on 16.04.2026 showed SLIUF at 32 weeks with Placenta posterior upper segment, Cephalic presentation with AFI 16.9cm with EFW 2010gm, with Dopplers normal. She was admitted at 37⁺² weeks with previous 3LSCS for EL.LSCS with tubectomy.

Investigations: Enclosed.

Blood Grouping : "B Positive"

Management: Course in hospital:

At admission on clinical examination the vitals were stable, uterus was relaxed.

Name	Mrs NOORAIN FATIMA	UHID	HNH-00015573
IP No	IP26-00006411	Admission Date	23-05-2026

Fetal well being was confirmed by an admission CTG which was found to be reactive. She was prepared for elective C- section with indwelling Foley's catheter and IV canula under aseptic conditions. Written informed consent for surgery taken. Preanesthetic check up done. Anesthetic premedication (IV Pantop and Perinorm) given. Antibiotic prophylaxis with Inj. Taxim 1 gm IV given. Patient shifted to theatre.

Surgery Notes:

Under spinal anesthesia she was painted and draped as per hospital protocol. The previous scar excised. Abdomen opened in layers. The parietal and visceral peritoneum carefully opened after identifying the urachus. Bladder was reflected. A Lower segment curvilinear incision given on the uterus. Baby delivered. Cord clamped and cut and cord blood collected for blood grouping and Rh typing. Baby handed over to pediatrician. Placenta delivered with controlled cord traction. Uterus closed in layers. Hemostasis secured. Instruments and swab count checked. Rectus sheath closed. Skin closed with subcuticular sutures. Wound dressing done. Vagina cleaned with Betadine solution after expelling clots. Misoprostol 600 mcg given per rectum as prophylaxis against Postpartum hemorrhage. Patient was shifted out of theatre to post operative recovery room.

***Uterus plastered to anterior abdominal wall, sharp dissection done, abdomen entered through window creation**

***Bilateral tubectomy done by Modified Pomeroy technique**

Delivery Details:

Date : 23.05.2026

Name	Mrs NOORAIN FATIMA	UHID	HNH-00015573
IP No	IP26-00006411	Admission Date	23-05-2026

Time of Delivery :12:43 pm

Type of Delivery : Elective Lower Segment Caesarean Section with tubectomy

Indication : Previous 3 LSCS

Anaesthesia : Spinal

Baby Details:

Date : 23.05.2026

Time :12:43 pm

Sex : Male

Weight : 3.54 kg

Apgar : 8,9

Gestational Age: 37⁺² weeks

NICU Admission: No

Post-Operative Notes:

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

Advice:

Name	Mrs NOORAIN FATIMA	UHID	HNH-00015573
IP No	IP26-00006411	Admission Date	23-05-2026

1. Tab. Augmentin 625 mg twice daily till 30.05.2026 (9am-9pm) after food.
2. Tab Metronidazole 400 mg thrice daily till 30.05.2026 (9am-3pm-10pm) after food.
3. Tab. Calpol (Paracetamol 500mg) 2 tablets thrice daily till 28.05.2026 (8am-2pm-10pm) after food.
4. Tab. Voveran (Diclofenac-50mg) 1 tablet thrice daily till 28.05.2026 (9am-3pm-11pm) after food.
5. Tab. Pantodac (Pantoprazole - 40mg) 1 tablet twice daily till 30.05.2026 (7am-7pm) before food.
6. Inj Clexane 60mg (Enoxaparin) once daily (10pm) subcutaneously till 28.05.2026
7. Tab. Livogen (Elemental Iron - 50mg, folic acid 1.5mg) once daily (7am) for three months before breakfast.
8. Tab. Shelcal (Elemental Calcium 500mg, vitamin D3 250 IU) once daily (2pm) till breast feeding after food.
9. Nebasulf Powder for local application.

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

Review with **Dr. SUCHITRA SRIRAMPUR** after **10** days on **04.06.2026**

For Women Who Have Had a Caesarean Section

Name	Mrs NOORAIN FATIMA	UHID	HNH-00015573
IP No	IP26-00006411	Admission Date	23-05-2026

Care of the wound:

- 1.You can bath and shower.
- 2.The wound can get wet during a bath or shower. Dry it thoroughly and gently by dabbing with a gauze piece. Do not rub the wound.
- 3.This gauze piece needs to be discarded after one use.
- 4.Prior to touching the wound clean hands thoroughly with Microshield solution and allow them to air dry or use disposable paper napkins.
- 5.Apply Nebasulf or Neomycin dusting powder on the wound after it is dry.
- 6.Do not touch the wound with unwashed hands.

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

Patient/
Attender

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


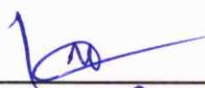
Name	Mrs NOORAIN FATIMA	UHID	HNH-00015573
IP No	IP26-00006411	Admission Date	23-05-2026

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


Registrar/Resident/C.M.O

Consultant:
Dr. SUCHITRA SRIRAMPUR,
MBBS, MD (OBS & GYN)
HMC10563

PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00015573 IP26-00006411 Mrs NOORAIN FATIMA 29-01-1999 27 Y 3 M 24 D (F) Dr. SUCHITRA SRIRAMPUR 		Date & Time of Admission 23/5/26 @ 9:13 AM	Date & Time of Transfer Order 23/5/26 @ 7:30 PM
		Transfer Ordered by Dr. Veena	Reason for Transfer Observation
From Unit pre post	To Unit Room (200) 305	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 35	Number of Imaging Films 1	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	RL-100ml/hr	1	
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Sis. Mounika 		Name of Person Ordered Transfer Dr. Veena	
Patient & Clinical Records Received by : madhuri 23/5/26 @ 7:30 PM			
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

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006411 **Admit Date :** 23-May-2026 **Admit Time :** 09:13 AM **UHID :** HNH-00015573

Patient Details :

Patient Name : Mrs NOORAIN FATIMA **Age :** 27 Y 3 M 24 D
Guardian : Mr MIR FAHAD ALI **DOB :** 29-01-1999
Gender : Female **Religion :**
Occupation : **Martial Status :**
Address (H) : H.NO: 10-1-1188, A.C. GUARDS. A G'S Office **Phone No :** 9700921493/ 7093172607
Hyderabad Telangana INDIA 500004 **E-mail :** NA@GMAIL.COM

Admission Details :

Bed Type : TWIN SHARING **Bed No :** LDR-415 **Ward Name :** 4F -OT
Room No : LDR-415 **Admission Type :** First Visit

Contact Details :

Name : Mr MIR FAHAD ALI **Relationship :** Husband
Contact Address : H.NO: 10-1-1188, A.C. GUARDS. A G'S Office **Phone No :** 9700921493
Hyderabad Telangana INDIA 500004

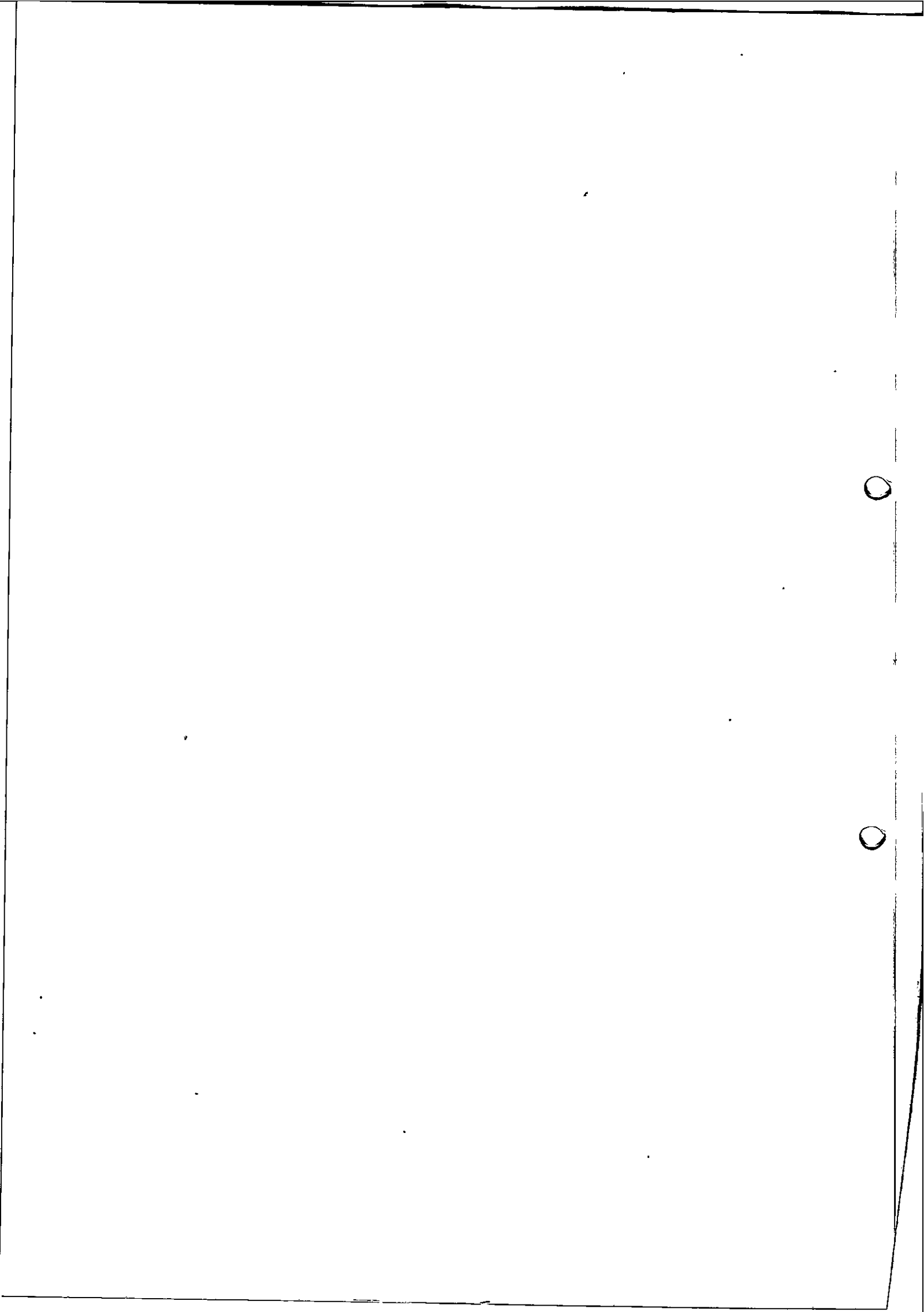
Signature

Doctor Details :

Doctor Name : Dr. SUCHITRA SRIRAMPUR **Specialisation :** OBSTETRICS AND GYNECOLOGY
Referral Doctor : SELF **Phone No :**
Co-Consultant :

Payment Details :

Deposit Amount : 40000.00
Payment Mode : DC/CC Card **Payor Name :** SELFPAY



to see

ACTIVITY RECORD FOR BILLING

Name: -----
 UHID No : -----
 Date of Admission : -----
 Room / Bed No : ----- Ward : ----- Suggested Billable bed type : -----

HNH-00015573 IP26-00006411
 Mrs NOORAIN FATIMA 27 Y 3 M 24 D (F)
 29-01-1999
 Dr. SUCHITRA SRIRAMPUR

Consultant : ----- Dept : -----
 Date of Discharge : ----- Time: -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
22/5/26	12:10 pm	Pre-post	OT	[Signature]
23/5/26	2:10 pm	OT	pre-post	[Signature]
23/5/26	2:30 PM	Pre Post	Floor	[Signature]

Cross Consultation Visit

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



IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

Admitted for ELUSCS.

Obstetric Formula:

G4P313.

Obstetric History:

I - LSCS - gyn; fch.

II - LSCS - gyn; fch

Present Pregnancy Record:

III LSCS - gyn; fch.

IV PP NT scan - (N)

RISK FACTORS:

-11FAScan - (N)

[Empty box for notes]

Height: cm

Weight: kg

Allergies:

Breast: Normal Abnormal

General Examination:

Consciousness: -

Pallor: -

Icterus: -

Edema: -

Temp: Afebr

PR: 86h

BP: 110/70 mmHg

DTR: -

CVS: S1S2 (N)

RS: Bk Atr (N)

Liver/Spleen: (N)

Urine Output: -

DIAGNOSIS

G4P313 = 3 prev LSCS = 37⁺wk. for ELUSCS.

LMP: 4/9/25

EDD: 11/6/26.

Corrected EDD:

GA: 37+2wk

Menstrual History: Regular: Yes No

Obstetric Examination

Fundal Height: ut 24.

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



<p>Family History:</p> <p>Nil</p>	<p>Surgical History:</p> <p>Nil</p>
<p>Medical History:</p> <p>Nil</p>	<p>Medication History:</p> <p>T. Mon. OD</p> <p>T. Calam OD</p>
<p>Plan of Care:</p> <ul style="list-style-type: none"> - Admissions etc. etc. - NBM - Pacts preparation. - Informed consent. - Pre op medication - Shift to OT on call. 	<p>Investigations:</p> <p><u>B+ve</u></p> <p>HIV } NR. HbsAg } VDRL }</p> <p>15/5 1207 / 10,300 / 1.61 lakh</p> <p>16/4 surf cephal PI - Put up s. lig - 16-9. Doppler (N) 32wk 2.01 kg.</p>

Doctor Name: Dr. Dna

Signature:

Date & Time: 23/5/26 9:30 AM

Consultant Name: Dr. Suchitra

Signature:

Date & Time:



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/5/26 2815 pm	cls/B Dr Dina POD-0 (P ₄ L ₄)	Adv NBM till 6hr
Up-300ml clear D/o-50cc	BP: 110/77 mmHg PR: 66/min P/A: utrw L/E - NMB	- IV fluids - Drugs as charted - Analgesics & thrombo- prophylaxis as per A&BW
		- U/o monitoring - D/o monitoring - TED STOCKINGS - Monitor vitals - Inform SAs
23/5/26 7pm	cls/B Dr. Veena POD-0 / P ₄ L ₄ Pt is stable, No clo o/e GC fair, Afebrile BP - 112/72 mmHg PR - 76 bpm SpO ₂ - 98% on RA. P/A - Ut well retracted BS (+) L/E - BWSL U/o - 100ml/hr, clear DT - 100 ml, Serous (emptied)	Adv - Oral sips f/b liquid diet (>9pm) - Drugs as charted - vital monitoring - No charting - Drain care - Ted stockings - w/o excessive bleeding P/w. - Inform SAs - Shift to room noted by Madhu @ 7:30pm

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/5/26 8am	<p>cls/B Dr. Neena</p> <p>POD-1 / P4L4</p> <p>PT is stable, Noct</p> <p>ole GC fair, Afebrile</p> <p>Vitals - stable</p> <p>n/p - OI well retracted</p> <p>BS(F), DT - 50ml; serious</p> <p>Ue - BWNL</p> <p>U/O - 100ml/hr, clear urine</p>	<p>Poley's removed @ 8am</p> <p>Adv</p> <ul style="list-style-type: none"> ✓ Soft diet ✓ Drugs as charted ✓ Vital monitoring, 2 checks ✓ Ted stockings ✓ Drain care ✓ w/o excessive bleeding ✓ Encourage to void ✓ Inform SOS
Baby @ Jms		
b f ✓		
SX		
		<p>MB Sunanda</p>
24/5/26 12:30 PM	<p>cls/B Dr. DUA</p> <p>POD-1 [P4L4 + 4LSCS]</p> <p>No complaints</p> <p>GC fair, Afebrile</p> <p>Baby + Mother BP: 112/74 mmHg</p> <p>PR: 96 bpm</p> <p>SPO2: 99% on RA</p> <p>P/A U/O - Retracted well</p> <p>Ue - Bleeding WNL</p> <p>Drain: 90 cc. serous.</p>	<p>Adv</p> <ul style="list-style-type: none"> ✓ Soft diet ✓ Drugs as charted ✓ TED stockings ✓ Drain care & ^{output} monitoring ✓ w/o excessive bleeding ✓ Monitor vitals ✓ Inform SOS
urine } passed flatus } stool }		
		<p>MB Sunanda (PT.O)</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/5/26	Drain removed. Vitals normal. ASD - tomorrow	<u>Melitta</u>
24/5/26 9pm	C/S/B Dr. Dug POD-1 [Pyloric Hcs] No complaints GC fair - Afebrile Vitals - (N) P/A Uts retracted well. N/G - NAB	Adv - Soft diet - Drugs as charted - TED Stocking - w/F Excessive bloody PV. - Monitor vitals - Infeen ses. ASD tomorrow.
Baby's Mother UV FV SV		
25/5/26 1:30AM	C/S/B Dr. Dug POD-2 No complaint GC fair Vitals - stable P/A Uts retracted well N/G NAB	Adv - Soft diet - Drugs as charted - TED Stocking - w/F Excessive bloody PV - ASD today - Monitor vitals, Infeen ses
UV FV SV		



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/05/2026 10:35am	obs by Dr Naveena	
	OLE GC - fair	Ado
	Afebrile.	- Regular diet
	PR: 91 bpm	- Adequate hydration
	BP: 114/76 mmHg.	- drugs as charted
V ✓	CUSRS: NAD.	- wlf PV bleeding
F ✓	PA: ut. retracted.	- Monitor vitals
	Soft, NT	- Ambulation
S ✓	Dressing: dry & clean	- Inform SOS
	llf: PV bleeding wnl	
	Baby: Mother side.	
	Patient can be	Dr Naveena
	discharged	

HNH-00015573 IP26-00006411
 Mrs NOORAIN FATIMA
 29-01-1999 27 Y 3 M 24 D (F)
 Dr. SUCHITRA SRIRAMPUR



Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

DRUG : Inj METRONIDAZOLE				Date Time	23/5	24/5	25/5	26/5												
Dose	Route	Frequency	Start Dt.																	
500mg	IV	TID	23/5																	
Name & Signature of the Doctor Starting the Drugs: Dr. Dina				[Signature]																
Additional Instructions: For 48 hours				[Signature]																
Daily Doctor's Endorsement by a Sign																				
DRUG : Inj PANTOPRAZOLE				Date Time	23/5	24/5	25/5	26/5												
Dose	Route	Frequency	Start Dt.																	
40mg	IV	BD	23/5																	
Name & Signature of the Doctor Starting the Drugs:				[Signature]																
Additional Instructions:				[Signature]																
Daily Doctor's Endorsement by a Sign																				
DRUG : INJ CLEXANE				Date Time	23/5	24/5	25/5	26/5												
Dose	Route	Frequency	Start Dt.																	
60mg	S.C	OD	24/5																	
Name & Signature of the Doctor Starting the Drugs: DR SHINY				[Signature]																
Additional Instructions: INJ ENOXAPARIN AT 6AM For 5 DAYS				[Signature]																
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

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

VERIFIED BY NAME

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
23/5	10 AM	IM PANTOPRAZOLE	40mg	IV	[Signature]	Sujatha A. Lati
23/5	10 AM	IM METACLOPRAMIDE	10mg	IV	[Signature]	Sujatha A. Lati
23/05	12:44 PM	INT OXYTOCIN	3U	IV	[Signature]	A Archi
23/05	1:05 PM	INT METHERGIN	0.2mg	IV	[Signature]	A Archi
23/05	1:08 PM	INT ONDANSETRON	4mg	IV	[Signature]	A Archi
23/05	1:50 PM	SUP TRAMADOL	100mg	P/R	[Signature]	A Archi
23/05	1:50 PM	SUP DICLOFENAC	100mg	P/R	[Signature]	A Archi
23/5	6 PM	INT PARACETAMOL	1g	IV	[Signature]	A Archi

VERIFIED BY: Name Signature



I.V. FLUIDS CHART

Weight: Ward:

Signature

VERIFIED BY : Name

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
23/5	9AM	RINGER LACTATE	IV	100ml/hr	[Signature]	[Signature]		[Signature]	[Signature]
23/5	12PM	RINGER LACTATE	IV	100ml/hr	[Signature]	[Signature]		[Signature]	[Signature]
23/05	12:40pm	RINGER LACTATE	IV	FF	[Signature]	[Signature]		[Signature]	[Signature]
23/05	1:00pm	RINGER LACTATE	IV	500ml/hr	[Signature]	[Signature]		[Signature]	[Signature]
23/5	4PM	RINGER LACTATE	IV	100ml/hr FF	[Signature]	[Signature]		[Signature]	[Signature]
23/5	5PM	RINGER LACTATE.	IV	100ml/hr	[Signature]	[Signature]		[Signature]	[Signature]
23/5	6PM	RINGER LACTATE	IV	100ml/hr	[Signature]	[Signature]		[Signature]	[Signature]
24/5	2am	RINGER LACTATE	IV	100ml/hr	[Signature]	[Signature]		[Signature]	[Signature]
24/5	7am	RINGER LACTATE	IV	100ml/hr	[Signature]	[Signature]		[Signature]	[Signature]
		STOP			[Signature]				



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	Tab Teon	1tab	PO	OD		<input type="checkbox"/> C <input type="checkbox"/> DC
2	Tab Calcium	1tab	PO	OD		<input 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. Ana

Date & Time: 23/5/26 9:30 AM

Nurse Name & Signature: Sujatha

Date & Time: 23/5/26 @ 10 AM

HNH-00015573 IP26-00006411
Mrs NOORAIN FATIMA
29-01-1999 27 Y 3 M 24 D (F)
Dr. SUCHITRA SRIRAMPUR



305



RESULT SHEET

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

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Blood grouping	B positive					
HLV	} NR					
HBSAg						
HCV						

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

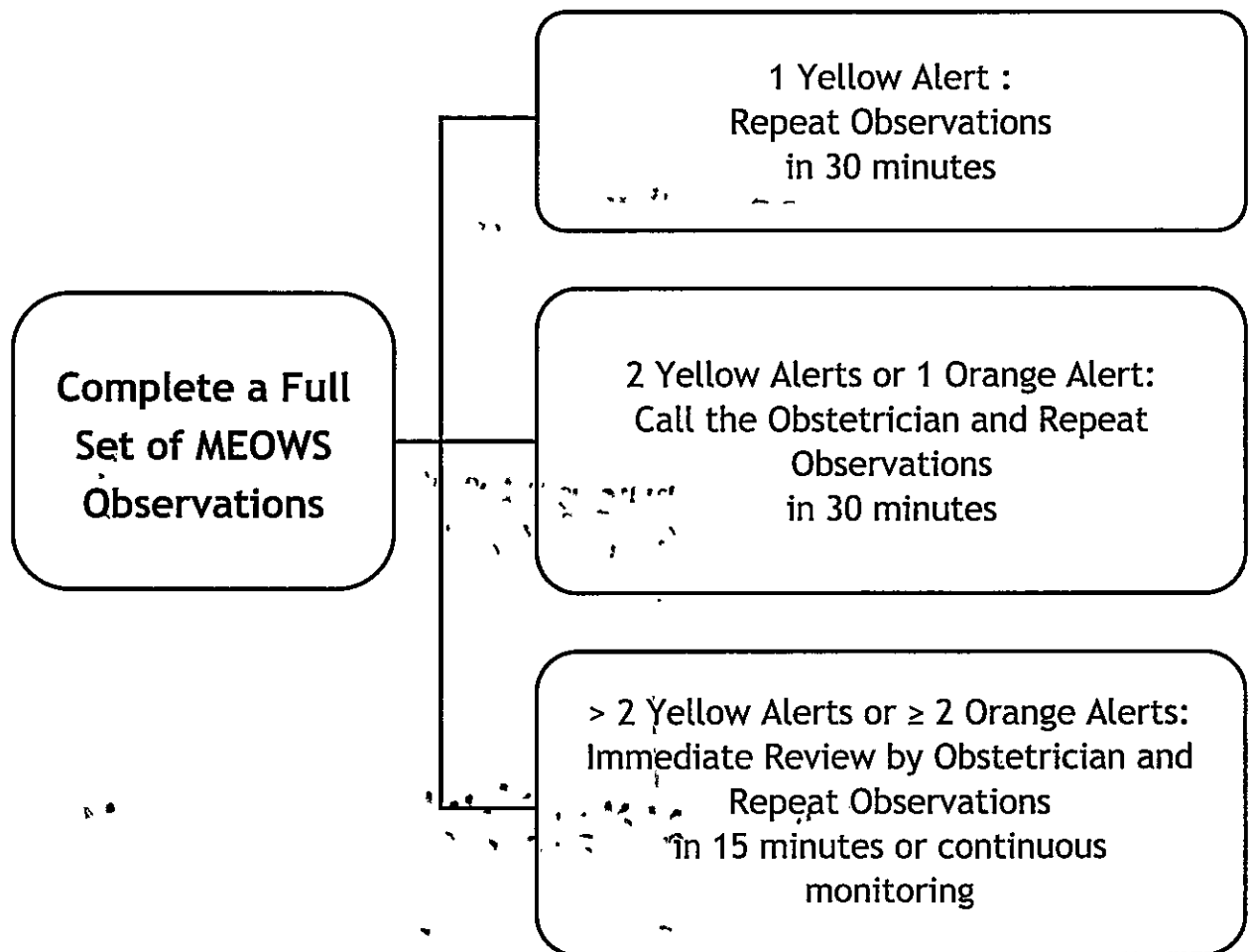
 ECHO :

 CT :

 MRI :

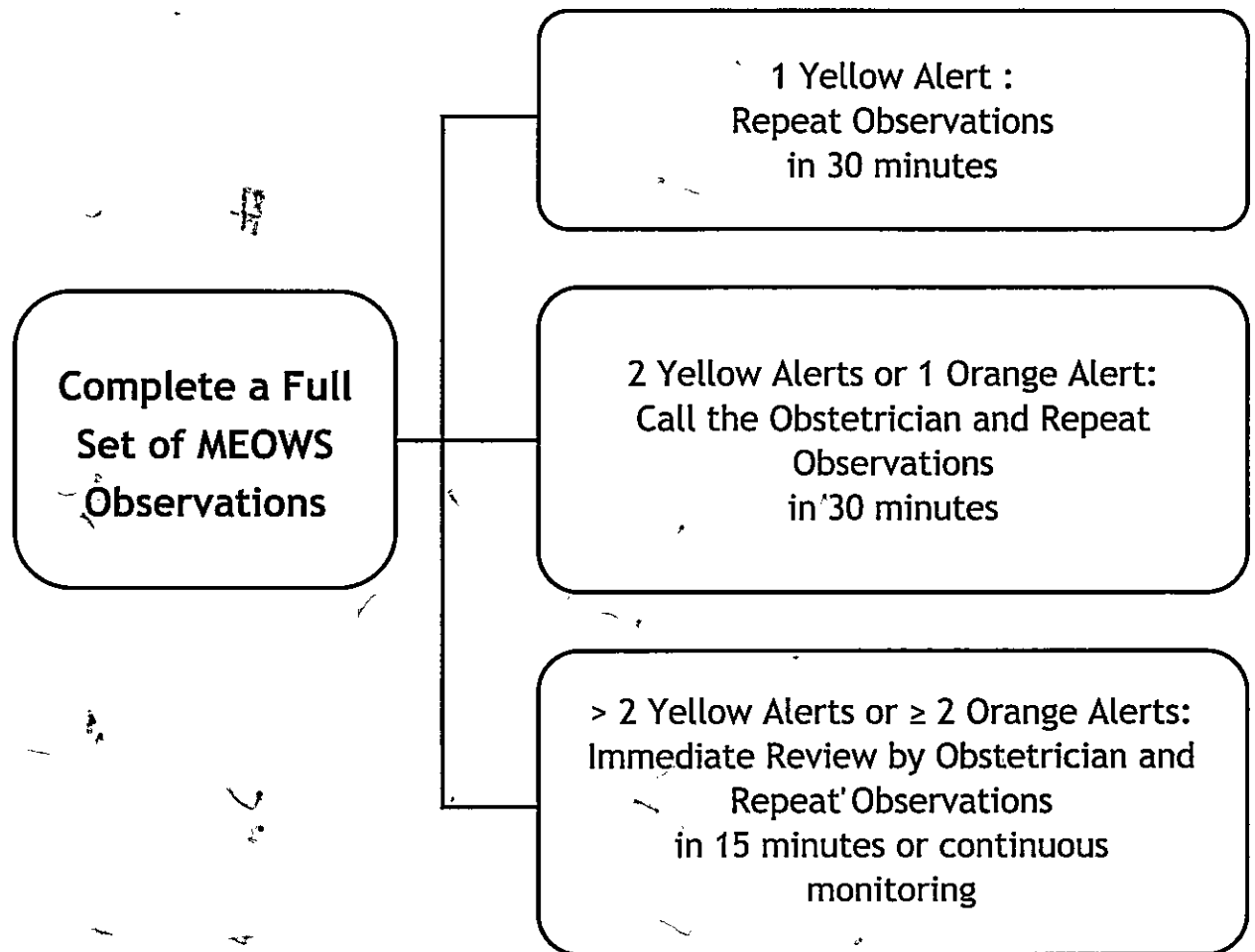
 Others (ECG, Contrast Studies etc.) :

Obstetrics and Gynaecology Early Warning Signs



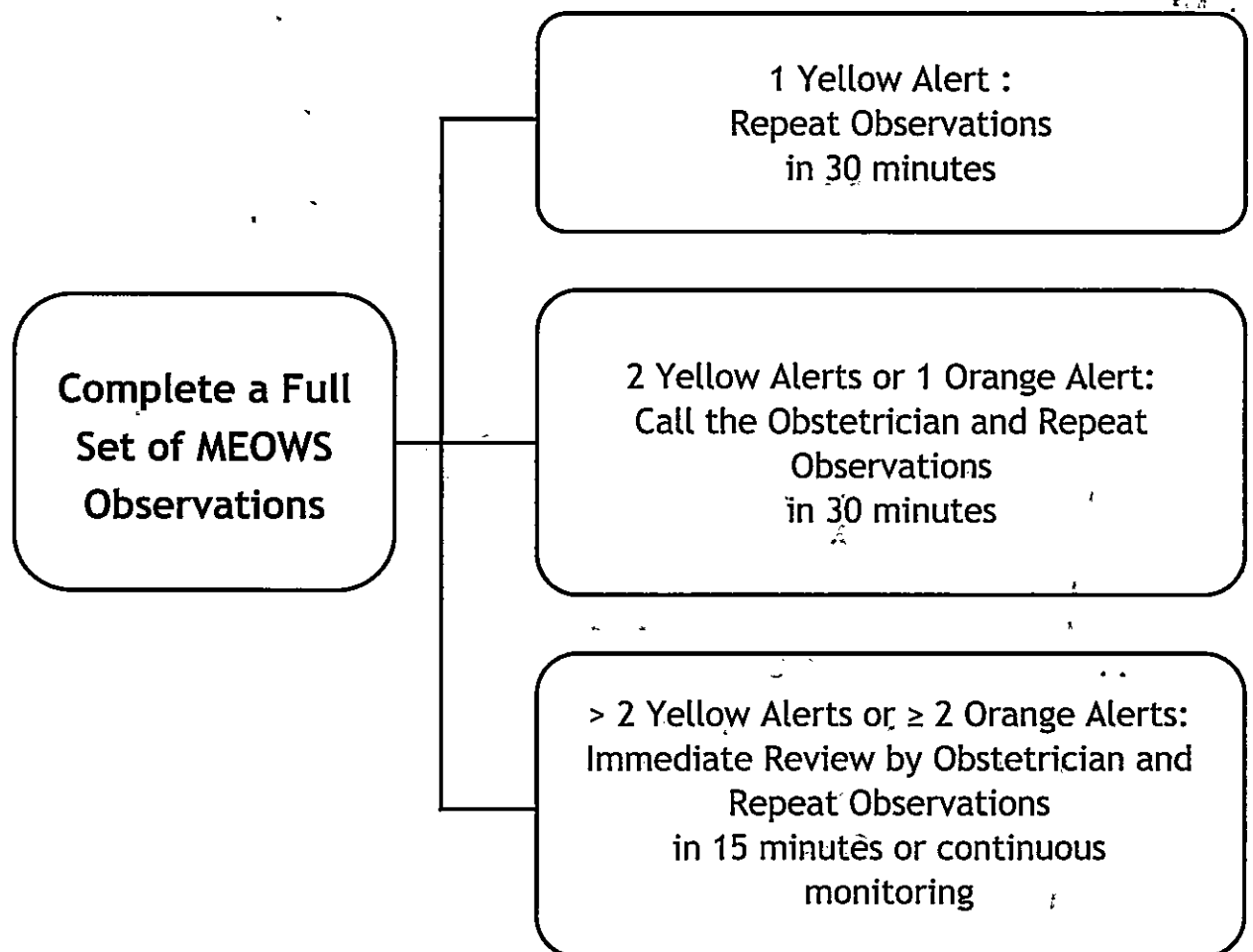
* The Modified Early Warning Score (MEOWS)

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

Date	Time	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
	08:00 am	RL		100ml	-	-	-	-	-	-	-	-
	09:00 am	RL		100ml	-	-	-	-	-	-	-	-
	10:00 am	RL		100ml	-	-	-	-	-	-	-	-
	11:00 am	RL		100ml	-	-	-	-	-	-	-	-
	12:00 pm	RL		100ml	-	-	-	-	-	-	-	-
	01:00 pm	RL		100ml	-	-	-	-	-	-	-	-
Total Intake :					Total Output :							
	02:00 pm	RL	NBM	100ml	-	-	-	-	-	200ml	-	-
	03:00 pm	RL	NBM	100ml	-	-	-	-	-	-	-	-
	04:00 pm	RL	NBM	100ml	-	-	-	-	-	-	-	-
	05:00 pm	RL	NBM	100ml	-	-	-	-	-	150ml	-	-
	06:00 pm	RL		100ml	-	-	-	-	-	-	-	-
	07:00 pm	RL	SIPS	500ml	-	-	-	-	-	100ml	100ml	-
Total Intake :					Total Output :							
	08:00 pm	RL		100ml	-	-	-	-	-	-	-	-
	09:00 pm	RL		100ml	-	-	-	-	-	-	-	-
	10:00 pm	RL	coco- nut water	100ml	-	-	-	-	-	-	-	-
	11:00 pm	RL		100ml	-	-	-	-	-	400ml	-	-
	12:00 am	RL		100ml	-	-	-	-	-	-	-	-
	01:00 am	RL		100ml	-	-	-	-	-	-	-	-
Total Intake :					Total Output :							
	02:00 am	RL	SOP	100ml	-	-	-	-	-	-	-	-
	03:00 am	RL		100ml	-	-	-	-	-	-	-	-
	04:00 am	RL	H ₂ O	100ml	-	-	-	-	-	-	-	-
	05:00 am	RL		100ml	-	-	-	-	-	-	-	-
	06:00 am	RL		100ml	-	-	-	-	-	1000ml	-	-
	07:00 am	RL		100ml	-	-	-	-	-	-	-	-
Total Intake :					Total Output :							

Total 24 hrs. Intake 2400 ml

Total 24 hrs. Output 2450 ml



FLUID CHART

Sheet No. :

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

Date	Time	Intake				Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
24/5/20			Mouth	I.V	N.G								
	08:00 am												
	09:00 am	o	Jelly										
	10:00 am	o	H ₂ O										
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
24/5/20	02:00 pm												
	03:00 pm	o	Jelly										
	04:00 pm	o	Chick										
	05:00 pm												
	06:00 pm												
	07:00 pm												
	Total Intake :						Total Output :						
24/5/20	08:00 pm												
	09:00 pm	o	Mashed										
	10:00 pm	o	H ₂ O										
	11:00 pm												
	12:00 am												
	01:00 am												
	Total Intake :						Total Output :						
25/5/20	02:00 am												
	03:00 am												
	04:00 am	o	H ₂ O										
	05:00 am												
	06:00 am												
	07:00 am												
	Total Intake :						Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output

Patient Sticker



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	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	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	
-----------------------------	--



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	0	0	0	0	0	0	0		
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	0	0	0	NA	NA	NA	NA	NA		
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	0	0	0	NA	NA	NA	NA	NA		
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	0	0	0	NA	NA	NA	NA	NA		
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	0	0	0	NA	NA	NA	NA	NA		
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	0	0	0	NA	NA	NA	NA	NA		
Signature of the Nurse				<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>		

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 : *[Signature]* Name : *[Signature]*

Signature of Ward In Charge :

Signature : *[Signature]* Name : *[Signature]*

HNH-00015573 IP26-00006411
 Mrs NOORAIN FATIMA
 29-01-1999 27 Y 3 M 24 D (F)

Dr. SUCHITRA SRIRAMPUR

BRADEN 'Q' SCALE



Date : 23/5/2015 23/5/2015 24/5/2015
 Time : 8 AM 12 PM 11 AM 12 PM

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	3	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	3	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	3	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	2	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	2	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4

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

TOTAL SCORE	28	28	17	28
Evaluator's Name	Fj	Q	Q	Q

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



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
23/5/26	6PM	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	
24/5/26	10AM	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	
24/5/26	2pm	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	
24/5/26	10pm	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	
25/5/26	8AM	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:

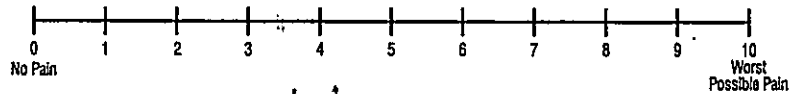
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 - a) At least every 2 hours for the first 24 hours
 - b) Then every 4 hours.
 - c) Prior to pain pain-relieving intervention.
 - d) Within 30 – 60 minutes after pain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

Wong - Baker (Pediatrics) Above 7 Years



0
No Hurt

2
Hurts Little Bit

4
Hurts Little More

6
Even More

8
Hurts Whole Lot

10
Hurts Worst



URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 23/5

Date of Removal: 24/5/2020 8AM

Parameters	Date		23/5		23/5		23/5		24/5	
		Shift Time	RAM	G	N	MG				
Need for the Catheter	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hand Hygiene	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Usage of Sterile Equipment	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the Collection bag below the level of bladder	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Check the Tube for Obstruction (Free of Kinking)	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Is Catheter dated as policy	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Collecting bag is been emptied regularly?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Maintenance of closed system for the catheter	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Dressing clean and dry?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the line removed as Policy?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Performance of Perineal Care	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Onset of New Fever	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<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
Asses for the leakage at the site of insertion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Name of the Nurse			Sujatha	Akshya	Akshya					
Signature of the Nurse			[Signature]	[Signature]	[Signature]					

11.11.11

11.11.11

11.11.11





Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	23/5	23/5/26	23/5/24	Fall Risk Grading		
		Score		62	N1	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	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		0			
IV / Heparin Lock or Saline	Yes	20	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	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	20			
Signature			fi					

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

Handwritten notes and diagrams, possibly related to a technical drawing or a list of items. The text is faint and difficult to decipher, but appears to include some numbers and possibly names or descriptions.

1
1

1
1





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
23/5	10 AM	1/10	Noorain	<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	NA
23/5/26	4 PM	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	NA
23/5/26	10 PM	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	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		
				<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:

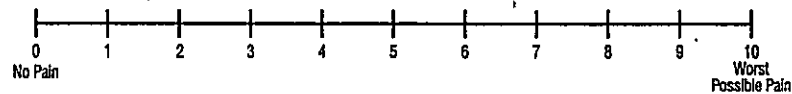
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 - a) At least every 2 hours for the first 24 hours
 - b) Then every 4 hours.
 - c) Prior to pain relieving intervention.
 - d) Within 30 – 60 minutes after pain relief 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 or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

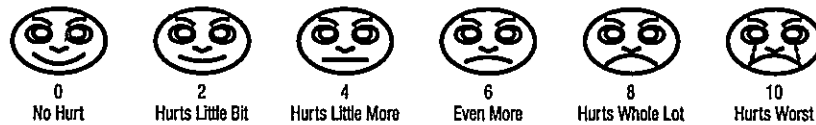
Numerical Pain Scale (Obstetric and Gynecology)



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



NURSING CARE RECORD

Date: 23/5/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am to 2pm	→ Assess the patient's condition → plan for vitals → plan for I/O chart	8Am to 2pm	→ Assessed the patient's condition → maintain vitals & record → maintain I/O chart	patient is stable.	vitals is normal	[Signature]
Afternoon	2pm to 8pm	→ Assess the pt condition → monitor the vitals & record → Administration of medication → maintain I/O chart & record	2pm to 8pm	→ Assessed the pt condition → monitored the vitals & recorded → Administered medication as per doctor order → maintained I/O chart & record	pt is stable	maintain I/O chart & record.	[Signature]
Night	8pm to 8Am	Assess the pt condition monitor the vitals maintain I/O chart medication administer at per doctor order	8pm to 8Am	Assessed the pt condition monitored the vitals maintained I/O chart. medication administer at per doctor order	patient is stable now	vitals is normal	[Signature]

NURSING CARE RECORD

Date: 24/5/20

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM to 2PM	→ To assess the pt. condition & record. → To check the vitals & record. → To administer the medication as per drug chart → I/O chart maintain	8AM to 2PM	→ To assessed the pt. condition & recorded → To checked the vitals & recorded → To administered the medication as per drug chart → I/O chart maintained	→ Patient is stable now → Patient is on soft diet now	→ Re-checked the vitals → I/O → IVE cannula is present	Supriya
	2PM to 8PM	→ Assess the pt condition → Monitor vitals & record → Maintain I/O chart → Administer medication as per drug chart	2PM to 8PM	→ assessed the pt condition & recorded → moni-ored vitals & recorded → Administered medication as per drug	→ pt is stable	rechecked vital	
Night	8PM to 8AM	→ Assess the pt condition → Monitor the v/s → maintain the I/O → Drug as per chart	8PM to 8AM	→ Assess the pt condition → Monitor the v/s → maintain the I/O → Drug as per chart	→ Now pt is stable	→ Rechecked the v/s	

HNH-00015573 IP26-00006411
 Mrs NOORAIN FATIMA
 29-01-1999 27 Y 3 M 26 D (F)
 Dr. SUCHITRA SRIRAMPUR



NURSING CARE RECORD



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	8am to 2pm	<ul style="list-style-type: none"> → To assess the pt. condition → To check the vitals & record → To administer the medication as per drug chart → I/O chart maintain 	8am to 2pm	<ul style="list-style-type: none"> → To assessed the pt. condition → To checked the vitals & recorded → To administered the medication as per drug chart → I/O chart maintained 	<ul style="list-style-type: none"> → Patient is stable now 	<ul style="list-style-type: none"> → Re-checked the vitals → I/O → Today closed dressing to be done 	Supriya
Afternoon							
Night							

Patient Sticker

NURSING CARE RECORD



Date:

Goals

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

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



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <u>G3P3L3 E3 Previous LSCS @ 38w2 weeks for FHL self-aborting</u>	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	<u>23/5</u>	<u>23/5/26</u>	<u>23/5/26</u>	<u>24/5/26</u>	<u>24/5</u>	<u>24/5</u>	
	Shift	<u>8AM</u>	<u>2PM</u>	<u>N1</u>	<u>M2</u>	<u>E2</u>	<u>N1</u>	
	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>-</u>	<u>-</u>	<u>-</u>	
	Diet:	<u>NBM</u>	<u>-</u>	<u>Liquid</u>	<u>Soft</u>	<u>Soft</u>	<u>Soft</u>	
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>-</u>	<u>-</u>	<u>-</u>	
	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 checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	<u>97.7</u>	<u>97.9</u>	<u>97.8</u>	<u>97.6</u>	<u>98.5</u>	<u>98.5</u>
		Res:	<u>20</u>	<u>20b/m</u>	<u>20b/m</u>	<u>20b/m</u>	<u>20b/m</u>	<u>20b/m</u>
		SpO ₂ :	<u>99.1</u>	<u>98.1</u>	<u>98.1</u>	<u>99.1</u>	<u>99.1</u>	<u>98.1</u>
		Pulse:	<u>85</u>	<u>87b/m</u>	<u>80b/m</u>	<u>86b/m</u>	<u>85b/m</u>	<u>86b/m</u>
		BP:	<u>115/75</u>	<u>112/70</u>	<u>117/69b/m</u>	<u>112/71</u>	<u>120/77</u>	<u>122b/m</u>
		LOC:	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
		Fall Risk Score:	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
Pain Score:	<u>-</u>	<u>-</u>	<u>-</u>	<u>0</u>	<u>0</u>	<u>0</u>		
Skin Integrity	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>Good</u>	<u>Good</u>	<u>Good</u>		
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 checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Physiotherapy:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>-</u>	<u>-</u>	<u>-</u>	
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Diet:	<u>NBM</u>	<u>Liquid</u>	<u>Liquid</u>	<u>Soft</u>	<u>Soft</u>	<u>Soft</u>	
	Critical Lab Test / Values:	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	
	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 checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	ADL (Dependent / Non Dependent):	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>-</u>	<u>-</u>	<u>-</u>	
Post Operative Procedure Special Orders:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>-</u>	<u>-</u>	<u>-</u>		
Handed Over By Name :	<u>Sujatha</u>	<u>Akhya</u>	<u>Shravan</u>	<u>Supriya</u>	<u>Sujatha</u>	<u>Shravan</u>		
Signature / ID :	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:	<u>23/5/26</u>	<u>23/5/26</u>	<u>24/5/26</u>	<u>24/5/26</u>	<u>24/5/26</u>	<u>25/5/26</u>		
Time:	<u>2PM</u>	<u>2PM</u>	<u>8PM</u>	<u>2PM</u>	<u>8PM</u>	<u>8AM</u>		
Taken Over By Name :	<u>Akhya</u>	<u>Shravan</u>	<u>Supriya</u>	<u>Sujatha</u>	<u>Shravan</u>	<u>Supriya</u>		
Signature / ID :	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:	<u>23/5/26</u>	<u>23/5/26</u>	<u>24/5/26</u>	<u>24/5/26</u>	<u>24/5/26</u>	<u>25/5/26</u>		
Time:	<u>2PM</u>	<u>8PM</u>	<u>8AM</u>	<u>8PM</u>	<u>8PM</u>	<u>8AM</u>		

HNH-00015573 IP26-00006411

Mrs NOORAIN FATIMA
29-01-1999 27 Y 3 M 26 D (F)
Dr. SUCHITRA SRIRAMPUR



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: EL-LSCS	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	25/5/26						
	Shift	M6						
	Medical Condition (Any special condition to be noted):	-						
	Diet:	Soft						
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	-						
	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 checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	98.1°F					
		Res:	20b/m					
		SpO ₂ :	99%					
		Pulse:	86					
		BP:	116/71					
		LOC:	-					
		Fall Risk Score:	-					
	Pain Score:	"0"						
	Skin Integrity	Good						
Recommendations	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Physiotherapy:	-						
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Diet:	Soft						
	Critical Lab Test / Values:	-						
	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 checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" 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 checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" 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 checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	ADL (Dependent / Non Dependent):	-						
	Post Operative Procedure Special Orders:	-						
	Handed Over By Name :	Supriya						
	Signature / ID :							
	Date:	25/5/26						
	Time:	2pm						
	Taken Over By Name :							
	Signature / ID :							
	Date:							
	Time:							

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CAESARIAN SECTION OPERATIVE NOTES

Surgeon's Name: <i>Dr. J.V. Reddy</i>	Date of Delivery: <i>23.05.2026</i>
Assistant Surgeon: <i>Dr. Suchitra & Dr. Ramya</i>	Time of Delivery: <i>12:43 pm</i>
Anaesthetist's Name: <i>Dr. Heena</i>	Gender of Baby: <i>MALE</i>
Type of Anaesthesia: <i>Spinal</i>	Weight of Baby: <i>3.5 kg</i>
Neonatologist:	AGPAR Score: <i>8, 9</i>
Scrub Nurse:	NICU Admission: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Pre-Operative Diagnosis: *G4P213 = 3 prev LSCS = 37⁺ wk*

Elective Emergency Indication: *previous LSCS*

Urgency

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

Decision time: Knife to rectus:

CTG Description: *Reactive*

If there was a delay give the reasons:

Surgical Procedure: *ELECTIVE LOWER SEGMENT CESAREAN SECTION + BILATERAL TUBECTOMY*

Post Operative Diagnosis: *POD-0 Pulu = 4 prev LSCS*

Peri-Operative Complications:

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

Name and Number of Surgical Specimen sent for examination:

Examination Findings when Appropriate:

Presentation: Cephalic Breech Other Cervical Dilatation: cm
 5th Palpable: Fetal Position:
 Station: -3 -2 -1 0 +1 +2 Moulding: None + ++ +++
 Caput: + ++ +++ Meconium: None + ++ +++
 Bladder Catheterized: Yes No Urine: Clear Blood Stained

Skin Incision: Pfannenstiel Transverse Midline Other
 Uterine Incision: Lower Segment Classical Inverted T J Incision
 Previous Scar: Intact Thinned out Ruptured No Scar
 Incision Through Placenta: Yes No *Ulcerus adherent to Ant Abdominal wall.*
 Delivery of head: Manual Forceps *clean dissection done -> Abdomen entered*
 Liquor: Clear Meconium: I II III Blood Offensive Not Offensive *Window*
 Delivery of Placenta: Manual CCT Complete Incomplete Piecemeal *Creation*
 Cord Appearance: Cord around the neck Yes No
 Appearance of placenta: Cavity explored Yes No
 Uterus, tubes and ovaries: Normal Not Normal Sterilization: Yes No

Uterine Closure: One Layer Two Layers *P/L tubectomy done by Modified Pomeroy technique.*
 Peritoneal Closure: Pelvic Abdominal None *Vicryl No. 1 Suture*
 Sheath Closure: *Vicryl No. 1 Suture*
 Fat Closure: Yes No *Prolene No. 1 Suture*
 Skin Closure: Subcuticular Mattress *Monocryl No. 1 Suture*
 Vaginal Evacuated Yes No
 Drain: Yes No Remove in days Await instructions
 Catheter Yes No Remove in days Await instructions
 Swap & Instruments count correct? Yes No Post-op Antibiotics Yes No
 Intra-Operative Antibiotics Cover: Yes No Thromboprophylaxis Yes No

Post-Operative Notes:
 - NBM
 - IV Fluids & IV Ab for USH
 - Drugs as charted
 - Analgesics & thromboprophylaxis as per AXON.
 - U/o Monitoring
 - Monitor vital
 - Infection
 - Drain output Monitoring
 TED STOCKINGS

Doctor Name: Dr. Suchitra Doctor Signature: Suchitra

Date & Time: 23/5/26 12:20 pm

OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 23/5/26 Time of Arrival: 9AM Time Seen by Nurse: 9AM

1) Level of Consciousness: Conscious Semi-Conscious Unconscious

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

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

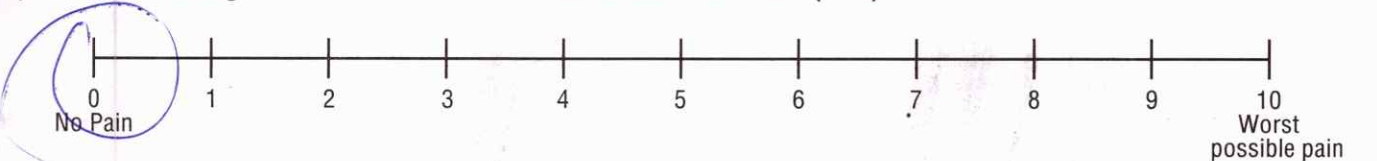
3) Vital Signs: Temperature: 97.8 Pulse: 85 RR: 20 SpO₂: 99.1 BP: 115/75 Weight:

4) Gestational Criteria:

Gravida:	<u>G4</u>	<u>P3</u>	<u>L3</u>	<u>A</u>
LMP:	<u>4/9/25</u>	EDD:	<u>11/6/26</u>	Gestational Age: <u>37 + 2 weeks</u>

Uterine Contraction	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> NA	Onset	Time	Frequency:
Membrane Rupture	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> NA	Onset	Time	Fluid Color:
Vaginal bleeding	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> NA	Onset	Time	Amount:
Pre Eclampsia Symptoms	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> NA	If Yes specify: Headache / Visual Symptoms / Pain Abdomen / Vomiting		
Good fetal Movement	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA	If No specify:		

5) Pain Screening: Numerical Pain Scale (NPS)



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

6) Past History:

- a) Surgeries:
- b) Medical:

7) **Allergy:** Yes No, If Yes :

8) **Current Medications:** Prenatal Vitamin None Others:

9) **Prenatal Medical History:**

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

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

OTAS	Level 1 (Resuscitative)	Level 2 (Emergent)	Level 3 (Urgent)	Level 4 (Less Urgent)	Level 5 (Non Urgent)
Level 1 (Resuscitative)	Immediate	≤ 15 minutes	≤ 30 minutes	≤ 60 minutes	≤ 120 minutes (2 Hours)
Re-Assessment	Continuous Nursing Care	Every 15 Minutes	Every 15 Minutes	Every 30 Minutes	Every 60 Minutes
Labour / Fluid	Imminent Birth	Suspected Pre-term Labour / PPROM < 37 Weeks	Signs of Active Labour > 37 weeks	Signs of Early Labour/ SR0M > 37 weeks	Discomforts of Pregnancy
Bleeding	Active Vaginal bleeding with/ without abdominal pain	Bleeding associated with cramping (<spotting) <37 weeks	Bleeding associated with cramping (>spotting) >37 weeks	Spotting	
Hypertension	Seizure activity	Hypertension > 160/110 and / or headache, visual disturbance, RUQ pain	Mild hypertension >140/90 with/without associated signs and symptoms		
Fetal Assessment	Abnormal FHR tracing Non-Fetal Movement	Atypical FHR tracing, abnormal dopplers Diseased fetal movement			
Others	<ul style="list-style-type: none"> • Acute onsite severe abdominal pain • Altered level of consciousness • Cord prolapse • Severe respiratory distress • Suspected sepsis 	<ul style="list-style-type: none"> • Major trauma • Shortness of breath • Unplanned and unattended birth 	<ul style="list-style-type: none"> • Abdominal/back pain greater than expected in pregnancy • Flank pain / hematuria • Nausea /vomiting and /or diarrhea with suspected dehydration 	<ul style="list-style-type: none"> • Ongoing assessment from out patient clinic (for hypertension, blood work) • Minor trauma (minor MVC/fall) • Nausea/Vomiting and /or diarrhea • Signs of infection (ie dysuria ,cough, fever, chills) 	<ul style="list-style-type: none"> • Anything that does not seem to pose threat to mother or fetus • Cervical ripening • Out patient placenta previa protocols • Pre-booked visits (ie Rh and progesterone injections, NST • Assessment for version • Rashes

Time seen by Doctor:

Nurse Name : Seialthe Nurse Signature: Si

Date: 23/5/18 Time: 8 AM



LABOUR AND DELIVERY NURSING ASSESSMENT

Date of Admission: 23/5

Baseline Information:

Admission From: ER OPD Admission Desk Others: specify

Primary Language: Telugu English Hindi Others

Do you require an interpreter? Yes No

Source of Information: Patient Family Others

Personal belonging if any: Jewelry Nose Ring Bangles Anklets Finger Ring Bracelets
 handed over to

Allergies: Yes No Medications Blood Transfusion Food Other:
 If yes, identify

Chief Complaints: Doctor Notified on Admission: Yes No
 Name of the Doctor: Dr. Dug
 Time Notified: 9 AM

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

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

Blood Group: B+ve LMP: 4/9/25 EDD: 11/6/26 Gestational age during admission: 37+2 weeks

Contractions: Vaginal Discharge:

Obstetric History: G 4 P 3 L 3 A Previous LSCS

Height: Weight: BMI:

Temp: 97.8 HR: 85 RR: 20 BP: 115/75 SpO₂ 99%

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

<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Rh Incompatibility	<input type="checkbox"/> Fertility Treatment
<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Previous LSCS	<input type="checkbox"/> Preterm Labour
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Gestational Hypertension	<input type="checkbox"/> Others: (Specify)
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Bad Obstetric History	
<input type="checkbox"/> Anemia	<input type="checkbox"/> Obesity (BMI)	
	<input type="checkbox"/> Twins / Multiple Pregnancy	

Family History: No Abnormalities Detected

- Heart Disease Hypertension Diabetes Stroke Seizures Kidney disease
 Liver disease Other

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

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

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

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

- Mobility problem Walking Problem No Abnormality Detected
 Developmental Delay Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

- Overweight Poor Appetite > 3 Days Needs Therapeutic Diet.
 Under Weight Diabetes Mellitus No Abnormality Detected

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

- Calm & Cooperative Restless Depressed Agitated Confused
 Others

Inform consultant for positive criteria

SOCIAL SCREENING:

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

Social History: Lives With

Orientation has been given regarding the following aspects:

- Call Bell in Reach : Yes No Waste Disposal Explained: Yes No
Infusion Pump : Yes No Hand hygiene Explained: Yes No Others

Above information given to *patient*

Name of Person Orientation was given to: *Mrs. Noorain Fatimah*

Orientation not given Reason:

Nurse Signature: *Pi*

Nurse Name: *Sriati*

Date & Time: *23/5/20 @ 9 AM*



BREAST FEEDING HANDOVER AND ASSESSMENT FORM

1. Breastfeeding initiated?

- a. Yes b. No

2. If No, Reason

3. Nipple condition:

- a. Nipple well formed
 b. Flat nipple
 c. Inverted nipple
 d. Short nipple

4. Milk flow:

- a. Good
 b. Drops of colostrums
 c. Dry

5. Steps for Positioning and attachment:

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



Feeding Positions:
Cross Cradle



Feeding Positions:
Football / Clutch

6. Was the position explained:

- a. Yes
- b. No

7. For Caesarian mothers:

- a. Mother is required sit and feed from the 4th feed
- b. Please explain football hold

8. NICU admission:

- a. Mother needs to stimulate her breast for 2 min every 2 hours

9. Additional notes:

Continuity of Care:

Date: 23/5/26

→ Assess the Baby condition

→ DBT and hold & burping

→ Provide warm care to the baby

→ Maintain Dlo chest Etc

Handover given by AK/16

Handover taken by

Signature AK/16

Signature

Date & Time: 23/5/26

Date & Time:

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Suchitra
 Asst. Surgeon : Dr. J.V. Reddy, Dr. Ramya
 Anaesthetist : Dr. Heena
 Scrub Nurse : S. Archana

Patient Name :
 UHID No. :
 Date : 23/5/20

HNH-00015573 IP26-00006411
 Mrs NOORAIN FATIMA
 29-01-1999 27 3 M 24 D (F)
 Dr. SUCHITRA SRIRAMPUR

Gender : P
 In-time : 12:25pm
 Out-time : 1:50pm



Before Induction of Anaesthesia >>

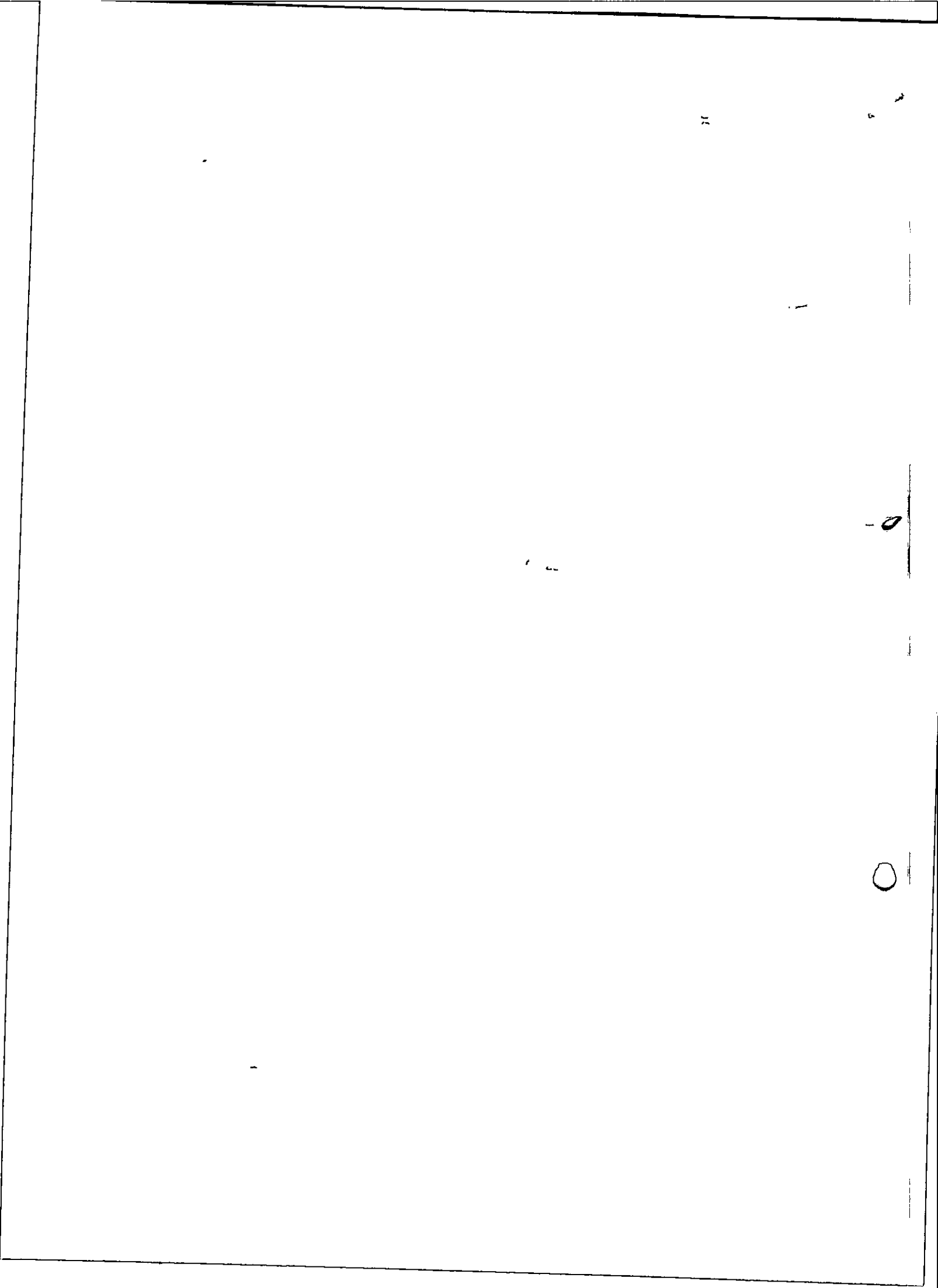
Before Skin Incision >>

Before Patient Leaves Operating Room

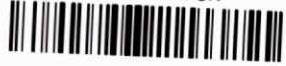


SIGN IN	Time: <u>12:25pm</u>
Patient Has Confirmed	
Identity	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Site	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Procedure	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Consent	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Site Marked	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA
Anaesthesia Safety Check Completed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Pulse Oximeter on Patient & Functioning	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Does Patient have a:	
Known Allergy?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Difficult Airway / Aspiration Risk?	
Yes, & Equipment / Assistance Available	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Risk of > 500ml Blood Loss (7ml/kg In Children)?	
Yes, and Adequate Intravenous Access and Fluids Planned	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Blood Units Reserved	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Has Antibiotic Prophylaxis been given within the last 60 minutes?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Signature : <u>[Signature]</u>	
Name : <u>Heena</u>	

TIME OUT	Time: <u>12:25pm</u>
Confirm all team members have introduced themselves by Name and Role <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm	
Correct Patient (Check ID Band)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Correct Site	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Correct Procedure	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Anticipated Critical Events	
Surgeon Reviews:	
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Anaesthesia Team Reviews:	
Are There Any Patient-specific Concerns?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
Nursing Team Reviews:	
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Is Essential Imaging Displayed?	
Power Supply, Earthing, Power Backup and functioning of equipment checked.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Signature : <u>[Signature]</u>	
Name : <u>Suchitra</u>	

SIGN OUT	Time: <u>1:50pm</u>
Nurse Verbally Confirms with the Team:	
The Name of the Procedure Recorded	<input type="checkbox"/> Yes <input type="checkbox"/> No
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
The Specimen is Labelled (including patient name)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Whether there are any Equipment Problems to be addressed	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
To Surgeon, Anaesthetist and Nurse:	
What are the key concerns for recovery and management of this patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Signature : <u>[Signature]</u>	
Name : <u>Suchitra</u>	



PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00015573 IP26-00006411 Mrs NOORAIN FATIMA 29-01-1999 27 Y 3 M 24 D (F) Dr. SUCHITRA SRIRAMPUR 		Date & Time of Admission 23/5/26 @ 9:13 am	Date & Time of Transfer Order 23/5/26 @ 2:10 pm.
		Transfer Ordered by Dr. Heena	Reason for Transfer observation
From Unit 05	To Unit Pre-post	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File	Number of Imaging Films —	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	RL	1	
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring 		Name of Person Ordered Transfer Dr. Heena.	
Patient & Clinical Records Received by : 			
Date & Time of Patient Received : 23/5/26 @ 2:10 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

PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00015573 IP26-00006411 Mrs NOORAIN FATIMA 29-01-1999 27 Y 3 M 24 D (F) Dr. SUCHITRA SRIRAMPUR 		Date & Time of Admission 23/05/20 @ 9:13 AM	Date & Time of Transfer Order 23/05/20 @ 12:10 PM
		Transfer Ordered by DR. NAVEENA	Reason for Transfer EL-CES
From Unit Pre-Post	To Unit OT	Information to Attendant Yes <input type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 35	Number of Imaging Films 1	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
SI.No.	Item Name	Quantity	
1.	Fluocin		
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Sric Sujatha		Name of Person Ordered Transfer DR. NAVEENA	
Patient & Clinical Records Received by : Aritha			
Date & Time of Patient Received : 23/05/20 @ 12:10 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



INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

Patient Name : Mrs Noorain Gender: Male Female Age : 26 yr.
UHID No : HNH-00015573 Date : 23/5/26

Instruction:

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

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

ELECTIVE LOWER SEGMENT CESAREAN SEGMENT

upon

Mrs Noorain

(Name of the Patient)

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

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

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

bleeding, infection, injury to adjacent organs, bladder, bowel.
Need for blood transfusion

My signature on this form indicates that

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

Name of the Doctor who is performing the Surgery / Procedure:

Consentee :

Signature : [Signature]

Name : Noorain Fatima

Date & Time : 23/5/26 9:30 AM

Witness :

Signature : [Signature]

Name : Suchitra

Date & Time : 23/5/26 @ 9:30 AM

Patient Attendant :

Signature : [Signature]

Name : MIR FAYAD ALI

Relationship with Patient:

Date & Time : 23/5/26

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Dna

Date & Time : 23/5/26 9:30 AM

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE



HNH-00015573 IP26-00006411
 Patient Name : Mrs NOORAIN FATIMA
 29-01-1999 27 Y 3 M 24 D (F)
 Dr. SUCHITRA SRIRAMPUR

Gender: Male Female Age : 27yr

UHID No : 

Date : 23/5/26

Instruction:

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

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

BILATERAL TUBECTOMY

upon Mrs Noorain (Name of the Patient)

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

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


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


My signature on this form indicates that

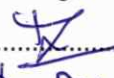
1. I have read and understood the information provided in this form
2. My doctor had adequately explained to me the operation or procedure along with the complications written above, along with the risks, benefits and other information.
3. I have had a chance to ask my surgeon questions.
4. I have received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

Consentee :
 Signature : 
 Name : Noorain Fatima
 Date & Time : 23/5/26 10am

Patient Attendant :
 Signature : 
 Name : MIR FAHAD ALI
 Relationship with Patient : Husband
 Date & Time : 23/5/26 10am

Witness :
 Signature : 
 Name : Sujatha
 Date & Time : 23/5/26 @ 10AM

Doctor (who is taking the consent) :
 Signature : 
 Name : Dr. Dina
 Date & Time : 23/5/26 10AM

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE



Patient Name : Mrs. ADRAJIN Age 26Y Gender : Male Female

UHID NO: _____ Surgeon Name: _____

Anaesthesiologist : DR SHINY

Operative procedure planned : ELECTIVE CESAREAN SECTION

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 and 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 Acidosis
- Incapacitating Chronic Obstructive Pulmonary Disease

Others : HYPOTENSION, BRADY CARDIA, POST DURAL PUNCTURE HEADACHE

Comments : _____

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

DECLARATION BY PATIENT / GUARDIAN / PROXY

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

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

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

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

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

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

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

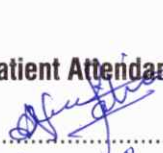
- Pregnant : Yes No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT


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

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


Patient / Patient Attendant :

Signature : 
Name : Neerain Fatima
Relationship with Patient: SELF
Date & Time : 23/05/26, 9:22AM

Witness :

Signature : 
Name : MIR FAHAD ALI
Date & Time : 23/05/26 @ 9:22AM

Doctor (who is taking the consent) :

Signature : 
Name : DR SHINY
Date & Time : 23/05/26, 9:20AM

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



Name: Mrs. NOOR AIN Age: 26y Sex: F UHID.No:

Date: 23/05/26 Time: 9:15 AM Proposed Operation: Electric dses + Tubectomy

Diagnosis: C4 P3 L3 ^{37 weeks} C prev LSCS

B.P / CRT: H.R: Weight: 103 ASA Physical Status: 1 2 3 4 5

27/03/26
 Hgb: 12.3 → 12.7
 PCV:
 WBC: 10,300
 Plate: 1.6 lakh
 PT: 19.2
 PTT: 43.1
 INR: 1.47

Laboratory Data:
 Glucose: RBS = 132 mg/dl
 Urea:
 Creat: 0.62
 Na:
 K:
 Ca++:
 Mg++:
 Cl-:

HIV: X-Ray:
 HBS Ag: ECG:
 HCV: 2D Echo:
 Blood group: B +ve Stress/Anglo:
 T3 Other:
 T4
 TSH: 1.54 → 2.09

Allergies: —

Medical History: CVS: /
 RESP: Diabetes: —
 CNS: —
 Renal:
 Hepatic / GE: Physical Activity: METS > 4
 Others:

Past Anaesthetic History: H/O 3 dses → 1st & 3rd → SA → U/E, 2nd dses → ?/?

Physical Exam:
 Airway: MP 1 2 3 4 Mouth Opening: Adequate Mentohyoid Distance: (N) Neck: (M) Teeth: No loose teeth
 Lungs: BL AE ⊕, clear
 Heart: S1S2 ⊕
 CNS: conscious, oriented
 Pregnant: Yes No NA Venous Access Site: Accessible Spine Exam for regional: Spaces Edematous

Anaesthetic Plan: MAC REGIONAL GA-ETT LMA

Peri-Operative Plan Explained to the Patient: Yes No

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:
 1. DVT Prophylaxis :
 2. NIL ORAL $\left\{ \begin{array}{l} \rightarrow \text{Water / ORS 2 Hours} \\ \rightarrow \text{Others 6 Hours} \end{array} \right\}$ (11:00pm)
 3. Informed Consent: Standard High Risk
 4. Post Operative Pain Management: Discussed with Patient
 5. Other Instructions:
Reserve 1 OPR BC
- CBP

Signature: [Signature] Name: DR. SHINY

HNH-00015573 IP26-00006411
 Mrs NOORAIN FATIMA
 29-01-1999 27 Y 3 M 24 D (F)
 Dr. SUCHITRA SRIRAMPUR

ANAESTHESIA CHART



Pre Induction Assessment:

Change in Patient Condition: Yes No Fasting Status: Consumed

Physical Status: Patient Identified Consent Present Chart Reviewed

H.R: 95 B.P / CRT: 123/67 SpO₂: 98% R.R: 15 cpm Last Feed: _____
 Pre-OP Diagnosis: G.U. P. L. 3. 3. 7 wks prev 2.5 CS Operation: Elective 2.5 CS Date: 23/05/26
 Surgeon: Dr. Suchitra Anaesthesiologist: DR. H.E.E.N.A / DR. SHINY Technician: SARASWATHI

TIME	N ₂ O / AIR / O ₂ LPM	HALO / SO / SEVO	Drugs:	Antibiotic	Suppository	Blood Loss
12:25						
1:25 pm						
			1. <u>Oxytocin 30 IU</u> 2. <u>Methergine 0.2mg IV</u> 3. <u>anderson 4mg IV</u>		<u>Sup Tramadol 100mg PR</u> <u>Sup Diclofenac 100mg PR</u>	
	FIO ₂ / SaO ₂ ETCO ₂ ECG Temperature Urine Output					
	<u>99 98 97 97 96 96</u> <u>5 Trg SR SR SR SR SR</u>					
5:55 pm			<u>1. Oxytocin 20U in 500ml RL @ 150ml/hr</u> <u>2. RL 300ml</u> <u>3. RL 500ml</u> <u>4. RL 500ml</u>			
	B.P V Systolic A Diastolic X Mean • Heart Rate Tourniquet on Time Tourniquet off Time Throat Pack In Throat Pack Out					

NOTES

Baby Birth Time: 12:43 pm
 Sex: Male

LAB Values

ABG _____

GRBS _____

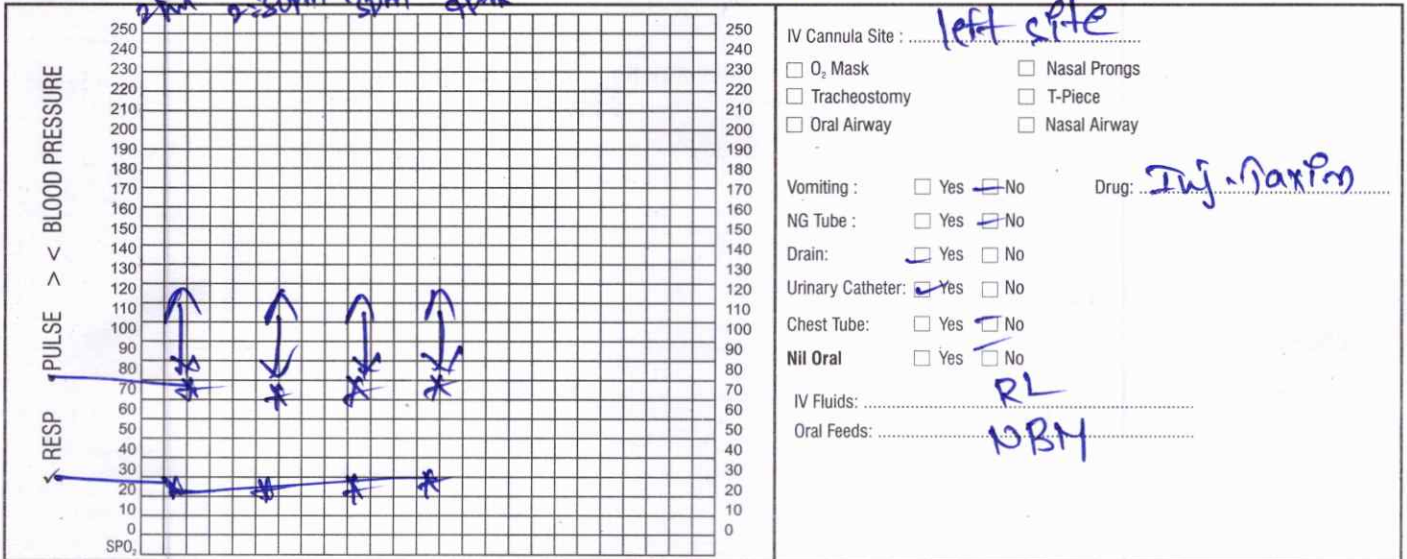
Others _____

<input checked="" type="checkbox"/> Equipment Checked and Functional <input checked="" type="checkbox"/> BP <input checked="" type="checkbox"/> Cuff Site: <u>RUL</u> <input type="checkbox"/> Art Site: _____ <input checked="" type="checkbox"/> EKG Lead <input type="checkbox"/> Temp Site <input type="checkbox"/> FIO ₂ Monitor <input type="checkbox"/> Agent Monitor <input checked="" type="checkbox"/> Pulse Oximeter <input type="checkbox"/> Capnograph <input type="checkbox"/> Ventilator <input type="checkbox"/> Nerve Stimulator Position: <u>SUPINE</u> <input checked="" type="checkbox"/> Pressure Points Checked Eye Care: <input type="checkbox"/> Oint <input type="checkbox"/> Tape <input type="checkbox"/> Padding <input checked="" type="checkbox"/> Awake	Temp: <input type="checkbox"/> HME <input type="checkbox"/> Fluid Warmer <input type="checkbox"/> Cling Film <input type="checkbox"/> OH Warmer <input type="checkbox"/> Hugger's <input type="checkbox"/> Cotton Wool <input type="checkbox"/> Other Times: Anaes Start: <u>12:25 pm</u> OP Start: _____ OP End: _____ Leave OR: <u>1:50 pm</u> Anaesthesia: <input type="checkbox"/> GA <input type="checkbox"/> Monitored Anaesthesia Care <input type="checkbox"/> Regional Line (Size & Location) <input type="checkbox"/> CVP: _____ <input type="checkbox"/> ART: _____ <input checked="" type="checkbox"/> <u>RUL 18G</u> <input type="checkbox"/> IV: _____ <input type="checkbox"/> IV: _____	Induction <input type="checkbox"/> IV <input type="checkbox"/> Inhal <input type="checkbox"/> Pre O ₂ <input type="checkbox"/> RSI <input type="checkbox"/> Others <input type="checkbox"/> Mask <input type="checkbox"/> SGA <input type="checkbox"/> Airway <input type="checkbox"/> Oral <input type="checkbox"/> Nasal ETT# _____ at _____ cm <input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Cuff <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Topical <input type="checkbox"/> Drug: _____ <input type="checkbox"/> Awake <input type="checkbox"/> Direct Vision <input type="checkbox"/> Video Laryngoscopy <input type="checkbox"/> Stylette / Bougie <input type="checkbox"/> Fiberoptic Blade# _____ Attempts: _____ Difficulty Why? _____ <input type="checkbox"/> Bilat = BS <input type="checkbox"/> Semi-Closed Circle <input type="checkbox"/> Closed Circle <input type="checkbox"/> Other	Regional: Extremity _____ Specify: _____ <input checked="" type="checkbox"/> Spinal <input type="checkbox"/> Epidural <input type="checkbox"/> Caudal Others: _____ Position: <u>SITTING</u> Site: <u>L3-L4</u> Needle Size: <u>25G Quincke</u> Depth: _____ Parasthesia <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Catheter at skin _____ cm Drug Name & Conc: <u>0.5% bupivacaine</u> Bolus: <u>heavy 2ml + 25mg</u> Infusion: _____ Block Level: <u>T₄</u> <u>Feet only</u> Comments: _____ Transportation to <input checked="" type="checkbox"/> PACU <input type="checkbox"/> ICU <input type="checkbox"/> Other Relaxant Reversed <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA Name of the Doctor: <u>DR SHINY</u> Signature of the Doctor: _____
---	--	--	--



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: Sis. Akhila Time Received: 1:55 PM Time Discharged: 7:30 PM



POST ANAESTHESIA SCORE (Modified Aldrete Score)	IN	MINUTES			OUT	SCORING INTERPRETATION
		30	60	90		
Able to move 4 extremities voluntary or on command = 2 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 0	ACTIVITY	1	2	2	2	A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0	RESPIRATION	2	2	2	2	
BP ± 20 of Pre Anaesthetic level = 2 BP ± 20-50 of Pre Anaesthetic level = 1 BP ± 50 of Pre Anaesthetic level = 0	CIRCULATION	2	2	2	2	
Fully awake = 2 Arousable on calling = 1 Not responding = 0	CONSCIOUSNESS	2	2	2	2	
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0	COLOR	2	2	2	2	
TOTAL		9	10	10	10	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
23/5	2pm	0/10	NA	<u>[Signature]</u>
23/5	3pm	0/10	NA	<u>[Signature]</u>
23/5	4pm	0/10	NA	<u>[Signature]</u>
23/5		0/10		

Pain Tool Used: N PASS FLACC Wong Baker NPS
 Anaesthesiologist Name: [Signature]
 Anaesthesiologist Signature: [Signature]
 Date & Time:
 PACU Nurse Name: [Signature]
 PACU Nurse Signature: [Signature]
 Date & Time: 23/5/26

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 relieving intervention
 d. With in 30-60 minutes after pain relief intervention
 Transferred to Unit by (PACU): 305
 Date & Time: 23/5/26

Patient Sticker



Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: Time: Procedure done by

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

Depth: Catheter at Skin: Attempts :

Parasthesia : Yes/No if yes details :

Solution Composition :

Any other issues :

a)

b)

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

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

Catheter Removed by and Tip Inspected :

Patient Satisfaction :

Discharge /Shifting ordered by

Doctor Signature:

Doctor Name:

Date and Time :

26-0000201575

NARCOTIC PRESCRIPTION FORM (PATIENT COPY)

Patient Name: Mrs. Noorain Fatima Age: 27y Gender: Female
 UHID No: ANH-0005573 IP No: JP26-00006411 Date: 23/5/26 Time: (Word-OT)
 Diagnosis: JCS

PRESCRIPTION DETAILS (Tick only one of the following)

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

Doctor Name: Dr. SK. Arjuna Doctor Registration No: TSMC/FMR/07725
 Signature: *[Signature]*

NARCOTIC DISPENSING FORM APPENDIX 4 – FORM NO. 3E

(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: JP26-000015573 Date: 23/05/26

Aadhaar No. of the Patient (Optional):

1.	Name : Mrs. Noorain Fatima	Remarks
2.	Complete postal address (with contact number, if any)	11 No. 10-1-1165-A C. Grounds 14th office Hyderabad Telangana 500004
3.	Brief description of the illness	JCS
4.	Whether registered with any other registered medical practitioner / recognized medical institution (If yes, details of the recorded)	NO
5.	Details of essential Narcotic drug dispensed	INJ: Fentanyl

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
23/5	INJ: Fentanyl	01	<i>[Signature]</i>	

Dispensed by (Name & ID No.): Sania (01944?) Signature: Sania
 Received by (Name & ID No.): Saraswathi (021006) Signature: *[Signature]*

Time:

26-0000201575

NARCOTIC PRESCRIPTION FORM (MEDICAL RECORD)

Patient Name: <u>Mrs. Noorain Fatma</u>	Age: <u>37y</u>	Gender: <u>Female</u>	
UHID No: <u>1026-0000201573</u>	IP No: <u>1026-0000201575</u>	Date: <u>23/5/26</u> Time: _____	
Diagnosis: <u>1 SCS (Word-OT)</u>			
PRESCRIPTION DETAILS (Tick only one of the following)			
S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/ML	<u>100 mcg</u>	<u>01 AMP</u>
2.	Morphine Sulphate Inj. 15mg/ML	—	—
3.	Remifentanyl Hydrochloride Inj. 2MG	—	—
4.	Remifentanyl Hydrochloride inj. 1MG	—	—
Doctor Name: <u>Dr. Ayata</u>		Doctor Registration No: <u>TSMR/EMR/07027</u>	
Signature: <u>[Signature]</u>			

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

IP Registration No: 1026-0000201573 Date: 23/05/26

Aadhaar No. of the Patient (Optional): _____

1.	Name: <u>Mrs. Noorain Fatma</u>	Remarks		
2.	Complete postal address (with contact number, if any)	<u>11ND-10-1-115-1 C. General 26 501/21</u>		
3.	Brief description of the illness	<u>1 SCS</u>		
4.	Whether registered with any other registered medical practitioner / recognized medical institution (If yes, details of the recorded)	<u>NO</u>		
5.	Details of essential Narcotic drug dispensed	<u>INJ: Fentanyl</u>		
Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
<u>3/5</u>	<u>INJ: Fentanyl</u>	<u>01</u>	<u>[Signature]</u>	

Dispensed by (Name & ID No.): [Signature] Signature: _____

Received by (Name & ID No.): [Signature] Signature: _____

Time: _____



NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name		Date	
UID No.		Time	
Diagnosis			
PRESCRIPTION DETAILS (check only one of the following)			
No.	Drug Name	Dosage	Remarks
1	Fentanyl Citrate Inj. 50mcg/1ml		
2	Morphine Sulfate Inj. 15mg/ml		
3	Ramifenanthol Hydrochloride Inj. 2MG		
4	Ramifenanthol Hydrochloride Inj. 1MG		
Doctor Name		Control Registration No.	
Signature			

NARCOTIC DISPENSING FORM
APPENDIX 4 - FORM NO. 3E

(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

Registration No. _____ Date _____

Address of the Patient (Optional) _____

1	Name	Remarks		
2	Complete postal address (with control number, if any)			
3	Brief description of the illness			
4	Whether registered with any other registered medical practitioner recognized medical institution (if yes, details of the institution)			
5	Details of essential narcotic drug dispensed			
Date	Name of the Essential Narcotic Drugs	Quantity	Signature & Stamp Impression of the patient / Patient Attender	Remarks, if any

Dispensed by (Name & ID No.) _____ Signature _____

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

Date _____

CLINICAL RECORDS

HNH-00015573 IP26-00006411
Mrs NOORAIN FATIMA
29-01-1999 27 Y 3 M 24 D (F)
Dr. SUCHITRA SRIRAMPUR

305



NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 24/5/20 Time: 11:00 am

Origin: Indian Height: 160 cm Weight: 60 kg BMI: ~26 kg/m²
 ~28 kg/m²
 ~30 kg/m²
23 kg/m²

Food Allergies: No P A

Diagnosis: LSCS

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

Diet Advised:

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

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

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

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

Patient's / Attendant's

Dietician's

Signature: _____

Signature: *Fobija*

Name: *Say*

Name: *Syeda Fobija Zaher*

Date & Time: 24/5/20; 11:00 am

Date & Time: 24/5/20; 11:00 am

