

Name	Mrs MEGHANA REDDY G	UHID	HNH-00003087
Father/Guardian	Mr B SUJITH REDDY	Age/Gender	29 Y 2 M 14 D/ Female
Address	FLAT NO 201 A BLOCK SUBHISHI GOWTHAMI KOMPALLY, Kompally, Hyderabad, Telangana, INDIA, 500014		
IP No	IP26-00006887	Admission Date	19-07-2026
Ref Doctor	Self.		
Discharge Date	20.07.2026		

DISCHARGE SUMMARY

Consultant:

Dr. SWAPNA SAMUDRALA
MBBS, MS (OBG)
69924

Diagnosis: G3P1L1A1 WITH 10⁺3 WEEKS PERIOD OF GESTATION WITH PREVIOUS LOWER SEGMENT CAESAREAN SECTION FOR MEDICAL TERMINATION OF PREGNANCY

MEDICAL TERMINATION OF PREGNANCY BY MERPC done on 19.07.2026

History:

LMP: 2 Months back.
EDD: 08.02.2027

Obstetric formula: G3P1L1A1
Gestation at admission: 10⁺3 weeks

Name	Mrs MEGHANA REDDY G	UHID	HNH-00003087
IP No	IP26-00006887	Admission Date	19-07-2026

Obstetric History:

- 1 - 2025, FTLSCS (INDI.: Maternal Request), Female, B.Wt.:3.7 kgs, A&H, Uneventful.
- 2 - Present Pregnancy, Spontaneous Conception.

Medical History: Nil.

Surgical History: 2025 feb - LSCS; 2025 june - Cu - T Insertion; 2026 july - Cu - T removal in view of Pregnancy.

Allergies: Nil.

Family History: Father - Pre T2DM.

Antenatal Details:

Mrs MEGHANA REDDY G came to Rainbow hospital at 10⁺³ weeks of gestation with CU T in situ. Couple wanted to go ahead with TOP. Under all asepsis, Cu T was removed. Scan on 16/7/2026 - Single live fetus at 10⁺³ weeks with Right Ovarian Corpus luteal Cyst. Couple was counselled regarding Inpatient MERPC + possibility of SERPC/ infection/ haemorrhage/ need for blood or blood products transfusion. Informed Consent taken. She took Tab mifepristone 600mg on 17.07.2026. She was admitted at 10⁺³ weeks for MTP by MERPC.

Investigations: Enclosed

Blood Group: "B" Positive

Management: On admission her vitals were stable. Routine blood investigations were sent and traced. Consent taken for medical termination of

Name	Mrs MEGHANA REDDY G	UHID	HNH-00003087
IP No	IP26-00006887	Admission Date	19-07-2026

pregnancy. Antibiotic prophylaxis Inj Taxim 1 gm was given. MERPC done with 1 dose of PGE1. She was closely monitored. She expelled products of conception at 12:45am with placenta expelled in toto. Scan done on 20.07.2026 showed RPOC measuring 22x14x20mm in fundus with organised clots in lower uterine segment and cervical canal. Gentle curettage done under USG guidance. 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. Tab Taxim O 200mg (Cefixime 200mg) twice daily after food (9am-9pm) till 24.07.2026.
2. Tab Misoprostol 200 mcg thrice daily (8am-3pm-10pm) for 21.07.2026
3. Tab Pantop 40mg twice daily before food (7am-7pm) till 24.07.2026
4. Tab Dolo 650mg SOS (for pain).
5. Tab Zincovit once daily at 2pm after food for 1 month.
6. RPOC scan on 03.08.2026

Review with **Dr. SWAPNA SAMUDRALA** after **2 week** on **03.08.2026** at Rainbow Children's Hospital with prior appointment (**Review consultation will be charged**).

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

Name	Mrs MEGHANA REDDY G	UHID	HNH-00003087
IP No	IP26-00006887	Admission Date	19-07-2026


Patient/ Attender

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

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


Registrar/Resident/C.M.O

Consultant:

Dr. SWAPNA SAMUDRALA
MBBS, MS (OBG)
69924

DEFICIENCY CHECK LIST OF CASE SHEET

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

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU /
2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006887

Admit Date : 19-Jul-2026

Admit Time : 10:36 PM UHID : HNH-00003087

Patient Details :

Patient Name : Mrs MEGHANA REDDY G

Age : 29 Y 2 M 13 D

Guardian : Mr B SUJITH REDDY

DOB : 06-05-1997

Gender : Female

Religion :

Occupation :

Martial Status :

Address (H) : FLAT NO 201 A BLOCK SUBHISHI GOWTHAMI
KOMPALLY Kompally Hyderabad Telangana
INDIA 500014

Phone No : 8686041821/ 9515173333

E-mail :
GMEGHANAREDDY2011@GMAIL.COM

Admission Details :

Bed Type : TWIN SHARING

Bed No : PDA-413

Ward Name : 4F -OT

Room No : PDA-413

Admission Type : First Visit

Contact Details :

Name : Mr B SUJITH REDDY

Relationship : Husband

Contact Address : FLAT NO 201 A BLOCK SUBHISHI
GOWTHAMI KOMPALLY Kompally Hyderabad
Telangana INDIA 500014

Phone No : 8686041821

B. Sujith Reddy
Signature

Doctor Details :

Doctor Name : Dr. SWAPNA SAMUDRALA

Specialisation : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self.

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 50000.00

Payment Mode : DC/CC Card

Payor Name : SELF PAY

ACTIVITY RECORD FOR BILLING

HNH-00003087 IP26-00006887
Mrs MEGHANA REDDY G
08-05-1997 29 Y 2 M 13 D (F)
Dr. SWAPNA SAMUDRALA

Name: -----

UHID No : ----- IP  Patient : ----- 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

Cross Consultation Visit

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

[illegible]

Date _____

Investigations

Order No.

Sign

19/7

CBP

12096

Luis

Cross checked done

[illegible]

Date _____

Name of Equipment

Connecting Time

Disconnecting Time

Order No.

Signature

20/7

Infusion pump

3 pm

и рт

5422

Simple

~~Cross linked polymer by Amine~~

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
10/1/26	IV Placement	(1)	5214 ✓	dkwla.
20/7/26	MERPC	-	215298 ✓	✓
20/7/26	RPOC	8793 ✓	2152918 ✓	✓
20/7/26	D & C		215417 ✓	✓
			Cooks check done by	

ANY OTHER INFORMATION

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



1.1. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 14/07/2026 Time of Admission :

Allergies: ☐ Not know any drug allergies

PRESENTING COMPLAINTS :

G₂P₁A₁ with low 3days POG with
 Pre. LSCS ~~with~~ for TOP. i/vlo
 unwanted pregnancy.
 USG (16/7/2026) : SCIU B.F → low + 3days
 Rt. ovary - Corpus luteal Cyst
 CRL - 37.4mm

MENSTRUAL HISTORY

Year of Marriage : 2024
 Previous Periods : Regular
 LMP : ??
 Contraception : None

OBSTETRIC HISTORY

Parity : G₂P₁
 Mode of Delivery : Previous LSCS
 Last Child Birth : 2025

PAST MEDICAL HISTORY

Nil

PAST SURGICAL HISTORY

LSCS - 2025, Feb.
 h/o CuT. Insertion
 in June 2025
 CuT. Removal on 17/7/2026



MEDICATION HISTORY:

Father - Pre T2 DM

Nil.

INITIAL ASSESSMENT:

Date <u>19/07/2026</u> Ht. <u>164cms</u> Wt. <u>86.1 kg</u> BMI <u>32.01 kg/m²</u> B.P. <u>104/65 mmHg</u> Pallor _____ CVR <u>SIS 2+ no murmur</u> Respiratory System <u>BLNORBS+</u> Thyroid <u>(N)</u>	Breasts _____ (N)	Local/Speculum Examination not done
Abdominal Examination Soft, NT pre-LSCS Scar (+)	Bimanual Pelvic Examination not done	

PROVISIONAL DIAGNOSIS: G₃ P₁ A₁ with 1st 3 days POG with previous LSCS for MTP

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT
<u>BGT B' Positive</u> <u>CBP (19/7/2026)</u> Hb - 12.4 plt - 2.42 PCV - 36.2 TLC - 13.51 HIV HbsAg } NR. HCV VDRL	Pains preparation T. Misoprostol 800mcg PV stat w/f PV bleeding / expulsion of fetus Pain abdomen Monitor Vitals Inform SCS

Name of the Doctor

Dr. Swapna S.

Dr. Swapna Samudrala
 Consultant Obstetrics and Gynecology

Signature of Doctor

Date & Time :

19/7/2026

Reg. No: 69924



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/2026 12:45am	cls/by Dr. Naveena	
	clo	Severe lower pain abdomen & PV bleeding
	o/c GC-Tam	
	Alebrane SpO ₂ 99% on RA	
	PR: 84bpm	
	BP: 100/60mmHg	
	CUS/RS: NIAD	
	PA: soft INT	
	UE: PV bleeding and fetus expelled with POC. (mini. bleeding.	
	clo/w Dr. Swapna	
		Adv
		T. Misoprostol 200mcg PV stat
		flb
		- T. Misoprostol 400mcg PO stat
		- w/r PV bleeding/pain abdomen
		- T/M RPOC Scan
		- Monitor Vitals
		- Inform SOS

Dr. Naveena

Patient Sticker



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



19/12/26

RESULT SHEET

Date	19/12/26				
Time					
Hb	12.4				
PCV	36.2				
RBC	4.76				
WBC	13.51				
N/L					
Platelets	242				
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 =						
HIV						
HbsAg						
Hev						

HIV
 HbsAg } NR.
 Hev

Culture and Sensitivities :

Radiology : USG :
 X-Ray :
 ECHO :
 CT :
 MRI :
 Others (ECG, Contrast Studies etc.,) :

HNH-00003087 IP26-00006887
 Mrs MEGHANA REDDY G
 08-05-1997 29 Y 2 M 14 D (F)
 Dr. SWAPNA SAMUDRALA



MEDICATION RECONCILIATION FORM

Drug Allergies: Nil ☒ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: Shifted to:

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						☐ 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. Naveena

Date & Time: 19/7/2026 @ 10:30pm

Nurse Name & Signature: Sejaltha

Date & Time: 19/7/26 @ 10:30pm

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



HNH-00003087 IP26-00006887
 Mrs MEGHANA REDDY G
 08-05-1987 29 Y 2 M 14 D (F)
 Dr. SWAPNA SAMUDRALA

REGULAR PRESCRIPTIONS

Weight. Ward.

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



Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

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

VERIFIED BY : Name Signature

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

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

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

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

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

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

HNH-00003087 IP26-00006887

Mrs MEGHANA REDDY G

08-05-1997 29 Y 2 M 14 D (F)

Dr. SWAPNA SAMUDRALA



Weight. Ward.

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
19/7	10:00pm	T. MISOPROSTOL	800mcg	PV	@	Sujatha Akhila
20/7	10:00AM	T. MISOPROSTOL	200mcg	PV	@	Sujatha Akhila
20/7	5:00AM	T. MISOPROSTOL	200mcg	PO	@	Sujatha Akhila
20/7	12 AM	T. MEFTAL SPAS	1 TAB	PO	@	Sujatha Akhila
20/7	2 AM	INS-TRAMADOL	50mg	IV	@	Sujatha Akhila
20/7	2:10AM	INS-ONDENSE-TRON	8mg	IV	@	Sujatha Akhila
20/7	2:30AM	INS. CEFOTAXIME	1gm	IV	@	Sujatha Akhila
20/7	4pm	CEFOTAXIME	1gm	IV	JP	Sujatha Akhila

IP26-00006887

08-05-1997 29 Y 2 M 14 D (F)

Dr. SWAPNA SAMUDRALA

Dr. SWAPNA SAMUDRALA



Weight. Ward.

[illegible]

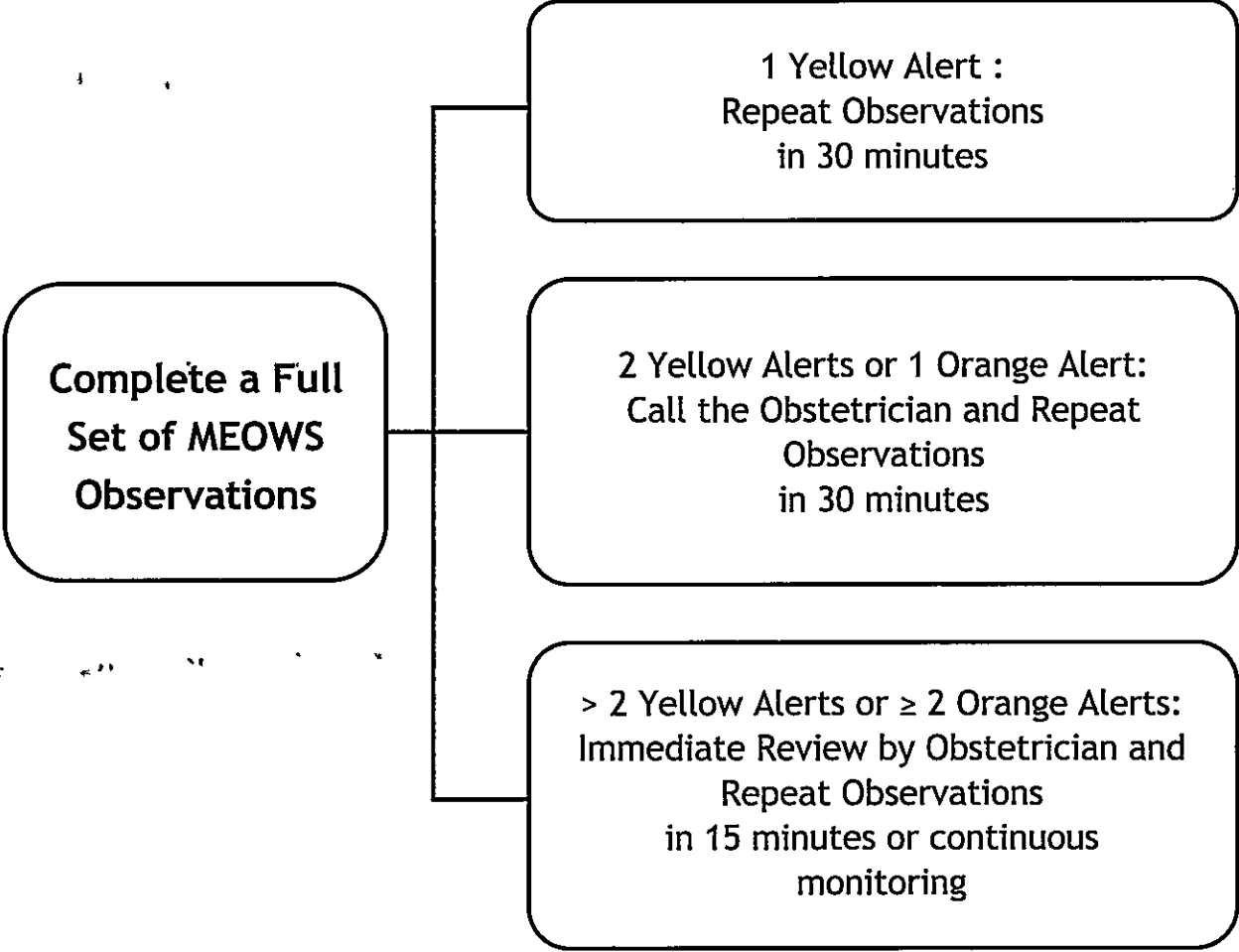


CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

19/2/26

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

**Obstetrics and Gynaecology
Early Warning Signs**



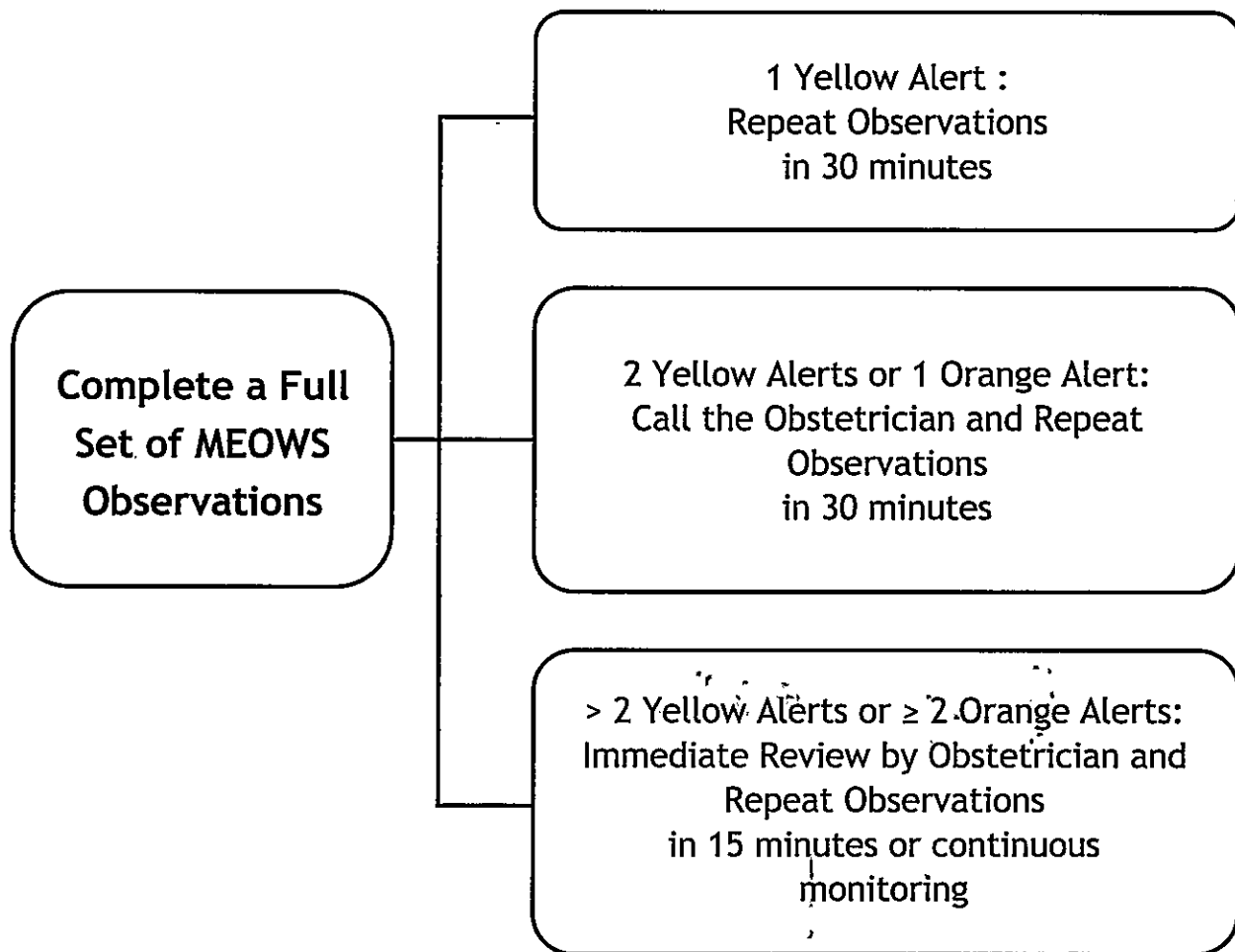
*The Modified Early Warning Score (MEOWS)



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

[illegible]

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

HNH-00003087 IP26-00006887
 Mrs MEGHANA REDDY G
 08-05-1997 29 Y 2 M 13 D (F)
 Dr. SWAPNA SAMUDRALA



FLUID CHART

Sheet No. : ①

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

		Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse		
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine				
			Mouth	I.V	N.G								
	08:00 am												
	09:00 am												
	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 :							
15/11	08:00 pm												
	09:00 pm												
	10:00 pm	Ho							✓	1			
	11:00 pm												
	12:00 am								✓	1			
	01:00 am	Ho											
Total Intake : taken						Total Output : passed							
20/11	02:00 am												
	03:00 am	Ho							✓	1			
	04:00 am												
	05:00 am												
	06:00 am								✓	1			
	07:00 am	upma											
Total Intake : taken						Total Output : passed							

Total 24 hrs. Intake

Total 24 hrs. Output

HNH-00003087 IP26-00006887
 Mrs MEGHANA REDDY G
 08-05-1997 29 Y 2 M 13 D (F)
 Dr. SWAPNA SAMUDRALA



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.

20/7/26		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
20/7/26	08:00 am	RL		100mls							✓	12
	09:00 am	RL	N	100mls								
	10:00 am	RL		100mls						✓		
	11:00 am	RL	B	100mls						✓		
	12:00 pm	RL		100mls						✓		
	01:00 pm	RL	M	100mls							✓	
Total Intake :						Total Output :						
	02:00 pm	DL		100								12
	03:00 pm	DL		100								
	04:00 pm	DL		100								
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						
Total 24 hrs. Intake						Total 24 hrs. Output						

Patient Sticker

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					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am												
	09:00 am												
	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

Patient Sticker

FLUID CHART

Sheet No. :

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

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

Total 24 hrs. Intake

Total 24 hrs. Output



CHECKLIST FOR THROMBOPHLEBITIS

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

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 : AKULG

Signature of Ward In Charge :

Signature : Name : KASHURI

Patient Sticker

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 cord pyrexia	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 personnel ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :

Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	Fall Risk Grading		
		Score			
History of Falling (immediately or w/in 3 months)	Yes	25	17/12/26	20/7/26	20/7/26
	No	0	N1	8PM	E2
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0	0		
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0		0	0
IV / Heparin Lock or Saline	Yes	20	20	20	20
	No	0			
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0			
Mental Status	Forgets limitations	15			
	Oriented to own ability	0		0	0
Total Morse Fall Scale Score:			20	20	20
Signature			Q	Q	Q

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

Morse Fall Risk Assessment Form

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

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

- ☐ Ensure patients use their prescribed eye glasses if any, in the hospital
- ☐ Use chairs with arm rests
- ☐ 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

BRADEN 'Q' SCALE

				Date :	08/05/2017	2017
				Time :	12	8 AM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: Responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4
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
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 of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4
TOTAL SCORE				28	28	28
Evaluator's Name				Q	Q	Q

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

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

Patient ID _____

BRADEN 'Q' SCALE

					Date :				
					Time :				
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.					
"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.					
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.					
Molsture 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.					
FRICION-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."					
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.					
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.					
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE				
Docu. No. : RCH /FRM / CLINICAL / 119					Evaluator's Name				

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)
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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

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
19/7	11pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Q
20/7	5am	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Q
20/7	10am	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Q
20/7	2pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Q
20/7	4pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Q
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

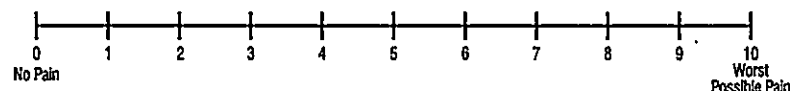
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



HNH-00003087 IP26-00006887
 Mrs MEGHANA REDDY G
 08-05-1997 29 Y 2 M 13 D (F)
 Dr. SWAPNA SAMUDRALA



NURSING CARE RECORD

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Date: 19/12/20

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night	8 PM	Assess the Pt condition → monitor the vitals 8 AM → Administration of medication → maintain Biochart & record	8 PM	Assessed the Pt condition → monitored the vitals & record → Administered medication as per doctor's order 8 AM → maintained Biochart & record	Pt is stable	Maintain Bio chart & record	Akshita

HNH-00003087
 Mrs MEGHANA REDDY G
 08-05-1997 29 Y 2 M 13 D (F)
 Dr. SWAPNA SAMUDRALA

IP26-00006887

NURSING CARE RECORD

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Date: 20/12/20

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8pm	⇒ Assess the patient condition	8pm	⇒ Assessed the pt condition	patient is stable	vital is normal	Candice
	10	⇒ Plan for vital	10	⇒ maintain vital entered			
	2pm	⇒ plan for Echo chart	2pm	⇒ maintain Echo chart			
Afternoon	2pm	⇒ Assess the pt condition	2pm	⇒ Assessed pt condition	vital is normal	pt is stable	Anurag
		→ check the vital's		→ checked vital's & recorded			
		→ Echo chart Machine		→ plan chart Echo chart			
		→ Plan for Medication		→ given Medication as per doctor's order			
Night	8pm		8pm				

Patient Sticker

NURSING CARE RECORD



Date:

Goals

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

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

Patient Sticker

NURSING CARE RECORD

Date:

Goals

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

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



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: LDR Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:				
BACKGROUND	Area	Shift Time	<u>1st</u> <u>N</u>	<u>2nd</u> <u>8AM</u>	<u>3rd</u> <u>2PM</u>		
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>		
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	<u>97.5</u>	<u>97.5</u>	<u>97.5</u>		
		Res:	<u>20bmt</u>	<u>20</u>	<u>20</u>		
		SpO ₂ :	<u>99%</u>	<u>100%</u>	<u>99%</u>		
		Pulse:	<u>87bmt</u>	<u>86</u>	<u>79</u>		
		BP:	<u>115/70</u>	<u>110/70</u>	<u>113/61</u>		
		Fall Risk Score:					
Pain Score:		<u>0/10</u>	<u>-</u>	<u>-</u>			
Recommendations	Safety Needs:		<u>yes</u>	<u>-</u>	<u>-</u>		
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:		<u>-</u>	<u>-</u>	<u>-</u>		
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>	<u>NA</u>		
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>			
Handed Over By Name :		<u>Akila</u>	<u>Chand</u>	<u>Chand</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>20/7/20</u>	<u>20/7/20</u>	<u>20/7/20</u>			
Time:		<u>8AM</u>	<u>2PM</u>	<u>8PM</u>			
Taken Over By Name :		<u>Chand</u>	<u>Akila</u>	<u>Akila</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>20/7/20</u>	<u>20/7/20</u>	<u>20/7/20</u>			
Time:		<u>8AM</u>	<u>8PM</u>	<u>8PM</u>			

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area: Shift Time:						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:						
	Temp:						
	Res:						
	SpO ₂ :						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
	Post Operative Procedure Special Orders:						
	Handed Over By Name :						
	Signature :						
	Date:						
	Time:						
	Taken Over By Name :						
	Signature :						
	Date:						
	Time:						

CONSENT FORM FOR MEDICAL TERMINATION OF PREGNANCY

Patient Name : MRS. MEGHANA REDDY.

Age : 29 YRS.

UHID No : HNH - 00003087

Date : 19/07/2026

I, the undersigned, ✓ Mrs. / Miss : MEGHANA REDDY ✓ W/o, D/o, C/o B. SUJITH REDDY.
aged 29 YRS years and residing at KOMPALLY request to terminate my pregnancy.

Reason for Undergoing Medical Term of Pregnancy : (Tick whichever applicable)

- ☐ The continuance of the pregnancy would involve a risk to my life due to serious medical disease.
- ☐ In order to prevent injury to my physical or mental health.
- ☐ The continuance of the pregnancy has a substantial risk of the newborn being born with serious physical / mental handicap.
- ☐ This pregnancy has resulted from me being raped.
- ☒ This pregnancy has occurred as a result of failure of contraceptive techniques -Intrauterine Device/ Oral Pills/ Condoms/ Coitus Interruptus/ periodic abstinence/ tubectomy/ vasectomy.
- ☐ In order to prevent a risk of injury to my physical or mental health by reason of my actual/ reasonably foreseeable environment.

I have been explained in the language known and understood by me about all the options available, counseled about the procedure, its risks, and costs & care to be taken after the procedure. Thus, I give my full valid consent as an act of my own free will to undergo the above-mentioned procedure to terminate my pregnancy.

I have been explained also the risks, benefits and alternatives of the procedure.

The future consequence of infertility has been explained to me in view of the voluntary termination of pregnancy and I am willing to accept the risk.

I also indemnify the Doctor and Rainbow Hospitals & its staff of any liability arising because of undergoing the above-mentioned procedure.

Name of the Doctor performing the procedure : Dr. SWAPNA SAMUDRALA

Patient :

Signature : [Signature]

Name : MRS. Meghana Reddy. G.

Date & Time : 19/7/2026 @ 9:45pm

Patient Attendant / Guardian :

Signature : B. Sujith Reddy.

Name : MR. B Sujith Reddy.

Relationship with Patient : Husband.

Date & Time : 19/7/2026 @ 9:45pm

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Naveena.

Date & Time : 19/7/2026 @ 9:45pm

Witness :

Signature : [Signature]

Name : Sujatha

Date & Time : 19/7/26 @ 9:45pm

*Guardian consent & signature needed in case of patient being less than 18 years or mentally unstable.