



Rainbow
Children's
Hospital

GUC-00093783 IP18-00036438
Dr. DEEPIKADEVI
26-02-1989 37 Y 4 M 18 D (F)
Dr. SELF

UHID-



CHARGE TRACKING SHEET

NAME OF CONSULTANT-

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin >		
Activity Sheet update by Nursing	15/8/26 10am		<i>[Signature]</i>				
Activity Sheet update by Pharmacy							



ACTIVITY RECORD FOR BILLIN

Name: Dr. Deepika Devi

UHID No: 93723 IP No: 36432 Consultant: Dr. Divya G. Dept:

Date of Admission: 12/7/26 Time: Date of Discharge: Time:

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
12/7/26	6:30pm	NUR	7th floor	Deni
13/7/26	5:40am	7th floor	LDR	Souk
13/7/26	6:30am	LDR	OT	S/A Bhatia 018002
13/7/26	8:10am	OT	MICU	019507
13/7/26	2:00pm	NUR	7th floor	Deni

CROSS CONSULTATION VISIT

	Doctor Name	Date	Order No.	Signature
1.	PAL	12/7/26	1-126094	Deni
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

[illegible]

13/7/26

p level for HPE

26022497

Signature

4/19/20

PROCEDURE

[illegible]

[illegible]

ANY OTHER INFORMATION:

10 blood reservation (1726093)

IN TIME 6:35 ^{am} OUT TIME 8:10 am

Surgeon: Dr. Dhivya Naren

procedure: Electri (sc) twins & cervical Strich Removal

Asst Surgeon: Dr. Karitha

Anesthetist: Dr. Sathis

Date: 12/7/26 Time: 9:20 am Prepared By: S/Lt Sathis 1957

11/7/26

9.2 a m.

St. Louis
0 1957

Billing Supervisor

GUC-00093783 IP18-00036438

Dr. DEEPIKADEVI

26-02-1989 37 Y 4 M 18 D (F)

Dr. SELF



DISCHARGE TRACKING SHEET

DR-

NAME OF CONSULTANT-

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement					
	INTIME	OUT TIME			
Arrangement of File by Nursing		15/7/22 12:30 pm	Dr. Protek		
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					



CROSS CONSULTATION FORM

Doctor Name : Date : Time :

Diagnosis :

Hospital :

Type of Referral :

☐ Emergency

☐ Urgent

☐ Non Urgent

Referred for : ☐ Opinion ☐ Co-Management ☐ Transfer of care

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Mrs. Deepika Devi / 709.

Postnatal Ear / Advice

Signature: _____

Findings and Recommendations :

HB physiotherapist Notes Dr. Mohanapriya (PT)

→ Do's and Don'ts Advised

06/24/20

→ Avoid lifting weights

- Bilateral leg raise should be avoided

- Pulling and pushing weights should be

avoided.

- Coughing and Huffing technique with proper care.

- Postural advice (Breastfeeding positions)
Diaper changes.

Consultant :

Name : Signature : Date & Time :

BE

- Posterior pelvic tilt

- Pelvic bridging

- Kegels

- Ankle mobilisation

- Knee mobilisation.

Review after 2 weeks

Cap
14/07/26.

Consultant:

Signature

VITAL SIGNS RECORD

Date :

Name :

GUC No.:

Time	Temperature	Pulse	RR	BP	SPO2	Remarks	Signature
3:00 PM	36.5°C	90	20	120/80	98%	2P 38-39	mmmm
3:30 PM	36.5°C	90	20	120/80	98%	4P 38-39	mmmm
4:00 PM	36.5°C	90	20	120/80	98%	6P 38-39	mmmm
4:30 PM	36.5°C	90	20	120/80	98%	8P 38-39	mmmm
5:00 PM	36.5°C	90	20	120/80	98%	10P 38-39	mmmm
5:30 PM	36.5°C	90	20	120/80	98%	12P 38-39	mmmm
6:00 PM	36.5°C	90	20	120/80	98%	14P 38-39	mmmm
6:30 PM	36.5°C	90	20	120/80	98%	16P 38-39	mmmm
7:00 PM	36.5°C	90	20	120/80	98%	18P 38-39	mmmm
7:30 PM	36.5°C	90	20	120/80	98%	20P 38-39	mmmm
8:00 PM	36.5°C	90	20	120/80	98%	22P 38-39	mmmm
8:30 PM	36.5°C	90	20	120/80	98%	24P 38-39	mmmm
9:00 PM	36.5°C	90	20	120/80	98%	26P 38-39	mmmm
9:30 PM	36.5°C	90	20	120/80	98%	28P 38-39	mmmm
10:00 PM	36.5°C	90	20	120/80	98%	30P 38-39	mmmm
10:30 PM	36.5°C	90	20	120/80	98%	32P 38-39	mmmm
11:00 PM	36.5°C	90	20	120/80	98%	34P 38-39	mmmm
11:30 PM	36.5°C	90	20	120/80	98%	36P 38-39	mmmm
12:00 AM	36.5°C	90	20	120/80	98%	38P 38-39	mmmm
12:30 AM	36.5°C	90	20	120/80	98%	40P 38-39	mmmm
1:00 AM	36.5°C	90	20	120/80	98%	42P 38-39	mmmm
1:30 AM	36.5°C	90	20	120/80	98%	44P 38-39	mmmm
2:00 AM	36.5°C	90	20	120/80	98%	46P 38-39	mmmm
2:30 AM	36.5°C	90	20	120/80	98%	48P 38-39	mmmm
3:00 AM	36.5°C	90	20	120/80	98%	50P 38-39	mmmm
3:30 AM	36.5°C	90	20	120/80	98%	52P 38-39	mmmm
4:00 AM	36.5°C	90	20	120/80	98%	54P 38-39	mmmm
4:30 AM	36.5°C	90	20	120/80	98%	56P 38-39	mmmm
5:00 AM	36.5°C	90	20	120/80	98%	58P 38-39	mmmm
5:30 AM	36.5°C	90	20	120/80	98%	60P 38-39	mmmm
6:00 AM	36.5°C	90	20	120/80	98%	62P 38-39	mmmm
6:30 AM	36.5°C	90	20	120/80	98%	64P 38-39	mmmm
7:00 AM	36.5°C	90	20	120/80	98%	66P 38-39	mmmm
7:30 AM	36.5°C	90	20	120/80	98%	68P 38-39	mmmm
8:00 AM	36.5°C	90	20	120/80	98%	70P 38-39	mmmm
8:30 AM	36.5°C	90	20	120/80	98%	72P 38-39	mmmm
9:00 AM	36.5°C	90	20	120/80	98%	74P 38-39	mmmm
9:30 AM	36.5°C	90	20	120/80	98%	76P 38-39	mmmm
10:00 AM	36.5°C	90	20	120/80	98%	78P 38-39	mmmm
10:30 AM	36.5°C	90	20	120/80	98%	80P 38-39	mmmm
11:00 AM	36.5°C	90	20	120/80	98%	82P 38-39	mmmm
11:30 AM	36.5°C	90	20	120/80	98%	84P 38-39	mmmm
12:00 PM	36.5°C	90	20	120/80	98%	86P 38-39	mmmm
12:30 PM	36.5°C	90	20	120/80	98%	88P 38-39	mmmm
1:00 PM	36.5°C	90	20	120/80	98%	90P 38-39	mmmm
1:30 PM	36.5°C	90	20	120/80	98%	92P 38-39	mmmm
2:00 PM	36.5°C	90	20	120/80	98%	94P 38-39	mmmm
2:30 PM	36.5°C	90	20	120/80	98%	96P 38-39	mmmm
3:00 PM	36.5°C	90	20	120/80	98%	98P 38-39	mmmm
3:30 PM	36.5°C	90	20	120/80	98%	100P 38-39	mmmm

ADMISSION SHEET

Registration Details :



Admission No : IP18-00036438

Admit Date : 12-Jul-2026

Admit Time : 02:55 PM UHID : GUC-00093783

Patient Details :

Patient Name : Dr. DEEPIKADEVI

Age : 37 Y 4 M 16 D

Guardian : Mr DR DINESH DEEPAK

DOB : 26-02-1989

Gender : Female

Religion :

Occupation :

Marital Status :

Address (H) : H303, CASAGRANDBELLISSIMO, 5TH
STREET, CPWD QUARTERS, KANNAN
COLONY, ALANDUR Alandur Chennai Tamil
Nadu INDIA 600016

Phone No : 8754587958/ 9043150150

E-mail : DRDINESHDEEPAK@GMAIL.COM

Admission Details :

Bed Type : MICU

Bed No : MICU 802

Ward Name : 8F-OT COMPLEX

Room No : MICU 802

Admission Type : First Visit

Contact Details :

Name : Mr DR DINESH DEEPAK

Relationship : Husband

Contact Address : H303, CASAGRANDBELLISSIMO, 5TH
STREET, CPWD QUARTERS, KANNAN
COLONY, ALANDUR Alandur Chennai Tamil
Nadu INDIA 600016

Phone No : 9043150150


Signature

Doctor Details :

Doctor Name : Dr. SELF

Specialisation : OBSTETRICS AND GYNECOLOGY

Referral Doctor : DR DIVYA NAVEEN

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY

GENERAL CONSENT FOR TREATMENT

Patient Name: Dr. DEEPIKADEVI

Age : 37 Y 4 M 16 D

IP No: IP18-00036438

Sex: Female

Consultant: Dr. SELF

Ward/Bed No: 8F-OT COMPLEX/MICU 802

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

Patient, be deemed advisable or necessary.

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

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

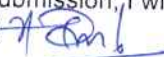
I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal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

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

Note:

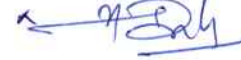
1 We do not allow use of medication brought from outside by the patient.

2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.

(Receivers Signature:.....) 

3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.

4 Financial and billing counseling has been done to me.

Signature of Patient/Relative: 

Name: Mr. Dr. Dinesh Deepak

Relationship: Husband

Date: 12/7/2026

Time: 8:55 pm

Witness Name: Jothi

Witness Signature: 

Patient Address:

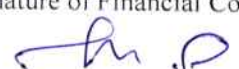
H303, CASAGRAND BELLISSIMO, 5TH
STREET, CPWD QUARTERS, KANNAN
COLONY, ALANDUR Alandur Chennai
Tamil Nadu INDIA 600016

BILLING POLICY

- ▶ **Billing Cycle:** - Bed charges will be calculated based on 12PM to 12PM checkout. Settlement post 12PM, room rent will be charged for half day extra & post 6PM, it will be charged for full day. Less than 24 hours stay will be considered as one day.
- ▶ Room Rent inclusive of Bed, Nursing, Consultation Charges and all other charges, like Diet, Investigations, IP or OP Procedures, Equipment, Cross Consultations, Blood/ Blood Products, Implants, Ward Consumables, Infection Preventive Measure Charges, Pharmacy and Consumables will be charged extra.
- ▶ 5% GST Charges applicable on more than INR 5,000/- Bed Charges which was effective from 18.07.2022 as per the GST Council.
- ▶ As per the G.O.I. guidelines, we can collect Rs 1,99,999/- only in cash mode, balance patient can pay through Credit Card/ Debit Card/ NEFT / RTGS / Demand Draft and Online Payment.
- ▶ In the event of TPA / Cashless denial or approval not received due to any reason then hospital tariff will be applicable and any discount or special rates given to TPA's / Corporate won't be applicable.
- ▶ If the Surgery/ Procedures performed in emergency hours (8PM-6AM), Public Holiday and on Sunday will be charged 30% extra.
- ▶ Asst. Surgeon and Anesthetist Charges will be charged 30% on the Surgeon Charges.
- ▶ Admission will be done according to the ward category chosen by the patient; charges will be applicable as per the ward category. All charges vary as per Room category, except Pharmacy and consumables.
- ▶ Patient / Guardian Self Attested Government ID proof is mandatory to submit at the admission.
- ▶ TPA/Insurance Processing Fee applicable for all Insurance Cases.
- ▶ In our hospital there is "No Discounts Policy". Kindly co-operate.
- ▶ No Duplicate/ Second copy of OP or IP bill will be issued.
- ▶ In case the patient is shifted from lower category to higher category, all the charges like consultant visits, investigations, operations and procedures etc. from the date of admission will be charged according to the higher category.
- ▶ If the patient is shifted to the ICU, the attendant should vacate the room. If the attender occupies the room, it will be charged as per dual occupancy.
- ▶ Room eligibility is purely subject to TPA approval. Proportionate difference of the bill amount is applicable in case the patient opts for higher category higher than the TPA approved, which has to be paid by the patient and may not be reimbursed by the TPA / Insurance Company at later stage.
- ▶ For Non - Medicals, Disposables, Consumables, Infusion Pump, Taxes, Implants, HIV/ HbsAg, Medical Records, Insurance Processing Fee, Double Occupancy and Registration Charges, Etc., credit cannot be extended. These items are not payable to us as per insurance company norms (Depends on the TPA/Insurance Co. T&C).
- ▶ It takes time for cash discharge is a minimum 3-4hrs. and in the case of insurance, it will take a minimum 6-7hrs.
- ▶ Difference, if any between the final bill amount and amount permitted / approved by the TPA or total bill amount in case of denial from TPA, has to be paid by the patient.
- ▶ Two attendants are permitted with patients in Deluxe, Private Rooms and only one is permitted in the rest of the categories of rooms. No attendant is permitted in ICU's.
- ▶ All the refunds more than Rs.5,000/- will be refunded through NEFT within 7 Bank working days.
- ▶ Patient attendant can collect for Interim/provisional bill of the patient from the billing section on daily basis. Interim Bill shall be based on the acknowledged services in HIS. Final Bill of the patient may vary from the Interim bill based on actual update taken on the day of discharge. It is requested that patients/attendants enquire daily about the bill amount from billing section and pay the outstanding as on that day. You are requested to clear your outstanding amount on daily basis before 12 PM. **Patient bill outstanding should not be increase more than 10,000/-**

DECLARATION

I have attended the Financial Counselling desk & understood the expected costs & other conditions applicable. In this case, the TPA/Insurance Company rejects the claim for whatsoever reasons at any point of time after discharge. I promise to settle the claim with the hospital as per Hospital Cash Tariff.

Patient Name : DR. DEEPIKA DEVI	UHID Number : ANC:00093783
Self/Attendant Name : DR. DINESH DEEPAK	Relation : Husband
Self/ Attendant Signature :  Phone Number : 8754587958	Name & Signature of Financial Counselor 



இந்திய தனிப்பட்ட அடையாள ஆணைய அமைப்பு

இந்திய அரசாங்கம்
—Unique-Identification-Authority-of-India—
Government of India

பதிவு அடையாளம் / Enrollment No. : 1111/11116/01872

19/02/2013

To
Deepikadevi
தீபிகாதேவி
D/O: Soustiradarane
B
First Cross Street
S B I Colony
Mohan Nagar
Nellithoppe
Nellithoppe, Puducherry
Puducherry - 605005
9443628341



KL235531469FT

23553146



உங்கள் ஆதார் எண் / Your Aadhaar No. :

9379 7801 7908

ஆதார் - சாதாரண மனிதனின் அதிகாரம்



இந்திய அரசாங்கம்

Government of India

தீபிகாதேவி
Deepikadevi



பிறந்த ஆண்டு / Year of Birth: 1969
பாலினம் / Female

9379 7801 7908



ஆதார் - சாதாரண மனிதனின் அதிகாரம்



Patient Sticker

IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

both
Able to perceive fetal movements well.
Admitted for Elective LSCS

Obstetric Formula:

Primigravida

Obstetric History:

I - PP, IVF conception

Present Pregnancy Record:

- Booked & immunized -
- Both NT @, FTS low risk
- Anatomy scan @ NIFT low risk
- Growth scan @

RISK FACTORS:

IVF conception.
DCDA Twins - Twin 2 IUGR.
Cx stitch in situ. from 22 weeks.
Hypothyroid
Overt DM on Insulin

Height: 160 cm

Weight: 98.5 kg

Allergies: CHLOROQUINE / COX-2

Breast: ☒ Normal ☐ Abnormal

General Examination:

Consciousness: full

Icterus: No

Temp: 37.2

BP: 140/80 mmHg

CVS: 152 bpm

Liver/Spleen: soft

Pallor: NO

Edema: NO

PR: 100 bpm

DTR: +

RS B/L Ae +

Urine Output: adequate

LMP: Unknown

Corrected EDD:

Menstrual History: Regular: ☒ Yes ☐ No

Obstetric Examination

Fundal Height: overdistended for GA

Ut. Activity: ☒ Relaxed ☐ Mild ☐ Mod ☐ Severe

Liquor: ☒ Adequate ☐ Oligo ☐ Poly

PP: ☐ Cephalic ☐ Breech ☐ Others

Head Fifths Palpable:

FHS: Both ☒ Normal ☐ Tachy ☐ Brady ☐ Absent

Per Speculum Examination

Draining: ☐ Present ☒ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination

Cervix: ☐ Long ☐ Partially effaced ☐ Effaced

Os: Closed Dilated

Membranes: ☐ Present ☐ Absent

Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Presenting Part: ☐ Vertex ☐ Breech ☐ Others

Sutton: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Pelvis: ☐ Adequate ☐ Doubtful

DIAGNOSIS

Primigravida
B positive

32 weeks

IVF
conception

Overt
Diabetes
on

Twin 2
IUGR

Hypothyroid

Cx Cerclage

Insulin
in situ
Elective
LSCS



Family History:

Both parents - T2DM
HTN

Surgical History:

oocyte retrieval
McDonald's stitch ↓ GA 14/3/26
Ethilon knot, anterior

Medical History: Overt DM since 4 months
POG on metformin → Insulin
hypothyroid x 15 years

Antenatal steroids covered (9th 10th June)

Stopped T. ECOSPIRIN yesterday

Medication History:

T. ELTROXIN 100mcg OD
J. FIASP 18-16-12 units SC
J. LANTUS OD-6 units SC

Plan of Care: I/T Dr. Dinya Naveen

Active

- Admission
- parts preparation
- Early simple lunch by 7pm
- NPO from 8pm
- IVF 30 RL @ 150ml/hr
- follow premeds
- informed consent
- 1 unit PRBC reservation
- Sy. DUPHAC 20ml HS
- shift to ward
- shift back to LDR at 5:30am 13/7
- inform NICU

Investigations:

CTG

CBG - 151 mg/dl

Doctor Name:

Dr. Dinyalakshini

Signature:

[Signature]

Date & Time:

12/7/26, 3:30pm

Consultant Name:

Dr. Dinya Naveen

Signature:

[Signature]

Date & Time:

12/7/26, 3:30pm

IP18-00036438

GUC-00093783
Dr. DEEPIKADEVI

Dr. DEEPIK
22.02.1989

37 Y 4 M 16 D (F)

Dr. SELF



Patier



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



BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

RESULT SHEET

Date	9/7/20				B POSITIVE
Time					
Hb	11.6				
PCV	37.5				
RBC					
WBC	14700				HN HBSAg VDRL Anti HCV } NR
N/L					
Platelets	317				
CRP	13.1				
ESR	100				9/7 TSH - 1972.
PCT					
RBS					
Na	136				
K	4.5				
Cl	107				
Ca/Mg					
Phosphate					
Urea	10				
Creatinine	0.5				
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid	2.5				
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR	10.4/0.9				
APTT	24.7				
CSF Protein / Sugar					
Cells					
N/L					



1

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/7/26 8:30pm	8/B. Dr. Anandhaemari	
	primigranda B. pontine IVF conception DCDA twin	
	GA - 32 weeks + 1 day	
	out diabetes on insulin Hypothyroid Twin 2 IVGR	
T-F	cervical encroachment	
BP - 96/60	Plan - Elective LSCS tomorrow @ 6:30 AM	
BP - 140/80	mtg	
SpO2 - 99.1 LRA	Able to perceive fetal movements well	
	No complaints	
	GE - GC fair, afebrile mild	
	no pallor / BL pedal edema	
		Advice
Bedside USG	CVS	
DCDA Twin	B NAD	
Both FH good.	P/A - ut overdistended	- Follow pre-operative instructions
	for GA	- IVF 30 RL @ 150ml/hr
	relaxed	throughout night
	Both FH good.	
		1500

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/07/2026	Patient received in MICU	
8:10 AM	C/S/B Dr. Vinittha / Dr. Shroeder	
[DOS]	O/E Pt GC fair, Afebrile	Advice
T-(R)	P° / PE°	- NPO x 4 hours
PR - 80/min	CVS	- vitals monitoring
BP - 110/70 mmHg	RS / NAD	- IV FOLIC 125ml/hr
UO - 50ml, clear	Pl - Soft	- follow drug chart
Both babies - NICU	Uterus well contracted	- CBD removal x 24 hours
BL - Breast soft	Dressing ⊕ & Dry	- INJ. CLEXANE 60mg SC @ 8pm
	HE - BWNL	- CBG monitoring insulin as per sliding scale
	CBD insitu, clear urine draining	- Ilo charting
	8/2217	- WLF ↑ Bleeding PV
13/07/2026	C/S/B Dr. Vinittha / Dr. Dhinyalakshmi	
1pm	Pt tolerating liquids well	Advice
[POD - 0]	Pt reviewed, Nil clo	- Liquid diet
T-(R)	O/E Pt GC fair, Afebrile	- IV FOLIC @ 125ml/hr
PR - 90/min	P° / PE°	- Kenji @ 5pm
BP - 120/80 mmHg	CVS	- Soft diet @ 7pm
UO -	RS / NAD	- vitals monitoring
Both babies - NICU	Pl - ut well contracted	- follow drug chart
BL - Breast soft	Soft, BS ⊕	- CBD removal c/m 8am
Flatus passed	Dressing ⊕ & Dry	- INJ. CLEXANE 60mg SC @ 8pm
	HE - BWNL	- CBG monitoring insulin as per sliding scale
	CBD insitu clear	- Ilo charting
Shift to ward	8/2217	- WLF ↑ Bleeding PV



(2)

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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/7/2026 3pm	S/B Dr. Anil Kumar	
POD#0	pt reviewed	
	passed flatus	
	O/E: afebrile	
BP 110/20mmHg	Gc fair	Plan
PR 80bpm	P° / R°	- Kanji 5pm
Temp (T)	P/A uterus w/c	- soft solid diet 7pm
	soft	- CRD c/m 8Am
B/L breast soft	BS ⊕	- clecane 60mcg 2pm today
Babies H/C/D	dressing delay	- CBS - sliding scale
	L/E BUNH	- T/A chart
	Foley's intact	- w/t ↑ bleeding p/v
	clear urine	- m bed ambulation
	LHCO = 60ml	
		128035
13/07/2026 9pm	C/S/B Dr. Panithas	
	O/E	
CR ⊕	PT ac fair	Advice
HR 140/86	afebrile	- Soft Diet
PR 80bpm	P° / R°	- Vitals monitoring
	Cvs /	- C/m monitoring
	RS / NAD	- RSP 4th hourly
C/m 126	P/A - soft r/s ⊕	- CRSD c/m 8Am
HAEP ⊕	Ut firm & cont well	
Rady N/C	dressing on	
	4g - RSWNL	

14/6/26

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/07/2026	C/S/B Dr. Akshitha / Dr. Shreedevi	
8:45 AM		
POD - 1	PT reviewed, Nil c/o	<u>Advice</u>
	O/E PT GC fair, Afebrile	- Soft diet
T - (N)	P / PE	- Plenty of oral fluids
PR - 86/min	WS / RS / NAD	- Vitals monitoring
BP - 130/80 mmHg		- CGM monitoring
	PlA - ut well contracted	- BP 4th hourly monitoring
Both babies NICU	Soft, BS ⊕	- Inform 1st mid
Not voided yet	Dressing ⊕ & Dry	- Inform (S)
Flatus Passed	UE - BWNL	- Ambulation
BIL - Breast Soft		
14/7/26	S/B Dr. Divyalakshmi	
3pm		
POD - 1	PT reviewed. Nil c/o.	
	No S/S of hypoglycemia	
	O/E: pt GC fair, afebrile	<u>Advice</u>
	P / PE	- Continue same orders.
T - N		- Ambulation
PR - 80/min	PlA: Soft, BS ⊕	- Lactation Consultant
BP - 130/80 mmHg	ut - contracted well	- Inform S/S
passed flatus	dressing dry	
voiding freely		
passed stool	UE - BWNL	

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker



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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker



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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

GUC-00093783 IP18-00036438
Dr. DEEPIKADEVI
26-02-1989 37 Y 4 M 16 D (F)
Dr. SELF

Docu. No. : RCH / FRM / CLINICAL /



DR'S SHIFT CHANGE HANDOVER FORM


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Date:

Department:

Shift:

S.No	Patient Identification	Diagnosis / Procedure	Clinical Findings Problems	Special Concerns / Investigations / Abnormal Results	Recommendations / Follow up needed	Handing Over Doctor	Receiving Over Doctor

DOCTOR'S SHIFT CHANGE HANDOVER FORM

Date:

Department:

Shift:

S.No	Patient Identification	Diagnosis / Procedure	Clinical Findings Problems	Special Concerns / Investigations / Abnormal Results	Recommendations / Follow up needed	Handing Over Doctor	Receiving Over Doctor

Patient Sticker



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MEDICATION RECONCILIATION FORM

Drug Allergies: Tab. CHLOROQUINE / Cor-2 ☒ 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: MUM Shifted to: 7th floor

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Tab. ELTROXIN	100mg	po	OD		☒ C ☐ DC
2	Ij. LANTUS	units	sc	TDS		☒ C ☐ DC
3	Ij. FIASP		sc	TDS		☒ 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 :

Date & Time :

Nurse Name & Signature :

Date & Time :



2

MEDICATION RECONCILIATION FORM

Drug Allergies: TAB. CHLOROQUINE/COX-02 ☐ 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: 7th floor Shifted to: LDR

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	1mg. Parv	4mg	IV	stat		☐ C ☐ DC
2	1mg Emeset	4mg	IV	stat		☐ C ☐ DC
3	1mg supacef	1.5g	1ml ID	stat		☐ 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. Manjhaemai N

Date & Time: 13/7/20

Nurse Name & Signature: Gowtham

Date & Time: 13/7/20 @ 5.30am

REGISTRATION AND IDENTIFICATION

One Applicant: 14-00000-1 (14-00000-1)

Registration Book: 14-00000-1 (14-00000-1)

In the first line of the registration book, the name of the applicant is written in the first line of the registration book.

14-00000-1 (14-00000-1)

240	GENERIC NAME (PRINTED)	GENERIC NAME (PRINTED)
1	14-00000-1	14-00000-1
2	14-00000-1	14-00000-1
3	14-00000-1	14-00000-1
4	14-00000-1	14-00000-1
5	14-00000-1	14-00000-1
6	14-00000-1	14-00000-1
7	14-00000-1	14-00000-1
8	14-00000-1	14-00000-1
9	14-00000-1	14-00000-1
10	14-00000-1	14-00000-1

REGISTRATION HISTORY (14-00000-1)

14-00000-1 (14-00000-1)

14-00000-1 (14-00000-1)

14-00000-1 (14-00000-1)

14-00000-1 (14-00000-1)



3

MEDICATION RECONCILIATION FORM

Drug Allergies: Tab. CHLORO QUINE 1000-2 ☐ 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: LDR Shifted to: OT

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	<u>100 SUPACEF</u>	<u>1.5g</u>	<u>IV</u>	<u>Stat</u>	<u>13/7/20 at 6:30am</u>	☐ 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. Anandhaeswari P

Date & Time: 13/7/20 at 6:30am

Nurse Name & Signature: S. Anandhaeswari

Date & Time: 13/7/20 6:30am

GUC-00093783 IP18-00036438
Dr. DEEPIKADEVI
26-02-1989 37 Y 4 M 17 D (F)
Dr. SELF



4

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MEDICATION RECONCILIATION FORM

Drug Allergies: TAB. CHLOROQUINE / Lax-2

☒ 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: OT

Shifted to: MICU

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	CARDOTOCIN	1000 U	IV	STAT		☐ C ☒ DC
2	OXYTOCIN	20 U	IV infusion	STAT		☐ C ☒ DC
3	EMGICET	4mg	IV	PRN		☒ C ☐ DC
4	TRAPIC	1g	IV	STAT		☐ C ☒ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

MEDICATION HISTORY RECORDED / VERIFIED BY

* C- Continue, DC - Discontinue

Doctor Name & Signature: Sah SATYAJ CHANDAN

Date & Time: 13/7/26 8am

Nurse Name & Signature: S/A Suthi

Date & Time: 13/7/26 8am

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



MEDICATION RECONCILIATION FORM

Drug Allergies: TAB. CHLOROQUINE 1000-2

☐ 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: MMU

Shifted to: 7th floor

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	<u>Inj. SUPACEF</u>	<u>1.5gm</u>	<u>IV BD</u>	<u>BD</u>		☒ C ☐ DC
2	<u>Inj. PAN</u>	<u>40mg</u>	<u>IV BD</u>	<u>BD</u>		☒ C ☐ DC
3	<u>Inj. PARACETAMOL</u>	<u>1gm</u>	<u>IV TDS</u>	<u>TDS</u>		☒ C ☐ DC
4	<u>Inj. CLEXANE (CEFTROXIM)</u>	<u>60mcg</u>	<u>SC</u>	<u>OD</u>		☒ C ☐ DC
5	<u>Tab. THYRONORM</u>	<u>100mg</u>	<u>PO</u>	<u>OD</u>		☒ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

MEDICATION HISTORY RECORDED / VERIFIED BY

* C - Continue, DC - Discontinue

Doctor Name & Signature: Dr. Dnyalalshmi S.R.

Date & Time: 13/7/26, 1:15pm

Nurse Name & Signature: M. Dhanu

Date & Time: 13/7/26 at 2:00pm



DRUG CHART

Date of Admission: 12/17/26 Drug Allergies: Tab. CHLOROQUINE 100-2 ☐ 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 : <u>INJ. TRAMADOL</u>				Date Time
Dose <u>50mg</u>	Route <u>Im</u>	Frequency <u>(SOS)</u>	Start Date <u>13/7/26</u>	
Doctor's Signature <u>[Signature]</u>		Valid Period	Pharm.	
Additional Instructions:				

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

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

VERIFIED BY : Name Signature



REGULAR PRESCRIPTIONS

Weight. 96 kg. Ward. 2nd floor

DRUG : Tab. CILTROXIN				Date	13/7	14/7	15/7													
Dose	Route	Frequency	Start Date	Time	9A	KH	SS													
100mg	PO	OD	13/7	6Am	9A	SS	AP													
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:				empty stomach																
Daily Doctor's Endorsement by a Sign																				
DRUG : Ij. SUPACEF				Date	13/7	14/7	15/7													
Dose	Route	Frequency	Start Date	Time	6Am	1	KH	SS												
1.5g	IV	1-01	13/7	6Am	1	SS														
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:				SPM 6PM U.S. NS V.A. V.A.																
Daily Doctor's Endorsement by a Sign				stop																
DRUG : Ij. PANTOPRAZOLE				Date	13/7	14/7	15/7													
Dose	Route	Frequency	Start Date	Time	6Am	1	KH	SS												
40mg	IV	1-01	13/7	6Am	1	SS														
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:				SPM NS 6PM V.A. V.A.																
Daily Doctor's Endorsement by a Sign				stop																
DRUG : Ij. PARACETAMOL				Date	13/7	14/7	15/7													
Dose	Route	Frequency	Start Date	Time	12Am	1	KH	SS												
1gm	IV	1-1-1	13/7	12Am	1	SS														
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:				SPM P.L. 6-9																
Daily Doctor's Endorsement by a Sign				stop																
				NS 4PM V.A. V.A.																



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
12/7	8:30 PM	SYP. DUPHACAL	15ml	PO	[Signature]	[Signature]
13/7	5:40 AM	Ij. SUPACEF	0.1ml	ID	[Signature]	[Signature]
13/7	5:20 AM	Ij. PANV	40mg	IV	[Signature]	[Signature]
13/7	5:20 AM	Ij. EMISET	4mg	IV	[Signature]	[Signature]
13/7	6:20 AM	Ij. SUPACEF	15g	IV	[Signature]	[Signature]
13/7	6:40	CANDETACIN	100 U	IV	[Signature]	[Signature]
13/7	6:40 AM	EMISET	4 mg	IV	[Signature]	[Signature]
13/7	6:40	TRADIC	1G	IV	[Signature]	[Signature]
13/7	6:50	OXYTOCIN	20 U	IV	[Signature]	[Signature]

Signature
VERIFIED BY: Name



I.V. FLUIDS CHART

Weight. 92.5/99 Ward. 102

[illegible]

GUC-00093783 IP18-00036438
Dr. DEEPIKADEVI
26-02-1989 37 Y 4 M 17 D (F)
Dr. SELF



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Dr. Deepika Devi

Sheet No:

REGULAR PRESCRIPTIONS

Weight 9854 Ward 202

DRUG : <u>Lj. CLEXANE</u>				Date Time	<u>13/7 14:55</u>
Dose	Route	Frequency	Start Dt.		
<u>60mg</u>	<u>SC</u>	<u>OD</u>	<u>13/7</u>	<u>8pm</u>	<u>SS SS</u>
Name & Signature of the Doctor Starting the Drugs:				<u>[Signature] 164285</u>	
Additional Instructions:				<u>Totally</u>	
<u>(3) These doses</u>					
Daily Doctor's Endorsement by a Sign					
DRUG : <u>T. AUGMENTIN</u>				Date Time	<u>15/7 10:17</u>
Dose	Route	Frequency	Start Dt.		
<u>625mg</u>	<u>PO</u>	<u>1-0-1</u>	<u>14/7/26</u>	<u>8pm</u>	<u>E.S</u>
Name & Signature of the Doctor Starting the Drugs:				<u>[Signature] 182217</u>	
Additional Instructions:				<u>8pm</u>	
Daily Doctor's Endorsement by a Sign				<u>DI</u>	
DRUG : <u>T. ACTON OR</u>				Date Time	<u>14/7 15:17</u>
Dose	Route	Frequency	Start Dt.		
<u>1Tab</u>	<u>PO</u>	<u>1-0-1</u>	<u>14/7/26</u>	<u>8am</u>	<u>P.K</u>
Name & Signature of the Doctor Starting the Drugs:				<u>[Signature] 182217</u>	
Additional Instructions:				<u>8pm E.S</u>	
Daily Doctor's Endorsement by a Sign				<u>P.O.A</u>	
DRUG : <u>T. PANTO CID</u>				Date Time	<u>16/7</u>
Dose	Route	Frequency	Start Dt.		
<u>1Tab</u>	<u>PO</u>	<u>1-0-0</u>	<u>15/7/26</u>	<u>7am</u>	
Name & Signature of the Doctor Starting the Drugs:				<u>[Signature] 182217</u>	
Additional Instructions:				<u>Empty stomach in morning</u>	
Daily Doctor's Endorsement by a Sign					

Signature
VERIFIED BY : Name

Patient Sticker

REGULAR PRESCRIPTIONS

Weight Ward

DRUG : SYP. DUPHALAC				Date	Time	Weight	Ward
Dose	Route	Frequency	Start Dt.	9am	14/7/15		
20ml	PO	1-0-1	14/7/26		PA		
Name & Signature of the Doctor Starting the Drugs:							
Additional Instructions:							
Daily Doctor's Endorsement by a Sign							
DRUG :				Date	Time		
Dose	Route	Frequency	Start Dt.				
Name & Signature of the Doctor Starting the Drugs:							
Additional Instructions:							
Daily Doctor's Endorsement by a Sign							
DRUG :				Date	Time		
Dose	Route	Frequency	Start Dt.				
Name & Signature of the Doctor Starting the Drugs:							
Additional Instructions:							
Daily Doctor's Endorsement by a Sign							
DRUG :				Date	Time		
Dose	Route	Frequency	Start Dt.				
Name & Signature of the Doctor Starting the Drugs:							
Additional Instructions:							
Daily Doctor's Endorsement by a Sign							
DRUG :				Date	Time		
Dose	Route	Frequency	Start Dt.				
Name & Signature of the Doctor Starting the Drugs:							
Additional Instructions:							
Daily Doctor's Endorsement by a Sign							

VERIFIED BY : Name Signature



IP18-00036438

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Name:

Weight: 965 kgs

Sheet No:

Docu. No. : RCH /FRM / CLINICAL / 136

Dr. Deepika devi.

CUC. 0093283. Age. 31 Fem

Dr. Sath

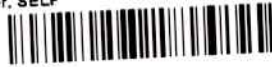
Pharmacist
Dr. Sath

MEDICATION CHART AUDIT CHECKLIST - IP

	DRUG 1	DRUG 2	DRUG 3	DRUG 4	DRUG 5	DRUG 6	DRUG 7
DRUG NAME	T. El Troien	Pr. Supacet	Pr. Panto	Pr. Panto	Pr. Cleseane		
FREQUENCY	OD	BD	BD	TDS	BD		
DOCTORS							
2. INCORRECT DRUG SELECTION							
2. NO/WRONG DOSE							
3. NO/ WRONG UNIT OF MESUREMENT							
4. NO/ WRONG FREQUENCY							
5. NO/WRONG ROUTE							
6. NO/ WRONG CONCENTRATION							
7. NO/WRONG RATE OF ADMINISTRATION							
8. ILLEGIBLE PRESCRIPTION							
9. NON APPROVED/ERROR PRONE ABBREVIATION USED	✓	✓	✓	✓	✓		
10. NON- USAGE OF CAPITAL LETTERS FOR DRUG NAMES	✗	✗	✗	✗	✗		
11. NON-USAGE OF GENERIC NAMES							
12. DRUG-DRUG INTERACTION							
13. DRUG- FOOD INTERACTION							
14. WRONG FORMULATION TRANSCRIBED							
15. WRONG DRUG TRANSCRIBED/INDENTED							
16. WRONG STRENGTH TRANSCRIBED/INDENTED							
PHARMACIST							
17. WRONG DRUG							
18. WRONG FORMULATION							
19. WRONG STRENGTH DISPENSED							
20. EXPIRED/NEAR EXPIRY DRUG DISPENSED							
21. NO/ WRONG LABELLING							
22. DELAY IN DISPENSE(<30 MINTS)							
23. GENERIC OR CLASS SUBSTITUTED DONE WITHOUT CONSULTATION WITH THE CONSULTANT							
NURSES							
24. WRONG PATIENT							
25. IMPROPER DOSE							
26. DOSE OMISSION							
27. WRONG DRUG							
28. WRONG FORMULATION							
29. WRONG ROUTE							
30. WRONG DURATION							
31. WRONG TIME							
32. NO DOCUMENTATION							
33. DOCUMENTATION WITHOUT ADMINISTRATION							
DISCREPANCY							
INTERVENTIONS							
TOTAL NUMBER OF OPPORTUNITIES							

1. NON-COMPLAINE YES/NO (If yes mention : Doctor/Pharmacist/Nurses), 2. MEDICATION ERROR FORM/INCIDENT FORM RAISED (YES/NO), 3. CAPA DONE (YES/NO), 4. (ERROR PRONE ABBREVIATION USED IN THE MEDICATION CHART (TICK IF USED).

DRUG NAME FREQUENCY DOCTORS	MEDICATION CHART AUDIT CHECKLIST - IP						
	DRUG 1	DRUG 2	DRUG 3	DRUG 4	DRUG 5	DRUG 6	DRUG 7
1. INCORRECT DRUG SELECTION							
2. NO/WRONG DOSE							
3. NO/ WRONG UNIT OF MESUREMENT							
4. NO/ WRONG FREQUENCY							
5. NO/WRONG ROUTE							
6. NO/ WRONG CONCENTRATION							
7. NO/WRONG RATE OF ADMINISTRATION							
8. ILLEGIBLE PRESCRIPTION							
9. NON APPROVED/ERROR PRONE ABBREVIATION USED							
10. NON- USAGE OF CAPITAL LETTERS FOR DRUG NAMES							
11. NON-USAGE OF GENERIC NAMES							
12. DRUG-DRUG INTERACTION							
13. DRUG- FOOD INTERACTION							
14. WRONG FORMULATION TRANSCRIBED							
15. WRONG DRUG TRANSCRIBED/INDENTED							
16. WRONG STRENGTH TRANSCRIBED/INDENTED							
PHARMACIST							
17. WRONG DRUG							
18. WRONG FORMULATION							
19. WRONG STRENGTH DISPENSED							
20. EXPIRED/NEAR EXPIRY DRUG DISPENSED							
21. NO/ WRONG LABELLING							
22. DELAY IN DISPENSE(<30 MINTS)							
23. GENERIC OR CLASS SUBSTITUTED DONE WITHOUT CONSULTATION WITH THE CONSULTANT							
NURSES							
24. WRONG PATIENT							
25. IMPROPER DOSE							
26. DOSE OMISSION							
27. WRONG DRUG							
28. WRONG FORMULATION							
29. WRONG ROUTE							
30. WRONG DURATION							
31. WRONG TIME							
32. NO DOCUMENTATION							
33. DOCUMENTATION WITHOUT ADMINISTRATION							
DISCREPANCY	1. NON-COMPLAINE YES/NO (If yes mention : Doctor/Pharmacist/Nurses), 2. MEDICATION ERROR FORM/INCIDENT FORM RAISED (YES/NO), 3. CAPA DONE (YES/NO), 4. (ERROR PRONE ABBREVIATION USED IN THE MEDICATION CHART (TICK IF USED)).						
INTERVENTIONS							
TOTAL NUMBER OF OPPORTUNITIES							



Patient Sticker

Early Warning Observation Score Chart - Obstetrics

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

Date		8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
Time																									
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																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
40																									
Systolic Blood Pressure	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70																								
60																									
50																									
Diastolic Blood Pressure	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
NEURO RESPONSE [✓]	Alert																								
	Voice																								
URINE mls / hour	> 30																								
	< 30																								
Proteinuria	Protein ++																								
	Protein > ++																								
Lochia	Normal																								
	Heavy / Foul																								
Liquor	Clear / Pink																								
	Green																								
TOTAL YELLOW SCORES																									
TOTAL ORANGE SCORES																									
Nurse Initial																									

GUC-00093783
Dr. DEEPIKADEV
26-02-1989
Dr. SELF

IP18-00036438
37 Y 4 M 17 D (F)



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Maternal Observation Score Chart - Obstetrics

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

Date		Time																								
13/7/26		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	21	22	22	22	22	22	22	22	22	22	22	22	22	22	22	22	22	22	22	22	22	22	22	22	
	0 - 10																									
Saturations	94 - 100 %	99	99	98	94	94	94	94	94	94	94	94	94	94	94	94	94	94	94	94	94	94	94	94	94	
	< 94 %																									
Administered O ₂ (L/min.)		RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	
Temp °C	40																									
	39																									
	38																									
	37	98.6	98.7	98.8	98.9	99.0	99.1	99.2	99.3	99.4	99.5	99.6	99.7	99.8	99.9	100.0	100.1	100.2	100.3	100.4	100.5	100.6	100.7	100.8	100.9	
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120		
	90																									
	80																									
	70																									
	60																									
	50																									
	40																									
	Systolic Blood Pressure	190																								
		180																								
		170																								
160																										
150																										
140																										
130		120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195	200	205	210	215	220	225	230		
120																										
110																										
100																										
90																										
80																										
70																										
60																										
50																										
Diastolic Blood Pressure	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
	40																									
	NEURO RESPONSE [✓]	Alert	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Voice		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Pain		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Unresponsive																										
URINE mls / hour	> 30	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	< 30																									
Proteinuria	Protein ++																									
	Protein > ++																									
Lochia	Normal	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	Heavy / Foul																									
Liquor	Clear / Pink	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	Green																									
TOTAL YELLOW SCORES		8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	
TOTAL ORANGE SCORES		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Nurse Initial		RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	

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3

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Maternal Observation Score Chart - Obstetrics

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

14/7/20		Date	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
Time																										
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20	88					20				20				20				20							
	0 - 10																									
Saturations	94 - 100 %	98				99				99				98				100					100			
	< 94 %																									
Administered O ₂ (L/min.)		2L				2L				2L				2L				2L				2L				
Temp °C	40																									
	39																									
	38																									
	37						98.5							98.5				98.5				97.5				
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100						85				85			85			85				85					
	90																									
	80																									
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressure	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
50																										
Diastolic Blood Pressure	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
50																										
40																										
NEURO RESPONSE [✓]	Alert																									
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30																									
	< 30																									
Proteinuria	Protein ++																									
	Protein > ++																									
Lochia	Normal																									
	Heavy / Foul																									
Liquor	Clear / Pink																									
	Green																									
TOTAL YELLOW SCORES							1				1				1				1							
TOTAL ORANGE SCORES							1				1				1				1							
Nurse Initial																										



FLUID CHART

Sheet No. : ①

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm					on Admission						
	03:00 pm											
	04:00 pm	100ml	100ml						100ml			
	05:00 pm											
	06:00 pm	420	100									
	07:00 pm											
Total Intake : 200ml						Total Output : 100ml						
	08:00 pm											
	09:00 pm	N		150								
	10:00 pm	P		150					250ml			
	11:00 pm	P		150								
	12:00 am	O		150								
	01:00 am			150								
Total Intake : 750ml						Total Output : 250ml						
	02:00 am	N		150								
	03:00 am	N		150								
	04:00 am	P		150					250ml			
	05:00 am	P		150								
	06:00 am	O		150					250ml			
	07:00 am			150ml								
Total Intake : 900ml						Total Output : 500ml						
Total 24 hrs. Intake		11850ml										
Total 24 hrs. Output		850ml										



FLUID CHART

Sheet No. : 2

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V.	N.G.	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am			1850 mL						100 mL	0	
	09:00 am			125	100 mL					200 mL	0	
	10:00 am			125	100 mL					200	0	
	11:00 am			125	100 mL					150	0	
	12:00 pm			125	100 mL					150	0	
	01:00 pm	H ₂ O 500 mL		125	100 mL					150	0	
Total Intake :			3625 mL			Total Output :			950 mL			
	02:00 pm	TLC 200 mL		125						60	0	pen
	03:00 pm	H ₂ O 100		125						150	0	SW
	04:00 pm	H ₂ O 100		125						200	0	SW
	05:00 pm	SW 100		125						250	0	SW
	06:00 pm	H ₂ O 150		125						150	0	SW
	07:00 pm	H ₂ O 100		125						200	0	SW
Total Intake :			750 + 750 = 1500 mL			Total Output :			1000 mL			
	08:00 pm	H ₂ O 100 mL		125						150	0	
	09:00 pm			125						200	0	
	10:00 pm	H ₂ O 200 mL		125						200	0	
	11:00 pm			125						150	0	
	12:00 am	H ₂ O 100 mL		Stop						100	0	
	01:00 am									200	0	
Total Intake :			1000 mL + 500 mL			Total Output :			950 mL			
	02:00 am									150	0	
	03:00 am	H ₂ O 500 mL								150	0	
	04:00 am									200	0	
	05:00 am									200	0	
	06:00 am	H ₂ O 200 mL								150	0	
	07:00 am									200	0	
Total Intake :			250 mL			Total Output :			710 mL			
Total 24 hrs. Intake			5167.5 mL			Total 24 hrs. Output			3620 mL			



FLUID CHART

Sheet No. : ③

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		Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G						
14/7/20	08:00 am									0	P.G
	09:00 am	H ₂ O 200								0	P.G
	10:00 am	Soup 150								0	P.G
	11:00 am					✓		Istoid 350ml		0	P.G
	12:00 pm	H ₂ O 200								0	P.G
	01:00 pm								200ml	0	P.G
Total Intake : 450 ml					Total Output : 550 ml						
	02:00 pm	H ₂ O 50								0	SN
	03:00 pm	H ₂ O 150				✓			250	0	SN
	04:00 pm									0	SN
	05:00 pm	H ₂ O 200								0	SN
	06:00 pm	milk 100							300	0	SN
	07:00 pm										
Total Intake : 500 ml					Total Output : 550 ml						
	08:00 pm	H ₂ O 200ml								0	SN
	09:00 pm									0	SN
	10:00 pm	H ₂ O 100ml							250	0	SN
	11:00 pm									0	SN
	12:00 am	H ₂ O 200ml								0	SN
	01:00 am								150ml	0	SN
Total Intake : 500 ml					Total Output : 450 ml						
	02:00 am									0	SN
	03:00 am									0	SN
	04:00 am	H ₂ O 200ml							200ml	0	SN
	05:00 am									0	SN
	06:00 am	milk 200ml								0	SN
	07:00 am								250ml	0	SN
Total Intake : 400 ml					Total Output : 450 ml						
Total 24 hrs. Intake		1850.									
Total 24 hrs. Output		1450ml.									

FLUID INTAKE

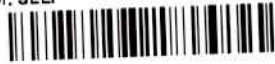
10/1/20

Sheet No. 1

1. All measurements in ml.
2. Add up each column separately. Total fluid intake.

Date		Time	Volume of fluid	Intake
10/1/20	10:00 am	10:00 am	100 ml	100 ml
		10:30 am	100 ml	200 ml
		11:00 am	100 ml	300 ml
		11:30 am	100 ml	400 ml
		12:00 pm	100 ml	500 ml
		Total intake:		
10/1/20	1:00 pm	1:00 pm	100 ml	600 ml
		1:30 pm	100 ml	700 ml
		2:00 pm	100 ml	800 ml
		2:30 pm	100 ml	900 ml
		3:00 pm	100 ml	1000 ml
		Total intake:		
10/1/20	3:30 pm	3:30 pm	100 ml	1100 ml
		4:00 pm	100 ml	1200 ml
		4:30 pm	100 ml	1300 ml
		5:00 pm	100 ml	1400 ml
		5:30 pm	100 ml	1500 ml
		Total intake:		
10/1/20	6:00 pm	6:00 pm	100 ml	1600 ml
		6:30 pm	100 ml	1700 ml
		7:00 pm	100 ml	1800 ml
		7:30 pm	100 ml	1900 ml
		8:00 pm	100 ml	2000 ml
		Total intake:		
10/1/20	8:30 pm	8:30 pm	100 ml	2100 ml
		9:00 pm	100 ml	2200 ml
		9:30 pm	100 ml	2300 ml
		10:00 pm	100 ml	2400 ml
		10:30 pm	100 ml	2500 ml
		Total intake:		
Total 24 hr. intake			2500 ml	

Patient Sticker



NURSING SHIFT HAND OVER FORM

SITUATION		Diagnosis: <u>Premil 2wks / Deaf twin / Hypothyroid.</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known		
		Surgery / Procedure:		If Yes Specify:		
		Post OP Day:				
BACKGROUND	Date	<u>12/14/26</u>	<u>12/15/26</u>	<u>12/16/26</u>	<u>12/17/26</u>	
	Shift	<u>E</u>	<u>N</u>	<u>M</u>	<u>E</u>	
ASSESSMENT	Medical Condition (Any special condition to be noted):	<u>Hypothyroid</u>	<u>Hypothyroid</u>	<u>Hypothyroid</u>	<u>Hypothyroid</u>	
	Diet:	<u>Adi</u>	<u>Adi</u>	<u>NPO</u>	<u>Soft diet</u>	
ASSESSMENT	Allergy:	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	
	Ventilation (RA, NP, NIV, VENTI):	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	<u>98.2</u>	<u>98.2</u>	<u>98.2</u>	<u>98.2</u>
		Res:	<u>20</u>	<u>20</u>	<u>20</u>	<u>20</u>
		SpO ₂ :	<u>100%</u>	<u>98%</u>	<u>100%</u>	<u>100%</u>
		Pulse:	<u>80b/min</u>	<u>80b/min</u>	<u>80b/min</u>	<u>80b/min</u>
		BP:	<u>140/80</u>	<u>130/80</u>	<u>110/70</u>	<u>110/70</u>
	Fall Risk Score:	LOC:	<u>conscious</u>	<u>conscious</u>	<u>conscious</u>	<u>conscious</u>
		Fall Risk Score:	<u>0/10</u>	<u>1/10</u>	<u>0/10</u>	<u>0/10</u>
Pain Score:		<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	
Skin Integrity:		<u>intact</u>	<u>intact</u>	<u>intact</u>	<u>intact</u>	
Safety Needs:		☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	
Recommendations	Physiotherapy:	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	
	Others Specify:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Special Diet:	<u>Adi</u>	<u>NPO</u>	<u>NPO</u>	<u>Soft diet</u>	
	Critical Lab Test / Values:	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	
	Other Special Orders / Medications:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	PU Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	DVT Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	ADL (Dependent / Non Dependent):	<u>dependent</u>	<u>dependent</u>	<u>Dependent</u>	<u>dependent</u>	
Post Operative Procedure Special Orders:		<u>-</u>				
Handed Over By Name :		<u>reni</u>				
Signature / ID :		<u>12/14/26</u>				
Date:		<u>12/14/26</u>				
Time:		<u>9:00pm</u>				
Taken Over By Name :		<u>sonip</u>				
Signature / ID :		<u>09/038</u>				
Date:		<u>12/14/26</u>				
Time:		<u>8pm</u>				

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
	Surgery / Procedure:		Post OP Day:					
BACKGROUND	Date	Shift	/	/	/	/	/	/
	Medical Condition (Any special condition to be noted):							
	Diet:							
ASSESSMENT	Allergy:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):							
	Tubes/Drains/Catheter:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp:						
		Res:						
		SpO ₂ :						
		Pulse:						
		BP:						
		LOC:						
		Fall Risk Score:						
	Pain Score:							
	Skin Integrity							
Recommendations	Safety Needs:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:							
	Others Specify:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:							
	Critical Lab Test / Values:							
	Other Special Orders / Medications:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
ADL (Dependent / Non Dependent):								
Post Operative Procedure Special Orders:								
Handed Over By Name :								
Signature / ID :								
Date:								
Time:								
Taken Over By Name :								
Signature / ID :								
Date:								
Time:								



NURSING CARE RECORD

Date: 12/7/20

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	2:30 pm	Improved knowledge to some extent	3pm	* Clarify doubts * Educate about medication regimen	Clarify doubts and Improved knowledge to some extent	Reassessment Done	True 01/02/20
Night	8pm	Maintain good nutritional status.	8:30 pm	Maintained good nutritive status	monitored I/O chart	Reassessment done.	Soiya 01/02/20



NURSING CARE RECORD

Date: 13/7/20

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am	Achieve acceptable Pain control and comfort	8:30 AM	Assess Pain using Pain Scale. → Position Patient comfortably. → Provide non-pharmacological measures	Patient Vitals signs Stable.	Reassessment done.	Key / 17/20
Afternoon	2pm	Achieve acceptable pain control and comfort	2:30 pm	Assess pain using pain scale. → Position patient comfortably.	patient Vitals are stable	Reassessment done	Key / 17/20
Night	8pm	Act maintain Good Nutritional Status	8:30 pm	Assess pain Patient was stable. Vitals also maintain. → D/o chart maintain	Patient was comfortable.	Reassessment done	Key / 17/20



Patient

①

JRSSES NOTES

☐ No Known Drug Allergies

☒ Drug Allergies Tub - CH LOROQUINE / COV-2

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
12/1/26	3.35 pm	Admission notes on 12/1/26 Pt got admitted in 8th floor under by Dr Divya Naveen Nijam. Pt conscious & oriented. Pt general condition is good. Pt Conn for Electric LSCs for trans monitoring. 6.30 ^{am} . Primi / 1st conception / 2nd / Hypertensive! DGA twin. Pt vitae usual & recommend admission ICU connecting FHR is good but h Pt UBA, 151 mg/dl. Pt condition explain to attende.	pen/01/26
	4.30 pm	Pt ICU disconnecting band by Dr Divya Nijam. Pt shifted to ward.	pen/01/26
	5.30 pm	SIB too. Sentil Sir examination in for patient. Pt down Pt condition informed too. Sentil Sir.	pen/01/26
	6 pm	Pt shifted to ward Pt heading down to 7th floor Staff 10 pm received FHR to becoming high duty doctors rounds next before shifting OT FHR to be checking to be followed up in 8 pm. Patient parts portion not done to be followed.	pen/01/26

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

☐ No known drug allergies

☐ Drug Allergies (H)

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
12/7/26	6.30pm	Patient shifted from 1DR to 7th Floor. Patient case standing over given to 7th Floor Staff	Paul 01620
	6.45pm	Reviewing Notes:- Patient Review from 1DR to 7th Floor She was conscious & oriented was fair only & Discharge was fair - 14/4/26	
	7.10pm	pt Report handily over w(N) Dr. Jarr	Dr. Jarr
		Night Duty Notes.	
	7.30pm	Patient Handover received from Emergency Staff. Patient alert and oriented. Plan for elective c/s. NPO from 8pm. (C) PRBC transfusion. Re-shift 1DR.	Dr. Jarr
	8pm	checked vital signs and recorded.	
	9.10pm	IV line put and IVF-PL - 150ml/hr. On flow	Dr. J
13/7/26	12am	checked vital signs and recorded	Dr. J
	2am	patient sleeping well.	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



(2)

NURSES NOTES

☒ No Known Drug Allergies

☐ Drug Allergies Tab: PHLOROXINE - Cor-2

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
13/7	4am	Three Ps no other complaint. checked vital sig and Recorded.	20/11/18
	4:30am	Patient postpartum done. Patient taken Bath.	20/11/18
	5:30 am	Inj - par - long Inj - emeset 4mg. Inj - paracet 0.1ml test dose all pre medication given.	20/11/18
	5:40 am	Patient shift to LDR Staff Relieving notes	20/11/18
	5:40 Am	patient is relieving from the floor to LDR pt have hand over taken from the floor staff Nurse patient was stable pt vital are stable BP 130/90 mmHg Informed Dr Annashuani iv fluids commenced on flow 150ml/hr iv line paten. checked for ftr is good (D) patient general condition fair	20/11/18
	6:30 Am	⇒ catheterization was done by Dr Annashuani iv fluids on going pt care hand over given to OT staff Nurse No allergic reaction Inj paracet 1.5g given full dose given pt shifted to OT	20/11/18

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

☒ No Known Drug Allergies

☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
13/7/26	6.35am	OT Notes on 13/7/26 patient details handover taken from S/L while receiving patient conscious & oriented v/s are monitored. IV line patter catheterized. patient shifted to OT-3 at 6.35am on the OT table to connect the cardiac monitor. IV connected most connected. LSA was given painky draping done. procedure started at 6am on. Electro LSCs twin cervical strict removal done during the surgery there is no any complication. IV D5W flow v/s are monitored after cervical strict removal. after procedure was done draping done dressing done patient after shift to MICU admission to MICU S/L sent 8.10am → Receiving nurse at 0157	Sent 0157
13/7/26	8.10AM	Receiving the Patient from OT to LOR. While receiving the Patient conscious and oriented afebrile, NPO, T ₁₀₁ PL $\frac{1}{2}$ leg symptoms smaller on flow.	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

☒ No Known Drug Allergies

☐ Drug Allergies

Pan. Chloroquine 1000-2

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
13/7/26		Let PL 1000/1000 on Flow	
13/7/26		CBD were clear of all clots.	
		Has No Swelling over the	
		operated area. Has mild	
		fever over the operated	
		Site	→ 10/11/26
	9AM	→ B: Breast 80% No engorgement.	
		→ U: Uterus firm contracted	
		well.	
		→ B: Bowel Movement Present	
		→ B: Patient on CBD	
		last bowel out 2000.	
		→ L: Lochia Rubra Present	
		No evidence of Foul Smell	
		→ E: Poda assessment not	
		appropriate.	
		→ H: Homans sign negative	
		→ E: Patient emotional	
		Stable good.	→ 10/11/26
	10AM	→ CBD were drained	
		clear of clots. Patient	
		vital signs are stable.	
		BP: 131/94 mmHg, RR: 20/breath	
		P: 92b/min. SpO2: 97%. General	
		condition fair. Per bleeding	
		Normal	→ 10/11/26

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient



NURSES NOTES

☒ No Known Drug Allergies

☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
13/7/20	11 AM	⇒ Pt bleeding Abnormal Patient vital signs closely General condition fair ⇒ reg/ban	
	12 pm	⇒ Hx No foreign body the opened area - Her mild Pain over the opened site ⇒ reg/01176	
	1 pm	⇒ LFT RL 12 hourly on Flaw, CBO were checked clean & adequate ⇒ reg/01176	
	30 1 pm	⇒ Patient orders Sterile No Urine TC wound given. Patient report head ache to Evening duty staff ⇒ reg/01176	
	1.30 pm	Emergency duty (13/7/2020) patient handing over taken by morning duty staff. All patient conscious and oriented. General condition fair ply bleeding minimal ⇒ reg/01176	
	2 pm	patient checked. vital are stable. ply bleeding minimal B - Process was seen v - uterus was contracted	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

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Your Right to a Safe Delivery

☒ No Known Drug Allergies

☐ Drug Allergies

(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)

DATE	TIME		SIGNATURE
13/8/20	cont	B - Bowel movement present	
		B - Perineal wound present.	
		B - Patient is CRON 1st out put 60ml	
		L - Lochia rubra present - no foul smelling.	
		T - Rectal assessment not applicable.	
		U - Homan's sign negative.	
		C - Patient emotional status is good	
	2:00pm	pt vital checked & normal fine warm on touch no bleeding minimal pt shifted to ward pt handling over to 7th floor staff to be followed down ward.	ben/01/16/20
	2:20pm	Recovery Notes:- pt Recovered from LPR to 7th floor She was conscious & oriented was taking oral & Diets was fluid on flow & Diets was has no specific complaint at present on CRON 1st out was with sign no change	ben/01/16/20

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

- ☐ No Known Drug Allergies
☐ Drug Allergies

na

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
12/7/20		Review general condition is fair	ona
	4pm	Also vital signs are checked Sp- 140/80 mmHg JIF is Mrs. Akshitha Mann Admitte Chand every 1 hr once	ona
	6pm	has no oozing (as) bleeding from the operative site as CSB more dried was taken	ona
	7pm	She is stable pr report handup due to (N) dinner start	ona
		Night duty Note.	
12/7/20	1:30pm	patient Handover taken to Evening duty staff patient conscious & oriented R line patient	ona
	8pm	Vitals checked & record vitals stable. Patient was left due to start	ona
	8:10pm	Due to medication given as per drug chart order B - Breast soft NO engorgement	ona
	10pm	U - uterus contracted well, B - Bowel movement present. B - Patient was CBD	ona

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

☐ No Known Drug Allergies

☒ Drug Allergies

tit T. chloroquine / cox-2

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
13/7	10pm.	L = Lochia rubra present no evolution of foul smell. E = Rokit asermit not applicable. H - Homans sign negative E - patient emotional status good	<i>[Signature]</i> 08/20
14/7/20	10am	Vitals checked & recorded Vitals stable. Patient was sleeping. No other complaints. Due to medication given as per physio chart order.	
	2pm	D/o chart manually into also show my	<i>[Signature]</i> 08/20
	4pm	checked vital sign and recorded	
	6pm	Administered due medication as per chart and recorded	<i>[Signature]</i> 08/20
	7:30am	Handover given to morning duty staff.	08/20
		Morning duty on 14/7/20	
	11:30am	patient detail landing over taken from night duty staff. Patient conscious and oriented. Patient is on (BIC). patient is on soft diet. patient iv line patent. patient tomorrow dis plan	<i>[Signature]</i> 08/20

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies

T. Monaghan / 100V-2

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
14/12/20	8 AM	Vital signs checked and recorded B- Breasts soft. No engorgement UE- Uterus contracted. Involution present B- Bowel movement present. flatus present B- Patient in on CRLO. Urine clear drained. L- Lochiae Rubra present. No foul Smell E- REEDA is not applicable H- Homan's sign Negative S- Suction status good	Sh
	8:45 AM	Dr. Akshitha came seen the patient advised by soft diet, Pains of one fluid, Chm Monitoring, BP 124/81, J-forn 1st void, J-forn (100), Ambulatory	Sh
	9 AM	CRLO removed the patient Ambulated the patient. PU tender in Normal	Sh
	12 PM	Maintain Intake and Output chart. Vital signs checked and recorded	Sh
	12:30 PM	Urine voided 100ml voided. J-forn 1st void Dr. Akshitha came BP 120/80 J-forn 1st void Homan. advised by no need Medication	Sh
	1:30 PM	pt detach handy care on Evening duty 'start	Sh

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00093783

IP18-00036438

Dr. DEEPIKADEVI

28-02-1989

37 Y 4 M 17 D

(F)

Dr. SELF



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



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CAESAREAN SECTION OPERATIVE NOTES

Surgeon's Name: <u>Dr. Dhivya Narayan</u>	Date of Delivery: <u>TWIN-I</u>	<u>TWIN-II</u>
Assistant Surgeon: <u>Dr. Karitha</u>	Time of Delivery: <u>6.53 am</u>	<u>6.54 am</u>
Anaesthetist's Name: <u>Dr. Sathish</u>	Gender of Baby: <u>girl</u>	<u>Boy</u>
Type of Anaesthesia: <u>JSN</u>	Weight of Baby: <u>1.958 kg</u>	<u>890 gm</u>
Neonatologist: <u>Dr. Arithar / Dr. Potluri</u>	AGPAR Score:	
Scrub Nurse: <u>S/N Siva</u>	NICU Admission: ☒ Yes ☐ No	

Pre-Operative Diagnosis: PRIMI / DCDA TWINS / IVE / OVERT DM ON INSULIN
TWIN-II IUGR Indication: DCDA TWINS / TWIN-II
IUGR

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

Decision time: Knife to rectus:

CTG Description: Reassuring

If there was a delay give the reasons:

Surgical Procedure: ELECTIVE LOWER SEGMENT CAESAREAN SECTION. + CERVICAL STITCH REMOVAL.

Post Operative Diagnosis:

PL2 / EL-LSCS / PDD-0 / OVERT DM / HYPOTHYROID

Peri-Operative Complications:

- NIL

Amount of Blood Loss: ~350 ml Blood Transfused (in ML): NIL

Name and Number of Surgical Specimen sent for examination:

Both placenta for HPE

① TWIN I - cephalic
TWIN II - Breech

② Cervical stitch removed
intoto.

Examination Findings when Appropriate:

Presentation: ☐ Cephalic ☐ Breech ☐ Other

5th Palpable:

Station: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Caput: ☐ + ☐ ++ ☐ +++

Bladder Catheterized: ☒ Yes ☐ No

Cervical Dilatation: 05 closed cm

Fetal Position:

Moulding: ☒ None ☐ + ☐ ++ ☐ +++

Meconium: ☒ None ☐ + ☐ ++ ☐ +++

Urine: ☒ Clear ☐ Blood Stained

Skin Incision: ☒ Pfannenstiel ☐ Transverse

Uterine Incision: ☐ Lower Segment ☐ Classical

Previous Scar: ☐ Intact ☐ Thinned out

Incision Through Placenta: ☐ Yes ☒ No

Delivery of head: ☒ Manual ☐ Forceps

Liquor: ☒ Clear ☐ Meconium: ☐ I ☐ II ☐ III

Delivery of Placenta: ☐ Manual ☐ CCT

Cord Appearance:

Appearance of placenta: Both placenta - (N)

Uterus, tubes and ovaries: ☒ Normal ☐ Not Normal

☐ Midline

☐ Inverted T

☐ Ruptured

☐ Other

☐ J Incision

☒ No Scar

☐ Blood ☐ Offensive ☐ Not Offensive

☐ Complete ☐ Incomplete ☐ Piecemeal

Cord around the neck ☐ Yes ☒ No

Cavity explored ☒ Yes ☐ No

Sterilization: ☐ Yes ☒ No

Uterine Closure: ☐ One Layer ☒ Two Layers

Peritoneal Closure: ☐ Pelvic ☐ Abdominal ☐ None

Sheath Closure:

Fat Closure: ☐ Yes ☒ No

Skin Closure: ☒ Subcuticular ☐ Mattress

Vaginal Evacuated

Drain:

Catheter

Swap & Instruments count correct? ☐ Yes ☐ No

Intra-Operative Antibiotics Cover: ☐ Yes ☐ No

Post-Operative Notes:

1. NPO x 4 hours → liquids → Karji → solids.

2. IVF RL @ 125ml/hr.

3. Ij. SUPACEF 1.5gm IV BD

4. Ij. PAN 40mg IV BD

5. Ij. PARACETAMOL 1gm TDS

6. Ij. CLEXANE 60mg SC OD 8pm (after 12 hrs)

7. CBD removal x 24hr.

8. CBG monitoring. Insulin as per sliding scale

9. I/O charting.

10. W/F + bleeding pr.

Doctor Name: Dr. Danya Naveen

Doctor Signature: @anya

Date & Time: 13/07/2026, 8:10AM

11-July TRAMADOL SDS- 30mg



SURGICAL SAFETY CHECKLIST

son: Dr. Divya Naveen
Asst. Surgeon: Dr. Karthik
Anaesthetist: Dr. Sathish
Scrub Nurse: S/n Siva

Patient Name: Dr. Deepika Devi Age: 37.4 Gender: F
UHID No.: 93783 Surgery Name: Elective LSCS
Date: 13/1/26 In-time: 6.35am Out-time: 8.10am

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Before Induction of Anaesthesia >>

Before Skin Incision >>

Before Patient Leaves Operating Room

SIGN IN		Time: <u>6.36am</u>
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: <u>Sathish</u>		
Name: <u>SATHISH CHANDEN</u>		

TIME OUT		Time: <u>6.38am</u>
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?		
	☐ Yes ☒ No ☐ NA	
Anaesthesia Team Reviews:		
Are There Any Patient-specific Concerns?		
	☒ 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	
Power Supply, Earthing, Power Backup and functioning of equipment checked.		
	☒ Yes ☐ No	
Signature: <u>Dr. Divya Naveen</u>		
Name: <u>Dr. Divya Naveen</u>		

SIGN OUT		Time: <u>8.08am</u>
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: <u>Sathish</u>		
Name: <u>Sathish</u>		

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE



Patient Name: **Dr. DEEPIKA DEVI** GUC-00093783 IP18-00036438
 26-02-1989 37 Y 4 M 16 D (F) *un* Gender: ☐ Male ☒ Female Age: **37**
 UHID No: **Dr. SELF** Date: **12/7/26**

Instruction:

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

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

ELECTIVE LOWER SEGMENT CESAREAN SECTION
 upon **Ind - DCDA TWINS (Name of the Patient) DR. DEEPIKA DEVI TWIN 2 IVGR**

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

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

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

Bleeding, infection, injury to adjacent structures, need for blood transfusion, risk of thromboembolism, anesthesia related complications, NICU stay, NICU care.

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. Dinya Naveen**

Consentee:

Signature: *[Signature]*

Name: **Deepika Devi**

Date & Time: **12/7/26 at 6pm**

Witness:

Signature:

Name:

Date & Time:

Patient Attendant:

Signature: *[Signature]*

Name: **Dr. DINESH DEVI**

Relationship with Patient: **IVS BAND**

Date & Time: **12/7/26 at 6pm**

Doctor (who is taking the consent):

Signature: *[Signature]* **16/12/26**

Name: **Dr. Dinya Naveen**

Date & Time: **12/7/26**

THE OFFICE
SPECIAL PROJECT

1. Name of Project
2. Date of Report
3. Name of Author
4. Name of Reviewer
5. Name of Approver

6. Summary of Project
7. Objectives of Project
8. Methodology of Project
9. Results of Project
10. Conclusion of Project

11. Recommendations of Project
12. Acknowledgements of Project
13. References of Project
14. Appendix of Project
15. Glossary of Project

16. Index of Project
17. List of Figures of Project
18. List of Tables of Project
19. List of Equations of Project
20. List of Symbols of Project

CONSENT FORM FOR ANAESTHESIA

Patient Name : **Dr. DEEPIKADEVI**
UHID NO:
Anaesthesiologist: **SATHISH**

IP18-00036438
GUC-00093783
26-02-1989
37 Y 4 M 16 D (F)
Dr. SELF

Age : Gender : Male ☐ Female ☐

Surgeon Name:

Operative procedure planned : **LOWER SECTOMY**

(CAESAREAN SECTION)

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

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

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

- ☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure
☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma/ Renal Tubular Acidosis
☐ Incapacitating Chronic Obstructive Pulmonary Disease ☐ Others : **HYPERTENSION, HYPOTENSION**

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

DECLARATION BY PATIENT / GUARDIAN / PROXY

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

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

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 anaesthesia 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 anaesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

I have been explained all my queries in the language understood by me.

Patient / Patient Attendant :

Signature : **Dr. Deepika Devi**
Name : **Dr. Deepika Devi**
Relationship with Patient : **Husband**
Date & Time : **12/7/2018 @ 5:15 PM**

Witness :

Signature :
Name :
Date & Time :

Doctor (who is taking the consent) :

Signature : **T. Senthil Kumar**

Name : **Dr. T. Senthil Kumar**

Date & Time : **12/7/2018, 5:15 PM**

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

GUC-00093783

IP18-00036438

Dr. DEEPIKADEVI

26-02-1989

37 Y 4 M 16 D (F)

Name: Mr. S.ELF

Age: 37 yr

Sex:

UHID.No :

Date: ..

Proposed Operation:

Diagnosis: Primi / Twin

B.P / CRT: 142/82

H.R: 100/min

Weight: 98.5 kg

ASA Physical Status:

☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5

Hgb: 11.6

Glucose:

Laboratory Data:

HIV:

X-Ray:

PCV:

Urea: 10

Alb:

HBS Ag: 1/NS

ECG:

WBC:

Creat: 0.5

Total Bill:

HCV: 1/NS

2D Echo:

Plate:

Na: 136

Dir. Bill:

Blood group: B+

Stress/Angio:

PT:

K: 4.5

LDH:

T3

Other:

PTT:

Ca ++:

Alk phos:

T4

INR:

Mg ++:

Amylase:

TSH: 1.972

Cl -:

SGOT/SGPT:

Allergies: To T-Chloroquine & COX-2 inhibitors

Medical History:

CVS: dh+

Plcld Hypertension on T. Enoxin 100mg OD

RESP: Bat+

Diabetes: Plcld T2DM x16 months on Insulin 16/14/12

CNS:

Renal:

Hepatic / GE:

Physical Activity:

Others:

Past Anaesthetic History:

H/o Cervical Anesthesia & TIVA 4 months back.

Physical Exam:

Airway:

MP 1 2 3 4

Mouth Opening: Ady.

Mentohyoid Distance:

Neck: (N)

Teeth: (N)

Lungs:

Bat+

Heart:

SS

CNS:

Pregnant: ☐ Yes ☐ No ☐ NA

Venous Access Site:

Spine Exam for regional:

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

- DVT Prophylaxis:
- NIL ORAL
 Water / ORS 2 Hours
 Others 6 Hours
- Informed Consent: ☐ Standard ☒ High Risk
- Post Operative Pain Management: ☐ Discussed with Patient
- Other Instructions:

Signature: [Signature] Name: Dr. T. S. Srinivasan

Patient Sticker

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: S. S. S. S.Time Received: 8:10aTime Discharged: 8:10a

250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 < RESP • PULSE > BLOOD PRESSURE SPO ₂	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0		IV Cannula Site: _____ ☐ O ₂ Mask ☐ Nasal Prongs ☐ Tracheostomy ☐ T-Piece ☐ Oral Airway ☐ Nasal Airway Vomiting: ☐ Yes ☐ No Drug: _____ NG Tube: ☐ Yes ☐ No Drain: ☐ Yes ☐ No Urinary Catheter: ☐ Yes ☐ No Chest Tube: ☐ Yes ☐ No Nil Oral ☐ Yes ☐ No IV Fluids: _____ Oral Feeds: _____				
	POST ANAESTHESIA SCORE (Modified Aldrete Score)		SCORING INTERPRETATION				
Able to move 4 extremities voluntary or on command = 2 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 0	ACTIVITY	IN	30	60	90	OUT	A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0	RESPIRATION	1	1	2			
BP = 20 of Pre Anaesthetic level = 2 BP = 20-50 of Pre Anaesthetic level = 1 BP = 50 of Pre Anaesthetic level = 0	CIRCULATION	2	2	2			
Fully awake = 2 Arousable on calling = 1 Not responding = 0	CONSCIOUSNESS	2	2	2			
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0	COLOR	2	2	2			
TOTAL							

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature

Pain Tool Used: ☐ N PASS ☐ FLACC ☐ Wong Baker ☐ NPSAnaesthesiologist Name: S. S. S. S.Anaesthesiologist Signature: S. S. S. S.

Date & Time: _____

PACU Nurse Name: S. S. S. S.PACU Nurse Signature: S. S. S. S.Date & Time: 13/1/26 @ 8:10a

Reassessment Frequency:

- Every eight hours for all hospitalized patients.
- For post surgical patient, patient with chronic pain, patient with severe pain
 - Every 2 hours for first 24 hours
 - After 24 hours every 4 hours
 - Prior to pain relieving intervention
 - With in 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU): S. S. S. S.Date & Time: 13/1/26 @ 8:10a

Patient Sticker

b)

Delivery Details : Time : APGAR: SVD / Instrumental / LSCS (if LSCS Details)
Catheter Removed by and Tip Inspected :
Patient Satisfaction :

Date and Time :

PATIENT TRANSFER FORM

GUC-00093783 IP18-00036438
Dr. DEEPIKADEV
26-02-1989 37 Y 4 M 17 D (F)
Dr. SELF



Treating Consultant Name <i>Dr. Diviya naran</i>		Date & Time of Admission <i>12/17/20 at 5.30pm</i>	Date & Time of Transfer Order <i>13/1/20 at 2pm</i>
Transfer Ordered by <i>Dr. White</i>		Reason for Transfer <i>Dr. shifted to ward</i>	
From Unit <i>MUM</i>	To Unit <i>7th floor</i>	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File <i>In file @</i>	Number of Imaging Films <i>one @</i>	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 ☐ <i>Dr. shifted to ward and over by Dr. White</i>			
Name & Signature of Person who is Transferring <i>Srinivas</i>		Name of Person Ordered Transfer <i>Dr. White</i>	
Patient & Clinical Records Received by : <i>Srinivas</i>			
Date & Time of Patient Received : <i>13/1/20 at 2pm</i>			

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



PRE - OPERATIVE CHECK LIST

Date: 13/7/2016

Gender: ☐ M ☒ F

Patient's Name: DR. DEEPAKADENI
UHD: 93783
Blood Group: B+ve
Surgeon: DR. DIVYA NAUVEN
Planned Surgery: Elective LSCS
Date & Time of Operation: 13/7/2016 @ 6:30am

Anesthetist:

Tick Appropriate Boxes

To be filled by Nurse Incharge / Senior Nurse:

INSTRUCTIONS

S.No	YES	NO	NA
1.	☒	☐	☐
2.	☒	☐	☐
3.	☒	☐	☐
4.	☒	☐	☐
5.	☒	☐	☐
6.	☒	☐	☐
7.	☒	☐	☐
8.	☒	☐	☐
9.	☒	☐	☐
10.	☒	☐	☐
11.	☒	☐	☐
12.	☒	☐	☐
13.	☒	☐	☐
14.	☒	☐	☐
15.	☒	☐	☐
16.	☒	☐	☐

NOTE: if any of above is ticked "NO" Discuss with the registrar / consultant immediately

Billing Clearance taken
Billing Executive Name:
Billing Executive Signature:
Date & Time: 13/7/2016

Nurse In-Charge Name:
Signature of Nurse In-Charge:
Date & Time: 13/7/2016

Doc. No.: RCH / FRM / CLINICAL / 107

1912

1912

1912

1912

1912

1912

1912

s Name:.....
 GUC-00093783
 Dr. DEEPIKADEV
 26-02-1989
 Dr. SELF
 IP18-00036438
 37 Y 4 M 16 D


Age :...

Consultant

40.

Sex: ☐ M ☐ F

CANNULA 2

Time:

CANNULA 1

Date: 12/1/16 Time: 9-10 pm

Location: Left Anesthetic vein

Size: 18 G

Cannula inserted by: Dr. Savomija

Nursing: [blank]

SI: [blank]

Date :

Date :
Location : continuo.

Size :

Cannula inserted by :

Cannula inserted by: <u>SP</u>					Date
Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
12/1/26	9:10pm	☐ Yes ☒ No	☐ Yes ☒ No	observed	OK
	11:10	☐ Yes ☒ No	☐ Yes ☒ No	observed	OK
12/1/26	1:10	☐ Yes ☒ No	☐ Yes ☒ No	observed	OK
	3:10	☐ Yes ☒ No	☐ Yes ☒ No	observed	OK
	5:10	☐ Yes ☒ No	☐ Yes ☒ No	observed	OK
	7AM	☐ Yes ☒ No	☐ Yes ☒ No	observed	OK
	2AMT	☐ Yes ☒ No	☐ Yes ☒ No	observed	OK
	10AMT	☐ Yes ☒ No	☐ Yes ☒ No	observed	OK
	12PM	☐ Yes ☒ No	☐ Yes ☒ No	observed	OK
	2pm	☐ Yes ☒ No	☐ Yes ☒ No	observed	OK
	4pm	☐ Yes ☒ No	☐ Yes ☒ No	observed	OK
	6pm	☐ Yes ☒ No	☐ Yes ☒ No	observed	OK
	8pm	☐ Yes ☒ No	☐ Yes ☒ No	observed	OK
	10pm	☐ Yes ☒ No	☐ Yes ☒ No	observed	OK
14/7	12AMT	☐ Yes ☒ No	☐ Yes ☒ No	observed	OK
	2AM	☐ Yes ☒ No	☐ Yes ☒ No	observed	OK
	4AM	☐ Yes ☒ No	☐ Yes ☒ No	observed	OK
	6AM	☐ Yes ☒ No	☐ Yes ☒ No	observed	OK
14/7	8AM	☐ Yes ☒ No	☐ Yes ☒ No	observed	OK
15/7	12pm	☐ Yes ☒ No	☐ Yes ☒ No	observed	OK
	2pm	☐ Yes ☒ No	☐ Yes ☒ No	observed	OK
	4pm	☐ Yes ☒ No	☐ Yes ☒ No	observed	OK
	6pm	☐ Yes ☒ No	☐ Yes ☒ No	observed	OK
	8pm	☐ Yes ☒ No	☐ Yes ☒ No	observed	OK
	10pm	☐ Yes ☒ No	☐ Yes ☒ No	observed	OK
	12AM	☐ Yes ☒ No	☐ Yes ☒ No	observed	OK
	2am	☐ Yes ☒ No	☐ Yes ☒ No	observed	OK

Cannula removed : ☐ Yes ☐ No, if yes date and time :
 RX any initiated : ☐ Yes ☐ No ☐ N/A If Yes specify-
 Phlebitis score:

[illegible]

Cannula removed : ☐ Yes ☐ No, if yes date and time :
 RX any initiated : ☐ Yes ☐ No ☐ NA If Yes specify-
 Phlebitis score:

NOTE :

- * To be assessed within 30 minutes of insertion.
- * Every 2 hours if on fluid infusion.
- * Every 4 hours if only on IV medication.

V.I.F.

V.I.P. SCORE (VISUAL INFUSION PHLEBITIS SCORE)..... Next page

PHLEBITIS ASSESSMENT AND MANAGEMENT RECORD

Cannula inserted by :

Time:

Cannula inserted by:

Time:

[illegible]

Cannula removed: ☐ Yes ☐ No, if yes date and time: _____
 RX any initiated: ☐ Yes ☐ No ☐ NA If Yes specify- _____
 Phlebitis score: _____

[illegible]

Cannula removed: ☐ Yes ☐ No, if yes date and time: ☐ Yes ☐ No
 RX any initiated: ☐ Yes ☐ No ☐ NA If Yes specify-
 Phlebitis score:

NOTE:

- * To be assessed within 30 minutes of insertion.
- * Every 2 hours if on fluid infusion.
- * Every 4 hours if only on IV medication.

V.I.P. SCORE (VISUAL INFUSION PHLEBITIS SCORE)					
0	1	2	3	4	5
IV site appears healthy	ONE of the following is evident: * Slight pain near I.V. site or slight redness near I.V. site	TWO of the following is evident: * Pain near I.V. Site * Erythema * Induration	ALL of the following is evident: * Pain along path of cannula * Erythema * Induration	ALL of the following is evident and extensive: * Pain along path of cannula * Erythema * Induration * Palpable venous cord	ALL of the following is evident and extensive: * Pain along path of cannula * Erythema * Induration * Palpable venous cord * Pyrexia
OBSERVE CANNULA	OBSERVE CANNULA	RESITE / REMOVE CANNULA	RESITE / REMOVE CANNULA CONSIDER TREATMENT	RESITE / REMOVE CANNULA CONSIDER TREATMENT	INITIATE TRETMENT RESITE / REMOVE CANNULA

GUC-00093783
Dr. DEEPIKADEV
26-02-1989
Dr. SELF

IP18-00036438
37 Y 4 M 16 D (F)



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It takes a lot to treat the little.

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BY RAINBOW HOSPITALS
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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	N	M	E	Fall Risk Grading		
		Score	12/7/26	13/7/26	13/7/26	Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25						
	No	0	0	0	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15	15	15	18	Low Risk	0 - 24	Standard Fall Precaution
	No	0	0	0	0			
Ambulatory Aid	Furniture	30				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	Crutches, Cane(S), Walker	15			0			
	None /Bed Rest /Nurse Assist	0	0	0	0			
IV / Heparin Lock or Saline	Yes	20			26			
	No	0	0	0	0			
GAIT / Transferring	Impaired	20			0	High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10		10	0			
	Normal /On Bed Rest /Immobile	0	0	0	0			
Mental Status	Forgets limitations	15			0			
	Oriented to own ability	0	0	0	0			
Total Morse Fall Scale Score:			15	25	35			
		Signature	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>			

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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1-015049-20

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GUC-00093783
Dr. DEEPIKADEVI
28-02-1989
Dr. SELF

IP18-00036438

37 Y 4 M 17 D (F)



Morse Fall Risk Assessment Form

**Rainbow[®]
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It takes a lot to treat the little.

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BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Choose Highest Applicable Score from each Category		Date / Time	N 13/7/26	M 14/7/26	F 15/7/26	Fall Risk Grading		
		Score						
History of Falling (immediately or w/in 3 months)	Yes	25				Risk Level	Morse Fall Score (MFS)	Action
	No	0	0	0	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15	15	15	15	Low Risk	0 - 24	Standard Fall Precaution
	No	0	0	0	0			
Ambulatory Aid	Furniture	30				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0	0	0			
IV / Heparin Lock or Saline	Yes	20				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	No	0	0	0	0			
GAIT / Transferring	Impaired	20						
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0	0	0	0			
Mental Status	Forgets limitations	15						
	Oriented to own ability	0	0	0	0			
Total Morse Fall Scale Score:			15	15	15			
Signature			<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>			

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
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- ☐ 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

11/10/1911

11/10/1911

11/10/1911

11/10/1911

11/10/1911

GUC-00003783 IP18-00036438
Dr. DEEPIKADEVI
26-02-1989 37 Y 4 M 18 D (F)
Dr. SELF



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	0	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15	15	15	Low Risk	0 - 24	Standard Fall Precaution
	No	0					
Ambulatory Aid	Furniture	30			Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	Crutches, Cane(S), Walker	15					
	None /Bed Rest /Nurse Assist	0	0	0			
IV / Heparin Lock or Saline	Yes	20	20	20	High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	No	0					
GAIT / Transferring	Impaired	20					
	Weak (uses touch for balance)	10					
	Normal /On Bed Rest /Immobile	0	0	0			
Mental Status	Forgets limitations	15					
	Oriented to own ability	0					
Total Morse Fall Scale Score:			35	35			
Signature			<i>[Signature]</i>	<i>[Signature]</i>			

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

Математика
 10 класс
 Вариант 1

1. Решите уравнение: $\sin^2 x + \cos^2 x = 1$

2. Найдите значение выражения: $\sin^2 30^\circ + \cos^2 60^\circ$

3. ...

4. ...

5. ...

BRADEN Q SCALE

IP-18-00036438

GUC-00093783

Dr. DEEPIKADEV

26-02-1989 37 Y 4 M 16 D (F)

Dr. SELF



		Date: 21/12/17		Time: 10:30	
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance. 1. Bedfast: Confined to bed	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently. 2. Chairfast: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently. 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. No limitations: Makes major and frequent changes in position without assistance. 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.	10
*Activity The degree of physical activity	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.	10
Sensory Perception	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.	10
Moisture Degree to which skin is exposed to moisture	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.	10
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	10
Nutritional Usual food intake pattern	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.	10
Tissue Perfusion & Oxygenation					
TOTAL SCORE				20	20
Evaluator's Name				Dr. SELF	10/12/17

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	⑩ Regular Turning Schedule ⑩ Enable as much activity as possible ⑩ Protect the heels ⑩ Use pressure redistribution surfaces ⑩ Manage moisture, friction and shear ⑩ 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	⑩ Use the Same Protocol as for "At Risk" Patients ⑩ 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	⑩ Follow the same protocol as for "Moderate Risk" Patients ⑩ In addition to regular turning schedule ⑩ 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	⑩ Use same protocol as for "High Risk" Patients ⑩ 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

GUC-00093783
Dr. DEEPIKADEVI
26-02-1989
Dr. SELF

IP18-00036438

37 Y 4 M 17 D (F)



BRADEN 'Q' SCALE

Rainbow
Children's
Hospital

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

			Date : 13/7	WIC	14/2	14/7	
			Time : N	M	E	Ch	
Mobility	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
'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
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
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
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
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	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
TOTAL SCORE					28	28	28
Evaluator's Name					Devi	Devi	Devi

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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It takes a lot to read the Bible.
Your Right

				Date : 15/3				
				Time : 4				
Mobility	1. Completely mobile: 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			
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TOTAL SCORE					28			
Evaluator's Name					60794			

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PAIN ASSESSMENT FORM

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It takes a lot to treat the little.

BirthRight
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Your Right to a Safe Delivery

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
12/7/26	3:00 PM	0/10	nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	no pain	as 10/12
13/7/26	8 AM	0/10	nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	no pain	as 10/12
13/7/26	2 PM	1/10	Post. W side	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☒ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☐ Yes ☐ No	position	as 10/12
13/7/26	8 PM	1/10	Surgical site pain	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☒ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☐ Yes ☐ No	position change	as 10/12
14/7/26	8 AM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	nil	as 10/12
14/7/26	2 PM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☒ No	nil	as 10/12
14/7/26	4 PM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☒ No	nil	as 10/12
14/7/26	6 PM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☒ No	nil	as 10/12
14/7/26	8 PM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☒ No	nil	as 10/12
15/7/26	10 PM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☒ No	nil	as 10/12
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

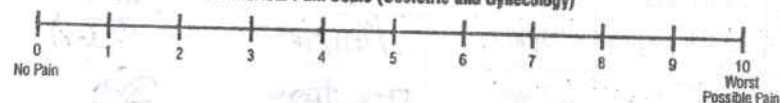
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 - 60 minutes after pain relief intervention.

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 or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

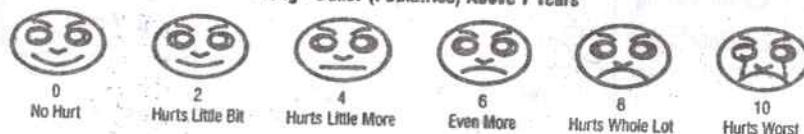
Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



Patient Sticker



OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 12/1/20 Time of Arrival: 3:25 PM Time Seen by Nurse: 3:30 PM

1) Level of Consciousness: ☒ Conscious ☐ Semi-Conscious ☐ Unconscious

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

- ☐ Severe Pain / Moderate Pain
☐ Bleeding PV: Slight / Heavy
☐ Decreased Fetal Movement
☐ No Fetal Movement

- ☐ Preterm rupture of Membranes / Leaking Water PV
☐ Preterm Labor/ Labor
☐ Spontaneous Rupture of Membrane / Leaking Water PV

☒ Other Reason: pt came for EL. LSH

3) Vital Signs: Temperature: 98.2 Pulse: 80 RR: 20 SpO₂: 100 BP: 140/60 Weight: 98.5

4) Gestational Criteria:

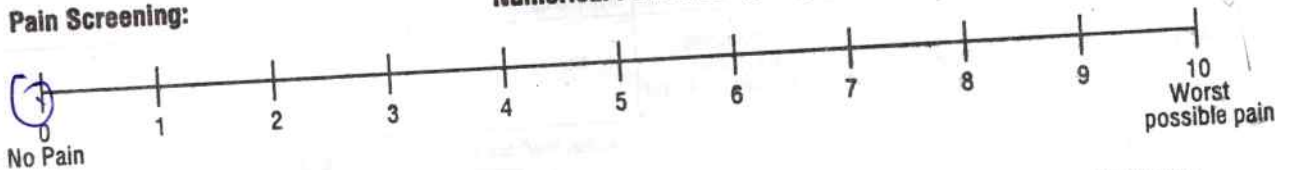
Gravida:	<u>Primi</u>	P	L	A
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LMP: unknown EDD: 6/15/20 Gestational Age: 38w4d

Uterine Contraction	☐ Yes ☒ No ☐ NA	Onset	Time	Frequency:
Membrane Rupture	☐ Yes ☒ No ☐ NA	Onset	Time	Fluid Color:
Vaginal bleeding	☐ Yes ☒ No ☐ NA	Onset	Time	Amount:
Pre Eclampsia Symptoms	☐ Yes ☒ No ☐ NA	If Yes specify: Headache / Visual Symptoms / Pain Abdomen / Vomiting		
Good fetal Movement	☒ Yes ☐ No ☐ NA	If No specify:		

5) Pain Screening:

Numerical Pain Scale (NPS)



- ⑩ Location: ml
⑩ Duration: ml Days / Weeks / Months (Strike out which is not applicable)
⑩ Character: ml
⑩ Frequency: ml
⑩ Interventions: ml

6) Past History:

- a) Surgeries: Cesarean delivery (McDonalds stitch)
b) Medical: Hypertension / Over diabetes

- 7) Allergy: ☒ Yes ☐ No, If Yes: Tub.
- 8) Current Medications: ☐ Prenatal Vitamin ☐ None ☐ Others: Tub. 1-1.5g daily morning
7.5 flasp bd with.
- 9) Prenatal Medical History:
- ☒ None
- ☐ Chronic Hypertension
- ☐ Gestational Hypertension
- ☐ Diabetes
- ☐ Gestational Diabetes
- ☐ Low placenta
- ☐ Others if yes, specify

Triage Category: (Please tick on the category)

Refer to **OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)**

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

OTAS	Level 1 (Resuscitative)	Level 2 (Emergent)	Level 3 (Urgent)	Level 4 (Less Urgent)	Level 5 (Non Urgent)
Level 1 (Resuscitative)	Immediate	≤ 15 minutes	≤ 30 minutes	≤ 60 minutes	≤ 120 minutes (2 Hours)
Re-Assessment	Continuous Nursing Care	Every 15 Minutes	Every 15 Minutes	Every 30 Minutes	Every 60 Minutes
Labour / Fluid	Imminent Birth	Suspected Pre-term Labour / PPROM < 37 Weeks	Signs of Active Labour > 37 weeks	Signs of Early Labour/ SROM > 37 weeks	Discomforts of Pregnancy
Bleeding	Active Vaginal bleeding with/ without abdominal pain	Bleeding associated with cramping (<spotting) <37 weeks	Bleeding associated with cramping (>spotting) >37 weeks	Spotting	
Hypertension	Seizure activity	Hypertension > 160/110 and / or headache, visual disturbance, RUQ pain	Mild hypertension > 140/90 with/without associated signs and symptoms		
Fetal Assessment	Abnormal FHR tracing Non-Fetal Movement	Atypical FHR tracing, abnormal dopplers Diseased fetal movement			
Others	● Acute onsite severe abdominal pain ● Altered level of consciousness ● Cord prolapse ● Severe respiratory distress ● Suspected sepsis	● Major trauma ● Shortness of breath ● Unplanned and unattended birth	● Abdominal/back pain greater than expected in pregnancy ● Flank pain / hematuria ● Nausea/vomiting and/or diarrhea with suspected dehydration	● Ongoing assessment from out patient clinic (for hypertension, blood work) ● Minor trauma (minor MVC/fall) ● Nausea/Vomiting and/or diarrhea ● Signs of infection (ie dysuria, cough, fever, chills)	● Anything that does not seem to pose threat to mother or fetus ● Cervical ripening ● Out patient placenta previa protocols ● Pre-booked visits (ie Rh and progesterone injections, NST) ● Assessment for version ● Rashes

Time seen by Doctor: 3:30 PM

Nurse Name: M. Devi

Date: 12/7/20

Time: 3:25 PM

Nurse Signature: [Signature]

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RISK ASSESSMENT TOOL FOR DEEP VEIN THROMBOSIS

POSTNATAL ASSESSMENT AND MANAGEMENT (TO BE ASSESSED ON DELIVERY SUITE)

Date: 12/7/20

	Tick	Score
Pre - Existing Risk Factors		
Previous VTE (except a single event related to major surgery)		4
Previous VTE provoked by major surgery		3
Known high-risk thrombophilia		3
Medical comorbidities e.g. cancer, heart failure; active systemic lupus erythematosus, inflammatory polyarthropathy or inflammatory bowel disease; nephrotic syndrome; type I diabetes mellitus with nephropathy; sickle cell disease; current intravenous drug user		1
Family history of unprovoked or estrogen-related VTE in first-degree relative		1
Known low-risk thrombophilia (no VTE)	✓	1
Age (≥ 35 years)	✓	1 or 2
Obesity		1
Parity ≥ 3		1
Smoker		1
Gross varicose veins		
Obstetric Risk Factors		
Pre-eclampsia in current pregnancy	✓	1
ART/IVF (antenatal only)		1
Multiple pregnancy		2
Caesarean section in labour	✓	1
Elective caesarean section		1
Mid-cavity or rotational operative delivery		1
Prolonged labour (24 hours)		1
PPH (1 litre or transfusion)	✓	1
Preterm birth 37 ⁺ weeks in current pregnancy		1
Stillbirth in current pregnancy		
Transient Risk Factors		
Any surgical procedure in pregnancy or puerperium except immediate repair of the perineum, e.g. appendectomy, postpartum sterilization		3
Hyperemesis		4
OHSS (first trimester only)		1
Current systemic infection		1
Immobility, dehydration	✓	
Total		
Signature of the Nurse	m. Dan 21/7/20	
Action Plan		

RISK ASSESSMENT FOR VENOUS THROMBOEMBOLISM (VTE)

- ✓ If total score ≥ 4 antenatally, consider thromboprophylaxis from the first trimester.
- ✓ If total score 3 antenatally, consider thromboprophylaxis from 28 weeks.
- ✓ If total score ≥ 2 postnatally, consider thromboprophylaxis for at least 10 days.
- ✓ If admitted to hospital antenatally consider thromboprophylaxis.
- ✓ If prolonged admission (≥ 3 days) or readmission to hospital within the puerperium consider thromboprophylaxis.

For patient with an identified bleeding risk, the balance of risks of bleeding and thrombosis should be discussed in consultation with a haematologist with expertise in thrombosis and bleeding in pregnancy.

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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Part - I.

Patient's / Learner Language: Tamil

Patient / Learner Literacy: ☐ Read ☐ Write ☒ Speak

Willingness to Learn: Yes ☒ No ☐

Healthcare Literacy: Yes ☐ No ☒

Identified Education Needs:

1. Primi
Diagnosis

Plan

3. Pain Management

4. Informed Consent

5. Medication / Therapy (safety, effects/ side effect, interactions)

6. Discharge Medication

7. Infection Control Measures

8. Diagnostic Test / Procedures

9. Nutrition / Diet

10. Fall Risk Education

11. Safe use of Medical Equipment / Implantable Devices
Safety

12. Patient's / Family Rights

13. Risk / Safety

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
12/1/16	4:00 pm	Informed Consent	Dr explain to curam in the surgery procedure.	Patient	Education level.	Oral.	Repetit values & barrier	Verbalized understanding	Good	DM
12/1/16	10:00 am	yes	Explanation about diet	patient	NO	Oral				
16/1/16	4:00 pm	Yes	post Operative care	Pr	NO Learning Barrier	Oral	None	Verbalized understanding	Good	E
15/1/16	10:00 am	yes	Explanation about nutrition	patient	NO	Oral	None	Verbalized understanding	Good	PLM

Part - III: CODES

Who was taught: ☒ Patient ☐ Father ☐ Mother ☐ Spouse ☐ Son ☐ Daughter ☐ Caregiver ☐ Other (Specify)

Learning Barriers:

1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences

Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed

Mechanism/s to overcome barrier/s:

1. None	3. Reassurance & Support	5. Respect values & beliefs
2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference

Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review

7. Other, Specify

10. Financial Difficulties
11. Beliefs and Values
12. Impaired Vision/ or Hearing
13. Cultural/Religion Practice
14. Others (Specify)



CONSENT FOR BLOOD TRANSFUSION

Patient Name : Dr. Deepika Devi Age: 37 Gender : F

UHID No.: :IP No.: Ward/Bed No.

Type of Blood Product : 1 UNIT PACKED RED BLOOD CELLS

I hereby give my consent for whole blood transfusion / 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 HIV antibodies, Hepatitis B surface antigens, Hepatitis C antibodies, Malaria and Syphilla. I have also been explained that transfusion transmitted infections can vary rarely 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 component transfusions carry risk of transfusion associated reactions.

All the above-mentioned risks 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 the whole blood component transfusion to me / my Patient named

Name of Patient / ~~Attendant~~ DR. DEEPIKA DEVI

Signature of Patient / ~~Attendant~~ [Signature]

Date 12.07-26

Time : 4:30 pm

Relationship with Patient: self

GUC-00093783
Dr. DEEPIKADEV
26-02-1989
Dr. SELF

IP18-00036438

37 Y 4 M 17 D (F)



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BREAST FEEDING HANDOVER AND ASSESSMENT FORM

1. Breastfeeding initiated?

- ☒ a. Yes ☐ b. No

2. If No, Reason

3. Nipple condition:

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

4. Milk flow:

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

5. Steps for Positioning and attachment:

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



Feeding Positions:
Cross Cradle



Feeding Positions:
Football / Clutch

6. Was the position explained:

- ☐ a. Yes
☐ b. No

7. For Caesarian mothers:

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

8. NICU admission:

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

9. Additional notes:

Continuity of Care:

Date: 13/7/26

Baby now

Handover given by P. Punter

Signature [Signature]

Date & Time: 13/7/26 at 9am

Handover taken by S. Murrell

Signature [Signature]

Date & Time: 13/7/26 4:25pm

GUC-00093783
Dr. DEEPIKADEVI
26-02-1989
Dr. SELF

IP18-00036438

37 Y 4 M 17 D (F)



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SSI PREVENTION CHECKLIST

INTERPRETATION		PERFORMED
PREOPERATIVE		
S.No		
1	Do not remove hair at the surgical site unless the presence of hair will affect the procedure. Use clipper if necessary	YES
2	Decolonize surgical patients with skin antiseptic(Chlorhexidine bath /wipes)	YES
3	Antibiotic prophylaxis given within 60mts prior to skin incision	YES
4	Use a checklist based on the world health organization-19 item surgical checklist to ensure adherence to best practice	YES
INTRAOPERATIVE		
5	Using chlorhexidine gluconate and alcohol-containing skin preparatory agent in combination	YES
6	Maintain normothermia during the surgical procedure (>36 deg C)	YES
POSTOPERATIVE		
7	Maintain and monitor blood glucose levels regardless of diabetes status between 110 and 150 mg/dl	NO
8	Application of incisional negative pressure wound dressing	NO



URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 13/7/20 Date of Removal: 14/7/20 09AM

Parameters	Date	Shift Time	13/7/20 N/6:30AM	13/7 M	13/7 P	13/7 N			
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			S/A Alok	S/A Alok	S/A Alok	S/A Alok			
Signature of the Nurse			[Signature]	[Signature]	[Signature]	[Signature]			

PRIMARY CARETAKER BUNDLE CHECK LIST

Name of the child		Date of birth		Age		Sex		Religion		Caste		Address		Signature of the caretaker		Signature of the health worker	
1. Name of the child		2. Date of birth		3. Age		4. Sex		5. Religion		6. Caste		7. Address		8. Signature of the caretaker		9. Signature of the health worker	
10. Name of the child		11. Date of birth		12. Age		13. Sex		14. Religion		15. Caste		16. Address		17. Signature of the caretaker		18. Signature of the health worker	
19. Name of the child		20. Date of birth		21. Age		22. Sex		23. Religion		24. Caste		25. Address		26. Signature of the caretaker		27. Signature of the health worker	
28. Name of the child		29. Date of birth		30. Age		31. Sex		32. Religion		33. Caste		34. Address		35. Signature of the caretaker		36. Signature of the health worker	
37. Name of the child		38. Date of birth		39. Age		40. Sex		41. Religion		42. Caste		43. Address		44. Signature of the caretaker		45. Signature of the health worker	
46. Name of the child		47. Date of birth		48. Age		49. Sex		50. Religion		51. Caste		52. Address		53. Signature of the caretaker		54. Signature of the health worker	
55. Name of the child		56. Date of birth		57. Age		58. Sex		59. Religion		60. Caste		61. Address		62. Signature of the caretaker		63. Signature of the health worker	
64. Name of the child		65. Date of birth		66. Age		67. Sex		68. Religion		69. Caste		70. Address		71. Signature of the caretaker		72. Signature of the health worker	
73. Name of the child		74. Date of birth		75. Age		76. Sex		77. Religion		78. Caste		79. Address		80. Signature of the caretaker		81. Signature of the health worker	
82. Name of the child		83. Date of birth		84. Age		85. Sex		86. Religion		87. Caste		88. Address		89. Signature of the caretaker		90. Signature of the health worker	
91. Name of the child		92. Date of birth		93. Age		94. Sex		95. Religion		96. Caste		97. Address		98. Signature of the caretaker		99. Signature of the health worker	
100. Name of the child		101. Date of birth		102. Age		103. Sex		104. Religion		105. Caste		106. Address		107. Signature of the caretaker		108. Signature of the health worker	



Date & Time of Transfer:		YES/NO	REMARKS
1 Patient Identification			
a. Patient Identification Patient name, age, UHID/hospital number confirmed		yes	
b. Surgical procedure & correct site verified		yes	
2 Airway & Breathing			
a. Oxygen delivery (mask/cannula/ventilator) secured		yes	
b. SpO ₂ within safe range		yes	
c. If ETT: position confirmed, ties secure, cuff inflated			
3 Circulation & Hemodynamic Stability			
a. IV lines secured & infusion running correctly		yes	
b. No active uncontrolled bleeding		no	
c. Last vitals recorded before transfer		yes	
d. Central line hubs are closed		no	
e. Dressing Intact			
4 Pain Assessment			
a. Pain score assessed & analgesia given		yes	
b. Reassessment done		yes	
5 Wound, Dressings & Drains			
a. Surgical dressing intact		no	
b. All drains fixed, output noted			
c. Catheter secure & urine output recorded		yes	
d. Splints/casts/traction devices stabilized		yes	
6 Medications Pre & Post-Op Orders			
a. Medications due time noted		yes	
b. Pre & Post-op instructions (NPO, position, mobilization) communicated		yes	
c. Emergency meds given in OT (time & dose documented)		yes	
7 Equipment Safety & Transport Preparedness			
a. Oxygen cylinder full & ambu bag at bedside		yes	
b. Bed/side rails up and brakes applied		yes	
c. Special positioning maintained as per surgery		no	
8 High-Risk Patient Safety (if applicable)			
a. Chest tube: underwater seal below chest level		no	
b. Epidural catheter secure, infusion checked		no	
c. Pressure areas protected (heels/elbows)		no	
9 BLOOD AND BLOOD PRODUCTS TRANSFUSED			
10 REPORTS AND LABS HANDED OVER			
11 BIOPSY/HPE SENT			
12 Documentation			
a. Documentation completeness		yes	
Transferring Nurse:		Shabellu Oboor	
Receiving Nurse:		S/A poo's DATT	
Signature of Incharge:			



Rainbow
Children's
Hospital

PATIENT TRANSFER NURSING HANDOVER CHECKLIST

Date & Time of Transfer: 13/1/26

OT

TRANSFERRED TO: Mico

	YES/NO	REMARKS
1 Patient Identification		
a. Patient Identification Patient name, age, UHID/hospital number confirmed	YH	
b. Surgical procedure & correct site verified	YH	
2 Airway & Breathing		
a. Oxygen delivery (mask/cannula/ventilator) secured	YH	
b. SpO ₂ within safe range	YH	
c. If ETT: position confirmed, ties secure, cuff inflated	NO	
3 Circulation & Hemodynamic Stability		
a. IV lines secured & infusion running correctly	YH	
b. No active uncontrolled bleeding	NO	
c. Last vitals recorded before transfer	YH	
d. Central line hubs are closed	NO	
e. Dressing Intact	YH	
4 Pain Assessment		
a. Pain score assessed & analgesia given	YH	
b. Reassessment done	YH	
5 Wound, Dressings & Drains		
a. Surgical dressing intact	YH	
b. All drains fixed, output noted	YH	
c. Catheter secure & urine output recorded	YH	
d. Splints/casts/traction devices stabilized	NO	
6 Medications Pre & Post-Op Orders		
a. Medications due time noted	YH	
b. Pre & Post-op instructions (NPO, position, mobilization) communicated	YH	
c. Emergency meds given in OT (time & dose documented)	YH	
7 Equipment Safety & Transport Preparedness		
a. Oxygen cylinder full & ambu bag at bedside	NO	
b. Bed/side rails up and brakes applied	NO	
c. Special positioning maintained as per surgery	YH	
8 High-Risk Patient Safety (if applicable)		
a. Chest tube: underwater seal below chest level	NO	
b. Epidural catheter secure, infusion checked	NO	
c. Pressure areas protected (heels/elbows)	YH	
9 BLOOD AND BLOOD PRODUCTS TRANSFUSED	NO	
10 REPORTS AND LABS HANDED OVER	NO	
11 BIOPSY/HPE SENT		
12 Documentation		
a. Documentation completeness	YH	
Transferring Nurse: S/N Swakinsing		
Receiving Nurse:		
Signature of Incharge:		

PATIENT TRANSFER FORM

GUC-00093783 IP18-00036438

Dr. DEEPIKADEVI

26-02-1989

37 Y 4 M 16 D

(F)

Dr. SELF



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Date & Time of Admission <i>12/1/26 at 2.55pm</i>		Date & Time of Transfer Order <i>12/1/26 at 6.30pm</i>
Treating Consultant Name <i>Dr. Divya</i>	Transfer Ordered by <i>Dr. Divyabaleshi</i>	Reason for Transfer <i>It shifted to ward</i>
From Unit <i>MMU</i>	To Unit <i>7th floor</i>	Information to Attendant Yes ☒ No ☐
Number of Sheets in Clinical File <i>In file - ①</i>	Number of Imaging Films <i>CTU - ①</i>	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 ☐ <i>It shifted to ward over by Dr. Divyabaleshi</i>		
Name & Signature of Person who is Transferring <i>SIN Don 21/5/20</i>		Name of Person Ordered Transfer <i>Dr. Divyabaleshi</i>
Patient & Clinical Records Received by : <i>Shrini</i>		
Date & Time of Patient Received : <i>over at 6.45 pm</i>		
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

GUC-00093783
Dr. DEEPIKADEV
26-02-1989 37 Y 4 M 16 D (F)
Dr. SELF



Date & Time of Admission

12/7/26 @ 2:55pm

Date & Time of Transfer Order

13/7/26 @ 5:30am

Treating Consultant Name

Dr. Divya Naveen

Transfer Ordered by

Dr. Ananthashwari

Reason for Transfer

Further management

From Unit

7th floor

To Unit

LDR

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.

2.

3.

4.

5.

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

Name & Signature of Person who is Transferring

Soumya @ 13/7/26

Name of Person Ordered Transfer

Dr. Ananthashwari

Patient & Clinical Records Received by :

S/N Akalya @ 808

Date & Time of Patient Received :

13/7/2026 @ 5:40am

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

PATIENT TRANSFER FORM

Patient Name: <u>Mr. J. Smith</u> Room: <u>101</u>	
Date of Transfer: <u>12/15/20</u>	
Reason for Transfer: <u>Discharge to Home</u>	
Referring Physician: <u>Dr. J. Smith</u>	
Receiving Physician: <u>Dr. J. Smith</u>	
Date of Admission: <u>12/15/20</u>	
Discharge Date: <u>12/15/20</u>	
Discharge Time: <u>10:00 AM</u>	
Discharge Location: <u>Home</u>	
Discharge Instructions: <u>Take medications as prescribed. Follow up with Dr. J. Smith in 2 weeks.</u>	
Signature of Referring Physician: <u>[Signature]</u>	
Signature of Receiving Physician: <u>[Signature]</u>	
Signature of Nurse: <u>[Signature]</u>	
Signature of Patient: <u>[Signature]</u>	

Nurse

Patient

PATIENT TRANSFER FORM

(3)

GUC-00093783 IP18-00036438
Dr. DEEPIKADEVI
28-02-1989 37 Y 4 M 17 D (F)
Dr. SELF



Date & Time of Admission

12/12/2014 2:55 pm

Date & Time of Transfer Order

13/12/2014 6:30 AM

Transfer Ordered by

Dr. Annadashwar

Reason for Transfer

FL 1818

Dr. Divya Naveen

From Unit

LDR

To Unit

OT

Information to Attendant

Yes ☒

No ☐

Number of Sheets in Clinical File

Whole 2P
File

Number of Imaging Films

CT

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 ☐

PT shifted to ward

Name & Signature of Person who is Transferring

Dr. Abhaya
018080

Name of Person Ordered Transfer

Dr. Annadashwar

Patient & Clinical Records Received by :

9/10 Smith
01957

Date & Time of Patient Received :

13/12/2014 6:50

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

1. Patient Name & DOB

2. Referring Physician

3. Date of Transfer

4. Time of Transfer

5. Reason for Transfer

6. Referring Facility

7. Receiving Facility

8. Referring Physician Signature

9. Referring Facility Signature

10. Receiving Physician Signature

11. Receiving Facility Signature

12. Date

13. Time

14. Initials

15. Signature

16. Receiving Physician Signature

17. Receiving Facility Signature

18. Receiving Facility Signature

19. Receiving Facility Signature

20. Receiving Facility Signature

21. Receiving Facility Signature

22. Receiving Facility Signature

23. Receiving Facility Signature

24. Receiving Facility Signature

25. Receiving Facility Signature

PATIENT TRANSFER FORM

GUC-00093783 IP18-00036438
Dr. DEEPIKADEVI
26-02-1989 37 Y 4 M 17 D (F)
Dr. SELF



Date & Time of Admission <i>13/7/26 at 2:55 PM</i>		Date & Time of Transfer Order <i>13/7/26</i>
Treating Consultant Name <i>Dr. Dhivya Narayan</i>	Transfer Ordered by <i>Dr. Sathul</i>	Reason for Transfer <i>Further Management</i>
From Unit <i>OT</i>	To Unit <i>MICU</i>	Information to Attendant Yes ☒ No ☐
Number of Sheets in Clinical File <i>IP file - 1</i>	Number of Imaging Films <i>-</i>	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 ☐		
Name & Signature of Person who is Transferring <i>Slr. Sathul 01357</i>		Name of Person Ordered Transfer <i>Dr. Sathul</i>
Patient & Clinical Records Received by : <i>13/7/26</i>		
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

ATTACHMENT FORM

ATTACHMENT FORM	
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GUC-00093783 IP18-00036438
Dr. DEEPIKADEVI
26-02-1989 37 Y 4 M 18 D (F)
Dr. SELF



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NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 14/07/2026 Time: 12:15 PM

Origin: _____

Height: 160 cm

Weight: 98.5 kg

BMI: ☐ ~ 26 kg/m²
☐ ~ 28 kg/m²
☒ ~ 30 kg/m²

Food Allergies: Nil

Diagnosis: ELECTIVE LSCS

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

Onset DM since 4 Months
Hypothyroid

Diet Advised:

Liquid Diet – ORS/ Coconut Water / Butter Milk / Barley Water / Soups ①

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

Soft Diet – Soft Rice, Dal and Vegetable Curries Soft Cooked, Curd ②

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

Patient's / Attendant's

Signature: _____

Name: Dr. Deepikadevi

Date & Time: 14/07/2026 12:10 PM

Dietician's

Signature: _____

Name: A. Sandhya Fekheem

Date & Time: 14/07/2026 12:15 PM

DIETARY NOTES

Date	Time	Notes	Sign
13/07/26	08:15 AM	NPO x 4 hours.	A.M. (018336)
	DOS.	FL - LKS done.	
	1 PM	- Patient is on liquid diet - Patient is stable. Oral intake is better. - Advised to take plenty of oral fluids - water, tender coconut water, fruit juices (etc) - Fluids - 2.5l - 3l/d. - Followed by Kanj. @ 5 PM.	A.M. (018336)
14/07/26	08:30 AM	- Patient is on Soft Diet - Patient is stable. Oral intake is Adequate. - Advised to take easy to digest foods. - Consume small - frequent meals. - Advised to take galatagogues foods for milk secretion such as garlic, fennel @ Oats (etc) - RDA - Values - Energy - + 600 Kcal. - Protein - + 17 - 19 g/d. - Stools Passed.	A.M. (018336)

GUC-00093783 IP18-00036438
Dr. DEEPIKADEV
26-02-1989 37 Y 4 M 17 D (F)
Dr. SELF



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SURGERY DETAILS

Date : 13/7/26

Patient Name: Dr. Deepikadevi Date of Birth: 26-02-1989 Age: 37y

Gender: F Ward: OT UHID No.: 93783/31438

Date of Surgery: 13/7/26 ☐ OT-1 ☐ OT-2 ☒ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Elective CS for TWINS & cervical Strich removal

Time In : 6:35 am

Time Out : 8:10 am

	NAME	AMOUNT
1. Surgeon	Dr. Dhanya Nair	
2. Anaesthetist	Dr. Sathish	
3. Assistant Surgeon	Dr. Paritha	
4. OT Technician	Mr. Raja	
5. Circulating Nurse	S/n Suganthi	
6. Assistant Nurse	S/n Siva	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No:

Order by:

Record finalized done by [Signature]

Invasión 6.47a.

Z. J. Supad 1.59m @ 6.25m.

Baby del
tas - busa.

Patient Sticker

Elexue 13/12/20

Rainbow[®]
Children's
Hospital
It takes a lot to trust the little.BirthRight[®]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

CONSUMABLES OF OT

Circulating staff: elav suganli Technician: my. baia Date: 13/12/20 Time:

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube			Major Pack <u>6cc</u>		01	Inj VtK		2
LMA			Sutures <u>2347</u>		02	Cord Clamp		2
ECG leads <u>(A) P/N</u>		3	<u>1306</u>		01	Suction Catheter <u>6F</u>		2
HME filter: A/P/N						Feeding Tube <u>6F, 7F</u>		3/1
Syringes: 10 cc ✓		05				Vacuum Suction Set		01
05 cc ✓		4	Gloves <u>7.P.F</u>		1	Surgical Gloves		
02 cc ✓		4+1	<u>6 1/2 P.F</u>		02	Gauze Pack ✓		2
01 cc			<u>P.F 7 1/2</u>		01	Syringe <u>1ml 2ml 5ml</u>		2/2
Cautery plate <u>(A) P/N</u>		1	Surgical blade <u>22</u>		01	Surgical Blade # 20		
IV set ✓		2	NG tube			Koochies (S)		
RL ✓		2	Cautery pencil <u>7</u>		01	Evatoin		9
NS: 10ml / 100ml / 500ml / 1000ml		01/1	Koochies <u>12x1001</u>		01	Bioxamic		2
			Ointments			Airtacil		1
			Suction Catheter			Airway <u>(2) (3)</u>		1/1
Fentanyl ✓		1	Cap, Mask			Lox <u>2x Jolly</u>		1
Morphine			Gauze Pack <u>120</u>		1/1	Men		1
Ketamine			Mop Pack		02	Caritec		1
Propofol ✓		3	Steristrip			Needle <u>20G</u>		1
Rocuronium			Underpad ✓		01	Needle <u>26 1/2</u>		1
Glycopyrolate ✓		1	Draw sheet			Carboprost		1
Myopyrolate			Abgel		01	O2 mask <u>(A)</u>		1
Ondansetron ✓		1	Foleys catheter			Syringe <u>20ml</u>		1
Pencan 25g/ Spinal Needle 22			Urobag			Ruparigesic		2
Bupivacaine 0.25%			Chest Drainage Catheter			Drs 500ml		1
Bupivacaine 0.25%(Heavy)			Romodrain bag			Taj. Justin		1
Antibiotics			Bandage			Duates 10ml		1
			Tegaderm			Spinal needle <u>25h (120mm)</u>		1
Suppositories			Ioban			5ml Emaroldy		
Anamol: 80mg / 250mg / 170 mg			Double J Stent			Syringe		2
Supridol: 100mg			Vacuum Suction set ✓		1	Lox <u>2x 30ml</u>		1
Justin: 12.5 mg / 25mg / 100mg		01	Plastic Bed Sheet <u>Ammon</u>		02	Anaun <u>(A)</u>		1
Tab. Misoprost: 200mg		01	Betadine Solution		02	Supraproct		1
<u>Miso - 600mg</u>		01	Microshield			BABY diaper		01
<u>Swick table 4x4</u>		01	Cotton Balls			<u>120 to 4000</u>		02
<u>Newnom pad</u>		01	Latex Gloves		10P			
<u>Newnom Kistel</u>		01	Ramdone Scrub					
<u>Baby wipe's</u>		01	Saral					

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No.

Ordered by:

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

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RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

Door No.157 to 160, Anna Salai, Guindy, Guindy Chennai Tamil Nadu INDIA
600015
Tel No : 044-40122444

VAT TIN : 33AABCR4014M1ZK

CIN : L85110TG1998PLC029914

DL NO :

Registered Office: 8-2-120/103/1, Survey No.403, Road No.2, Banjara Hills, Hyderabad 500034,
Telangana.

INPATIENT ISSUES AGAINST ORDERS



IP No	IP18-00036447	Ward	3F-NICU 1
Patient Name	Baby B/O DEEPIKADEVI TWIN-2	Bed Name	NICU 307
Age/Sex	0 Y 0 M 0 D 3 H / Male	Order No	18-0001726325
Date	13/07/2026 10:02	Prescription No	PRIP18-0626812
Payor	SELF PAY	Dispensed Date	13/07/2026 10:03
UHID	GUC-00093803		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	BABY DIAPER NEW BORN TEDDYS 10S PACK		H	07072026	12/30	1	255.00	255.00
2	GAUZE 7.5X7.5 12 PLY (5 NOS) NON XRAY	Bapuji Surgicals	GENERAL	M2641119	04/30	1	100.00	100.00
3	KLICK CLAMP	ROMSONS		G26D040017	03/31	1	42.00	42.00
Total :							397.00	397.00

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN



RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

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600015

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Registered Office: 8-2-120/103/1, Survey No.403, Road No.2, Banjara Hills, Hyderabad 500034,
Telangana.

INPATIENT ISSUES AGAINST ORDERS



IP No	IP18-00036447	Ward	3F-NICU 1
Patient Name	Baby B/O DEEPIKADEVI TWIN-2	Bed Name	NICU 307
Age/Sex	0 Y 0 M 0 D 3 H / Male	Order No	18-0001726326
Date	13/07/2026 10:02	Prescription No	PRIP18-0626813
Payor	SELPAY	Dispensed Date	13/07/2026 10:03
UHID	GUC-00093803		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	BABY WIPES 72S BUTTERFLY		H	44RW44GU	03/28	1	299.00	299.00
Total :							299.00	299.00

for RAINBOW CHILDREN'S MEDICARE LIMITED

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Pharmacist Name : GRACE PAUL RAJAN



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INPATIENT ISSUES AGAINST ORDERS



IP No	IP18-00036438	Ward	8F-OT COMPLEX
Patient Name	Dr. DEEPIKADEVI	Bed Name	MICU 802
Age/Sex	37 Y 4 M 17 D / Female	Order No	18-0001726313
Date	13/07/2026 09:48	Prescription No	PRIP18-0626805
Payor	SELF PAY	Dispensed Date	13/07/2026 09:49
UHID	GUC-00093783		

Total :	5,594.17	6,915.37
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for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN



RAINBOW CHILDREN'S MEDICARE LIMITED

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INPATIENT ISSUES AGAINST ORDERS



IP No	IP18-00036438	Ward	8F-OT COMPLEX
Patient Name	Dr. DEEPIKADEVI	Bed Name	MICU 802
Age/Sex	37 Y 4 M 17 D / Female	Order No	18-0001726313
Date	13/07/2026 09:48	Prescription No	PRIP18-0626805
Payor	SELF PAY	Dispensed Date	13/07/2026 09:49
UHID	GUC-00093783		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	AIRWAY-2 80 MM	ROMSONS		10052026	05/29	1	270.00	270.00
2	AIRWAY- 3 90 MM	ROMSONS	GENERAL	20260310	03/29	1	234.00	234.00
3	ANAWIN HEAVY 5 MG INJ 4 ML	Neon Laboratories Ltd	H	KP1713936	01/28	1	31.47	31.47
4	ARTACIL 25MG 2.5ML INJ	Neon Laboratories Ltd	H	1303356	07/27	1	45.30	45.30
5	BIOXAMIC 500 MG INJ	Biocare Pharmaceuticals	H	C3BIO004	01/28	2	73.23	146.46
6	BUPRIGESIC INJ AMP 0.3 MG 1 ML	Neon Laboratories Ltd	H	45121	01/29	2	31.10	62.20
7	CABOPROST INJ AMP 250 MCG 1 ML	Neon Laboratories Ltd	H	097133	08/27	1	318.50	318.50
8	CARITEC INJ 100MG	Sun Pharmaceutical Industries Ltd		F702601G	01/29	1	467.81	467.81
9	DNS 500ML BOTTLE-NIRLIFE	NIRLIFE HEALTH CARE		1K255521	10/28	1	91.35	91.35
10	DSYRINGE 10ML (NIPRO)	NIPRO	GENERAL	26C30K60	02/31	5	28.13	140.65
11	DSYRINGE 20ML(NIPRO)	NIPRO	GENERAL	026B11K32	01/31	1	61.00	61.00
12	DSYRINGE 5ML.(NIPRO)	NIPRO	GENERAL	26C13K17	02/31	4	21.56	86.24
13	DSYRINGE EMERALD 5ML BP (BD)	BECTON DICKINSON (BD)		5322615	10/30	2	12.00	24.00
14	DSYRINGS 2.5ML(NIPRO)	NIPRO	GENERAL	26B12K44	01/31	8	11.25	90.00
15	D WATER 10 ML AMPULE	Aculife Health Care Pvt.Ltd(Nirlif	H	2254216	10/28	1	2.58	2.58
16	E.C.G ELECTRODES (ADULT)	JMS	GENERAL	12226S08G	03/28	3	32.34	97.02
17	EVATOCIN (OXYTOCIN) INJ 5 IU 1 ML	Neon Laboratories Ltd	H	091690	02/28	9	18.90	170.10
18	INTRAFLW (AUTO STOP) ROMSONS	ROMSONS		K26B010515	01/31	2	525.00	1,050.00
19	JUSTIN INJ 75 MG 1 ML	Neon Laboratories Ltd	H	BDW19AIA	08/27	1	23.80	23.80
20	LOX 2% JELLY 30 GM	NEON LABORATORIES LTD	H	L1815	01/28	1	34.58	34.58
21	LOX INJ 2 % 30 ML	Neon Laboratories Ltd	H	KM144328	11/27	1	33.30	33.30
22	MCT-ROF 100MG 10ML	Neon Laboratories Ltd	H	NA1353004	10/27	3	69.10	207.30
23	MEM INJ 0.2 MG 1 ML	NEON LABORATORIES LTD	H	039256	05/27	1	15.90	15.90
24	NEEDLE 20 G	Dispovan		50532D	11/30	1	2.66	2.66
25	NEEDLE 26 1 1 2INCH	Dispovan	GENERAL	01654R	12/30	1	3.38	3.38
26	ONDOKIND INJ 4 MG 2 ML	SWISS CRITICURE		BA26025	01/28	1	12.72	12.72
27	OxygenMask With Tubing - Adult ROMSONS-FC		GENERAL	G26B040107	01/31	1	336.00	336.00
28	PREGELLED SURGICAL PLATES(ADULT)	Erbee	GENERAL	2510302409	10/27	1	1,275.00	1,275.00
29	PYROLATE INJ AMP 0.2MG 1 ML	NEON LABORATORIES LTD	H	KP1254174	11/28	1	15.37	15.37
30	RL 500 ML CLOSED SYSTEM	Fresenius Kabi India Pvt Ltd		1D262104	03/29	2	69.84	139.68
31	SPINAL NEEDLE 25 G WITACARE(120MM)	VYGON		250725AI	07/30	1	1,427.00	1,427.00



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VAT TIN : 33AABCR4014M1ZK

CIN : L85110TG1998PLC029914

DL NO :

Registered Office: 8-2-120/103/1, Survey No.403, Road No.2, Banjara Hills, Hyderabad 500034, Telangana.

INPATIENT ISSUES AGAINST ORDERS



IP No	IP18-00036438	Ward	8F-OT COMPLEX
Patient Name	Dr. DEEPIKADEVI	Bed Name	MICU 802
Age/Sex	37 Y 4 M 17 D / Female	Order No	18-0001726314
Date	13/07/2026 09:48	Prescription No	PRIP18-0626806
Payor	SELF PAY	Dispensed Date	13/07/2026 09:49
UHID	GUC-00093783		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	ABGEL 20X10	Sutures India	GENERAL	R010126	01/29	1	151.00	151.00
2	CAUTERY PENCIL (ADVANCE)	The Advanced cadiomed	GENERAL	250824	08/28	1	1,303.00	1,303.00
3	DISPOSABLE APRONS STERILE XL	Mediblu		1010626	04/29	2	120.00	240.00
4	Encore Microptic gloves- 6.5		H	2603019005	03/29	2	128.00	256.00
5	GAUZE 7.5X7.5 12 PLY (5 NOS) NON XRAY	Bapuji Surgicals	GENERAL	M2641119	04/30	1	100.00	100.00
6	GAUZ SWAB 10 X 10 CM 12PLY 5S X-RAY	Bapuji Surgicals	GENERAL	M2645010	03/29	4	123.00	492.00
7	JUSTIN SUPPOSITORIES 100 MG 5 S	Neon Laboratories Ltd	H	BLNP274053	11/28	1	18.74	18.74
8	KIWI	Smb Corporation	GENERAL	251488	10/27	1	7,875.00	7,875.00
9	LSCS DRAPE PACK	Mediblu	H	1010626	05/29	1	2,250.00	2,250.00
10	MISOPROST TAB 200MCG 4S	CIPLA LIMITED	H	5GH0470	01/27	1	20.26	20.26
11	MISOPROST TAB 600MCG 1S	CIPLA LIMITED	H	6GH0162	08/27	1	105.12	105.12
12	MONOCRYL 3-0 NW 1326	ETHICON SUTURES-J&J C1		T5124	09/30	1	997.00	997.00
13	MOPS 30X30 8PLY 5S X-RAY	DATT MEDI PRODUCTS	H	M2642004	12/29	2	949.00	1,898.00
14	NEW MOM DISP MATERNITY PAD FIXATOR - XL	DYNAMIC TECHNO	General	105327	01/31	1	210.00	210.00
15	NEW MOM DISP MATERNITY PADS MAXIPAD	DYNAMIC TECHNO		0153715	03/31	1	204.00	204.00
16	NITRILE EXAMINATION GLOVES P F- MEDIUM	ELITE MEDICALS	GENERAL	ENPF030020	11/28	20	25.00	500.00
17	NS 100ML ACCULIFE - EH	Aculife Health Care Pvt.Ltd(Nirlif		1B260029	04/28	1	21.01	21.01
18	NS 500ML CLOSED BOTTLE	Denis Chem Lab Ltd	H	1D262046	03/29	1	94.55	94.55
19	QUICKSUITE OT TABLE SHEET MIDLINE SUITEL		H	2606161	06/31	1	775.00	775.00
20	RAMADINE SOLUTION 10% 100 ML	RAMAN & WEIL PVT LTD		RC126036	04/28	2	103.00	206.00
21	SGLOVE # 7.5 POWDER FREE	ANSEL	GENERAL	260300891T	05/29	1	128.00	128.00
22	SURGICAL BLADE 22	Surgeon	GENERAL	051125	10/30	1	7.67	7.67
23	UNDERPADS CARE 60 X 90 (FRIENDS)			25062026	12/30	1	205.00	205.00
24	VACCUME SUCTION SET	ROMSONS	GENERAL	G26C010430	02/31	1	543.00	543.00
25	VICRYL PLUS 1 VP - (2347)	ETHICON SUTURES-J&J C1		T5072	10/30	2	951.00	1,902.00

RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

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600015
Tel No : 044-40122444

CIN : L85110TG1998PLC029914

VAT TIN : 33AABCR4014M1ZK

DL NO :

Registered Office: 8-2-120/103/1, Survey No.403, Road No.2, Banjara Hills, Hyderabad 500034, Telangana.

Rainbow
Children's
Hospital



INPATIENT ISSUES AGAINST ORDERS

IP No

IP18-00036438

Patient Name

Dr. DEEPIKADEVI

Age/Sex

37 Y 4 M 17 D / Female

Date

13/07/2026 09:48

Payor

SELPAY

UHID

GUC-00093783

Ward

8F-OT COMPLEX

Bed Name

MICU 802

Order No

18-0001726315

Prescription No

PRIP18-0626807

Dispensed Date

13/07/2026 09:50

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	SGLOVE 7.0(POWDER FREE)	ANSEL	GENERAL	260300831T	03/29	1	128.00	128.00
Total :							128.00	128.00

for RAINBOW CHILDREN'S MEDICARE LIMITED

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

Receiver Name



RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

Door No.157 to 160, Anna Salai, Guindy, Guindy Chennai Tamil Nadu INDIA
600015

Tel No : 044-40122444

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CIN : L85110TG1998PLC029914

DL NO :

Registered Office: 8-2-120/103/1, Survey No.403, Road No.2, Banjara Hills, Hyderabad 500034,
Telangana.

INPATIENT ISSUES AGAINST ORDERS



IP No	IP18-00036438	Ward	8F-OT COMPLEX
Patient Name	Dr. DEEPIKADEVI	Bed Name	MICU 802
Age/Sex	37 Y 4 M 17 D / Female	Order No	18-0001726314
Date	13/07/2026 09:48	Prescription No	PRIP18-0626806
Payor	SELPAY	Dispensed Date	13/07/2026 09:49
UHID	GUC-00093783		

Total :	17,407.35	20,502.35
---------	-----------	-----------

Receiver Name

for RAINBOW CHILDREN'S MEDICARE LIMITED

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN



RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

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VAT TIN : 33AABCR4014M1ZK

CIN : L85110TG1998PLC029914

DL NO :

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INPATIENT ISSUES AGAINST ORDERS



IP No	IP18-00036446	Ward	3F-NICU 1
Patient Name	Baby B/O DEEPIKADEVI TWIN -1	Bed Name	NICU 301
Age/Sex	0 Y 0 M 0 D 3 H / Female	Order No	18-0001726319
Date	13/07/2026 09:56	Prescription No	PRIP18-0626809
Payor	SELF PAY	Dispensed Date	13/07/2026 09:56
UHID	GUC-00093802		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	GAUZE 7.5X7.5 12 PLY (5 NOS) NON XRAY	Bapuji Surgicals	GENERAL	M2641119	04/30	1	100.00	100.00
2	KLICK CLAMP	ROMSONS		G26D040017	03/31	1	42.00	42.00
3	VACCUME SUCTION SET	ROMSONS	GENERAL	G26C010430	02/31	1	543.00	543.00
						Total :	685.00	685.00

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN



RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

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600015
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VAT TIN : 33AABCR4014M1ZK

CIN : L85110TG1998PLC029914

DL NO :

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INPATIENT ISSUES AGAINST ORDERS



IP No	IP18-00036446	Ward	3F-NICU 1
Patient Name	Baby B/O DEEPIKADEVI TWIN -1	Bed Name	NICU 301
Age/Sex	0 Y 0 M 0 D 3 H / Female	Order No	18-0001726318
Date	13/07/2026 09:56	Prescription No	PRIP18-0626810
Payor	SELF PAY	Dispensed Date	13/07/2026 09:57
UHID	GUC-00093802		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	DSYRINGE 1ML (BD)	BECTON DICKINSON (BD)	GENERAL	6043348	01/31	1	24.00	24.00
2	DSYRINGE 5ML.(NIPRO)	NIPRO	GENERAL	26C13K17	02/31	1	21.56	21.56
3	INFANT FEEDING TUBE-6	ROMSONS	GENERAL	G26D01O693	03/31	1	68.00	68.00
4	INFANT FEEDING TUBE-7	ROMSONS	GENERAL	G25K01O369	10/30	1	63.00	63.00
5	Menadione Sod Bisul 1 ml	HINDUSTAN LABS		0075	12/27	1	28.92	28.92
6	SUCTION CATHETER 6 ROMSONS	ROMSONS	GENERAL	K26A010558	12/30	1	91.00	91.00
Total :							296.48	296.48

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

RAINBOW CHILDREN'S MEDICARE LIMITED**Rainbow Children's Hospital - Guindy**

Door No.157 to 160, Anna Salai, Guindy, Guindy Chennai Tamil Nadu INDIA
600015
Tel No : 044-40122444

VAT TIN : 33AABCR4014M1ZK

CIN : L85110TG1998PLC029914

DL NO :

Registered Office: 8-2-120/103/1, Survey No.403, Road No.2, Banjara Hills, Hyderabad 500034, Telangana.

INPATIENT ISSUES AGAINST ORDERS

IP No	IP18-00036447	Ward	3F-NICU 1
Patient Name	Baby B/O DEEPIKADEVI TWIN-2	Bed Name	NICU 307
Age/Sex	0 Y 0 M 0 D 3 H / Male	Order No	18-0001726327
Date	13/07/2026 10:02	Prescription No	PRIP18-0626811
Payor	SELF PAY	Dispensed Date	13/07/2026 10:02
UHID	GUC-00093803		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	DSYRINGE 1ML (BD)	BECTON DICKINSON (BD)	GENERAL	6043348	01/31	1	24.00	24.00
2	DSYRINGE 5ML (NIPRO)	NIPRO	GENERAL	26C13K17	02/31	1	21.56	21.56
3	INFANT FEEDING TUBE-6	ROMSONS	GENERAL	G26D01O693	03/31	2	68.00	136.00
4	INFANT FEEDING TUBE-7	ROMSONS	GENERAL	G25K01O369	10/30	1	63.00	63.00
5	Menadione Sod Bisul 1 ml	HINDUSTAN LABS		0075	12/27	1	28.92	28.92
6	SUCTION CATHETER 6 ROMSONS	ROMSONS	GENERAL	K26A010558	12/30	1	91.00	91.00
Total :							296.48	364.48

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

