Dr. Shanthi

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

ESTIMATION SLIP

Date : 2/2/26 **UHID / IP No. :** HNIH-0001630 **Sl No.** 1660

Name of Patient : Mr. Kavya **Age:** 42yr **Gender:** F

Father's / Husband's Name : Mr. Naga Sugandh **Corporate / Occupation :**

Address : Rodupipal **Phone :** 9700199206 **Email :** 9700575656

Procedure / Plan : Lap. Hysterectomy **EDD/Dos:** July-26

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

TARIFF INFORMATION :

Particulars	Package Amounts (Rs.)	
Room Category	Normal Delivery	LSCS
Multi Shared Ward		
Shared Ward	Lap. Hysterectomy	
Twin Shared Ward →	1.30L &	Plans
Private Room		
Super Deluxe Room	+ Non Payable Extra 20%	
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 :	Length of Stay for :
	Pharmacy up to	Pharmacy up to
	Investigations up to	Investigations up to
Others		

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

Initial Minimum Deposit : 10,000/- Advance time of Admission

REMARKS :

1. Room eligibility is purely subject to TPA approval and the Package / Room Tariff starts from the time of admission. The estimated amount may Change according to duration of stay, medical condition, investigations, pharmacy and any other procedure.
2. Proportionate difference of bill amount is applicable in case the patient opts for a category higher than the TPA approved, which has to be paid by the patient and may not be reimbursed by the TPA at later stage.
3. **Total baby charges are extra which include admission, pharmacy, vaccinations, investigations, disposables, consumables, equipments, speciality consultations, etc.**
4. In Case the patient gets discharged earlier than the packages permitted days, no refund of any type is applicable and if the length of stay is beyond the package permitted, additional payment is applicable for which kindly contact the Financial Counselling desk between 9am to 6pm
5. **For Non-medicals, Disposables, Consumables, Taxes, Kiwi Cup charges, Implants, Tubectomy charges, HIV/HbsAg, Anti-D, Medical Records, Double Occupancy and Registration Charges, etc. credit cannot be exchanged. These items are not payable to us as per Insurance company norms.**
6. Difference if any between the final bill amount and amount permitted/approved by TPA or total bill amount in case of denial from TPA has to be paid by the patient. In case of denial, cash tariff would be applicable.
7. Two attendants are permitted with patients in SDLX, DLX and PVT rooms and only one attendant is permitted in the rest of the categories of rooms and no attendant is permitted in ICU's
8. Tariffs are subject to revision
9. Kindly check your billing status on day to day basis at IP Billing Department.
10. Additional Charges on package are applicable for Non-working hours and Non-working days (sundays and public holidays)

DECLARATION

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

Signature of the Client

Husband
Signatory Relationship

Signature of the financial Counselor

H-00016310 IP26-00006757
Mrs KAVYA
09-09-1982 43 Y 9 M 27 D (F)
Dr. SANTHI ANTHARVEDI

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SURGERY DETAILS

Date : 6/7/26

Patient Name: Mrs. Kavya Date of Birth: 09-09-1982 Age: 43yrs

Gender: female Ward : OT-2 UHID No.: HNH-00016310
IP26-00006757

Date of Surgery: 6/7/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Total Laparoscopic Hysterectomy + B/L salpingectomy

Time in : 10:00 Am Time Out : 12:15 PM

		NAME	AMOUNT
1.	Surgeon	Dr. Santhi Dr. Swathi Hv.	
2.	Anaesthetist	Dr. Samir, Dr. Bandha	
3.	Assistant Surgeon	Dr. Dua	
4.	OT Technician	Sr. Pallavi	
5.	Circulating Nurse	Sr. Natalu, Sr. Karuna	
6.	Assistant Nurse	Sr. Sangeetha Br. Balu	

Mrs KAVYA (43 Y 9 M 27 D/ F)
UTERS
NINV00213
HN26011081UTERS

vessel sealing :- 26-00002111 34.

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

Signature of the Surgeon

Karuna.
Signature of Circulating Nurse

Order No: 26-00002111 35 Order by: Sangeetha

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

HNH-00016310 IP26-00006757
Mrs KAVYA
09-09-1982 43 Y 9 M 27 D (F)
Dr. SANTHI ANTHARVEDI

TdH

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CONSUMABLES OF OT

Circulating staff : Kasuna Technician : Pallavi Date : 6/7/26 Time :

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube 7.0 cuffed		01	Major Pack	01		Inj Vit.K		
LMA			Sutures TURP	01		Cord Clamp		
ECG leads : A / P / N		03	~~STV Ethilon 2/0~~	01		Suction Catheter		
HME filter : A / P / N		02				Feeding Tube		
Syringes : 10 cc		03				Vaccum Suction Set		
05 cc		03	Gloves S.G 6.5	01 7 3+1		Surgical Gloves		
02 cc		04	Ethilon 6½ 2-0	01+1		Gauze Pack		
01 cc			Surgicare 6.5 7+1			Syringe 1ml / 2ml		
Cautery plate : A / P / N		01	Surgical blade 11 +1	01+1		Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL		02	Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml	01	+03	Koochies XXL	01				
Atropine		01	Ointments			Hir Legging Big		01
Adrenaline		01	Suction Catheter					
Fentanyl		01	Cap, Mask	10+10		~~Tur Set~~		~~01~~
Morphine		01	Gauze Pack 7.5cm	03				
Ketamine			Mop Pack		01	10 ml Syringe		01+1
Propofol		02	Steristrip					
Rocuronium		03	Underpad		02	~~Degaratam~~		~~01~~
Glycopyrolate		01	Draw sheet					
Myopyrolate		01	Abgel			Trasofix		01
Ondansetron		01	Foleys catheter 16.		01			
Pencan 25g/ Spinal Needle 22			Urobag		01			
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
PMOline 200 cm		01	Tegaderm 8582		04			
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg		01	Vaccum Suction set	01+1				
Justin : 12.5 mg / 25mg / 100mg		01	Plastic ~~Bed Sheet~~ Aprons	03				
Tab. Misoprost : 200mg			Betadine Solution	01+1				
O2 mask [A]		01	Microshield	01				
PEM		01	Cotton Balls	01		~~Airway Oral~~ [OT]		02
Nasal airway 28		01	Latex Gloves	20		Tramadol		01
Bivizon		01	Ramdione Scrub			Mg Magnecure		01
Splint 3		01	Saral			Aminophylline		01

Surgeon Anaesthesiologist Nurse OT Technician

Order No. 26-00002111578/211159. Ordered by : Sangeetha

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

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040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	HNH-00016310	Name	Mrs KAVYA
Age / Sex	43 Y 9 M 27 D / Female	Doctor	SANTHI ANTHARVEDI
Adm/Reg Date/Time	06/07/2026 07:40	Payor	VOLO HEALTH INSURANCE TPA PVT LTD
Order Date	06/07/2026 13:06	Ordernumber	26-0000211158
Visit ID	IP26-00006757	Ward/Bed No	4F -OT / PPO-417
Patient Address	120,ROAD NO2,LAME NO 2, GREENCITY COLONY, BODUPPAL., Boduppal, Hyderabad, Telangana, INDIA, 500092		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	Encore Micropic gloves-6.5		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
2	NS 1000 ML CLOSED EUROFLEX		1 Nos	IV Infusion / Once Daily	1 Days		3 Nos	Dispensed
3	SURGEON CAP(FEMALE) (PROTECTCARE)		1 Nos	External / Once Daily	1 Days		10 Nos	Dispensed
4	POVINAN2 SOLUTION 10% 100 ML		1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
5	ET TUBE 7.0 CUFFED RUSCH		1 Nos	External 10 AM	1 Days		1 Nos	Dispensed
6	ADROGLARE(ADRENALINE) INJ 1MG 1ML		1 Vial	External Once Daily	1 Days		1 Vial	Dispensed
7	MCT-ROF 100MG 10ML		1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
8	VACCUME SUCTION SET		1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
9	DSYRINGE 5ML (NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
10	RELIPARA(PARACETAMOL) 1000MG 100ML BOTTLE		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
11	COTTON BALLS 2 GM 5 NOS		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
12	FOLEYS CATHETER 16-UROCATH		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
13	ONDOKIND INJ 4 MG 2 ML		1 Nos	/ Once Daily	1 Days		1 Vial	Dispensed
14	AMINOPHYLLINE INJ25MG10ML		1 Vial	External Once Daily	1 Days		4 Vial	Dispensed
15	SURGICAL BLADE 11	SURGICAL BLADE 11	1 Nos	External - Once Daily	1 Days		1 Nos	Dispensed
16	ADULT DIAPERS-XXL		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
17	RL 500 ML CLOSED SYSTEM	RINGER LACTATE 500ML CLOSED	1 Bottle	/ Once Daily	2 Days		2 Bottle	Dispensed
18	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
19	SUPRIDOL SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
20	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
21	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		5 Nos	Dispensed
22	DICLOQUICK 1ML INJ		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
23	MOPS 30X30 MPLY SS X-RAY	MOPS 30X30 PLYDATT	1 Pack	/ Once Daily	1 Days		1 Pack	Dispensed
24	FACE MASK 3 LAYER - ELASTIC	FACE MASK 3 LAYER	1 Nos	External Once Daily	1 Days		10 Nos	Dispensed
25	TRANSOFIX DEVICE-4090500		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
26	UROBAG (ADULT) - URODYNE		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
27	ENCORE MICROPTIC GLOVES-7 PF		1 Nos	/ Once Daily	2 Days		2 Nos	Dispensed
28	NASOPHARYNGEAL TUBES 28	NASOPHARYNGEAL TUBE28	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
29	SPLINT - M	SPLINT 3	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
30	DSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
31	LEGGINGS DISPOSABLE (PROTECTCARE) BIG		1 Nos	/ 10 AM	1 Days		1 Nos	Dispensed
32	IRRIGATION(T,U,R SET)	IRRIGATION(T,U,R SET)	1 Nos	External Once Daily	1 Days		1 Nos	Dispensed
33	ROCURIUM INJ 50 MG 5 ML		1 Vial	External Once Daily	1 Days		3 Vial	Dispensed
34	JUSTIN SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
35	CRITIDOL INJ 50 MG 1 ML		1 Nos	/ Once Daily	1 Days		1 Vial	Dispensed
36	AIRWAY - # 100 MM	AIRWAY 4	1 Nos	/ Once Daily	2 Days		2 Nos	Dispensed
37	PREGELLED SURGICAL PLATES(ADULT)	PREGELLED PLATED ADULT	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
38	UNDERPADS 60X90 BUTTERFLY		1 Nos	External / 10 AM	1 Days		2 Nos	Dispensed
39	OxygenMask With Tubing - Adult ROMSONS-FC		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
40	BACTOPREP SOLUTION-5 100 ML		1 mL	/ Once Daily	1 Days		1 Nos	Dispensed
41	SGLOVE # 7.0(SURGICARE)	SURGICAL GLOVES 7.0	1 Nos	External Once Daily	1 Days		2 Nos	Dispensed
42	HIGH PRESSUR EXTENTION 200 CM HPXMAX		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
43	MAGNECURE INJ 2ML		1 Nos	/ Once Daily	1 Days		1 Vial	Dispensed
44	E.C.G ELECTRODES (ADULT)	ELECTRODES ADULT	3 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
45	DISPOSABLE APRONS STERILE XL	DISPOSABLE APPRON STERILE XL	1 Nos	/ Once Daily	3 Days		3 Nos	Dispensed

SANTHI ANTHARVEDI

Reg No : 49827

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

Note

* This prescription is valid only for specified duration.

* Do not refill medicines.

Rainbow Children's Hospital

Birth of a Rainbow

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040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	: HNH-00016310	**Name**	: Mrs KAVYA
Age / Sex	: 43 Y 9 M 27 D / Female	**Doctor**	: SANTHI ANTHARVEDI
Adm/Reg Date/Time	: 06/07/2026 07:40	**Payor**	: VOLO HEALTH INSURANCE TPA PVT LTD
Order Date	: 06/07/2026 13:06	**Ordernumber**	: 26-0000211159
Visit ID	: IP26-00006757	**Ward/Bed No**	: 4F -OT / PPO-417
Patient Address	126,ROAD NO2,LAME NO 2, GREENCITY COLONY, BODUPPAL., Boduppal, Hyderabad, Telangana, INDIA, 500092		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	NITRILE EXAMINATION GLOVES P F- MEDIUM		1 Nos	External / Once Daily	1 Days		20 Nos	Dispensed
2	MAJOR PACK (PROTECTCARE)		1 Nos	/ 10 AM	1 Days		1 Nos	Dispensed
3	CUROPINE (ATROPINE) INJ 1 Ml		1 Vial	External / Once Daily	1 Days		1 Vial	Dispensed
4	NS 100ML ACCULIFE - EH	NORMALSALINE 0.9% SODIUMCHLORIDE100ML CLO	1 mL	/ Once Daily	1 Days		1 mL	Dispensed
5	H.M.E FILTER (ADULT)-1641-POLYMED		1 Nos	External / 10 AM	1 Days		2 Nos	Dispensed
6	THEMIPYRRNOM 0.2MG INJ		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
7	GAUZE 7.5X7.5 12 PLY (5 NOS) NON XRAY	GAUZE 7.5X7.5 12 PLY 5 NOS	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
8	TEGADERM WITH PAD 5X7CMS (3582)(8582)	TEGADERM 8582	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
9	MYOPYROLATE-INJ-5ML		1 Nos	/ Once Daily	1 Days		1 Ampule	Dispe

SANTHI ANTHARVEDI

Reg No : 49827

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Note

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*** Do not refill medicines.**

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Name	Mrs KAVYA	**UHID**	HNH-00016310
Father/Guardian	Mr C.NAGA SUDENDRA	**Age/Gender**	43 Y 9 M 27 D/ Female
Address	126,ROAD NO2,LAME NO 2, GREENCITY COLONY, BODUPPAL., Boduppal, Hyderabad, Telangana, INDIA, 500092		
IP No	IP26-00006757	**Admission Date**	06-07-2026
Ref Doctor	Self.		
Discharge Date	09.07.2026		

DISCHARGE SUMMARY

Consultant:
Dr. SANTHI ANTHARVEDI
MBBS, MS OBGYN
49827

Co Consultant -
DR SWATHI HV
MS OBG
15501

Diagnosis: P2L2 WITH NVD WITH AUB - L WITH MILD ANEMIA

TOTAL LAPAROSCOPIC HYSTERECTOMY + BILATERAL SALPINGECTOMY DONE ON 06.07.2026

History: She presented with Heavy mensural bleeding since 7-8 months not associated with clots passage or dysmenorrhea . Scan (09.06.2026) showed Uterus bulky measuring 84*68*79 mm .E/o few heterogenous hyperechoic intramural fibroids in anterior myometrium largest measuring 47*41 mm , ET 6.8mm, B/L ovaries normal. Papsmear (05.06.2026)- NILM .HB- 9G% .She was

Name	Mrs KAVYA	**UHID**	HNH-00016310
IP No	IP26-00006757	**Admission Date**	06-07-2026

admitted for total laparoscopic hysterectomy and Bilateral salpingectomy.

Menstrual History:-
LMP- 26.06.2026
Previous cycles: Regular

Obstetric History: P2L2, NVD, LCB-10 years

Medical History: Nil
Surgical History: Laparoscopic tubectomy-2019
Allergies: Nil
Family History: Father-DM

Investigations: Enclosed.
Blood group: "B" Positive

Surgery Notes:
TOTAL LAPAROSCOPIC HYSTERECTOMY + BILATERAL SALPINGECTOMY UNDER GENERAL ANAESTHESIA

Indication: AUB-L

Operative findings:
- Uterus -14 weeks with multiple uterine fibroids.
- Bilateral fallopian tubes -Normal ,
- Bilateral fallope rings visualised
- Bilateral ovaries - Normal

Procedure:
- Position: Low lithotomy

Name	Mrs KAVYA	**UHID**	HNH-00016310
IP No	IP26-00006757	**Admission Date**	06-07-2026

- Primary port : 10mm , 3 accessory ports inserted :5mm each
- Uterus -14 weeks with multiple uterine fibroids
- Bilateral fallopian tubes -Normal ,
- Bilateral fallope rings visualised
- Bilateral ovaries - Normal
- Proceeded with Total laparoscopic hysterectomy+ bilateral salpingectomy
- Specimen retrieval done through vagina
- Vault sutured by stratafix No. 2-0
- Thorough irrigation and suction done
- Hemostasis secured
- Bilateral ureteric peristalsis visualised at the end of procedure
- Urine - clear
- Procedure uneventful
- Specimen: uterus+ cervix + bilateral fallopian tubes sent for HPE

Post-Operative Notes: She was closely monitored in the postoperative period. Her vital signs remained stable. She was encouraged to ambulate. She was shifted to room. Foleys removed and she voided spontaneously. On Post operative day 2 ,CBC was done ,Hb -7.4 g/dl,WBC-7.57 ,PLT-2.7 lakhs .1 Unit PRBC blood transfusion done on 07.07.2026. Inj. FCM 500mg given on 08.07.2026. Her general condition was satisfactory and she was found to be fit for discharge. Medications were explained to the patient supplemented by written information.

Advice:

1. T. Ceftum 500mg (Cefuroxime axetil) twice daily 9am-9pm till 13.07.2026 after food.
2. T. Pantop 40mg(Pantaprazole) once daily at 8am till 13.07.2026 before food.

Name	Mrs KAVYA	**UHID**	HNH-00016310
IP No	IP26-00006757	**Admission Date**	06-07-2026

3. Tab.Acecloplus twice daily (9am-- 9pm) till 11.07.2026 after food.
4. Tab Zofer (Ondansetron) 4mg SOS (for nausea/ vomiting)
5. T. Zincovit once daily at 2 pm for 1 month.
6. T.Livogen twice daily (8am-8pm) for 1 month.
7. Syp. Cremaffin 15ml once daily at bedtime(10pm)
8. Collect HPE report.

Review consultation with **Dr. SANTHI ANTHARVEDI**, after **1 week** on **16.07.2026** with **HPE report** (**Review consultation will be charged**).

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

Patient/ Attender

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

Registrar/Resident/C.M.O

Consultant:
Dr. SANTHI ANTHARVEDI
MBBS, M.S (OBS&GYN)
49827

Rainbow Childrens Hospital-Himayatnagar

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

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006757 **Admit Date** : 06-Jul-2026 **Admit Time** : 07:40 AM **UHID** : HNH-00016310

Patient Details :

Patient Name	: Mrs KAVYA	**Age**	: 43 Y 9 M 27 D
Guardian	: Mr C.NAGA SUDENDRA	**DOB**	: 09-09-1982
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 126,ROAD NO2,LAME NO 2, GREENCITY COLONY, BODUPPAL. Boduppal Hyderabad Telangana INDIA 500092	**Phone No**	: 9700575656/ 9700199206
		E-mail	: na@GMAIL.COM

Admission Details :

Bed Type : TWIN SHARING **Bed No** : PPO-417 **Ward Name** : 4F -OT

Room No : PPO-417 **Admission Type** : First Visit

Contact Details :

Name : Mr C.NAGA SUDENDRA **Relationship** : W/O

Contact Address : 126,ROAD NO2,LAME NO 2, GREENCITY COLONY, BODUPPAL. Boduppal Hyderabad Telangana INDIA 500092 **Phone No** : 9700575656

Signature

Doctor Details :

Doctor Name : Dr. SANTHI ANTHARVEDI **Specialisation** : OBSTETRICS AND GYNECOLOGY

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

Co-Consultant : Dr. SWATHI H V

Payment Details :

Payment Mode : DC/CC Card **Deposit Amount** : 10000.00

Payor Name : VOLO HEALTH INSURANCE TPA PVT LTD

PATIENT TRANSFER FORM

Rainbow® Children's Hospital
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HNH-00016310 IP26-00006757
Mrs KAVYA
09-09-1982 43 Y 9 M 29 D (F)
Dr. SANTHI ANTHARVEDI

	Date & Time of Admission	Date & Time of Transfer Order
	6/7/26 7:40Am	8/7/26. 11:45 Am.
Treating Consultant Name	Transfer Ordered by	Reason for Transfer
	Dr. Naveena	Inj: FCM.
From Unit	To Unit	Information to Attendant
	4th-floor.	Yes ☑ No ☐
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant
		Yes ☑ No ☐
		If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

maheshwari

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer

Patient & Clinical Records Received by : madhumitha s/

Date & Time of Patient Received : 8/7/26 @ 11:50Am.

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

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

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016310 IP26-00006757 Mrs KAVYA 09-09-1982 43 Y 9 M 28 D (F) Dr. SANTHI ANTHARVEDI	6/7/26 7:00AM	7/7/26 5:40pm
	Transfer Ordered by Dr. Naveena.	Reason for Transfer Observation
From Unit Dre post	To Unit Room (306)	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 35	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☑ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	P	
2.		
3.		
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sis. Mounika.	Dr. Naveena.

Patient & Clinical Records Received by : maheshwari

Date & Time of Patient Received : 6pm 7/7/26

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

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

CONSENT FOR BLOOD TRANSFUSION

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Name: Mrs Kavya Age: 43yr Gender: Male ☐ Female ☑

UHID.No : HNH-000 16310 Date: 7/7/26.

Type of Blood Product:

☐ Fresh Frozen Plasma	☑ Packed Red Blood Cells	☐ Random Donor Platelets
☐ Cryoprecipitate	☐ Single Donor Platelet	☐ Whole Blood
☐ Albumin	☐ Red Blood Cell	☐ Others .....

I Mrs Kavya. hereby give my consent for whole blood transfusion or the blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for Human Immunodeficiency Virus antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections occur even with screened blood, especially if it is in the "window period" and also due to various other infections which have not been screened for. I also understand that any blood components transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

The doctor has explained to me about the alternative for this procedure which is .....

.....

All the above-mentioned risk, benefits and alternatives have been explained to me by the doctor treating me / my patient in the language that I fully understand and I accept the same and give my consent for all transfusions (the whole blood / or blood components Packed Red Blood Cells, Red Blood Cell, Platelets, Fresh Frozen Plasma, Cryoprecipitate etc.) to me / my Patient during he present hospital stay and treatment.

Patient (Or Patient Relative / Guardian):

Signature: .....

Name: Kavya

Date & Time 7/7/26 @ 1pm

Doctor (Who is talking the consent)

Signature: .....

Name: Dr. Dua

Date & Time 7/7/26 @ 1pm

Witness

Signature: .....

Name: Naga Surendra

Date & Time .....

HNH-00016310
Mrs KAVYA
09-09-1982 43 Y 9 M 28 D (F)
Dr. SANTHI ANTHARVEDI
IP26-00006757

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BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 7/7/26 Time: 1.10pm

Blood Group of the Patient: B+ve Blood Group on the Blood Bag: B+ve

Blood Bank Issue No: 1330 Date of Collection: 21/6/26 Date of Expiry: 2/8/26

Date & Time of Starting Transfusion: 7/7/26 Planned duration of Transfusion: 4hrs.

Check for Correct Unit: ☑ Correct Patient: ☐

Blood products cross checked by: Nurse 1: Chaudhakale Nurse 2: madhumitha

Before starting transfusion vitals: Temp: 97.8°F HR 89 RR: 20 BP: 110/76 SpO_2 100

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO_2	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
7/7/26	1:10pm 15 Min	89	97.8°F	110/76	100%	—	—	—	—
7/7/26	1:25 15 Min	79	98.0°F	106/78	100%	—	—	—	—
7/7/26	1:35 30 Min	87	97.0°F	107/87	100%	—	—	—	—
7/7/26	2:35 30 Min	85	98.1°F	105/71	100%	—	—	—	—
7/7	3:30pm 30 Min	87	97.1°F	105/72	99%	—	—	—	—
7/7	4:30pm 1 Hr		98.1°F	108/70	99%	—	—	—	—
7/7	5:10pm 1 Hr		97.1°F	109/69		—	—	—	—

Comments: NO reaction

Name of the Incharge-Nurse: Sis. Kasthuri Name of the Nurse: Chaudhakale

Signature of the Incharge-Nurse: Signature of the Nurse:

Date & Time: 7/7/26 Date & Time: 7/7/26 at 1.10pm

Phone : 8790221175 , 8341711775

SURYA BLOOD CENTRE

(A unit of Telangana Devlopment Committee)

#3-6-150, First Floor, Above Indian Bank, Main Road, Himayatnagar, Hyderabad-29.

Lic No. 111/HD/TS/2021/BC/G

PACKED RED CELLS I.P. 220-280 ml

Anticoagulant : CPDA Solution U.S.P. 49 ml / 63ml

Prepared from a **VOLUNTARY DONOR / REPLACEMENT**

Blood Group.: **'B'** Rh (D) Type : **POSITIVE**

Blood Bag No. : 1330 Volume : 250 ml Collection Date : 21-6-26

Tested Date : 21-6-26 Expiry Date : 2-8-26

Tested and Found Negative for HIV I & II antibodies, HBsAg, HCV antibodies, VDRL & Malaria Parasites.

CAUTION 1) Do not use if there is any visible evidence of deterioration like haemolysis, clotting & discolourisation.

2) Storage temperature 2°-6° C.

3) Bring the Blood bag to room temperature before transfusion.

4) Do not keep the Blood Bag in De-Freezer compartment in refrigerator.

5) Shake gently before use. 6) Administer without warming.

7) Transfuse under medical supervision only.

8) Do not add any medicine to the blood.

9) Use a fresh, sterile pyrogen free disposable transfusion set with filter.

10) Do not dispense with out prescription.

11) Check Blood Group & Rh Type on label and Recipient Group & Rh type before administration.

12) Cross match before use. 13) Appropiate compatible, cross matched blood without a typical antibody in recipient should be used.

14) If Hemolysin is present in O«Negative blood units it should be transfused to the same blood group recipient only.

Please Note : It is advised that this Blood Bag which is stored in our Blood Centre refrigerator at ideal temperature must be transfused immediately without further storing it. This Blood Bank bears no responsibility if this bag is further stored with-

PATIENT TRANSFER FORM

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	Date & Time of Admission	Date & Time of Transfer Order
Treating Consultant Name	6/7/26 @ 7.40pm	7/7/26 @ 12.30pm @ 12pm.
Transfer Ordered by: Dr.	Reason for Transfer: Blood transfusion	
From Unit: (306)	To Unit: (4Blood)	Information to Attendant: Yes ☑ No ☐
Number of Sheets in Clinical File: 30	Number of Imaging Films: Nil	Personal belongings including clinical documents. If any handed over to attendant: Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

N/A

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

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

Patient & Clinical Records Received by : Chandrakala

Date & Time of Patient Received : 7/7/26 @ 12.30pm

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

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

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ACTIVITY RECORD FOR BILLING

Name :_____Mrs. Kavya_____

UHID No. : _____ IP No : _____ Consultant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
6/7/26	9:50 AM	PRE & Post	OT	Madhu/Kavya
6/7/26	12:30 pm.	OT	Pre Post	Nitesh / Madhu
6/7/26	8 pm	pre post	306	
7/7/26	11. am.	ward	LDR	Nakeswari
7/7/26	5.40pm	pre post	Ward (306)	Mounika.

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
7/7/26	CBP	11147	
8/7/26	Biopsy for Histopathology	11081 cross checked & done	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
6/7	Cardiac monitor	12:30Pm	8pm.	211133	[illegible]
6/7	Infusion Pump	12:30Pm	8pm		[illegible]
6/7	oxygen	12:30Pm	~~7pm~~ 8pm		[illegible]

Cross checked done

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
6/7	IV Placement		11086	Alok
6/7	catheterization		11135	
2/2/26	PAC — op	1	26-000 220240	Alok
		Cross-checked done.		
2/2/26	Blood transfusion	1	211564	
7/2/26	NHA	1	11683	
8/7	IV Iron therapy	1	211791	

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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Mrs KAVYA
09-09-1982 43 Y 9 M 27 D (F)
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I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 6/7/26 Time of Admission : .....

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

PRESENTING COMPLAINTS :

* C/o Heavy menstrual Bleeding : 7-8 months.
  D_3-D_4 - 7-8 pads/day., Clots (−)
  Dysmenorrhea (−)
* Bowel & bladder habits (N)
  (N) appetite.

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : 16yrs	Parity : P_2L_2
Previous Periods : Regular.	Mode of Delivery : 2 NVD
LMP : 26/6/26.	Last Child Birth : 10yrs.
Contraception : Lap* Tubectomy.	

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
Nil	Tubectomy - 2019.

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Mrs KAVYA
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Dr. SANTHI ANTHARVEDI

Father - DM

MEDICATION HISTORY:

Nil

INITIAL ASSESSMENT :

Date 6/7 Ht. ____ Wt. ____ BMI ____ B.P 110/70 Pallor (−) CVR S1S2 Respiratory System B/L NVBS Thyroid (N)	Breasts (N) Abdominal Examination Soft	Local/Speculum Examination − Bimanual Pelvic Examination −

PROVISIONAL DIAGNOSIS : P_2L_2 / 2NVD / AUB c

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT
Blood Group - B positive 1/7 Hb - 9g/dl Plt - 3.1 lakh WBC - 5.6k Pap - NILM (5/6/26) HIV, HbsAg, HCV - NR USG (9/6/26) TVS Ut - Bulky, size 84x68x79 mm c/o few heterogenous hypoechoic intramural fibroids in ant. myometrium largest m/s 47x41mm, ET - 6.8mm. Cx - (N). B/L ovaries - N.	- Plan :- TLH - Informed consent - Prepare parts - PAC - Inform OT / Anesthetist - Shift to OT on call. - Reserve 1 PRBC

Name of the Doctor : Dr. Swathi Antharvedi

Signature of Doctor ____

Date & Time : 6/7/26

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Mrs KAVYA
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Dr. SANTHI ANTHARVEDI

(1)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S/B Dr. Dna	
6/7/26		
12:15pm	POD-0 (S/P TLH+BS)	Adv
	Afebrile	- NBM till 7pm
	BP: 102/82 mmHg	- IV Fluids
	PR: 87bpm.	- Drugs as charted.
	SpO_2: 97%. on O_2 (4L)	- I/O charting
	P/A soft	- Monitor vitals
	L/E NAB.	- W/F Bleeding P.V.
	U/O - 100ml	- Inform SOS
	Clear.	
	[signature]	
	S/B Dr. Swathi HV	
6/7/2026	- POD-0, TLH+BS.	
5:00PM	- patient comfortable.	Advice:
		→ NBM till 7pm
	O/E: P = 80bpm	→ IV fluids
	BP - 100/80	- follow order
	no pallor	- CBC c/m @ 6AM.
	PA: soft.	- Remove foleys
U/O: adequate	BS sluggish	by 12pm tomorrow
	L/E: NAD.	
	Dr. Swathi H V, Consultant Obstetrics and Gynecology, Reg No: 15501 [signature]	→ If bowel sounds ⊕ start liquids over night

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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/2026 7pm	C/o/b Dr Mamatha	
	POD-0 / TLH+BS	
	C/C - Afebrile	Adv
	BP - 100/70	
	P/A - Soft, ASD-Dry	- Allow sips of water → if
	BS ⊕	tolerates → Liq diet today
	L/E - NAD	⊛ CBC C/m (6 Am)
	(Undipped mild soakage)	- I/O monitoring
	U/O - 50-60 cc/hr	- Foley's removal @ 12 pm 7/m (7/7/2026)
	- pt comfortable -	- Drugs as charted
		- T/SOS
	(Plan) iv iron before d/c	Dr Mamatha
	Can shift to room	Dr RAMYA THEJA
	noted by Chandrakala	
	Dr. RAMYA THEJA KADIYALA Reg. No: 01458	

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

(P.T.O)

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Mrs KAVYA
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Dr. SANTHI ANTHARVEDI

Mrs Kavya

(2)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/7/2026	CS/b	2 Mansha
8Am	POD-0	17LH CBS
	CC - for Afebril	Adv
	BP 120/70	- Diet - Soft
	PR 86	- Adequate Hydration.
	P/A soft	- Drugs as charted
	L/E - NAD	- I/O monitoring
	U/O ~ 70 cells	- Foley's removal @ 12pm. today
		- Inform SOS
	CBP (6/7/2026)	- IVF to stop after Soft Diet.
	Hb. 7.4 / 7.57 (WBC) / 272 (plt)	- Ambulation
		[signature]
11pm	CBC informed to Dr Shanthi. Mam	
	Adv	
	- 1U PRBC Transfusion today - Inform Anaesthesia	
	- Inj Ferric 500mg in 100ml NS IV Slow x 1 hour Tomorrow.	
	- Shift to 4th Floor	
	- T. Aceclofenac BD from 8/7/2026 (Stop IV Pcm / Diclof)	
	- If flatus not passed till tonight	
	Give T. Dulcolax @ night	[signature]

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Mrs KAVYA
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/s by Dr Sails	
7/7/26		R
	Afebrile	① Soft diet +
		plenty fluids
	Taco	
Hb- 7.4	Afeb	② Inj. Magnesium IV
	BP- 110/70	
Dubreath		③ T. Arcidopa ND
	P/A - soft	
		④ T. pantop BD.
		⑤ 1 unit of
		Blood Transfusion
7/7/26	C/s/B Dr. DNA	
9pm	POD-1 (S/P TLH+BS) c Anaemia (Hb- 7.4g).	
	CC Taie Afebrile	Adv
	BP: 104/70 mmHg	- soft diet
1 ⓤ PRBC on flow	PR: 86/m	- Plenty of oral fluids
	H/L NAD	- Drugs as charted
urine passed	P/A soft.	- Inj Fcm 500mg IV in
	BS ⊕	100 ml NS on 8/7/26
Flatus - Not passed	L/E NAD	- T. Dulcolax at Night if
		Flatus Not passed

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/7/26 4pm	c/s/b Dr. Swathi. HV	
	POD-1 (TLH + BS) c̄ anemia.	
	Pt is stable, No c/o Ongoing Blood transfusion. (1 PRBC) o/e GC fair, Pallor (+) BP- 106/70 mmHg PR- 102 bpm P/A - Soft, NT BS (+) UE - NAD Dr. Swathi H V, Consultant Obstetrics and Gynecology, Reg. No: 15501	- Inj PERINORM 10mg iv stat - Inj DICLOFENAC stat - Ambulation - plenty of fluids - c/o pain/fever/bleed pv /Abd distension - Inform SOS - Shift to Room
7/7/2026 7:00pm	c/s/by Dr. Naveena o/E GC fair Afebrile Vitals - stable PA: soft, NT. BS (+) Dressings: dry & clean UE: NAD	Adv - Soft diet Adequate hydration - Ambulation - T-Dulcolax. PO 2tab stat - T/m Inj: FCM transfusion - w/f PV bleeding. - Monitor Vitals - Inform SOS
U - ✓ F - ✗ S - ✗		N.B. maheshwari

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Mrs KAVYA
09-09-1982 43 Y 9 M 28 D (F)
Dr. SANTHI ANTHARVEDI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/7/2026 7:30pm	c/s/b by Dr. Swathi	
	→ 40 bloating sensation & Abd discomfort	
	o/E GC - fair	Adv
	Afebrile.	- liquid diet
	PR: 106 bpm.	- Adequate hydration
	BP: 110/76 mmHg.	
U - ✓	CVS/RS: NAD	- Ambulation 3rd day
F - +	PA: soft, NT	- Dulcolax suppositories
	Bowel sounds - present	2 PR stat
S - +	minimal distension ++.	- drugs as charted
	M/C: NAD.	- w/f PV bleeding
		- Monitor Vitals
		- Inform SOS
	Dr. Swathi H.V. Consultant Obstetrics and Gynecology Reg. No: 15501	N.B. Maheshwari 7/7/26 @ 8:30PM

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

HNH-00016310 IP26-00006757
Mrs KAVYA
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7/2026 7:00am	c/s/by Dr. Naveena	
	O/E GC - fair Afebrile. V ✓ Vitals - stable. PA: Soft, NT. F ✓ S/Dressing: dry & clean. S ✓ U/E: NAD	Adv - Soft diet. - Adequate hydration. - Ambulation - w/f PV bleeding - drugs as charting. - Monitor Vitals - Inform SOS.
	Dr. Naveena.	Ntd by Anusha
	S/B - Dr. SWATHI. HV	
8/7/2026 9:50AM	→ day 3. TLH+BS., → pt comfortable - passing flatus; had soft diet.	
V ✓ S ✓	O/E: P = 88bpm BP → 118/70mmHg. PA: soft, BS + D: dry. U/E: NAD	Advice: - soft diet. → Adequate hydration → Ambulation early → w/f pain/fever → oral hematinics → Inform SOS → plan D/S today.

Dr. Swathi HV
Consultant Obstetrics and Gynecology
Reg. No: 15501

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Mrs KAVYA
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7/26 1:15pm	Inj Fem 500mg IV in 100ml NS given	
	- No reaction.	
	R/- can be discharged	
	Send file for processing.	
	N.B. maheshwari 8/7/26 1:20pm.	

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00016310 IP26-00006757
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DRUG CHART

Date of Admission: 6/7/26 Drug Allergies: ..... ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As required Medication)

DRUG : ONDANSETRON.				Date / Time
Dose: 4mg	Route: IV.	Frequency: SOS.	Start Date: 6/7	
Doctor's Signature	Valid Period	Pharm.		
Additional Instructions:				

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

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

Verified by Dr. Dhakshayani

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

HNH-00016310 IP26-00006757
Mrs KAVYA
09-09-1982 43 Y 9 M 27 D (F)
Dr. SANTHI ANTHARVEDI

REGULAR PRESCRIPTIONS

Weight. 46kgs Ward. .....

DRUG : INJ. CEFFERAZONE SULBACTAM

Dose	Route	Frequency	Start Date
1.5g	IV	BID	6/7/26

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:
tell Oncharge

Daily Doctor's Endorsement by a Sign

Date/Time: 6/7 7/7 8/7
10AM 10PM

DRUG : PARACETAMOL

Dose	Route	Frequency	Start Date
1gm	IV	TID	6/7

Name & Signature of the Doctor Starting the Drugs:
Dr Amir

Additional Instructions:
till 7/7

Daily Doctor's Endorsement by a Sign

Date/Time: 6/7 7/7
6AM 10PM 2PM 6PM 10PM
STOP Dr. Naveena

DRUG : Inj PANTOPRAZOLE

Dose	Route	Frequency	Start Date
40mg	IV.	DD	6/7

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time: 6/7 7/7 8/7
6AM

DRUG : Inj DICLOFENAC

Dose	Route	Frequency	Start Date
75mg	IV	BD	6/7

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

Additional Instructions:
till 7/7

Daily Doctor's Endorsement by a Sign

Date/Time: 6/7 7/7
9AM 3PM 11PM
STOP Dr. Naveena

Verified by Dr. Dhakshayani

HNH-00016405 IP26-00006768
Master PYDA SHRI NAGA AGASTYA
30-11-2024 1 Y 7 M 7 D (M)
Dr. PRANEET REDDY NAYINI

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Shee

REGULAR PRESCRIPTIONS

Weight 4 6 days Ward .....

DRUG : T. ACECLO PLUS

Dose	Route	Frequency	Start Dt.
~~1 TAB~~	PO		

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:
ACECLOFENAC + PARACETAMOL

Daily Doctor's Endorsement by a Sign

Date / Time

STOP
Dr. Naveena.

DRUG : T ACECLO PLUS

Dose	Route	Frequency	Start Dt.
1 TAB	PO	BD	8/7

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

Additional Instructions:
ACECLOFENAC + PARACETAMOL.

Daily Doctor's Endorsement by a Sign

Date / Time 8/7 8PM 8PM

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

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REGULAR PRESCRIPTIONS

Sheet No: .... Weight .... Ward ....

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ➤ Time ▼

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ➤ Time ▼

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ➤ Time ▼

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ➤ Time ▼

HNH-00016310 IP26-00006757
Mrs KAVYA
09-09-1982 43 Y 9 M 27 D (F)
Dr. SANTHI ANTHARVEDI

IP26-00006757

Weight. 46kgs Ward. .....

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
6/7/26	9:15AM	INJ. PANTAPRAZOLE	40mg	IV		Madhu
6/7/26	9:52AM	INJ. METOCLOPRAMIDE	10mg	IV		Madhu
6/7/26	6AM	T. MISOPROSTOL	200mcg	P/V		Manika Akhila.
6/7	1030AM	MORPHINE	4.5mg	IV		Palavi Natasha
6/7	12:05PM	SUPP. DICLOFENAC	100mG	P/R	B de	Palavi Natasha
6/7	12:05PM	SUPP. TRAMADOL	100 MG	P/R	B de	Palavi Natasha
7/7	4PM	INJ-METOCLOPRAMIDE	10mg	IV		Mouni Akhila.
7/7	7:05PM	INJ PANTOP-RAZOLE	40mG	IV		mahi mahi
7/7	7:30pm	DULCOLAX SUPPOSITORIES	2 SUPP	PR		

Dr. Dhakshayani

HNH-00016310
Mrs KAVYA
09-09-1982 43 Y 9 M 27 D (F)
Dr. SANTHI ANTHARVEDI

I.V. FLUIDS CHART

Weight. 46kgs Ward. .....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
6/7/26	9PM	RINGER LACTATE	IV	100ml/hr ↓ 1000			6/7		
6/7	1030	RINGER LACTATE	IV	500			6/7		
6/7	11:45AM	RINGER LACTATE	IV	500ML/HR			6/7		
6/7	2:00PM	RINGER LACTATE	IV	100 ml/h			6/7		
6/7	6PM.	RINGER LACTATE	IV	100 ml/h			6/7		
6/7	12AM.	RINGER LACTATE	IV	100 ml/h			7/7		
7/7	6AM	RINGER LACTATE	IV	100 ml/h			7/7		
7/7	11PM.	RINGER LACTATE	IV	100 ml/h			7/7		
		Stop					stopping		
7/7	1.10PM	1 ⊙ PRBC transfusion	IV.			clear			

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

HNH-00016310 IP26-00006757
Mrs KAVYA
09-09-1982 43 Y 9 M 27 D (F)
Dr. SANTHI ANTHARVEDI

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RESULT SHEET

Date	7/7					
Time						
Hb	7.4					
PCV						
RBC	3.38.					
WBC	7.57					
N/L						
Platelets	272					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Blood group = B+ve			10 RRBC Reserved			
HIV						
HBsAg } NR						
HCV						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

HNH-00016310 IP26-00006757
Mrs KAVYA 43 Y 9 M 27 D (F)
09-09-1982
Dr. SANTHI ANTHARVEDI

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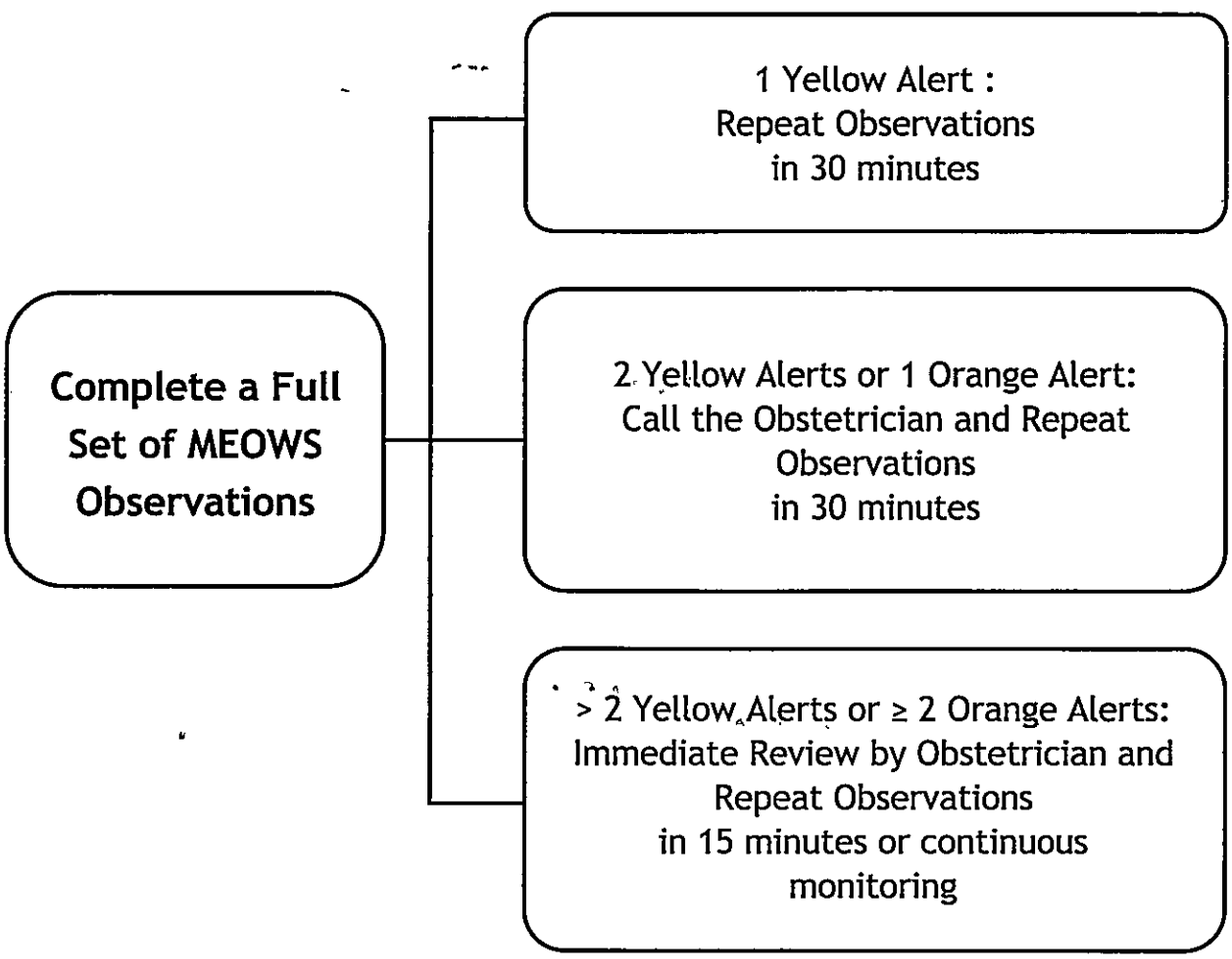
Early Warning Observation Score Chart - Obstetrics

6/7/26

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

		Date																						
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20	20		20		20	20	20	20	20	20	20	20	20	20		20			20					20	
	0 - 10																									
Saturations	94 - 100 %	99		99		99	99	99	99	99	99	99	99	100	100		100			100					100	
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37																									
	36	36		36		36		36		36		36														
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80	86		86		74	76	78	80	80	80	90	74	86			86			87					86	
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110	112		116		106	110	112	110	110	110	110	110	110			110			117					120	
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
	40																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70	77		71		72	74	76	70	70	70	90	80	70			72			70					71	
	60																									
	50																									
	40																									
NEURO RESPONSE [✓]	Alert				✓		✓		✓																	
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30	–																								
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal									✓	✓	✓														
	Heavy / Foul																									
Liquor	Clear / Pink									✓	✓	✓														
	Green																									
TOTAL YELLOW SCORES		2		2		2	2	2	2	2	2	2	2	2			2			2					2	
TOTAL ORANGE SCORES		0		0		0	0	0	0	0	0	0	0	0			0			0					0	
Nurse Initial																										

Obstetrics and Gynaecology Early Warning Signs



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

HNH-00016310 IP26-00006757
Mrs KAVYA
09-09-1982 43 Y 9 M 28 D (F)
Dr. SANTHI ANTHARVEDI

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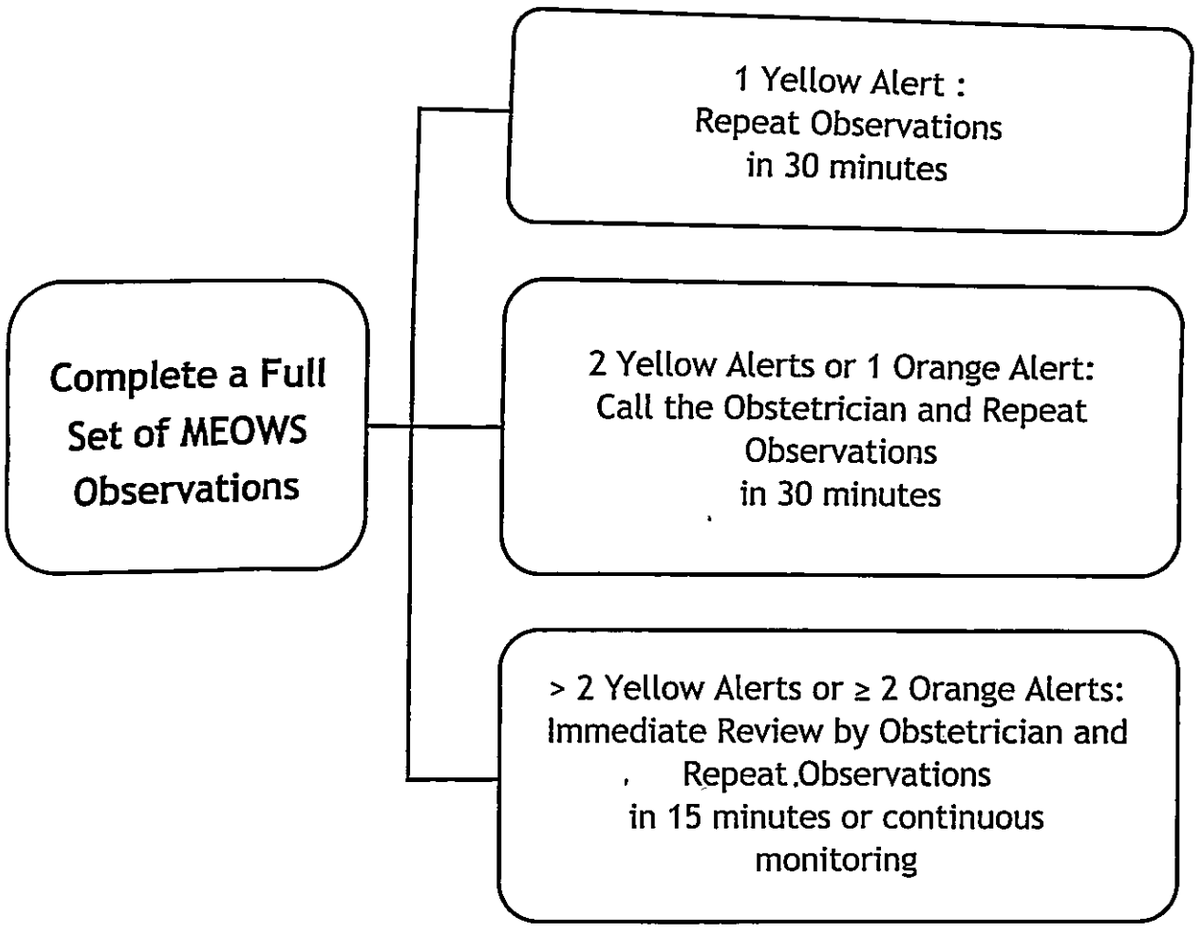
Early Warning Observation Score Chart - Obstetrics

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

7h

		Date																						
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20				22h	20h	20h						20h				22				20				20	
	0 - 10																									
Saturations	94 - 100 %				98%	99%	99%						98%				99%				99%				99%	
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37																									
	36				101°		98.6°F	98.6°F					98.6°F				97.5°F				97.5°F				98.6°F	
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100												106bpm													
	90																									
	80			93	98bpm		85bpm										98				80bpm				80	
	70																									
	60																									
	50																									
	40																									
↑ Systolic Blood Pressure	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120			119		100		111					117				112				120				115	
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
↓ Diastolic Blood Pressure	130																									
	120																									
	110																									
	100																									
	90																									
	80												(89)				(82)									
	70																									
	60			64		60		65					76				75				71				71	
	50																									
	40																									
NEURO RESPONSE [✓]	Alert																									
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30																									
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal																									
	Heavy / Foul																									
Liquor	Clear / Pink																									
	Green																									
TOTAL YELLOW SCORES				0		0		0					0				0									
TOTAL ORANGE SCORES				0		0		0					0				0				0				0	
Nurse Initial																										

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

H' -00016310 IP26-00006757
KAVYA
09-09-1982 43 Y 9 M 28 D (F)
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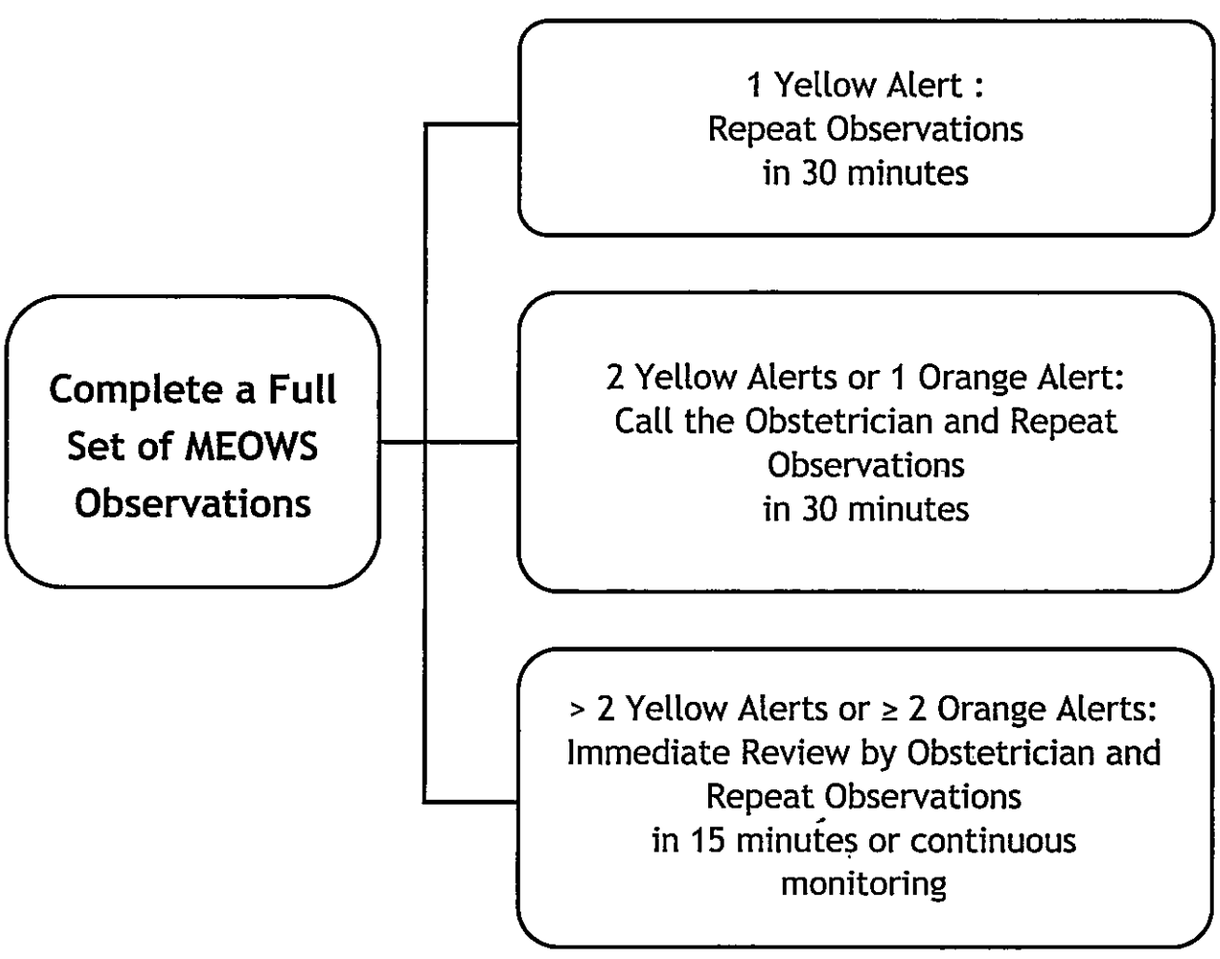
Early warning Observation Score Chart - Obstetrics

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

8/7

		Date																								
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20				20	18	20	20	20																	
	0 - 10																									
Saturations	94 - 100 %				99	100	99	99	98																	
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°C	40																									
	39																									
	38																									
	37																									
	36				36.1°F			36.1																			
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80				86	84	89	84	86																	
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120				105	101	111	112																		
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
	40																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60				73	71	74	76																		
	50																									
	40																									
NEURO RESPONSE [✓]	Alert				–	–	–	–																		
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30				–																					
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal				–																					
	Heavy / Foul																									
Liquor	Clear / Pink				–																					
	Green																									
TOTAL YELLOW SCORES					0	0	0	0																		
TOTAL ORANGE SCORES					0	0	0	0																		
Nurse Initial																										

Obstetrics and Gynaecology Early Warning Signs



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

HNH-00016310 IP26-00006757
Mrs KAVYA
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FLUID CHART

Sheet No. : ......(1)......

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

Date	Time	Intake: Nature of Fluid	Route: Mouth	Route: I.V	Route: N.G	Output: NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
6/7	08:00 am	R	N	100ml								
	09:00 am	RL	B	100ml								
	10:00 am	RL	M	100ml							0	
	11:00 am	RL	N	100ml		NA						0
	12:00 pm	RL	B	100ml						100ml		[illegible]
	01:00 pm	RL	M	100ml								
Total Intake :									**Total Output :**	Passed		
6/7	02:00 pm	RL	N	100ml								
	03:00 pm	RL	B	100ml								
	04:00 pm	RL		100ml								
	05:00 pm	RL	M	100ml		NA					0	
	06:00 pm	RL	Sips	100ml						500ml		[illegible]
	07:00 pm	RL		100ml								
Total Intake :									**Total Output :**			
6/7	08:00 pm	RL		100ml								
	09:00 pm	RL		100ml								
	10:00 pm	RL		100ml						200ml	0	[illegible]
	11:00 pm	RL		100ml		NA						
	12:00 am	RL		100ml				0	NA			
	01:00 am	RL		100ml						400ml		[illegible]
Total Intake :									**Total Output :**	Passed		
7/7	02:00 am	RL		100ml								
	03:00 am	RL		100ml								
	04:00 am	RL		100ml								
	05:00 am	RL		100ml		NA	0				0	0
	06:00 am	RL		100ml				0	NA	300ml		[illegible]
	07:00 am	RL		100ml								
Total Intake : Cont									**Total Output :**	Passed		

Total 24 hrs. Intake		Total 24 hrs. Output	

Docu. No. : RCH /FRM / CLINICAL / 092

HNH-00016310 IP26-00006757
Mrs KAVYA
09-09-1982 43 Y 9 M 28 D (F)
Dr. SANTHI ANTHARVEDI

Rainbow® Children's Hospital
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BirthRight™ BY RAINBOW HOSPITALS
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FLUID CHART

Sheet No. : ....

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

Date	Time	Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
7/7	08:00 am	RL	Idly	100ml		NA			NA			
	09:00 am			100ml								
	10:00 am			100ml						300ml		
	11:00 am			100ml			0					
	12:00 pm			100ml						✓		
	01:00 pm	PRBC		100ml								
Total Intake :						Total Output :						
7/7	02:00 pm	PRBC		100ml		NA		NA			0	
	03:00 pm	PRBC		100ml						✓		
	04:00 pm	PRBC	0	80ml								
	05:00 pm	PRBC		80ml			0					
	06:00 pm	PR		80ml								
	07:00 pm									✓		
Total Intake :						Total Output :						
7/7/26	08:00 pm	0	soup + H2O	0	NA		✓		NA	✓	0	
	09:00 pm											
	10:00 pm									✓		
	11:00 pm											
	12:00 am									✓		
	01:00 am											
Total Intake : Rawly						Total Output : U-2 M-1						
8/7/26	02:00 am	0		0	NA				NA	✓	0	
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am		✓									
Total Intake : Rawly						Total Output : U-1 M-0						

Total 24 hrs. Intake		Total 24 hrs. Output	

Docu. No. : RCH /FRM / CLINICAL / 092

HNH-00016310 IP26-00006757
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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
9/7	08:00 am											
	09:00 am											
	10:00 am		Jelly									
	11:00 am		+									
	12:00 pm		H_2O.									
	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	

HNH-00016310 IP26-00006757
Mrs KAVYA
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Your Right to a Safe Delivery

FLUID-CHART

Sheet No. : .....

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

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

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

HNH-00016310
Mrs KAVYA
09-09-1982
Dr. SANTHI ANTHARVEDI
IP26-00006757
43 Y 9 M 28 D
(F)

NURSING CARE RECORD

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

Date: 01/07/2026

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning				NA			
Afternoon	2pm 8pm	→ Assess the pt condition → Check the vital's → I/O chart Maintain → plan for NST	2pm 8pm	→ Assessed pt condition → Checked vitals & Maintained I/O chart → Admission NST done	vital's is Normal	pt is stable	Nurse
Night	8pm 8Am	→ Assess the pt condition. → monitor the vitals. → I/O chart. maintain. → drugs give as per drug chart.	8pm 8Am.	→ Assessed the pt condition. → monitored the vitals. → I/O chart monitored. → drugs given as per drug chart.	→ pt is stable Now.	→ pt is recovered the vitals.	

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Mrs KAVYA
09-09-1982 43 Y 9 M 28 D (F)
Dr. SANTHI ANTHARVEDI

BAH
M
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NURSING CARE RECORD

Date: 2/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM / 2PM	→ Assess the general condition of pt. → Monitor vitals → Maintain I/O chart → Administer medication → provide Comfortable position	8AM / 2PM	→ Assessed the general condition of pt. → Monitored vitals → Maintained I/O chart → Administered medication → provided comfortable position	pt is stable	Re assess vitals	Mouthak
Afternoon		Day Duty					
Night	8pm / 8AM	- Assess the pt Condition - Monitor vitals & I/O chart - drug as per chart - provide Comfortable position		- Assessed the pt Condition - Monitored vitals & I/O chart - drugged as per chart - provided Comfortable position	pt is stable	Rechecked vitals	

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NURSING CARE RECORD

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Date: 6/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am 2Pm	→Assess the pt condition →monitor the vitals & record →Administration of medication →maintain Flowchart & record	8Am 2Pm	→Assessed the pt condition →monitored the vitals & recorded →Administered medication as per doctor's →maintained Flo chart & recorded	pt is stable	maintain Flo chart & record.	Akila
Afternoon	8pm to 8pm	→Assess the patient condition →maintain vitals & record →maintain Flowchart	8pm to 8pm	→Assessed the patient condition →maintain vitals as record. →maintain Flowchart	patient is stable	vitals is normal	Cloud
Night	8pm to 8Am	→check the pt condition →monitor vitals as per doctor's →Administered medication as per doctor's		→checked the pt condition →monitoring vitals & record →Administered medication as per doctor's →Maintain Flowchart	→pt is stable	→vitals checked	

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Date: 7/3/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am – 2pm	→ Assess the pt condition. → monitor the vitals. → maintain I/O chart. → drugs give as per drug chart.	8Am – 2pm	→ Assessed the pt condition. → monitored the vitals. → maintained I/O chart. → drugs given as per drug chart.	→ pt is stable now	→ Reassessed the vitals	[signature]
Afternoon	2pm – 8pm	→ Assess the pt condition → monitor the vitals and record → maintained I/O chart record → Administration of medication as per doctor	2pm – 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	Akhila [signature]
Night	8pm to 8Am	→ Assess the pt condition → monitor the vitals → maintain I/O chart → Administer the medication as per drug chart	8pm to 8Am	→ Assessed pt condition → monitored vitals → maintained I/O chart → Administered medication as per drug chart	Patient is stable	Re-checked vitals	[signature]

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Mrs KAVYA
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NURSING CARE RECORD

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Date: 8/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM 2pm	→Assess the pt condition. →monitor the vitals. →plan Inj. FCM. Today. →drugs give as per drug chart.	8AM 2pm	→Assessed the pt vitals. →Assessed the pt condition. →planned Inj. FCM Today. →drugs given as per drug chart.	→pt is stable Now.	→Reassessed the vitals	
Afternoon							
Night							

Patient Sticker

NURSING CARE RECORD

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Date: .....

Goals

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

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

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NURSING SHIFT HAND OVER FORM - WARD

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

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☑ Not Known If Yes Specify:					
BACKGROUND	Area / Shift Time	6/7 M6	6/7 E2	6/7 [illegible]	7/7 M6	7/7 E2	7/7 N1
	Medical Condition (Any special condition to be noted):	NA	NA	NA	—	—	—
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Vital Signs: Temp:	97°F	97°F	98.4°F	98.1°C	97°F	98.2°F
	Res:	20b/mt	20	20b/m	20b/m	20b/mt	23b/m
	SpO_2:	99%	99%	99%	99%	98%	99%
	Pulse:	89b/mt	80b/mt	81b/m	82b/m	87b/mt	85b/m
	BP:	110/70	110/70	111/70	110/71	106/70	110/72
	Fall Risk Score:	—	—		—		—
	Pain Score:	0/10	0/10	0/10	1/10 [illegible]	0/10	—
Recommendations	Safety Needs:	yes	yes	✓	yes	✓	yes
	Physiotherapy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Others Specify:	—	—		—	—	—
	Special Diet:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Other Special Orders / Medications:	NA	NA	NA	NA	NA	—
Post Operative Procedure Special Orders:		NA	NA	NA	NA	NA	—
Handed Over By Name :		akhila	claudi	[illegible]	mahi	akhila	Anusha
Signature :		[signature]	[signature]	[signature]	[signature]	[signature]	[signature]
Date:		6/7/26	[illegible]	7/7/26	7/7/26	8/7/26	8/7/26
Time:		2pm	[illegible]	9AM	2pm	8PM	8AM
Taken Over By Name :		claudi	[illegible]	mahi	akhila	Anusha	mahi
Signature :		[signature]	[signature]	[signature]	[signature]	[signature]	[signature]
Date:		6/7/26	6/7/26	7/7/26	7/7/26	7/7/26	8/7/26
Time:		2pm	8pm	8Am	2pm	8PM	8Am

Docu. No. : RCH/FRM/CLINICAL/097

HNH-00016310 IP26-00006757
Mrs KAVYA
09-09-1982 43 Y 9 M 29 D (F)
Dr. SANTHI ANTHARVEDI

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..RSING SHIFT HAND OVER FORM - WARD

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

SITUATION	Diagnosis: TLH.	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area / Shift Time	8/7/26 M6					
	Medical Condition (Any special condition to be noted):	—					
ASSESSMENT	Allergy:	☐ Yes ☐ ~~No~~	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ ~~No~~	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.1°F					
	Res:	20b/m					
	SpO_2:	100%					
	Pulse:	75					
	BP:	107/85					
	Fall Risk Score:	—					
	Pain Score:	'0'					
Recommendations	Safety Needs:	Yes					
	Physiotherapy	☐ Yes ☐ ~~No~~	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	—					
	Special Diet:	☐ Yes ☐ ~~No~~	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	—					
Post Operative Procedure Special Orders:		—					
Handed Over By Name :		mahi					
Signature :		~~~					
Date:		8/7/26					
Time:		2pm					
Taken Over By Name :							
Signature :							
Date:							
Time:							

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Mrs KAVYA
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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 (6/7)			DAY-2 (7/7)			DAY-3 (8/7)			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			
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	–	NA	NA	NA	–	–	–			
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	–	NA	NA	NA	–	–	–			
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	–	NA	NA	NA	–	–	–			
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	–	NA	NA	NA	–	–	–			
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	–	NA	NA	NA	–	–	–			
		Signature of the Nurse											

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

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

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CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

HNH-00016310 IP26-00006757
Mrs KAVYA
09-09-1982 43 Y 9 M 27 D (F)
Dr. SANTHI ANTHARVEDI

BRADEN 'Q' SCALE

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					Date : 6/7	6/7	7/2	7/2
					Time : 16	E2	D	MC
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	3
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	3
				TOTAL SCORE	28	28	24	26
				Evaluator's Name	A	A		A

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

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

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

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BRADEN 'Q' SCALE

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				Date :	8/7			
				Time :	MG			
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4			
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4			
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4			
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4			
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4			
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4			
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	3			
				TOTAL SCORE	26			
				Evaluator's Name	[signature]			

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

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

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Mrs KAVYA
09-09-1982 43 Y 9 M 27 D (F)
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PAIN ASSESSMENT FORM

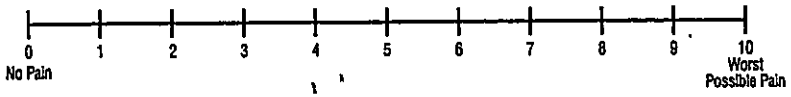
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
6/7	10AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
6/7	2pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
6/7	3pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
6/7	10p	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
7/7	1pm Paracetamol 1/10	0	abdominal pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
7/7	9pm	1/10	Abdomen	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	
8/7/26	9pm	0/10	NAT	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	
9/7/26.	12pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

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

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	6/7/26 H6	6/7/26 E2	6/7	Fall Risk Grading		
		Score						
History of Falling (immediately or w/in 3 months)	Yes	25				Risk Level	Morse Fall Score (MFS)	Action
	No	0						
Secondary Diagnosis (more than one diagnosis)	Yes	15						
	No	0	0	0	0	Low Risk	0 - 24	Standard Fall Precaution
Ambulatory Aid	Furniture	30						
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	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						
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
Mental Status	Forgets limitations	15						
	Oriented to own ability	0		0				
Total Morse Fall Scale Score:			20	20	20			
		Signature	A					

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 6/7/26 Date of Removal: .....

Parameters	Date / Shift Time	6/7 MG	8/7/26 D					
Need for the Catheter		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Hand Hygiene		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Usage of Sterile Equipment		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Is the Collection bag below the level of bladder		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Check the Tube for Obstruction (Free of Kinking)		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Is Catheter dated as policy		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Collecting bag is been emptied regularly?		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Maintenance of closed system for the catheter		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Dressing clean and dry?		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Is the line removed as Policy?		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Performance of Perineal Care		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Onset of New Fever		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Asses for the leakage at the site of insertion		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Name of the Nurse		Madhu						
Signature of the Nurse								

Removed

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

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08-09-1982 43 Y 9 M 29 D (F)
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IP26-00006757

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STAT / ONCE ONLY DRUGS

Name: .....

Weight: 46 kgs

Sheet No: .....

DATE	TIME	MEDICATION	DOSAGE & OTHER INSTRUCTIONS	ROUTE	SIGNATURE		
					Doctor	Nurse-1	Nurse-2
7/7	9pm	INJ-PARACETAMOL	1GM	IV			
8/7/26	12:45PM	INJ FERROUS CARBOXY MALTOSE	500mg	IV (in 100ml NS)			

Verified by Dr. Dhakshayani

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MEDICATION RECONCILIATION FORM

Drug Allergies: .... ☑ Not known any Drug Allergies

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

Shifting From: .... Shifted to: ....

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

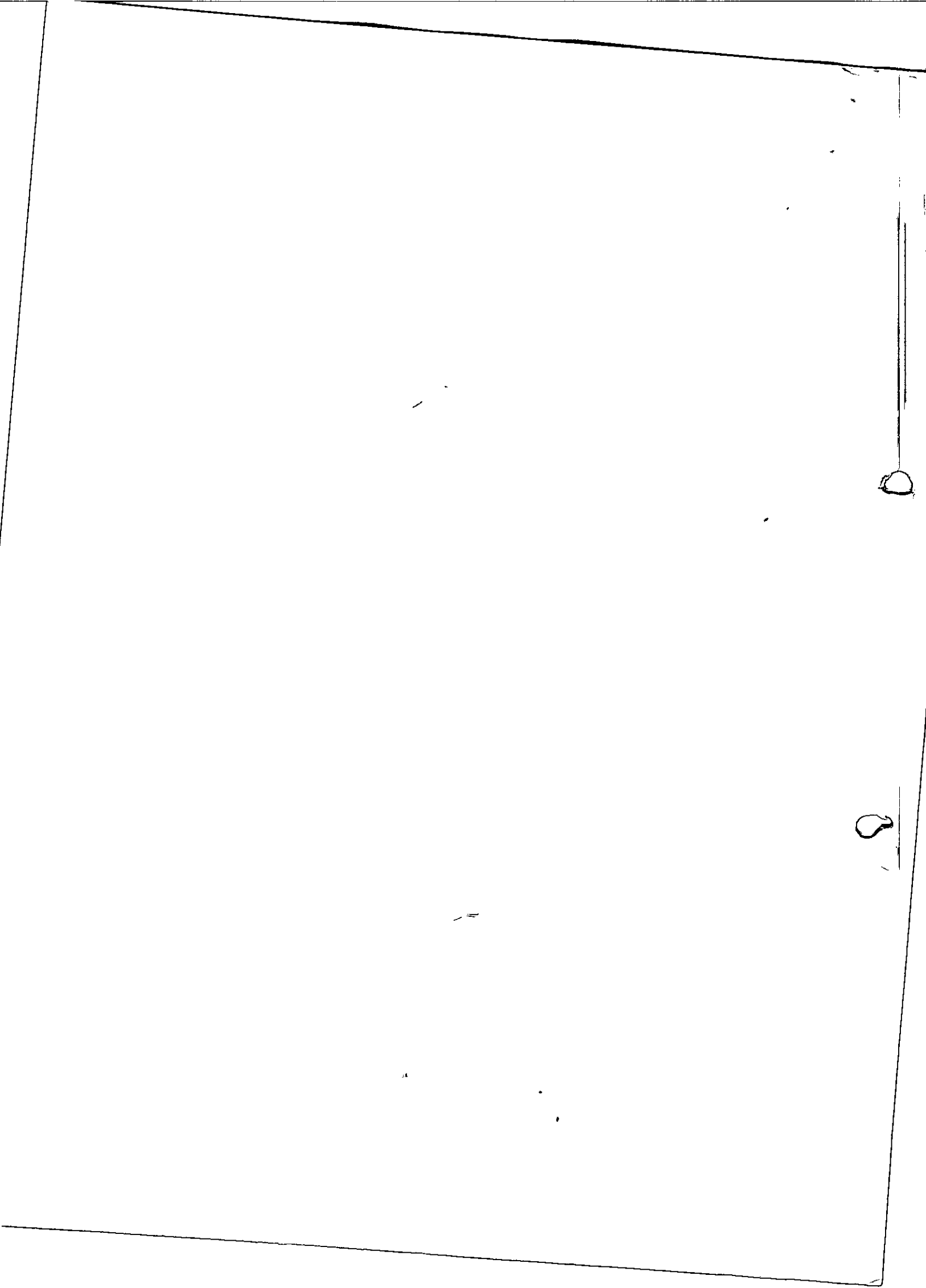
Doctor Name & Signature : Dr. G. Veera

Date & Time : 6/7/26 @ 8am

Nurse Name & Signature: Akila

Date & Time : 6/7/26 @ 8Am

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



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Mrs KAVYA
09-09-1982 43 Y 9 M 28 D (F)
Dr. SANTHI ANTHARVEDI

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NUTRITIONAL ASSESSMENT FOR GYNEC PATIENTS

Date: 7/7/26 Time: 11 Am

Origin: Indian Height: Weight: BMI:

Food Allergies: NO Dondakay 1

Diagnosis: TLH + BSO POD-1

Medical History: Nil

Surgical History: Nil

☐ Vegetarian ☑ Non-Vegetarian ☐ Vegan

Diet Advised: Soft Diet Iron rich diet

Patient's / Attendant's

Signature:

Name: Kavya.

Date & Time: 7/7/26 ; 11 Am

Dietician's

Signature:

Name: Sathwika. G

Date & Time: 7/7/26 ; 11 Am

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016310 IP26-00006757 Mrs KAVYA 09-09-1982 43 Y 9 M 27 D (F) Dr. SANTHI ANTHARVEDI	6/7/26 @ 8pm	6/7/26 @ 8pm
	Transfer Ordered by dr manisha	Reason for Transfer obs
From Unit pre-past	To Unit 306	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Chandrakala	dr manisha

Patient & Clinical Records Received by : Priyanka

Date & Time of Patient Received : 6/7/26 @ 8:15 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

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OPERATION THEATER NOTES

HNH-00016310 IP26-00006757
Mrs KAVYA
09-09-1982 43 Y 9 M 27 D (F)
Dr. SANTHI ANTHARVEDI

Patient's Name : ..... Age : ..... Gender : .....

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

Surgeon : Dr. Swathi	Asst. Surgeon : Dr. Dua.
Anesthetist :	OT Nurse :

Surgical Procedure :

Total Laparoscopic Hysterectomy + B/L Salpingectomy.

Indications for Surgery : AUB-L.
FIBROID

Date : 6/7/2026.	Start Time :	End Time :

PRE-OPERATIVE PREPARATION :

OPERATION NOTES: -- Pt- in low Lithotomy position
Primary port-10mm, 3 accessory port- 5mm.

Intra-Op Findings
- Uterus - 14 week size. & Multiple uterine fibroid
- B/L Fallopian tubes - Normal., B/L fallopexing noted.
- B/L Ovaries - Normal.

- Proceeded with Total laparoscopic Hysterectomy + Bilateral salpingectomy.

- Specimen retrieved through vaging.
- Vault sutured by stratafix No. 2-0.

- Thorough irrigation & suction done.

- Hemostasis secured
- B/L ureteric peristalsis visualized at the end of procedure.
- Urine clear.
- procedure uneventful.

Specimen - Uterus + cervix + B/L Fallopian Tube.

POST - OPERATIVE ORDERS :

- NBM till further orders
- IV Fluids - RL @100 ml/hr
- I.V. Antibiotics x 48hrs.
- Drugs as charted.
- I/O charting
- Monitor vitals
- Inform SOS
- CBC tomorrow

- plan Inj PCM 1g before B/S.

- Inj PCM 1gm IV TID
- Inj DICLOFENAC 75mg IV BD } x24hrs.

- Inj PANTOP 40mg OD
- Inj ONDEM 4mg SOS.

Dr Swathi I.V.

Consultant Surgeon's Name

Consultant Surgeon's Signature

Date : 6/7/2025 Time : 12:20pm

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Mrs KAVYA
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LABOUR AND DELIVERY NURSING ASSESSMENT

Date of Admission: 6/7/26

Baseline Information:

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

Primary Language: ☑ Telugu ☐ English ☐ Hindi ☐ Others

Do you require an interpreter? ☑ Yes ☐ No

Source of Information: ☑ Patient ☐ Family ☐ Others

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

handed over to family members

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

If yes , identify .....

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

..... care for surgery Name of the Doctor: Dr'

..... Time Notified: .....

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

Past Medical History	Past Surgical History	Previous Hospital Admission
–	–	–

Blood Group: ..... LMP: ..... EDD: ..... Gestational age during admission: .....

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

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

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

Temp: 98.1°F HR: 87bmt RR: 20bmt BP: 110/70 SpO_2 99%

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

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

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Mrs KAVYA
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Dr. SANTHI ANTHARVEDI

Family History: ☐ No Abnormalities Detected

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

☐ Liver disease ☐ Other .....

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

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

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

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

☐ Mobility problem ☐ Walking Problem ☑ No Abnormality Detected

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

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

☐ Under Weight ☐ Diabetes Mellitus ☑ No Abnormality Detected

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

☐ Others .....

Inform consultant for positive criteria

SOCIAL SCREENING:

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

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

Social History: Lives With ..family members..

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 ..Pt

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

Orientation not given Reason: ..N/A

Nurse Signature: ..

Nurse Name: ..dkuly

Date & Time: ..6/7/26

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016310 IP26-00006757 Mrs KAVYA 09-09-1982 43 Y 9 M 27 D (F) Dr. SANTHI ANTHARVEDI	6/7/26 @ 2:40Am	6/7/26 @ 9:50Am
	Transfer Ordered by Dr. DUG	Reason for Transfer TLH+BSO
From Unit Pre & Post	To Unit OT	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 30	Number of Imaging Films —	Personal belongings including clinical documents. If any handed over to attendant Yes ☑ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
nadeem @	Dr. DUG

Patient & Clinical Records Received by :
Kavya @ 09:55Am

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

SURGICAL SAFETY CHECKLIST

HNH-00016310 IP26-00006757
Mrs KAVYA
09-09-1982 43 Y 9 M 27 D (F)
Dr. SANTHI ANTHARVEDI

Surgeon : Dr. Santhi
Asst. Surgeon : Dr. Swathi
Anaesthetist : Dr. Samdri
Scrub Nurse : Sr. Sangeetha, Sr. Balu

Age : 43y Gender : fe
Surgery Name : Laproscopic Hystrectomy
Date : 6/7/26 In-time : 10:02Am Out-time : 12:15 Pm

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Before Induction of Anaesthesia ➢ ➢

SIGN IN Time: 9:55am

Patient Has Confirmed

- Identity ☑ Yes ☐ No
- Site ☑ Yes ☐ No
- Procedure ☑ Yes ☐ No
- Consent ☑ Yes ☐ No

Site Marked ☐ Yes ☐ No ☑ NA

Anaesthesia Safety Check Completed ☑ Yes ☐ No

Pulse Oximeter on Patient & Functioning ☑ Yes ☐ No

Does Patient have a:

- Known Allergy? ☐ Yes ☑ No

Difficult Airway / Aspiration Risk?

- Yes, & Equipment / Assistance Available ☐ Yes ☑ No

Risk of > 500ml Blood Loss (7ml/kg In Children)?

- Yes, and Adequate Intravenous Access and Fluids Planned ☑ Yes ☐ No ☐ NA
- Blood Units Reserved ☑ Yes ☐ No ☐ NA

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

Signature : [signature]

Name : [signature]

Before Skin Incision ➢ ➢

TIME OUT Time: 10:19 Am

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

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm

- Correct Patient (Check ID Band) ☑ Yes ☐ No
- Correct Site ☑ Yes ☐ No
- Correct Procedure ☑ Yes ☐ No

Anticipated Critical Events

Surgeon Reviews:

- What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? Bleeding, 1 hour, 500ml ☑ Yes ☐ No ☐ NA

Anaesthesia Team Reviews:

- Are There Any Patient-specific Concerns? anemia ☑ Yes ☐ No ☐ NA

Nursing Team Reviews:

- Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☑ Yes ☐ No ☐ NA

Is Essential Imaging Displayed? ☐ Yes ☐ No ☐ NA

Signature : Karuna

Name : Karuna @ 10:19Am

Before Patient Leaves Operating Room

SIGN OUT Time: 10:20 Am

Nurse Verbally Confirms with the Team:

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

To Surgeon, Anaesthetist and Nurse:

- What are the key concerns for recovery and management of this patient? ☑ Yes ☐ No

Signature : [signature]

Name : Dr. Swathi

Doc. No. : RCH / FRM / CLINICAL / 111

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PATIENT TRANSFER FORM

HNH-00016310 IP26-00006757
Mrs KAVYA
09-09-1982 43 Y 9 M 27 D (F)
Dr. SANTHI ANTHARVEDI

Date & Time of Admission	Date & Time of Transfer Order
6/7/26 @ 7:40 AM	6/7/26 @ 12:30 pm
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr. Santhi	Dr. Samir	Observation
From Unit	**To Unit**	**Information to Attendant**
OT	Pre Post	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant** Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

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

Patient & Clinical Records Received by : Madhumita

Date & Time of Patient Received : 6/7/26 @ 12:30 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

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Patient Name : Mrs. kavya Gender: ☐ Male ☑ Female Age : 43 yrs

UHID No : Date : 6/1/26

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)

MRS. KAVYA TOTAL LAPAROSCOPIC HYSTERECTOMY

upon

MRS. KAVYA (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.

Excessive bleeding, need for transfusion of blood or blood products, inadvertant injury to bowel, bladder or ureter, wound infection, chances of oophorectomy

My signature on this form indicates that

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

Name of the Doctor who is performing the Surgery / Procedure: Dr. Shanti Anthanvedi

Consentee :

Signature :

Name : Mrs. kavya

Date & Time : 6/1/26 @ 8am

Patient Attendant :

Signature :

Name : Ganga Sudhakar

Relationship with Patient: Husband

Date & Time : 6/1/26 @ 8am

Witness :

Signature :

Name : Akhila

Date & Time : 6/1/26

Doctor (who is taking the consent) :

Signature :

Name : Dr. G. Veena

Date & Time : 6/1/26 @ 8am

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : Mrs. KAVYA Age : 28y Gender : Male ☐ Female ☑

UHID NO HNH-0001631O Surgeon Name: Dr. SHANTH

Anaesthesiologist : Dr. SAMIR

Operative procedure planned : TOTAL LAPAROSCOPIC HYSTERECTOMY

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

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

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

☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure

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

☐ Incapacitating Cronic Obstructive Pulmonary Disease

☑ Others : Hypotension, Bleeding, Need for transfusion, Transfusion Reaction

Comments :

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

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon (me) / my patient Mrs. KAVYA the above mentioned (operation) / Diagnostic / Therapeutic procedures TOTAL LAPAROSCOPIC HYSTERECTOMY

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 : Kavya

Relationship with Patient: Sey

Date & Time : 6/7/26, 9:57 am

Witness :

Signature : .....

Name : Naga Sudendra

Date & Time : 07/26

Doctor (who is taking the consent) :

Signature : Dr. Ayesha

Name : .....

Date & Time : 06/07/26, 8:00Am

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: Mrs. Kavya Age: 43 y Sex: female UHID.No: HNH-16310

Date: 2/7 Time: 215 pm Proposed Operation: TLH.

Diagnosis: fibroid uterus.

B.P / CRT: 110/75 mm Hg H.R: .... Weight: 46 ASA Physical Status: ☐ 1 ☑ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 9.0	Glucose: 88	Protein:	HIV: NR	X-Ray:
PCV: 29.0	Urea:	Alb:	HBS Ag: NR	ECG: NSR - VR - 74/m
WBC: 5600	Creat:	Total Bill:	HCV: NR	2D Echo: EF - 66%
Plate: 3.03	Na:	Dir. Bill:	Blood group: B pos	Stress/Anglo: No RWMA
PT: 13.6	K:	LDH:	T3	Other: (N) chambers (N) valves
PTT: 30.4	Ca++:	Alk phos:	T4	
INR: 0.92	Mg++:	Amylase:	TSH 1.562	
	Cl -:	SGOT/SGPT:		

Allergies: food allergy (+)

Medical History: CVS: /

RESP: No significant medical history. Diabetes:

CNS:

Renal:

Hepatic / GE: Physical Activity: NYHA-I, METS > 4.

Others: P2L2 → LCB 10 yrs. / Both NVD.

Past Anaesthetic History: lap. sterilization + GA. > 10 yrs ago.

Physical Exam: coherent.

Airway: MP (1) 2 3 4 Mouth Opening: adq Mentohyoid Distance: 3FB Neck: (N) Teeth: intact

Lungs: BAE (+) clear clinically

Heart: S1+S2+ M0

CNS:

Pregnant: ☐ Yes ☐ No ☑ NA Venous Access Site: peripheral Spine Exam for regional: —

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

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

CURRENT MEDICATIONS	DOSAGE
- nil specific -	

Pre-Operative Instructions:

1. DVT Prophylaxis:
2. NIL ORAL → Water / ORS 2 Hours; → Others 6 Hours — 6 HOURS: 12AM ← 9AM; 7AM = WATER
3. Informed Consent: ☐ Standard ☐ High Risk
4. Post Operative Pain Management: ☐ Discussed with Patient
5. Other Instructions: - 1 (O) PRBC reserve c̄ crossmatch -

Signature: [signature] Name: Dr. Sameer Thayath

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

HNH-00016310 IP26-00006757
Mrs KAVYA
09-09-1982 43 Y 9 M 27 D (F)
Dr. SANTHI ANTHARVEDI

ANAESTHESIA CHART

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Pre Induction Assessment:

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

H.R: 79/m	B.P / CRT: 117/63	SpO_2: 100%.	R.R: 18/m	Last Feed: >6 hours
Pre-OP Diagnosis: thyroid ut.	Operation: TLH	Date: 6/7		
Surgeon: Dr HSV / Dr-Santhi	Anaesthesiologist: Dr Sanvi / Dr KB	Technician: Pallavi		

TIME: 10:00 (10) (20) (30) 11:00 (10) (20) (30) 12:00 12:15 12:30

N_2O /AIR/ O_2 LPM									
HALO /SO /SEVO									
Drugs:									
MIDAZOLAM	2mg IV								
FENTANYL	100mcg IV								
PROPOFOL	120mg IV								
ROCURONIUM	40mg IV.			+10mg					
MORPHINE	4.5mg IV								
PARACETAMOL	1gm IV								
FIO_2 / SaO_2	100	100	100	100	100	100	100	100	100
$ETCO_2$	30	30	30	32	33	35	36	35	38
ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR
Temperature	36.9 →					36		36	36
Urine Output									
Fluids / Blood	RL	~	~	→	→	→	→	→	→

Antibiotic given.
Suppository
TRAMADOL 100mg PR
DICLOFENAC 100mg PR
Blood Loss
NOTES

B.P
V Systolic
Λ Diastolic
X Mean
• Heart Rate
Tourniquet on Time
Tourniquet off Time
Throat Pack In
Throat Pack Out

240 220 200 180 160 140 120 100 80 60 40 20 10 0

LAB Values
ABG
GRBS
Others

☑ Equipment Checked and Functional
☑ BP (L) UL
☐ Cuff Site: .....
☐ Art Site: .....
☑ EKG Lead 3 leads
☐ Temp Site skin
☑ FIO_2 Monitor
☑ Agent Monitor
☑ Pulse Oximeter
☑ Capnograph
☑ Ventilator
☐ Nerve Stimulator

Position: Head Left
☑ Pressure Points Checked

Eye Care:
☐ Oint
☑ Tape
☑ Padding
☐ Awake

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

Times:
Anaes Start: 10 AM
OP Start: .....
OP End: .....
Leave OR: 12:45pm

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP: .....
☐ ART: .....
☑ IV: 18G (R) UL
☐ IV: .....
☐ IV: .....

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

☑ Mask ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
ETT# 7.0 at 20 cm
☑ Oral ☐ Nasal ☑ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug: .....

☐ Awake ☐ Direct Vision
☑ Video Laryngoscopy ☑ Stylette / Bougie
☐ Fiberoptic
Blade# 4 Attempts: 01
Difficulty Why? -

☐ **Bilat = BS**
☐ Semi-Closed Circle
☑ Closed Circle
☐ Other

Regional:
Extremity Specify: .....
☐ Spinal ☐ Epidural ☐ Caudal
Others: .....
Position: .....
Site: .....
Needle Size: ..... Depth: .....
Parasthesia ☐ Yes ☐ No
Catheter at skin ..... cm
Drug Name & Conc: .....
Bolus: .....
Infusion: .....
Block Level: .....
Comments: .....

Transportation to
☑ PACU ☐ ICU ☐ Other
Relaxant Reversed ☑ Yes ☐ No ☐ NA
Name of the Doctor: Dr Brunda
Signature of the Doctor: B dg

HNH-00016310 IP26-00006757
Mrs KAVYA
09-09-1982 43 Y 9 M 27 D (F)
Dr. SANTHI ANTHARVEDI

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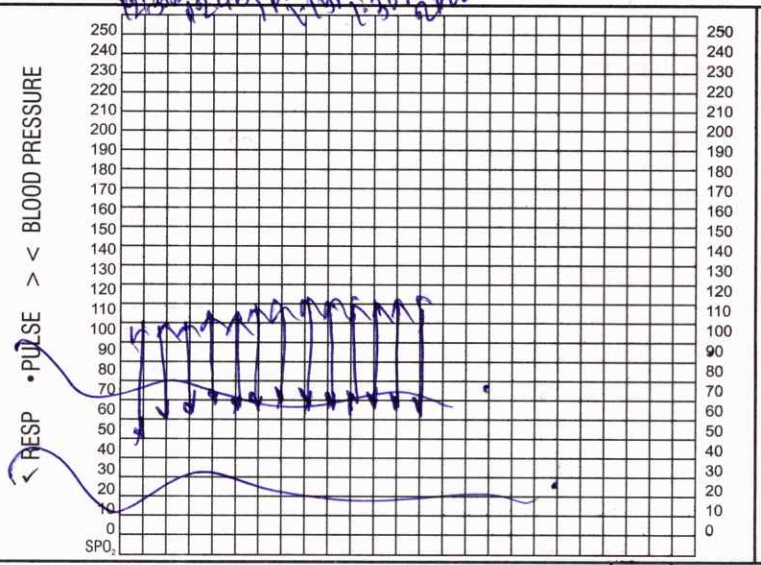
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Madhu Time Received : 12.30pm Time Discharged : 8pm



IV Cannula Site : Right

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

Vomiting : ☐ Yes ☐ No Drug : Kepinex
NG Tube : ☐ Yes ☐ No
Drain: ☐ Yes ☐ No
Urinary Catheter: ☐ Yes ☐ No
Chest Tube: ☐ Yes ☐ No
Nil Oral ☐ Yes ☐ No
IV Fluids : RL
Oral Feeds : Nil

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
6/7	12:30pm	0	Normal	
6/7	1:30pm	0	Normal	

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

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

PACU Nurse Name : .....
PACU Nurse Signature: .....
Date & Time: 6/7/26

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 reliving intervention
   d. With in 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU): 306
Date & Time: 6/7/26

Patient Sticker

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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 Left Right	Maternal BP	Maternal Pulse	FHR	Comments

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

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

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

#26 - 00002 11096

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NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name: Mrs. Kavya		Age: 43 Yrs	Gender: Female
UHID No: MNH-00016310	IP No: 26-00006757	Date: 6/7/26	Time:
Diagnosis: TLH			OT

PRESCRIPTION DETAILS (Tick only one of the following)

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

Doctor Name: Dr. SK Ayesha

Doctor Registration No: TSMC/FMR/07725

Signature:

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

IP Registration No: 26-00006757 **Date:** 6/7/26

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

		Remarks
1.	**Name :** Mrs. Kavya	
2.	Complete postal address (with contact number, if any)	Green city colony, Boduppal, Hyd
3.	Brief description of the illness	TLH
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	No
5.	Details of essential Narcotic drug dispensed	Morphine 15mg

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
6/7/26	Morphine 15mg	01		

Dispensed by (Name & ID No.): Sania (018462) Signature: Sania

Received by (Name & ID No.): U. Pallavi 017921 Signature: U. Pallavi

Time: .....

#26 - 00002 11096

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NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name: Mrs. Kavya		Age: 43 Yrs	Gender: Female
UHID No: HNH-00016310	IP No: 26-00006757	Date: 6/7/26	Time:
Diagnosis: TLH			OT

PRESCRIPTION DETAILS (Tick only one of the following)

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

Doctor Name: Dr. Sr. Ayesha

Doctor Registration No: TSMC/FMR/00725

Signature: [signature]

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

IP Registration No: 26-00006757 **Date:** 6/7/26

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

1.	**Name :** Mrs. Kavya	**Remarks**
2.	Complete postal address (with contact number, if any)	Green city colony, Boduppal, Hyd
3.	Brief description of the illness	TLH
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	No
5.	Details of essential Narcotic drug dispensed	Morphine 15mg

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
6/7/26	Morphine 15mg	01		

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

Received by (Name & ID No.): U. Pallavi 017921 Signature: U. Pallavi

Time: ....

Docu. No: RCH / FRM / CLINICAL / 133

H 26-0000211095

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NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name: Mrs. Kavya		Age: 43 Yrs	Gender: Female
UHID No: HNH-0001631O	IP No: 26-0000675-7	Date: 6/7/26	Time: 9.14 AM
Diagnosis: TLH			OT

PRESCRIPTION DETAILS (Tick only one of the following)

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

Doctor Name: Dr. SK. Ayesha

Doctor Registration No: TSMC/FMR/07725

Signature:

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

IP Registration No: 26-0000675 7 **Date:** 6/7/26

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

1.	**Name :** Mrs. Kavya	**Remarks**
2.	Complete postal address (with contact number, if any)	Greenacity colony, Boduppal Hyd.
3.	Brief description of the illness	TLH
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	NO
5.	Details of essential Narcotic drug dispensed	Fentanyl

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
6/7/26	Fentanyl	01		

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

Received by (Name & ID No.): U. Pallavi 017921 Signature: U. Pallavi

Time: .....

26-0000211095

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NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name: Mrs. Kaliya		Age: 43 Yrs	Gender: Female
UHID No: HRH 00016310	IP No: 26-0000675-7	Date: 6/7/26	Time: 9.14 AM
Diagnosis: TLH			OT

PRESCRIPTION DETAILS (Tick only one of the following)

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

Doctor Name: Dr. Sk. Ayesha

Doctor Registration No: TSMC/FMR/07725

Signature:

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

IP Registration No: 26-0000675-7 **Date:** 6/7/26

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

1.	**Name :** Mrs. Kaliya	**Remarks**
2.	Complete postal address (with contact number, if any) Greeen city colony. Bedulpal Hyd.	
3.	Brief description of the illness	TLH
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	NO
5.	Details of essential Narcotic drug dispensed	Fentanyl

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
6/7/26	Fentanyl	01		

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

Received by (Name & ID No.): U. Pallavi 017921 .... Signature: U. Pallavi

Time: ....

Docu. No: RCH / FRM / CLINICAL / 133