GUC-00093215 IP18-00036241
Mrs V. SARANYA
30-09-1993 32 Y 8 M 30 D (F)
Dr. UMA K

Rainbow Children's Hospital

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing							
Activity Sheet update by Pharmacy							

GUC-00093215 IP18-00036241
Mrs V. SARANYA
30-09-1993 32 Y 8 M 30 D (F)
Dr. UMA K

ainbow® hildren's ospital
akes a lot to treat the little.

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ACTIVITY RECORD FOR BILLI

Name: Mrs: Saranya

UHID No: ..... IP No: ..... Consultant: Dr: Uma Dept: LDR

Date of Admission: 29/6/26 Time: ..... Date of Discharge: ..... Time: .....

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
29/6/26	12:10pm	LDR	OT	[signature] 818080
29/6/26	1.15pm	OT	MICU	[signature]
29/6/26	3.40pm	LDR	704	[signature] 816808

CROSS CONSULTATION VISIT

	Doctor Name	Date	Order No.	Signature
1.	PAC	29/6/26	719078	[signature] 818080
2.	Dr. Rafeeq Sudhandhiry	30/6/2026	719735	[signature]
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
29/6	CTU (1)	9:30Am		008651	S/N Akalya 01888
29/6	Infusion pump	1:10pm		1719/15	S/N Akalya 01888

GUC-00093215 IP18-00036241
Mrs V. SARANYA
30-09-1993 32 Y 8 M 30 D (F)
Dr. UMA K

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SURGERY DETAILS

Date : 29/6/2026

Patient Name: Mrs. Saranya. Date of Birth: 30/9/1993 Age: 32yrs.

Gender: Female Ward : OT UHID No.: 93215 / 36241

Date of Surgery: 29/6/2026 ☐ OT -1 ☐ OT -2 ☑ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Emergency Lscs

Time in : 12.15pm Time Out : 1.15pm

	NAME	AMOUNT
1. Surgeon	: Dr. Uma	
2. Anaesthetist	: Dr. Sathish / Dr. Priyadharsheni	
3. Assistant Surgeon	: Dr. Priyanka	
4. OT Technician	: Mr. Raja	
5. Circulating Nurse	: pradeeparreesaiyan	
6. Assistant Nurse	: Sr. Sangeetha	

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

29.6.2026

Signature of Circulating Nurse

Signature of the Surgeon

Record Finished done
Thanuja 60/371

Order No: ..... Order by: .....

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

M/S. Saranya

Patient Sticker

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CONSUMABLES OF OT

Circulating staff : C.N. Pradeepa Sangeetha Technician : Mr. Shyam Date : 29/6/26 Time : 29/6/26

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			Major Pack Biospace		1	Inj Vit.K		1
LMA			Sutures 1/0 vicryl 2847		2	Cord Clamp		1
ECG leads : A / P / N		3	3/0 Mersilk 1326		1	Suction Catheter 8F		1
HME filter : A / P / N			Trucut 42442		1	Feeding Tube 6 FR		1
Syringes : 10 cc		3	P.F 6		1	Vaccum Suction Set		
05 cc		3+1	Gloves P.F 5½ Cube		3	Surgical Gloves 6½ & 6		6 1
02 cc			P.F 7		1	Gauze Pack plain		1
01 cc			P.F 6.5		2	Syringe ~~1ml~~ / ~~2ml~~ 5mL		1
Cautery plate : A / P / N		1	Surgical blade 22		1	Surgical Blade # 20		
IV set		1	NG tube			Koochies (S)		
RL		3	Cautery pencil		1	Proturgovin		1
NS : 10ml / 100ml / 500ml / 1000ml		1	Koochies			~~Vacum Suction~~		~~1~~
			Ointments			Bioracnic		2
			Suction Catheter			Spinal needle 25G (90mm)		
Fentanyl			Cap, Mask					1
Morphine			Gauze Pack R/O		4	~~Anaesin (H)~~		~~1~~
Ketamine			Mop Pack		1	Bupnigesic 5mL Emerald Syring		1
Propofol			Steristrip					
Rocuronium			Underpad		1			1
Glycopyrolate			~~Draw sheet~~ Quick Sheet		1	Evatocin		5
Myopyrolate			Abgel			Lox 2% 30ml		1
Ondansetron		1	Foleys catheter			Cabaprost		1
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
			Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set		2			
Justin : 12.5 mg / 25mg / 100mg		1	Plastic Bed Sheet					
Tab. Misoprost : ~~200mg~~ 6 tabs		1	Betadine Solution		1			
			Microshield					
			Cotton Balls					
			Latex Gloves		10p			
			Ramdione Scrub					
			Saral					

Surgeon Dr. Uma K Anaesthesiologist Dr. Sathish Nurse C.N. Sangeetha OT Technician Mr. Shyam

Order No. : ..... Ordered by : .....

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

RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

Rainbow Children's Hospital

BirthRight by Rainbow

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	IP18-00036241	**Ward**	8F-OT COMPLEX
Patient Name	Mrs V. SARANYA	**Bed Name**	MICU 803
Age/Sex	32 Y 8 M 30 D / Female	**Order No**	18-0001719227
Date	29/06/2026 15:00	**Prescription No**	PRIP18-0623921
Payor	SELFPAY	**Dispensed Date**	29/06/2026 15:13
UHID	GUC-00093215		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	SGLOVE 7.0(POWDER FREE)	ANSEL	GENERAL	240601021T	06/27	1	128.00	128.00
						Total :	**128.00**	**128.00**

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

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	IP18-00036241	**Ward**	8F-OT COMPLEX
Patient Name	Mrs V. SARANYA	**Bed Name**	MICU 803
Age/Sex	32 Y 8 M 30 D / Female	**Order No**	18-0001719198
Date	29/06/2026 14:24	**Prescription No**	PRIP18-0623920
Payor	SELFPAY	**Dispensed Date**	29/06/2026 15:13
UHID	GUC-00093215		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	JUSTIN SUPPOSITORIES 100 MG 5 S	Neon Laboratories Ltd	H	BLNP274053	11/28	1	18.74	18.74
2	LSCS DRAPE PACK	Mediblue	H	1010626	05/29	1	2,250.00	2,250.00
3	MISOPROST TAB 600MCG1S	CIPLA LIMITED	H	6GH0162	08/27	1	105.12	105.12
4	MONOCRYL 3-0 NW 1326	ETHICON SUTURES-J&J	C1	T5124	09/30	1	997.00	997.00
5	NS 100ML ACCULIFE - EH	Aculife Health Care Pvt.Ltd(Nirlif		1C2613680	02/29	1	44.93	44.93
6	SGLOVE # 6 (POWDER FREE)	ANSEL		260301001T	03/29	1	128.00	128.00
7	SGLOVE 5.5 SIGNATURE			250905391T	09/28	3	117.00	351.00
8	TRUGUT CHROMIC CATGUT SN4242	Sutures India		A250160S	11/30	1	223.00	223.00
9	VICRYL PLUS 1 VP - (2347)	ETHICON SUTURES-J&J	C1	T5O72	10/30	2	951.00	1,902.00
						Total :	**4,834.79**	**6,019.79**

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	IP18-00036241	**Ward**	8F-OT COMPLEX
Patient Name	Mrs V. SARANYA	**Bed Name**	MICU 803
Age/Sex	32 Y 8 M 30 D / Female	**Order No**	18-0001719199
Date	29/06/2026 14:24	**Prescription No**	PRIP18-0623919
Payor	SELFPAY	**Dispensed Date**	29/06/2026 15:12
UHID	GUC-00093215		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	DSYRINGE 10ML (NIPRO)	NIPRO	GENERAL	026B24K67	01/31	3	21.83	65.49
2	DSYRINGE 5ML.(NIPRO)	NIPRO	GENERAL	26C03K96	02/31	4	21.56	86.24
3	E.C.G ELECTRODES (ADULT)	JMS	GENERAL	12226S08G	03/28	3	32.34	97.02
4	INTRAFLOW (AUTO STOP) ROMSONS	ROMSONS		K26B010541	01/31	1	525.00	525.00
5	ONDOKIND INJ 4 MG 2 ML	SWISS CRITICURE		BA26025	01/28	1	12.72	12.72
6	PREGELLED SURGICAL PLATES(ADULT)	Erbee	GENERAL	2510302409	10/27	1	1,275.00	1,275.00
7	RL 500 ML CLOSED SYSTEM	Fresenius Kabi India Pvt Ltd		1D262078	03/29	3	69.39	208.17
						Total :	**1,957.84**	**2,269.64**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

Printed Time : 29-06-2026 15:12

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	IP18-00036241	**Ward**	8F-OT COMPLEX
Patient Name	Mrs V. SARANYA	**Bed Name**	MICU 803
Age/Sex	32 Y 8 M 30 D / Female	**Order No**	18-0001719225
Date	29/06/2026 15:00	**Prescription No**	PRIP18-0623918
Payor	SELFPAY	**Dispensed Date**	29/06/2026 15:11
UHID	GUC-00093215		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	BIOXAMIC 500 MG INJ	Biocare Pharmaceuticals	H	C3BIO004	01/28	2	73.23	146.46
2	BUPRIGESIC INJ AMP 0.3 MG 1 ML	Neon Laboratories Ltd	H	45120	11/28	1	31.10	31.10
3	CABOPROST INJ AMP 250 MCG 1 ML	Neon Laboratories Ltd	H	097132	08/27	1	318.50	318.50
4	DSYRINGE EMERALD 5ML BP (BD)	BECTON DICKINSON (BD)		5322615	10/30	1	12.00	12.00
5	EVATOCIN (OXYTOCIN) INJ 5 IU 1 ML	Neon Laboratories Ltd	H	091690	02/28	3	18.90	56.70
6	EVATOCIN (OXYTOCIN) INJ 5 IU 1 ML	Neon Laboratories Ltd	H	091690	02/28	2	18.90	37.80
7	LOX INJ 2 % 30 ML	Neon Laboratories Ltd	H	KM144328	11/27	1	33.30	33.30
						Total :	**505.93**	**635.86**

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	IP18-00036247	**Ward**	7F-PVT/SUITE
Patient Name	Baby B/O V. SARANYA	**Bed Name**	CRDL-PVT704-1
Age/Sex	0 Y 0 M 0 D 2 H / Male	**Order No**	18-0001719233
Date	29/06/2026 15:10	**Prescription No**	PRIP18-0623917
Payor	SELFPAY	**Dispensed Date**	29/06/2026 15:11
UHID	GUC-00093227		

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	26C03K96	02/31	1	21.56	21.56
3	INFANT FEEDING TUBE-6	ROMSONS	GENERAL	G26D010693	03/31	1	63.00	63.00
4	Menadione Sod Bisul 1 ml	HINDUSTAN LABS		0075	12/27	1	28.92	28.92
5	SUCTION CATHETER 8	ROMSONS	GENERAL	K25L010489	11/30	1	91.00	91.00
						Total :	**228.48**	**228.48**

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	IP18-00036247	**Ward**	7F-PVT/SUITE
Patient Name	Baby B/O V. SARANYA	**Bed Name**	CRDL-PVT704-1
Age/Sex	0 Y 0 M 0 D 2 H / Male	**Order No**	18-0001719232
Date	29/06/2026 15:10	**Prescription No**	PRIP18-0623923
Payor	SELFPAY	**Dispensed Date**	29/06/2026 15:14
UHID	GUC-00093227		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	Encore Microptic gloves-6.5		H	260501801T	05/29	1	128.00	128.00
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		G26A040003	12/30	1	39.00	39.00
4	PROTO GOWN (ADULT)	Diamond Medicare	GENERAL	1010626	05/29	1	250.00	250.00
5	SGLOVE # 6 (POWDER FREE)	ANSEL		260301001T	03/29	1	128.00	128.00
						Total :	**645.00**	**645.00**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

Printed Time : 29-06-2026 15:15

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	IP18-00036241	**Ward**	8F-OT COMPLEX
Patient Name	Mrs V. SARANYA	**Bed Name**	MICU 803
Age/Sex	32 Y 8 M 30 D / Female	**Order No**	18-0001719226
Date	29/06/2026 15:00	**Prescription No**	PRIP18-0623922
Payor	SELFPAY	**Dispensed Date**	29/06/2026 15:14
UHID	GUC-00093215		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	CAUTERY PENCIL (ADVANCE)	The Advanced cadiomed	GENERAL	250824	08/28	1	1,303.00	1,303.00
2	Encore Microptic gloves-6.5		H	260501801T	05/29	2	128.00	256.00
3	GAUZ SWAB 10 X 10 CM 12PLY 5S X-RAY	Bapuji Surgicals	GENERAL	M2645010	03/29	4	123.00	492.00
4	MOPS 30X30 8PLY 5S X-RAY	DATT MEDI PRODUCTS	H	M2642SF029	03/30	1	949.00	949.00
5	NITRILE EXAMINATION GLOVES P F- MEDIUM	ELITE MEDICALS	GENERAL	ENPF030020	11/28	20	25.00	500.00
6	QUICKSUITE OT TABLE SHEET MIDLINE SUITEL		H	2606021	06/31	1	775.00	775.00
7	RAMADINE SOLUTION 10% 100 ML	RAMAN & WEIL PVT LTD		RC126029	03/28	1	103.00	103.00
8	SURGICAL BLADE 22	Surgeon	GENERAL	051125	10/30	1	7.67	7.67
9	UNDERPADS CARE 60 X 90 (FRIENDS)			20062026	12/30	1	205.00	205.00
10	VACCUME SUCTION SET	ROMSONS	GENERAL	K26C010031	02/31	2	739.00	1,478.00
						Total :	**4,357.67**	**6,068.67**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

Printed Time : 29-06-2026 15:14

Rainbow Children's Hospital | BirthRight

DISCHARGE TRACKING SHEET

GUC-00093215 IP18-00036241
Mrs V. SARANYA
30-09-1993 32 Y 9 M 0 D (F)
Dr. UMA K

FLOOR- NAME OF CONSULTANT-

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement	1/7/2026 at 10:30AM				
	INTIME	OUT TIME			
Arrangement of File by Nursing		1/7/2026 at 10:30AM			
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

GUC-00093215 IP18-00036241
Mrs V. SARANYA
30-09-1993 32 Y 8 M 30 D (F)
Dr. UMA K

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

BED SIDE CHECK LIST FOR NURSES

Date:	29/6/26	30/6/26	1/7/26						
Doctor's Orders	yes	yes	yes						
Carried out or not	yes	yes	yes						
Bed Side									
Structured Handover done	yes	yes	yes						
IV Site	yes	yes	yes						
Central Lines	NA	NA	NA						
Arterial Lines	NA	NA	NA						
Feeding Catheter	NA	NA	NA						
Urinary Catheter	yes	yes	yes						
Skin Care	yes	yes	yes						
Eye Care	yes	yes	yes						
Mouth Care	yes	yes	yes						
Sterillum Bottle, Stethoscope	yes	yes	yes						
Suction Bottle (Should be clean & empty)	NA	NA	yes						
Intubation Tray	NA	NA	NA						
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	NA	NA	NA						
Ventilator Tubing,(Any Water, Blood)	NA	NA	NA						
Humidification	NA	NA	yes						
Check all Infusion (Labelling,Correct Preparation)	yes	yes	yes						
Chest Physio & Neb	NA	NA	NA						
Handed Over By Name :	Priya	Divya	Divya						
Signature :	Priya								
Date & Time:	29/6/26 8PM	30/6/26 8AM	1/7/26 8AM						
Hand Over Taken By Name :	Divya	Priya							
Signature :	Priya								
Date & Time:	30/6/26 8AM	1/7/26 8AM							

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Guindy

Door No.157 to 160, Anna Salai, Guindy, Guindy ,Chennai ,Tamil Nadu, INDIA ,600015.
TEL NO :044-40122444
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP18-00036241 **Admit Date** : 29-Jun-2026 **Admit Time** : 10:24 AM **UHID** : GUC-00093215

Patient Details :

Patient Name	: Mrs V. SARANYA	**Age**	: 32 Y 8 M 30 D
Guardian	: Mr P. IMMANUVEL	**DOB**	: 30-09-1993
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: NO:39/69, ALANDUR ROAD, SAIDAPET, CHENNAI Saidapet Madras Chennai Tamil Nadu INDIA 600015	**Phone No**	: 9677141685/ 9003031597
		E-mail	: NO@GMAIL.COM

Admission Details :

Bed Type : MICU **Bed No** : MICU 803 **Ward Name** : 8F-OT COMPLEX

Room No : MICU 803 **Admission Type** : First Visit

Contact Details :

Name : Mr P. IMMANUVEL **Relationship** : Husband

Contact Address : NO:39/69, ALANDUR ROAD, SAIDAPET, CHENNAI Saidapet Madras Chennai Tamil Nadu INDIA 600015 **Phone No** : 9677141685 / 9003031597

Signature

Doctor Details :

Doctor Name : Dr. UMA K **Specialisation** : OBSTETRICS AND GYNECOLOGY

Referral Doctor : DR.K.UMA **Phone No** :

Co-Consultant :

Payment Details :

Payment Mode : Cash **Deposit Amount** : 0.00

Payor Name : SELFPAY

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Guindy

Door No.157 to 160, Anna Salai, Guindy, Guindy ,Chennai ,Tamil Nadu, INDIA ,600015.
TEL NO :044-40122444
WEB : https://rainbowhospitals.in

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Mrs V. SARANYA**	**Age :**	**32 Y 8 M 30 D**
IP No:	**IP18-00036241**	**Sex:**	**Female**
Consultant:	**Dr. UMA K**	**Ward/Bed No:**	**8F-OT COMPLEX/MICU 803**

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: Immanuvel. P

Relationship: Husband.

Date: 29/06/2026 Time: 10.25 Am

Witness Name:

Witness Signature:

Patient Address:

NO:39/69, ALANDUR ROAD, SAIDAPET, CHENNAI Saidapet Madras Chennai Tamil Nadu INDIA 600015

Rainbow Children's Hospital | BirthRight BY RAINBOW HOSPITALS

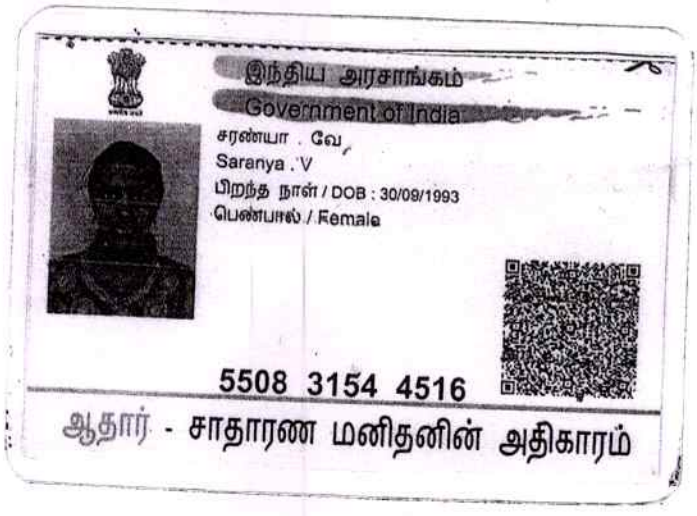
BILLING POLICY

- 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 9eapplicable.
- 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 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 arid 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 : Mrs. V. Saranya	UHID Number : GUC-00093215
Self/Attendant Name : Mr. Immanuel	Relation : Husband.
Self/ Attendant Signature : Phone Number : 9677141685	Name & Signature of Financial Counselor



இந்திய அரசாங்கம்
Government of India

சரண்யா . வே
Saranya . V
பிறந்த நாள் / DOB : 30/09/1993
பெண்பால் / Female

5508 3154 4516

ஆதார் - சாதாரண மனிதனின் அதிகாரம்

இந்திய தனித்துவ அடையாள ஆணைய அமைப்பு
Unique Identification Authority of India

ஆதார்

முகவரி:
தந்தை / தாய் பெயர்:
வேலாயுதம், 39/69, ஆலந்தூர் ரோடு, சைதாப்பேட்டை, சென்னை, சைதாப்பேட்டை, தமிழ் நாடு, 600015

Address:
D/O: Velayutham, 39/69, ALANDUR ROAD, Saidapet, Chennai, Saidapet, Tamil Nadu, 600015

5508 3154 4516

1947
1800 300 1947

help@uidai.gov.in

www.uidai.gov.in

GUC-00093215 IP18-00036247
Mrs V. SARANYA
30-09-1993 32 Y 8 M 30 D
Dr. UMA K

Docu. No. : RCH /FRM / CLINICAL / 162

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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Your Right to a Safe Delivery

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

GUC-00093215 IP18-00036241
Mrs V. SARANYA
30-09-1993 32 Y 8 M 30 D (F)
Dr. UMA K

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IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

* Pt c/o show since today morning
* Patient was admitted for LSCS
* Able to perceive fetal movements well
* No c/o Lower abdominal Pain, leaking PV

Obstetric Formula:
Primi

Obstetric History:
G_1 - PP, Spontaneous Conception

Present Pregnancy Record:
Booked and Immunised
NT Scan - Normal; FTS - Low risk
Anomaly Scan - Normal

RISK FACTORS:

Big Baby - 3.7kg

Height: 188 cm
Weight: 70.6 kg
Allergies: Nil
Breast: ☑ Normal ☐ Abnormal
General Examination:
Consciousness: Conscious Pallor: No
Icterus: No Edema: No
Temp: (N) PR: 89/min
BP: 120/80mmHg DTR:
CVS: $S_1 S_2$ (+) RS B/L NVBS (+)
Liver/Spleen: Urine Output:

LMP: 01/10/2025 EDD: 08/07/2026
Corrected EDD: GA: 38 weeks + 5 days
Menstrual History: Regular: ☑ Yes ☐ No

Obstetric Examination M/S - 2 yrs, NCM

Fundal Height: Term
Ut. Activity: ☑ Relaxed ☐ Mild ☐ Mod ☐ Severe
Liquor: ☑ Adequate ☐ Oligo ☐ Poly
PP: ☑ Cephalic ☐ Breech Others _____
Head Fifths Palpable: 4/5th
FHS: ☑ Normal ☐ Tachy ☐ Brady ☐ Absent

Per Speculum Examination

Draining: ☐ Present ☐ Absent ☐ Bleeding
Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination

Cervix: 2cm ☑ Long ☐ Partially effaced ☐ Effaced
Os: Closed _____ Dilated os admits one finger tight
Membranes: ☑ Present ☐ Absent
Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained
Presenting Part: ☑ Vertex ☐ Breech ☐ Others
Sutton: Brim ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2
Pelvis: ☑ Adequate ☐ Doubtful

DIAGNOSIS

Primi	LMP - 01/10/2025	GA - 38 weeks + 5 days
M/S - 2yrs	EDD - 08/07/2026	Big baby
NCM		
A - Positive	RMP	Admitted for LSCS

GUC-00093215 IP18-00036241
Mrs V. SARANYA
30-09-1993 32 Y 8 M 30 D (F)
Dr. UMA K

(1)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/6/26 12pm	S/B Dr. Divyalakshmi	
	C/I/C Dr. Uma	
Admission. c/c - Reactive	Advice :- To shift to OT. - Inform OT/NICU. - Inform SOS.	
		16 U 28
29/06/2026 1:15PM	C/S/B Dr. Viridtha / Dr. Dhivyalakshmi / Dr. Shreedevi	
Dos	Pt received in MICU	
T-N	Pt reviewed, Nil c/o	Advice - NPO x 6 hours
PR- 89/min	O/E Pt GC fair, Afebrile	- vitals Monitoring
BP- 120/80 mmHg	P° / PE°	- IVF / ORL @ 125ml/hr
	CVS/	- INJ. SYNTO 10 U in
UO - 200ml, clear	RS/NAD	100 ml/hr x (3) bottles.
Baby - M/S	P/A- ut well contracted	- Follow drug chart
B/L- Breast soft	Soft	- W/F ↑ Bleeding PV
	Dressing (+) & Dry	- CBD x 24 hours tomorrow 1pm
	UE - BNNL	- Hb / PCV / Urine R/E
	CBD insitu	after CBD removal.
	8/2217	

GUC-00093215 IP18-00036241
Mrs V. SARANYA
30-09-1993 32 Y 8 M 30 D (F)
Dr. UMA K

(2)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S/B Dr. Panithra.	
29/06/2026 9pm POD-0	Pt reviewed.	
	O/E	
	Pt ac fair afebrile	Advice
T: (N)	P/PR	- Clear liquid diet. Overnight.
BP-100/70mmHg.	CVS/	- Kanji only after passing flatus.
PR 70/min	RS/NAD	- CBD X 24 hours (Till 1:15PM).
	P/A - Soft, BS (+)	- Hb/PCV/urine Routine.
B/L Breast Soft	Ut firm & cont well	- Inj Cyuto maintainance
Baby-M/S.	Dressing Dry.	for 24 hours.
	YS- No undue Bleeding P/V.	
Passed flatus		

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

GUC-00093215
Mrs V. SARANYA
30-09-1993
Dr. UMA K
IP18-00036241
32 Y 8 M 30 D (F)

(B)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6/20 8:30 pm	S/B Dr. Mohana / Dr. Durgalakshmi . pt. reviewed Nil c/o.	
POD-1	O/E: pt GC fair, afebrile pallor / PEO	Admit - Ambulation - warm fluids - continue same orders
T=(N) PR-79/min BP-110/68mmHg SpO2-100% @ RA	CVS / RS / NAD	
voiding freely passed flatus	P/A: soft, BS (+) Ut. / Contracted well d	mild gaseous distention
	Baby m/s Breasts (soft)	6/7/20

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Mrs V. SARANYA
30-09-1993 32 Y 8 M 30 D (F)
Dr. UMA K

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RESULT SHEET

Date	15/6/26	16/5/26	30/6/26			
Time					A-POSITIVE	
Hb	13.5	12.6	12.6			
PCV	39	36	37		Oral report	
RBC						
WBC						
N/L						
Platelets		1.79			ECG ?	
CRP					ECHO ✓ Normal	
ESR					Trivial TR	
PCT					Trivial MR	
RBS	FBS-72 PPBS-90				EF-62%.	
Na						
K						
Cl					TSH-1.39	
Ca/Mg					FT4-1.27	
Phosphate					FT3-3.01	
Urea						
Creatinine					HbA1C-5.2	
ALP						
SGPT						
SGOT					BT-1min 35sec	
T.Bill/Conj					CT-4min 40sec	
T.Protein						
S.Albumin					HIV ✓	
S.Globulin					HBsAg ✓ Non-Reactive	
A/G Ratio					VDRL ✓	
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR	13/1.0					
APTT						
CSF Protein / Sugar		18221				
Cells	18221		18221			
N/L						

GUC-00093215 IP18-00036241
Mrs V. SARANYA
30-09-1993 32 Y 8 M 30 D (F)
Dr. UMA K

(1)

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MEDICATION RECONCILIATION FORM

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

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

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

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Shreeden TS2217

Date & Time : 29/6/2026 at 9:30Am

Nurse Name & Signature: S/NAtaly 01805 SA 01805

Date & Time : 29/6/26 at 9:30Am

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

GUC-00093215 IP18-00036241
Mrs V. SARANYA
30-09-1993 32 Y 8 M 30 D (F)
Dr. UMA K

(2)

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MEDICATION RECONCILIATION FORM

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

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

Shifting From: 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	INJ. SUPACEF	1.5g	IV	STAT	29/6/26 12:10PM	☐C ☑DC
2	INJ. PANTO	40mg	IV	STAT	29/6/26 11:40AM	☐C ☑DC
3	INJ. EMESET	4mg	IV	STAT	29/6/26 11:40AM	☐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. Shreedevi 182217

Date & Time : 29/6/2026 at 12:10pm

Nurse Name & Signature: SN Akalya/018088 ~~SN~~ 018088

Date & Time : 29/6/26 at 12:10pm

GUC-00093215
Mrs V. SARANYA
30-09-1993
Dr. UMA K
IP18-00036241
32 Y 8 M 30 D (F)

Rainbow® Children's Hospital
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MEDICATION RECONCILIATION FORM

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

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

Shifting From: LDR Shifted to: ToY

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	Inj. SUPACEF	1.5g	IV	BD	29/6/26 @ 12.10pm	☑C ☐DC
2	Inj. TRAPIC	1gm	IV	BD	29/6/26 @ 12.45pm	☑C ☐DC
3	Inj. PAN	40mg	IV	BD	29/6/26 @ 11.40am	☑C ☐DC
4	Inj. PARACETAMOL	1g	IV	TDS	-	☑C ☐DC
5	Inj. SYNTO	10 units in RL	IV	@ 10ml/hr x 3	-	☑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. Dr. Dayalakshmi

Date & Time : 29/6/26, 3pm

Nurse Name & Signature: Mrs Parameshwari

Date & Time : 29/6/26 @ 3pm

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

GUC-00093215 IP18-00036241
Mrs V. SARANYA
30-09-1993 32 Y 8 M 30 D (F)
Dr. UMA K

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MEDICATION RECONCILIATION FORM

Drug Allergies: Nil ☐ Not known any Drug Allergies

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

Shifting From: 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						☐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 :

Date & Time : 29/6/2020 AM

Nurse Name & Signature: Pradeepavaaayan / 02.07.04

Date & Time : 29/6/2020 at 1.15 pm.

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

GUC-00093215 IP18-00036241
Mrs V. SARANYA
30-09-1993 32 Y 8 M 30 D (F)
Dr. UMA K

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DRUG CHART

Date of Admission: 29/6/20 Drug Allergies: ..... ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As required Medication)

DRUG : INJ. TRAMADOL				Date / Time
Dose	Route	Frequency	Start Date	
50 mg	IM	(SOS)	29/6/20	
Doctor's Signature		Valid Period	Pharm.	
182217				
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 .....

GUC-00093215 IP18-00036241
Mrs V. SARANYA
30-09-1993 32 Y 8 M 30 D (F)
Dr. UMA K

Weight. 70.6/09 Ward. LDR

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
29/6/24	11:40AM	INJ. SUPACEF	0.1ml	Id	82217	SA
29/6/24	12:40AM	INJ. PANTO	40mg	IV	82217	SP
29/6/24	11:40AM	INJ. EMESET	4mg	IV	82217	SA
29/6/24	12:10PM	INJ. SUPACEF	1.5g	IV	82217	SP
29/6	12.35PM	INJ EMESET	4mg	IV	1546	SA
29/6	12-45PM	INJ TRAPIC	1g	IV	1546	SP
29/6	12-55PM	INJ SYNTO	2U	IV	1546	SA
29/6	1:05PM	T. MISOPROSTOL	600mcg	PR	16428	SP
29/6	6:00PM	JUSTIN SUPPOSITORY	100mg	PR	16428	SA

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

Patient		I.P. No.	Sheet No.	Wards	Weight (kg)

REGULAR PRESCRIPTIONS

DRUG : T. CEFTUM

Dose	Route	Frequency	Start Dt.
500mg	PO	1-0-1	1/7/26

Name & Signature of the Doctor starting the Drugs: & 182217

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

Date / Time	1/7
8Am	A.R / S.N
8pm	A.R

DRUG : T. PANTOPRAZOLE

Dose	Route	Frequency	Start Dt.
40mg	PO	1-0-1	1/7/26

Name & Signature of the Doctor starting the Drugs: & 182217

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

Date / Time	1/7
7Am	/
7pm	

DRUG : T. COMBIFLAM

Dose	Route	Frequency	Start Dt.
1Tab	PO	1-1-1	1/7/26

Name & Signature of the Doctor starting the Drugs: & 182217

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

Date / Time	1/7
8Am	A.R / S.N
2pm	
10pm	

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

Date / Time	

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Early Warning Observation Score Chart - Obstetrics

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

29/6/26

		Date																						
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20			20				20	20						20				20				20			
	0 - 10																									
Saturations	94 - 100 %			100				100	99	99					99%				98%				99%			
	< 94 %																									
Administered O_2 (L/min.)				RA				RA	RA	RA					RA				RA				RA			
Temp°c	40																									
	39																									
	38																									
	37							98°F		98°F					98.0°F				98.2°F				98.2°F			
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90			89				76		70					70 bpm				72 bpm				70 bpm			
	80																									
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130			120				120		110					118				110				120			
	120																									
	110																									
	100									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				0				0		0					0				0				0			
TOTAL ORANGE SCORES				0				0		0					0				0				0			
Nurse Initial				RA				MM		MM					PR				PR				PR			

(85) (74) (80)

Docu. No. : RCH /FRM / CLINICAL / 053

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arning Observation Score Chart - Obstetrics

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

30/6/20

		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20		22				20				20				20				22				20			
	0 - 10																									
Saturations	94 - 100 %		97%				98%				98%				98.6F				99%				98%			
	< 94 %																									
Administered O_2 (L/min.)			RA				RA				RA				RA				RA				RA			
Temp°c	40																									
	39																									
	38																									
	37		97.6F				98.2F				98.6F				98.6F				98.0F				98.0F			
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressure ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130		119				112				110				126				120				118			
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50		(81)				(80)								(57)				(86)				(94)			
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
	40		70				62				68				71				78				76			
NEURO RESPONSE [✓]	Alert		✓				✓				✓				✓				✓				✓			
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30		✓				✓				—				✓				✓				✓			
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal		✓				✓				✓				✓				✓				✓			
	Heavy / Foul																									
Liquor	Clear / Pink		—																							
	Green																									
TOTAL YELLOW SCORES			0				0				0				0				0				0			
TOTAL ORANGE SCORES			0				0				0				0				0				0			
Nurse Initial																										

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FLUID CHART

Sheet No. : 1

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

29/6/20

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombophlebitis Score	Sign. Nurse
	08:00 am											
	09:00 am	N	RL 500ml									
	10:00 am	P								200	0	SA
	11:00 am	O								50	0	SA
	12:00 pm										0	SA
	01:00 pm	RL	1300ml							250	0	SA
Total Intake :		1800ml RR Inj-Syntodo				Total Output :				500ml.		
	02:00 pm	N	125	100						50	0	
	03:00 pm		125	100						50		
	04:00 pm	P		100						150	0	
	05:00 pm	O		100						80		
	06:00 pm			100	1st syntodo bottle					70	0	
	07:00 pm	H20	50ml	100						80		
Total Intake :		50ml + 600ml + 650ml.				Total Output :				460ml.		
	08:00 pm			125	100ml					80	0	P.V
	09:00 pm	TC	150ml	125	100ml					100	0	P.V
	10:00 pm			125	100ml					100	0	P.V
	11:00 pm	Juice	150ml	125	100ml 2nd syntodo bottle					150	0	P.V
	12:00 am			125	100ml					100	0	P.V
	01:00 am	TC	150	125	100ml					100	0	P.V
Total Intake :		450ml + 750ml + 600 => 1800ml				Total Output :				630ml		
	02:00 am			125	100ml					100	0	P.V
	03:00 am	Juice	150	125	100ml					100	0	P.V
	04:00 am			125	100ml					250	0	P.V
	05:00 am	TC	150	125	100ml 3rd syntodo bottle					250	0	P.V
	06:00 am			125	100ml					250	0	P.V
	07:00 am	Juice	150	125	100ml					250	0	P.V
Total Intake :		450 + 750 + 600 = 1800ml				Total Output :				1200ml		

Total 24 hrs. Intake	6,1050ml

Total 24 hrs. Output	2,790ml

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FLUID CHART

Sheet No. : 2

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.

30/6/26		Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am	Ragi	100ml	125						250ml	0	AA
	09:00 am	H2O	150ml	125						250ml	0	AA
	10:00 am	H2O	150ml	125						200ml	0	AA
	11:00 am	H2O	100	125						250	0	AA
	12:00 pm	Soup	100	125	NG			Syrup	Syrup	250	0	AA
	01:00 pm	H2O	150ml							✓	0	AA
Total Intake :		150 + 625 = 1375								Total Output :		1000ml + 1 time
	02:00 pm	H2O	200ml								0	Sij
	03:00 pm											
	04:00 pm	TC	200ml							400ml		
	05:00 pm										0	Sij
	06:00 pm	Milk	200ml									
	07:00 pm	H20	100							✓	0	Sij
Total Intake :		700ml								Total Output :		400ml + 1 time
	08:00 pm										0	Sim
	09:00 pm	H20	200								0	Sim
	10:00 pm						✓			300	0	Sim
	11:00 pm	H20	200								0	Sim
	12:00 am	H20	100								0	Sim
	01:00 am	H20	200							350	0	Sim
Total Intake :		700ml								Total Output :		650ml
	02:00 am										0	Sim
	03:00 am	H20	200							300	0	Sim
	04:00 am	H20	100								0	Sim
	05:00 am										0	Sij
	06:00 am	H20	200							250	0	Raf
	07:00 am	H20	100								0	Sij
Total Intake :		600ml								Total Output :		550ml

Total 24 hrs. Intake	3,375ml	Total 24 hrs. Output	2,600ml

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NURSING SHIFT HAND OVER FORM

SITUATION

Diagnosis: Primi° 38+5days. Big Baby

Any Infection: ☐ Yes ☐ No ☐ Not Known
If Yes Specify: .....

Surgery / Procedure: EMLSCS

Post OP Day:

BACKGROUND

Date / Shift	29 M	29/6/26 Evening	29/6/26 N	30/6/26 M	30/6/26 E	30/6/26 N
Medical Condition (Any special condition to be noted):	N/A	Noted	Noted	Noted	Noted	Noted
Diet:	NPO	NPO	NPO	Liquid diet	Soft diet	Soft diet

ASSESSMENT

Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Ventilation (RA, NP, NIV, VENTI):	N/A	RA	RA	RA	RA	RA
Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Vital Signs: Temp:	98F	98°F	98.2°F	97.6°F	97°F	98.6F
Res:	30bpm	20bpm	20bpm	20bpm	20bpm	20bpm
SpO_2:	100%	99%	98%	97%	98%	99%
Pulse:	89bpm	80bpm	76bpm	78bpm	79bpm	79bpm
BP:	120/80	100/70	118/71		116/79	124/75
LOC:	Conscious	Conscious	Conscious	Conscious	Conscious	Conscious
Fall Risk Score:	0	20	20	20	20	20
Pain Score:	0/10	1/10	1/10	1/10	1/10	1/10
Skin Integrity	Normal	Intact	Intact	Intact	Intact	Intact

Recommendations

Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Physiotherapy:	N/A	NA	NA	NA	NA	NA
Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Special Diet:	NPO	NPO	NPO	Soft diet	Soft diet	Soft diet
Critical Lab Test / Values:	N/A	NA	NA	NA	NA	NA
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):	Dependent	Dependent	Dependent	dependent	dependent	dependent
Post Operative Procedure Special Orders:	N/A	-	-	-	-	-
Handed Over By Name :	S/N Aishwarya	S. Saranya	P. Kavya	Aishwarya	Soniya	C. Abirami
Signature / ID :	30/1808		P. Kavya			
Date:	29/6/26	29/6/26	30/6/26	30/6/26	30/6/26	30/6/26
Time:	2pm	8A	8AM	1:30PM	8pm	1:30PM
Taken Over By Name :	S/N Saranya	P. Kavya	Aishwarya	Aishwarya	Abirami	Harini
Signature / ID :		P. Kavya				
Date:	29/6/26	30/6/26	30/6/26	30/6/26	30/6/26	01/7
Time:	2pm	8pm	8AM.	8pm.	8pm	8AM

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NURSING CARE RECORD

Date: 29/6/2018

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	30 9AM	prevent falls & Injury	10AM	Keep Bed in low position with side rails up. Ensure call Bell is within reach Assist during Ambulation	patient was stable	Reassessment was Done	018088
Afternoon	2pm	Achieve acceptable Pain control & comfort	2-3pm	Assess pain using pain scale regularly position patient comfortably	patient feel better	Pain level reduced	016808
Night	8pm	Assess the patient condition Monitor vitals Maintain I/O Administers Medication	9pm	Assessed patient condition Monitored vitals Maintain I/O Administered Medication	patient feel better	patient vitals stable	009201

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NURSES NOTES

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☐ No Known Drug Allergies
☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
29/6/26		Admission Notes	
	9:30 AM	⇒ mrs: saranya come for show ⓐ under Dr: uma she is primi 38+5 days BG baby A+ve Blood grouping checked for vital signs recorded patient vital are stable conscious & oriented CTG was connected FHR is good ⓐ pists preparation was done pt general condition fair Dr: vinitha do PV Examination findings was she is 1 fingers loose 2cm long, Advised to CTG monitor for wortime case discuss with Dr: uma Advised to Em Less preparation pt is NPO to put IV line NO other compliants →	S/N Akalya 0/1808
	10Am	⇒ IV placement was done left metacurbalven IV fluids RL 120ml connected on flow →	S/N Akalya 0/1808
	10:30 Am	⇒ Dr: vinitha Advised to stoped CTG FHR is good ⓐ IV fluids on going pt general condition fair →	S/N Akalya 0/1808

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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NURSES NOTES

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☐ No Known Drug Allergies
☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Relieving Notes	
29/6/22	1:10pm	patient is relieving from OT to micu patient care hand over taken from OT staff Nurse pt was stable conscious & oriented IV line present & patten minimal of Bleeding IV fluids connected 125ml/hr patient is NPO. checked for vital stats recorded pt vital are stable relieving Outpt NRI Informed Dr. visitors.	
	1:30 pm	⇒ patient care hand over given to Evening duty staff Nurse.	S/N Akalya 01850
29/6/22	1.40pm	Evening duty Notes: patient details handed over taken from morning duty staff. patient conscious & oriented. vitals are checked & recorded. Emergency kits done. Baby mother side post op orders received. patient maintain NPO.	S/N Akalya 01850
	2pm	breast soft. Direct breast feeding given. Baby sucking well.	S/N Jayasudha 016808

S/N Jayasudha 016808

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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NURSES NOTES

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☐ No Known Drug Allergies
☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Receiving Notes.	
29/6/26	4 pm	Handover received from LDR staff. Patient Ps. conscious and Oriented. IV line present Rt. Synd-10cc on SOPL - 100ml/hr on flow. Patient Ps NPO till 7.10pm CBD Removal plan after 24 hours. C/M 1.15pm. HB, PCV were RE TOMORROW. After passing Flatus need to give Kanji plan.	Soujs DRSS.
	5pm	Patient urine output 75ml. INF - Synd 10cc - 100ml/hr on flow	Soujs ov
	7.30pm	Oral started. H2O - 30ml given Free Ps no vomiting complaints. Handover given to Night Duty staff.	Soujs ov

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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NURSES NOTES

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☑ No Known Drug Allergies
☐ Drug Allergies ..Nil.....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
20/6/26	7:30AM	Morning duty Notes.	
		Patient details handing over taken from Night duty Staff.	
		Bed Side Assessment done. →	2 nos
		Conscious & Oriented. IV line @ Patten	
		patient taken Ranji. PIV Bleeding	
		is Normal. CBD @ Urine clear →	2 nos.
	8AM.	Patient vitals Sign checked &	
		Recorded. vitals are Stable.	
		Flo chart Monitored. →	2 nos
	8:30AM	patient due Medication & drug	
		given as Per drug chart Order.	
		IV fluid RL - 500ml 100ml/hr on flow.	
		IV fluid & Inj. Synoid @ RL - 500ml 100ml/hr.	
		on flow. IV/F IV line patten. →	2 nos
	9PM	Seen by the Dr. Akshitha, Dr. Shreedevi	
		Advised. Soft diet @ 10AM,	
		vitals monitoring. Follow drug chart	
		W/F ↑ Bleeding P/V, CBD removal.	
		@ 1PM Today. Hb/PCV/Urine R/E	
		after CBD removal	
	10AM.	Health education Explain the	
		Patient & Attender Said. →	2 nos.
		B - Breast Soft NO Engorgement	
		Nipple Pattern	
		U - Uterus Contracted well	
		B - Bowel movement present	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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CAESAREAN SECTION OPERATIVE NOTES

Surgeon's Name: Dr. Uma	Date of Delivery: 29/06/2026
Assistant Surgeon: Dr. Priyanka	Time of Delivery: 12:33pm
Anaesthetist's Name: Dr. Priyadharshini	Gender of Baby: Boy
Type of Anaesthesia: Spinal	Weight of Baby: 3.852 kg
Neonatologist: Dr. Srilakshmi	AGPAR Score: 8/10, 9/10
Scrub Nurse: Sangeetha	NICU Admission: ☐ Yes ☑ No

Pre-Operative Diagnosis:

☐ Elective ☑ Emergency Indication: CPD

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: ..... Knief to rectus: 3min

CTG Description: Reactive.

If there was a delay give the reasons: .....

Surgical Procedure: EMERGENCY LOWER SEGMENT CESAREAN SECTION

Post Operative Diagnosis: P1L1 | POD-0 | POST LSCS

Peri-Operative Complications: Nil

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

Name and Number of Surgical Specimen sent for examination:

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	M 29/6/26	G 29/6/26	N 29/6/26
		Score	10	20	20
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0	0	0	0
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0	0	0	0
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0	0	0	0
IV / Heparin Lock or Saline	Yes	20		20	20
	No	0			
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10	10		
	Normal /On Bed Rest /Immobile	0		0	0
Mental Status	Forgets limitations	15			
	Oriented to own ability	0	0	0	0
Total Morse Fall Scale Score:			10	20	20
		Signature	Abdhya 0180	6/6	P.Lee

Fall Risk Grading		
Risk Level	**Morse Fall Score (MFS)**	**Action**
Low Risk	0 - 24	Standard Fall Precaution
Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
High Risk	≥ 51	Implement High Risk Fall Prevention Intervention

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	30/6/26	30/6/26	30/6/26
		Score	M	E	N
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	15
	No	0	0	0	0
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0	0	0	0
IV / Heparin Lock or Saline	Yes	20	20	25	25
	No	0			
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10	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:			45	40	~~35~~
		Signature			

Fall Risk Grading		
Risk Level	**Morse Fall Score (MFS)**	**Action**
Low Risk	0 - 24	Standard Fall Precaution
Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
High Risk	≥ 51	Implement High Risk Fall Prevention Intervention

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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(3)

Morse Fall Risk Assessment Form

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Choose Highest Applicable Score from each Category		Date / Time	1/7/2026			Fall Risk Grading		
		Score				Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25						
	No	0	0					
Secondary Diagnosis (more than one diagnosis)	Yes	15						
	No	0	0			Low Risk	0 - 24	Standard Fall Precaution
Ambulatory Aid	Furniture	30						
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0					
IV / Heparin Lock or Saline	Yes	20						
	No	0	0			Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
GAIT / Transferring	Impaired	20						
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0	0					
Mental Status	Forgets limitations	15						
	Oriented to own ability	0	0			High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
Total Morse Fall Scale Score:			0					
		Signature						

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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Dr. UMA K

BRADEN 'Q' SCALE

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					Date : 29/6/18	29/6	29/6	30/6
					Time : 10Am	3Pm	N	(AM)
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4	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	1	2	2
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR **Friction** . Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	1	1	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	4
				TOTAL SCORE	25	22	26	26
				Evaluator's Name				

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

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

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Dr. UMA K

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BRADEN 'Q' SCALE

(for Paediatric use)

Patient Name : .....

Age..... Gender : ☐ F ☐ M

				Date :	30/4	30/4	1/5	
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	
"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 lift 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 or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	3	3	3	
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	27	27	27	
				Evaluator's Name				

Highest Risk : 7 | High Risk : 8-16 | Mild Risk : 17-21 | No Risk : 22-28

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(3) # BRADEN 'Q' SCALE

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				Date :				
				Time :				
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.				
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.				
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.				
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.				
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."				
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.				
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.				
				TOTAL SCORE				
				Evaluator's Name				

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

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PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
29/6/26	10Am	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NO S/N pain	Akalya 01808
29/6/26	1:30pm	2/10	Surgical site	☐ Continuous ☐ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☑ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Comfortable position	Akalya 01808
29/6/26	3pm	1/10	Surgical site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☑ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Provide comfortable position	01808
29/6/26	8pm	Y/10	Surgical site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	comfortable positone	P.Ve 607261
[illegible]	[illegible]			☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
30/6/26	8am	1/10	Surgical site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	N/A	S/O onset
30/6/26	2pm	3/10	Surgical site	☐ Continuous ☐ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	inj Paracetamol given	S/O onset
30/6/26	8pm	1/10	Surgical site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	comfortable position.	607326
01/7/26	2Am	1/10	Surgical site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	comfortable position	[illegible]
1/7/2026	10a	0/10	NO	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	nil	[illegible]

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

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PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

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

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BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient's Name:.....

MRD NO GUC-00093215 IP18-00036241
Mrs V. SARANYA
30-09-1993 32 Y 8 M 30 D (F)
Dr. UMA K

Age :.....

Sex: ☐ M ☐ F

Consultant .....

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 29/6/26 Time: 10AM

Location : Left metacorbal vein

Size : 18G

Cannula inserted by : S/N Aiswarya 01800

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
29/6/26	10:30AM	☐Yes ☐No	☐Yes ☐No	Observed	SA
	12pm	☐Yes ☐No	☐Yes ☐No	observed	SA
	2pm	☐Yes ☐No	☐Yes ☐No	observed	SA
	4PM	☐Yes ☐No	☐Yes ☐No	"	SA
	6PM	☐Yes ☐No	☐Yes ☐No	"	SA
	8PM	☐Yes ☐No	☐Yes ☐No	Observed	P-V
	10PM	☐Yes ☐No	☐Yes ☐No	Observed	P-V
30/6/26	12AM	☐Yes ☐No	☐Yes ☐No	Observed	P-V
	2 AM	☐Yes ☐No	☐Yes ☐No	Observed	P-V
	4AM	☐Yes ☐No	☐Yes ☐No	Observed	P-V
	6AM	☐Yes ☐No	☐Yes ☐No		
1/7	10AM	☐Yes ☐No	☐Yes ☐No	observed	SA
	12PM	☐Yes ☐No	☐Yes ☐No	observed	SA
	2PM	☐Yes ☐No	☐Yes ☐No	Observed	SA
	4PM	☐Yes ☐No	☐Yes ☐No	Observed	SA
	6PM	☐Yes ☐No	☐Yes ☐No	Observed	SA
	8PM	☐Yes ☐No	☐Yes ☐No	observed	P-V
01/7/26	12AM	☐Yes ☐No	☐Yes ☐No	observed	SIM
	4AM	☐Yes ☐No	☐Yes ☐No	observed	SIM
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

Cannula removed : ☐Yes ☐No, if yes date and time : 1/7/2026 at 10am
RX any initiated : ☐Yes ☐No ☐NA If Yes specify-
Phlebitis score: 0

CANNULA 2

Date : Time:

Location :

Size :

Cannula inserted by :

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

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

GUC-00093215 IP18-00036241
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Dr. UMA K

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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Part - I.

Patient's / Learner Language: ..... Patient / Learner Literacy: ☐ Read ☐ Write ☐ Speak Willingness to Learn: Yes No Healthcare Literacy: Yes ☐ No

Identified Education Needs:

1. Diagnosis Plan
2. Treatment and Care
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		
29/6/26	10AM	YES	Explained about the NPO status	patient	No Learning Barriers	Books	None	YES	Good	S/N Nataraja 01806
30/6/26	Morning	Yes	New born warning Sign	PT	No Learning Barriers	Dry	None	yes	Good	No
1/7/26	10am	YES	Wound Care Explained to patient	Patient	Nil	Oral	None	YES	Good	

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C: Caregiver O: Other (Specify) .....

Learning Barriers:
1. No Learning Barriers
2. Physical Impairment
3. Emotional Barriers
4. Language Barrier
5. Educational Level
6. Desire / Motivate to Learn
7. Impaired Thought Process/Cognitive limitations
8. Responsibilities at Home
9. Cultural Differences
10. Financial Difficulties
11. Beliefs and Values
12. Impaired Vision/ or Hearing
13. Cultural/Religion Practice
14. Others (Specify .....

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

Mechanism/s to overcome barrier/s:
1. None
2. Obtain translator
3. Reassurance & Support
4. Teach Family / Others
5. Respect values & beliefs
6. Respect Cultural / Religion Preference
7. Other, Specify .....

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

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URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 29/6/26 Date of Removal: 30/6/26 at 12pm

Parameters / Date / Shift Time	29/6/26 M	29/6/26 E	29/6/26 N	30/6 M			
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 Obsiruction (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/M Vasanthi						
Signature of the Nurse	01808						

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

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Dr. UMA K
IP18-00036241
32 Y 8 M 30 D (F)

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BREAST FEEDING HANDOVER AND ASSESSMENT FORM

1. Breastfeeding initiated?
   - [x] a. Yes
   - [ ] b. No

2. If No, Reason .....

3. Nipple condition:
   - [x] a. Nipple well formed
   - [ ] b. Flat nipple
   - [ ] c. Inverted nipple
   - [ ] d. Short nipple

4. Milk flow:
   - [ ] a. Good
   - [x] 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
   - [x] d. The baby takes a latch on the areola and not on the nipple

Feeding Positions:
Cross Cradle

Feeding Positions:
Football / Clutch

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SSI PREVENTION CHECKLIST

S.No	INTERPRETATION	PERFORMED
	PREOPERATIVE	
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 prophalaxis 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

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OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 29/6/2026 Time of Arrival: 9:30Am Time Seen by Nurse: 29/6/2026

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: —

3) **Vital Signs:** Temperature: 98°F Pulse: 89bm RR: 20bm SpO_2: 100% BP: 130/80 mmHg Weight: 70.6kg

4) **Gestational Criteria:**

Gravida:	G 1	P —	L —	A —

LMP: 1/10/2025 EDD: 8/7/2026 Gestational Age: 38+5days

Uterine Contraction	☐ Yes	☐ No	☐ NA	Onset —	Time —	Frequency: —
Membrane Rupture	☐ Yes	☐ No	☐ NA	Onset —	Time —	Fluid Color: —
Vaginal bleeding	☑ Yes	☐ No	☐ NA	Onset 29/6/26	Time 6:40 Am	Amount: Show (+)
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)

0 No Pain 1 2 3 4 5 6 7 8 9 10 Worst possible pain

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

6) **Past History:**

a) Surgeries: Tooth alligment Surgery 11 years back

b) Medical: UTI during pregnancy

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. uma
Asst. Surgeon : Dr. Priyanka
Anaesthetist : Dr. sathish
Scrub Nurse : SN sangeetha

GUC-00093216 IP18-00036241
Mrs V. SARANYA
10-09-1993 32 Y 6 M 30 D (F)
Dr. UMA K

Age : 32y Gender : F
Name : Emergency Lscs
Out-time : 1:15 PM

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 12.15 pm

Patient Has Confirmed	
Identity	☑ Yes ☐ No
Site	☑ Yes ☐ No
Procedure	☑ Yes ☐ No
Consent	☑ Yes ☐ No
Site Marked	☑ Yes ☐ No ☐ NA
Anaesthesia Safety Check Completed	☑ Yes ☐ No
Pulse Oximeter on Patient & Functioning	☑ Yes ☐ No
Does Patient have a:	
Known Allergy?	☐ Yes ☑ No
Difficult Airway / Aspiration Risk?	
Yes, & Equipment / Assistance Available	☐ Yes ☑ No
Risk of > 500ml Blood Loss (7ml/kg In Children)?	
Yes, and Adequate Intravenous Access and Fluids Planned	☑ Yes ☐ No ☐ NA
Blood Units Reserved	☐ Yes ☑ No ☐ NA
Has Antibiotic Prophylaxis been given within the last 60 minutes?	☑ Yes ☐ No ☐ NA

Signature : Sol
Name : Dr. sathish

Before Skin Incision ➤➤

TIME OUT Time: 12.20 pm

Confirm all team members have introduced themselves by Name and Role	☑ Yes ☐ No
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm	
Correct Patient (Check ID Band)	☑ Yes ☐ No
Correct Site	☑ Yes ☐ No
Correct Procedure	☑ Yes ☐ No
Anticipated Critical Events	
Surgeon Reviews:	
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss?	☐ 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 : for 16.42.88
Name : Dr. Uma

Before Patient Leaves Operating Room

SIGN OUT Time: 1.15 pm

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 : Sangeetha
Name : SN sangeetha

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Mrs V. SARANYA
30-09-1993 32 Y 8 M 30 D (F)
Dr. UMA K

PRE - OPERATIVE CHECK LIST

Hospital
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BirthRight
BY RAINBOW HOSPITALS
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Date: 29/6/26

Patient's Name : Mrs! Saranya Age : 32/F Gender : ☐ M ☐

Blood Group : A+ve UHID : 93215

Planned Surgery : EM LSB Surgeon : Dr: UMA.K

Anesthetist : Dr: Ashwini Date & Time of Operation : 29/6/26

Tick Appropriate Boxes

To be filled by Nurse Incharge / Senior Nurse :

S.No	INSTRUCTIONS	YES	NO	NA
1.	Weight checked and recorded?	☑	☐	☐
2.	Is the patient fasting for over 6 hours Pre-Operatively?	☑	☐	☐
3.	Check Pre-OP Investigations & Results (CBP, Blood Group, BT, CT, PT / APTT, Viral Screening, CXR etc) available before starting the procedure	☑	☑	☐
4.	Enema given / Bowel Preparation	☐	☑	☐
5.	Remove all ornaments, etc and sterile gown given	☑	☐	☐
6.	Is Blood arranged as required?	☐	☑	☐
7.	If Blood has been ordered - is Blood bag ready?	☐	☑	☐
8.	IV Cannula to be placed / IV fluids if Indicated	☑	☐	☐
9.	Pre Anesthetic consultation with anesthesiologist	☑	☐	☐
10.	Pre Medications Given? (Sedatives / etc)	☑	☐	☐
11.	Skin Preparation	☑	☐	☐
12.	Site is marked	☑	☐	☐
13.	Surgery consent / High Risk consent taken by surgeon? (Consent should be taken by the operating surgeon only)	☑	☐	☐
14.	Implants are available	☐	☐	☐
15.	Equipment is avaialble	☑	☐	☐
16.	Other (if any)	☑	☐	☐

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

Billing Clearance taken

Billing Executive Name : Vellivalli C Nurse In-Charge Name : SNDeeraj

Billing Executive Signature : Nurse In-Charge Signature : 0180

Date & Time : 29/06/26 @ 11:10am Date & Time : 29/6/26

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

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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GUC-00093215 IP18-00036241
Mrs V. SARANYA
30-09-1993 32 Y 8 M 30 D (F)
Dr. UMA K

Patient Name : ..... Gender: ☐ Male ☐ Female Age : .....

UHID No : ..... Date : .....

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

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

..... Emergency lower segment cesarean section .....

..... upon .....

..... (Name of the Patient) Mrs. Saranya .....

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 surrounding structures (bowel, bladder, blood vessels), admission to MICU, ...
..... baby admission to NICU, respiratory distress, ...

My signature on this form indicates that

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

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

Consentee :

Signature : V. Saranya

Name : MRS. SARANYA

Date & Time : 29/6/2026

Patient Attendant

Signature : P. Emmanuel

Name : P. EMMANUEL

Relationship with Patient: HUSBAND

Date & Time : 29/6/2026

Witness :

Signature : .....

Name : .....

Date & Time : .....

Doctor (who is taking the consent) :

Signature : 12:13

Name : Dr. Vinitha

Date & Time : 29/6/26

CONSENT FORM FOR ANAESTHESIA

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Mrs V. SARANYA
30-09-1993 32 Y 8 M 30 D (F)
Dr. UMA K

Patient Name : .....

UHID NO: .....

..... Age : ..... Gender : Male ☐ Female ☐

..... Surgeon Name: .....

Anaesthesiologist : DR SATHISH / DR PRIYA Operative procedure planned : ELECTIVE LOWER SEGMENT CESAREAN SECTION

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

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

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

☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure

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

☐ Incapacitating Cronic Obstructive Pulmonary Disease ☐ Others : HYPOTENSION, BRADYCARDIA, PPH, DESATURATION.

- 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 anesthesia.

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

I authorize the 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 anesthesiologist 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 : V. Saranya

Name : Mrs. Saranya

~~Relationship~~ with Patient: patient

Date & Time : 29/6/26

Witness :

Signature : P. Emmanuel

Name : Mr. Immanuel

Date & Time : 29/6/26

Doctor (who is taking the consent) :

Signature : .....

Name : Dr Bajaj. R

Date & Time : 29/6/26 11.30am

Docu. No. : RCH / FRM / CLINICAL / 021

GUC-00093216 IP18-00036241
Mrs V. SARANYA
30-09-1993 32 Y 8 M 30 D (F)
Dr. UMA K

BirthRight Rainbow Children's Hospital

PATIENT TRANSFER NURSING HANDOVER CHECKLIST

Date & Time of Transfer: OT **TRANSFERRED TO :** MICU

		YES/NO	REMARKS
1	**Patient Identification**		
	a.Patient Identification Patient name, age, UHID/hospital number confirmed	✓	
	b.Surgical procedure & correct site verified	✓	
2	**Airway & Breathing**		
	a.Oxygen delivery (mask/cannula/ventilator) secured	✓	
	b.SpO_2 within safe range	✓	
	c.If ETT: position confirmed, ties secure, cuff inflated	✗	
3	**Circulation & Hemodynamic Stability**		
	a.IV lines secured & infusion running correctly	✓	
	b.No active uncontrolled bleeding	✓	
	c.Last vitals recorded before transfer	✓	
	d.Central line hubs are closed	✗	
	e.Dressing Intact	✓	
4	**Pain Assessment**		
	a.Pain score assessed & analgesia given	✓	
	b.Reassessment done	✓	
5	**Wound, Dressings & Drains**		
	a.Surgical dressing intact	✓	
	b.All drains fixed, output noted		
	c.Catheter secure & urine output recorded	✓	
	d.Splints/casts/traction devices stabilized	✗	
6	**Medications Pre & Post-Op Orders**		
	a.Medications due time noted	✓	
	b.Pre & Post-op instructions (NPO, position, mobilization) communicated	✓	
	c.Emergency meds given in OT (time & dose documented)	✓	
7	**Equipment Safety & Transport Preparedness**		
	a.Oxygen cylinder full & ambu bag at bedside	✓	
	b.Bed/side rails up and brakes applied	✓	
	c.Special positioning maintained as per surgery	✓	
8	**High-Risk Patient Safety (if applicable)**		
	a.Chest tube: underwater seal below chest level	✗	
	b.Epidural catheter secure, infusion checked	✗	
	c.Pressure areas protected (heels/elbows)	✓	
9	**BLOOD AND BLOOD PRODUCTS TRANSFUSED**	✓	
10	**REPORTS AND LABS HANDED OVER**	✗	
11	**BIOPSY/HPE SENT**	✗	
12	**Documentation**		
	a.Documentation completeness	✓	
	Transferring Nurse:		
	Receiving Nurse :		
	Signature of Incharge:		

PATIENT TRANSFER FORM

(2)

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UC-00093216 IP18-00036241
Mrs V. SARANYA
30-09-1993 32 Y 8 M 30 D (F)
Dr. UMA K

	Date & Time of Admission	Date & Time of Transfer Order
	29/6/26	29/6/2026 at. 1.15 pm.
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr. uma	Dr. Sathish	further management
From Unit	**To Unit**	**Information to Attendant**
OT	MICU.	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
one file	–	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	Name of Person Ordered Transfer
Staf Pradeepa veerappan	Dr. Sathish

Patient & Clinical Records Received by : Staff Nurse 01808

Date & Time of Patient Received : 29/6/26 at 1:10pm

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

GUC-00093215 IP18-00036241
Mrs V. SARANYA
30-09-1993 32 Y 8 M 30 D (F)
Dr. UMA K

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LABOUR AND DELIVERY NURSING ASSESSMENT

Date of Admission: 29/6/26

Baseline Information:

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

Primary Language: ☐ Telugu ☐ English ☐ Hindi ☐ Others Tamil

Do you require an interpreter? ☐ Yes ☑ No

Source of Information: ☑ Patient ☐ Family ☐ Others

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

handed over to Attenders'

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

If yes , identify .....

Chief Complaints: Patient complaints of show ⊕

Doctor Notified on Admission: ☑ Yes ☐ No

Name of the Doctor: Dr Smiths

Time Notified: 10 Am

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

Past Medical History	Past Surgical History	Previous Hospital Admission
History of UTI during pregnancy.	Tooth Alignment Surgery 11 years back	—

Blood Group: A+ve LMP: 1/10/25 EDD: 8/7/26 Gestational age during admission: 38+5 days

Contractions: NO Vaginal Discharge: show present

Obstetric History: G 1 P — L — A — Previous LSCS NO

Height: 188 Weight: 70.6 kg BMI: 26.21

Temp: 98F HR: 89 bpm RR: 20 BP: 120/80 mm Hg SpO_2 100%

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

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

GUC-00093215 IP18-00036241
Mrs V. SARANYA
30-09-1993 32 Y 8 M 30 D (F)
Dr. UMA K

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RISK ASSESSMENT TOOL FOR DEEP VEIN THROMBOSIS

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

Date: 29/6/2024

Pre - Existing Risk Factors	Tick	Score
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		3
Family history of unprovoked or estrogen-related VTE in first-degree relative		1
Known low-risk thrombophilia (no VTE)		1
Age (≥35 years)		1
Obesity	✓	1 or 2
Parity ≥ 3		1
Smoker		1
Gross varicose veins		1
Obstetric Risk Factors		
Pre-eclampsia in current pregnancy		1
ART/IVF (antenatal only)		1
Multiple pregnancy		1
Caesarean section in labour		2
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^{+0} weeks in current pregnancy		1
Stillbirth in current pregnancy		1
Transient Risk Factors		
Any surgical procedure in pregnancy or puerperium except immediate repair of the perineum, e.g. appendectomy, postpartum sterilization		3
Hyperemesis		3
OHSS (first trimester only)		4
Current systemic infection		1
Immobility, dehydration		1
Total		1
Signature of the Nurse	S/N Akshaya 29/6/2024	
Action Plan		

GUC-00093215 IP18-00036241
Mrs V. SARANYA
30-09-1993 32 Y 8 M 30 D (F)
Dr. UMA K

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PATIENT TRANSFER NURSING HANDOVER CHECKLIST

Date & Time of Transfer: 29/6/2026 LDR **TRANSFERRED TO :** OT

		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	No	
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	No	
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	No	
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**	No	
10	**REPORTS AND LABS HANDED OVER**	No	
11	**BIOPSY/HPE SENT**	No	
12	**Documentation**		
	a.Documentation completeness	Yes	
	Transferring Nurse: _____	S/N Bhavya/0180	
	Receiving Nurse : _____	SN	
	Signature of Incharge:	S/N Bhavya	

PATIENT TRANSFER FORM

(1)

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GUC-00093215 IP18-00036241
Mrs V. SARANYA
30-09-1993 32 Y 8 M 30 D (F)
Dr. UMA K

Treating Consultant Name	Date & Time of Admission	Date & Time of Transfer Order
Dr: Uma-lc	29/6/26 at 10:10 Am	29/6/26 at 12:10 Pm
	Transfer Ordered by	Reason for Transfer
	Dr: Vinitha	En LSCS
From Unit	To Unit	Information to Attendant
LDR	OT	Yes ☐ No ☐
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant
Whole IP Files	CTH-(1)	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 OT

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
S/N Akalya 01808	Dr. Vinitha

Patient & Clinical Records Received by : Staff Nurse

Date & Time of Patient Received : 29/6/2026. at 12.30 PM.

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

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