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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PATIENT DISCHARGE INTIMATION FROM NURSING STATION

CLEARANCE FOR DRUGS AND DISPOSABLES BILLING

GUC-00093943 IP18-00036552
Mrs ARUNA.K
25-10-1983 42 Y 8 M 27 D (F)
Dr. SELF

Date: 22/7/26

Gender: Female

Ward: .....

Room No: F06

Certified that in respect of the above patient:

- ☐ a. There are no drugs for return
- ☐ b. Emergency cupboard issues have been replenished
- ☑ c. No pending indents are there against above patient
- ☑ d. Checked the bed side cupboard of the bed
- ☑ e. Checked by the patient's Mother / Father in the room

Patient Authorised Sign

Date: .....

Time: .....

Nurse Sign P.Devi 607261

Date: 22/7/26

Time: 12-30 Pm

Pharmacy Sign

Date: 22.7.26

Time: 1.2 pm

Docu. No. : RCH /FRM / GENERAL / 117

Rainbow Children's Hospital

GUC-00093943 IP18-00036552
Mrs ARUNA K
25-10-1983 42 Y 8 M 27 D (F)
Dr. SELF

ARGE TRACKING SHEET

HID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing		12.30pm					
Activity Sheet update by Pharmacy							

ACTIVITY RECORD FOR BILLING

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Name: ..... GUC-00093943 Mrs ARUNA.K 25-10-1983 Dr. SELF 42 Y 8 M 26 D (F) IP18-00036552 .....

UHID No: ..... Consultant: ..... Dept: .....

Date of Admission: .... Date of Discharge: ..... Time: .....

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
21/7/26	8 AM	LDR	OT	
21/7/26	1:30pm	OT	NICU	
21/7/26	9PM.	LDR	7th Floor	

CROSS CONSULTATION VISIT

	Doctor Name	Date	Order No.	Signature
1.	PAC [OP]		[OP]	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
21/7/26	Biopsy Large	26023469	[illegible] 60781

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
21/7/26	Laprascopy	8:45AM	12pm	17 30823	
21/7/26	morcelator	11:15AM	11:40AM	1730822	
21/7/26	Infusion.	30 1PM	22/7/26 @ 12pm	17 30986.	

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
21/7/26	In Placent	(1)	7730580	
21/7/26	Blood issues	(1)	260232409	
21/7/26	FFB	(1)	260232402	
21/7/26	Catheterization	(1)	OT	

ANY OTHER INFORMATION:

procedure name : TLH

Surgeon name : Dr. vaishnavi

Assist surgeon Name: Dr. kisore reddy.

Anaesthuist name : Dr. Sathish . Dr. priyadharshini

Anaesthesia : GA

In time: 8:10Am out time: 1:30pm

607891

Date: ..... Time: ..... Prepared By: .....

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Children's Hospital | BirthRight

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

GUC-00093943 IP18-00036552
Mrs ARUNA.K
25-10-1983 42 Y 8 M 27 D (F)
Dr. SELF

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement	12.20 PM				
	INTIME	OUT TIME			
Arrangement of File by Nursing		12.25PM	P. [illegible] 607261		
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

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 : IP18-00036552 **Admit Date** : 21-Jul-2026 **Admit Time** : 04:20 AM **UHID** : GUC-00093943

Patient Details :

Patient Name	: Mrs ARUNA.K	**Age**	: 42 Y 8 M 26 D
Guardian	: JAYARAJ	**DOB**	: 25-10-1983
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 10/3A , LAKSHMI STREET , JAFFERKAANPET Ashok Nagar Chennai Tamil Nadu INDIA 600083	**Phone No**	: 9444322442/ 8344594383
		E-mail	: NO@GMAIL.COM

Admission Details :

Bed Type : MICU **Bed No** : MICU 805 **Ward Name** : 8F-OT COMPLEX

Room No : MICU 805 **Admission Type** : First Visit

Contact Details :

Name : JAYARAJ **Relationship** : Husband

Contact Address : 10/3A , LAKSHMI STREET , JAFFERKAANPET Ashok Nagar Chennai Tamil Nadu INDIA 600083 **Phone No** : 9444322442

Signature

Doctor Details :

Doctor Name : Dr. SELF **Specialisation** : OBSTETRICS AND GYNECOLOGY

Referral Doctor : DR.VAISHNAVI **Phone No** :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash **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 ARUNA.K**	**Age :**	**42 Y 8 M 26 D**
IP No:	**IP18-00036552**	**Sex:**	**Female**
Consultant:	**Dr. SELF**	**Ward/Bed No:**	**8F-OT COMPLEX/MICU 805**

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: JAYARAJ .

Relationship: HUSBAND .

Date: 21/07/26. Time: 04:20 AM

Witness Name: P. Thamarai Selvan

Witness Signature:

Patient Address:

10/3A , LAKSHMI STREET ,
JAFFERKAANPET Ashok Nagar Chennai
Tamil Nadu INDIA 600083

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 ARUNA . K	UHID Number : 93946
Self/Attendant Name : JAYARAJ.	Relation : HUSBAND
Self/ Attendant Signature : Phone Number :	Name & Signature of Financial Counselor

Ref. No. : F/GYNIC/18

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I.P. ADMISSION SHEET FOR GYNECOLOGY

GUC-00093943 IP18-00036552
Mrs ARUNA.K
25-10-1983 42 Y 8 M 26 D (F)
Dr. SELF

Date of Admission : _____

Time of Admission : _____

PERSONAL DETAILS

Name : ARUNA. Age 42. Date of Birth _____

UHID No.: _____ IP No.: _____

Department : OBG. Consultant : Dr. Vaishnavi.

PRESENTING COMPLAINTS

42yrs | P2L2 | NVD | LCB 10yrs | ST not done | AUB-L.

patient received

c/o heavy menstrual bleeding x 1 year
during cycles.
on day 2/3.

5/40 days.

changes 1 pad every 2 hours.

clots ⊕

no dysmenorrhea

c/o fatigue / tiredness ⊕.

H/o inj. FCM twice on 1st & 10th July.
(Hb=7g/dL)
↓
Repeat Hb=9.9 g/dL.

on Tab Regesterone since 29/6/26 x 2 weeks.
Last dose 20/7/26.

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage :	Parity : P2L2
Previous Periods : 5/40 days.	Mode of Delivery NVD
LMP : 9/6/26.	Last Child Birth : 10yrs.
Contraception : NIL.	

MEDICAL HISTORY	SURGICAL HISTORY
NIL.	NIL.
FAMILY HISTORY	**NOTES / ALLERGIES**
mother - T2DM | SHTN.	NIL.

INITIAL ASSESSMENT :

Date 21/7/26.

Ht. 162cms Wt. 65kgs.

BMI

B.P 116/67 mmHg.

Pallor (-).

CVS S1S2 (+).

Respiratory System BAE (+)

Thyroid (N).

PR 63bpm.

Breasts (N)

Abdominal Examination

soft.

Local / Speculum Examination

not done.

Bimanual Pelvic Examination

not done

Cardiac fitness obtained ✓

PROVISIONAL DIAGNOSIS : P2L2 \| NVD \| LCB 10yrs \| ST not done \| AUB - L.

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT	PRESCRIPTION
	• NPO. • Consent. • Prepare parts • Secure IV line • Reserve 2 O PRBC 1 O FFP.	• inj. supacef } preop. • inj. pan • inj. emeset

Name of the Doctor : Dr. Vaishnavi.

Date : 21/7/26 **Time :** 5 AM.

12435.

Signature of Doctor

F

GUC-00093943
Mrs ARUNA.K
25-10-1983
Dr. SELF

IP18-00036552
42 Y 8 M 26 D (F)

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RESULT SHEET

Date	18/7/26.	9/7/26.				
Time				B +ve		
Hb	9.9.	8.5.				
PCV		30.5.				
RBC						
WBC		6720.				
N/L						
Platelets		4.6.				
CRP						
ESR				ECG - NSR.		
PCT				2D ECHO - (N)		
RBS				EF = 67%.		
Na		142.		No RWMA.		
K		4.72.				
Cl		104.		HbA1c = 5.4.		
Ca/Mg						
Phosphate						
Urea	27/6/26: 17			HBSAg, HCV, HIV: Non reactive		
Creatinine		8				
ALP		46.				
SGPT		6.		27/6/26.		
SGOT		22				
T.Bill/Conj		0.2/0.13		TSH = 2.48.		
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid		4.7.				
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : pap smear - negative for IEL/malignancy.
Endo asp. - done on 21/7/26. - Report awaited.

27/6/26. IVS pelvis.
Uterus 11.9x12.8x9.2|.
ET = 7.1 mm.

29/6/26.

Radiology :

USG : heteroechoic lesion 13.2 x 10.6 in posterior uterine wall ? intramural fibroid.

X-Ray :

ECHO : (R) ovary 3.52x2.03x2.67 cms, vol. = 9.97cc
(L) ovary not visualised.

CT :

MRI

Others (ECG, Contrast Studies etc.,) :

MRI - Pelvis.
- Uterus bulky, AV.
- IM fibroid in post wall & fundus 8.2 x 11 x 12 cms displacing endo inferiorly.
- ET = 3.5 mm.
- (R) ovary enlarged.
  L> simple cyst 18x11 mm.

(1)

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25-10-1983
Dr. SELF

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/8/26 7.50 Am	O/B Dr VAISHNAVI	
	Planned for TLH c or ¢ BSO	
	O/E afebrile	
+O	no pallor/PE	R
PR-80/min	Cy	- NPO
BP-110/80mmHg	no/may	- IVF 10ml on flow
	P/Abd	- Shift to OT
	Uterus 14wks	
		[signature] (Dr. Vaishnavi?)

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

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7/2026	C/S/B Dr. Vinitha / Dr. Shreedevi	
1:30pm		
POD - 0	Pt received in MICU	Advice
	Pt reviewed, Nil C/o	- NPO x 6 hours
T - (N)	O/E Pt GC fair, Afebrile	- Vitals Monitoring
PR - 70/min	P° / PE°	- IVF 20RL / 20NS / 10 5% D @ 100ml/hr
BP - 100/60 mmHg	CVS /	
UO - 250ml, clear	RS / NAD	
SpO2 - 100% RA	P/A - Soft	- I/o charting / PTR charting
1 U PRBC given intra op	Dressing (+), No soakage	- Follow drug chart
	UE - No undue bleeding	- CBD c/m 7Am
	UBD in situ, clear urine draining	- Vaginal Pack to be removed @ 6pm today
	& B2217	- Inform (SOS)
21/7/26	S/B Dr. Vinitha	
6PM	Pt reviewed; NO C/o	
POD #0	O/E: GC fair; Afebrile	
	P° / PE°	C/D/W Dr Vaishnavi
BP: 117/65 mmHg	CVS / NAD	Adv:
PR: 76/min	RS /	Start sips of water @ 7pm
SpO2: 100% RA	P/A: Soft ; BS (+)	I/O chart; Vitals monitor
	Dressing (+) No soakage	Follow drug chart
V/O Clear 100 ml	UE: No undue bleeding	CBD removal on 7am
	Vaginal pack removed	Sedation HS
	No bleeding / clots	Inform SOS

VHR 12W3

GUC-00093943
Mrs ARUNA.K
25-10-1983
Dr. SELF
IP18-00036552
42 Y 8 M 26 D
(F)

(2)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7/26	S/B - Dr Anandhaeswari	
8:30 pm	42yrs / P2L2 / post	TLH c BSO (Ind. AUB-L) salpingectomy
Day of surgery		No complaints
	O/E - GC fair, afebrile, Hydration fair	
	no pallor / no PE	Advice
T - (N)	CVS - S1S2 (+)	- Liquid diet
PR - 83/min	B - NVBS (+)	- Adequate hydration
BP - 116/74	P/A - soft, BS (+)	
SpO2 - 99% RA	drain intact	- Vitals monitoring
	No soakage	- Sedation IM HS
U/O - 250ml clear in		- Follow drug chart
urobag.	L/E - No bleeding PV	
	CBD in situ	- Remove CBD @ 7AM.
		Shift the patient to ward
		(signature) 156007

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

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

GUC-00093943
Mrs ARUNA.K
25-10-1983
Dr. SELF
IP18-00036552
42 Y 8 M 26 D (F)

(3)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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Date: ..... Department: ..... Shift: .....

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

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

Rainbow® Children's Hospital
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BirthRight BY RAINBOW HOSPITALS
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Date: ..... Department: ..... Shift: .....

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

GUC-00093943 IP18-00036552
Mrs ARUNA.K
25-10-1983 42 Y 8 M 26 D (F)
Dr. SELF

(1)

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ON 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 : ....

Date & Time : ....

Nurse Name & Signature: S. [illegible] 10117020

Date & Time : 21/7/20

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

GUC-00093943 IP18-00036552
Mrs ARUNA.K
25-10-1983 42 Y 8 M 26 D (F)
Dr. SELF

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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	INJ PARACIP	1g	IV	stat	21/7 12pm	☐C ☐DC
2	INJ DEXA	8mg	IV	stat	21/7	☐C ☐DC
3	INJ TRAPIC	1g	IV	stat	21/7	☐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 Priya

Date & Time : 21/7/26

Nurse Name & Signature: Thanu

Date & Time : 21/7/26 @ 1:30pm.

GUC-00093943
Mrs ARUNA.K
25-10-1983
Dr. SELF

IP18-00036552

42 Y 8 M 26 D (F)

(2)

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BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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: ICU ..... Shifted to: 7th Floor .....

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

Nurse Name & Signature: B. Nivetha.

Date & Time : 21/7/26.

Patient Sticker

GUC-00093943 IP18-00036552
Mrs ARUNA.K
25-10-1983 42 Y 8 M 26 D (F)
Dr. SELF

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DRUG CHART

Date of Admission: ..... 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 :				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:				

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

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

Patient Sticker

REGULAR PRESCRIPTIONS

Weight: 65 .... Ward. 22a ....

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

Patient Sticker

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight ....[illegible].... Ward ....[illegible]....

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

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

Docu. No. : RCH /FRM / CLINICAL / 108

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Sheet No: .....

REGULAR PRESCRIPTIONS

Weight ..... Ward .....

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

DRUG : INJ. SUPACEF

Dose	Route	Frequency	Start Dt.
1.5g	IV	1-0-1	21/7/21

Name & Signature of the Doctor Starting the Drugs: 182217

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	21/7	22/7
8Am	/	SM/DK
7:30pm	SA	
8pm	SP	

DRUG : INJ. PANTOPRAZOLE

Dose	Route	Frequency	Start Dt.
40mg	IV	1-0-1	21/7/21

Name & Signature of the Doctor Starting the Drugs: 182217

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	21/7	22/7
7Am	/	ES/AP
7pm	SA/SP	

DRUG : INJ. PARACETAMOL

Dose	Route	Frequency	Start Dt.
1g	IV	1-1-1	21/7/21

Name & Signature of the Doctor Starting the Drugs: 182217

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	21/7	22/7
8Am	/	SM/PK
2pm	/	
8pm	SA	
10pm	SP	

DRUG : ~~DAPS~~.

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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Weight. 65 Ward. 202

	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.	

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
			0.1ML	ID	128435	SN DS
21/7/26	6:30 AM	INJ SUPACEF	1.5gm	IV	128435	SP TJ
21/7/26		INJ SUPACEF				
			40mg	IV	128435	SN DS
21/7/26	6:30 AM	INJ PAN				
21/7/26	6:30 AM	INJ EMESET	4mg	IV	128435	SN DS
			0.1ML	ID	128435	SN DS
21/7/26	7:51 AM	INJ XYLO				
21/7	9 am	INJ DEXA	8mg	IV		PT SK
21/7	12pm	INJ PARA	1g	IV		PT SK
21/7	10:00 am	INJ TRAPIC	1g	IV		PT SK
20/7	10pm	INJ. PETHIDINE	50mg	IM	182217	PS EP

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I.V. FLUIDS CHART

Weight. 55 kg Ward. 2nd

Date	Time	Composition of Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
21/7/26	6 AM	IVF 10 RL	IV	75 cc/hr	22/7/26	SK	21/7		SK
21/7	8.10 am to	RL 10	IV	over		PT SK	21/7		PT SK
21/7	11.15 am	RL 10	IV	3.0 hrs		PT SK	21/7		PT SK
21/7		RL 10	IV			PT SK	21/7		PT SK
21/7	11.15 am	RL 10	IV	over 2 hrs		PT SK	21/7		PT SK
21/7	12.30 pm	RL 10	IV	rushed		PT SK	21/7		PT

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

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STAT / ONCE ONLY DRUGS

Name: ..... Weight: ..... kgs

Sheet No: .....

DATE	TIME	MEDICATION	DOSAGE & OTHER INSTRUCTIONS	ROUTE	SIGNATURE		
					Doctor	Nurse-1	Nurse-2
22/7/21	10 pm	INJ PHENERGAN	25mg	Im	[signature] 22/7	ES	SP

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Observation Score Chart - Obstetrics

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

21/7

		Date																						
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20																							20bt		
	0 - 10																									
Saturations	94 - 100 %																							98		
	< 94 %																									
Administered O_2 (L/min.)																								RA		
Temp°c	40																									
	39																									
	38																									
	37																							37.6		
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
	40																							80bt		
Systolic Blood Pressure ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120																							117		
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
	40																							64		
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																								—		
TOTAL ORANGE SCORES																								—		
Nurse Initial																								9		

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(2)

Early Warning Observation Score Chart - Obstetrics

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

2/7/26

		8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
Date		2/7/26																							
RESP (write rate in corresp. box)	11 - 20			20		20	20	20	20	19	19	19	20	22	22	20		22				21			
Saturations	94 - 100 %			98		99	99	99	100	100	100	100	100	99	99	99		99				99			
Administered O_2 (L/min.)																						RA			
Temp °C				97.8		98.1	98	98	98	98F	98F	98	98		98.4	98		97.6F				98F			
Heart Rate				87b/m		70b/m	70	80	70	71	77	78	76	85	84	82		80				78/m			
Systolic Blood Pressure				110		100	100	112	114	118	100	112	100	110	114	116		120			(70)	118			
Diastolic Blood Pressure				60		80	80	60	60	60	60	70	80	70	74	70		76				60			
NEURO RESPONSE [✓]	Alert			✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓				✓			
URINE mls / hour	> 30			✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓						✓			
Proteinuria	Protein + +																								
Lochia	Normal			✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓				✓			
Liquor	Clear / Pink			✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓						✓			
TOTAL YELLOW SCORES				–		–	–	–	0	0	0	0	0	0	0	0		0				0			
TOTAL ORANGE SCORES				–		–	–	0	0	0	0	0	0	0	0	0		0				0			
Nurse Initial				[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]				[illegible]			

Printed row bands: RESP > 30, 21 - 30, 11 - 20, 0 - 10; Saturations 94 - 100 %, < 94 %; Temp °C 40, 39, 38, 37, 36, 35, < 35; Heart Rate 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40; Systolic Blood Pressure 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50; Diastolic Blood Pressure 130, 120, 110, 100, 90, 80, 70, 60, 50, 40; NEURO RESPONSE Alert, Voice, Pain, Unresponsive; URINE > 30, < 30; Proteinuria Protein + +, Protein > + +; Lochia Normal, Heavy / Foul; Liquor Clear / Pink, Green.

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42 Y 8 M 26 D (F)

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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.

21/4/26		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am	Patient Received from LDR @ 5am										
	05:00 am	00		125						0		dy
	06:00 am	P		125					200	0		dy
	07:00 am	0		125						0		dy
Total Intake :		375ml				Total Output :			200ml			

Total 24 hrs. Intake	375ml	Total 24 hrs. Output	200 ml

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FLUID CHART

Sheet No. : .....

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

Date	Time	Intake: 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 Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am		NPO								0	
	09:00 am		NPO	500ml							0	
	10:00 am		NPO	500ml						100ml	0	
	11:00 am		NPO	500ml							0	
	12:00 pm		NPO	500ml							0	
	01:00 pm		NPO							250ml	0	
Total Intake :			2000ml			**Total Output :**				350ml		
	02:00 pm	N		125						100	0	
	03:00 pm			125						200	0	
	04:00 pm	P		125						200	0	
	05:00 pm			125						150	0	
	06:00 pm	O		125						100	0	
	07:00 pm			125						100	0	
Total Intake :		750ml				**Total Output :**				850ml		
	08:00 pm	cntw	100ml	ns						150ml		
	09:00 pm			125						250	0	
	10:00 pm	H2o	100m	125						150	0	
	11:00 pm			125						150	0	
	12:00 am	Tcwat	150m	125						150	0	
	01:00 am			125						200m		
Total Intake :		250+750=	1100m			**Total Output :**				500ml		
	02:00 am			125m						250m	0	
	03:00 am	Tcwa	100m	125m						200m	0	
	04:00 am			125m						100ml	0	
	05:00 am			125m						150m	0	
	06:00 am	Tcw	150m	125m						100ml	0	
	07:00 am			125						100ml	0	
Total Intake :		250+750=	1120m			**Total Output :**				1000m		

Total 24 hrs. Intake	4950m	Total 24 hrs. Output	2700m

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NURSING CARE RECORD

Date: 20/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning		—		—	—	—	
Afternoon							
Night	5am	Maintain Personal Hygiene.		Assessed patient condition Maintain vital sign's and I/O chart. Maintain hand hygiene.	Maintain Hand hygiene.	Reassessment was done. vital are stable	[signature] 08950

Docu. No: RCH /FRM / CLINICAL / 148

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NURSING CARE RECORD

Date: 21/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning				I			
Afternoon	2pm	Achieve Acceptable pain control & comfort	2:30 pm	Assess pain using pain scale regularly position pt comfortably	patient was stable	Reassessment was done	Abdulla 0180
Night	8pm	Achieve acceptance pain control & comfort	8:30 pm	Assess pain using pain scale regularly. Position pt comfortably.	Patient was stable.	Reassessment done	[illegible] 01173

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①

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NURSES NOTES

(USE BALL POINT PEN ONLY)

☐ No Knc

☐ Drug Allergies .... Nil ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		→ Receiving Notes On:- 20/7/26 ←
21/7/26	5am	patient Received from LDR patient
		come procedure patient.
		admission done patient is
		conscious and oriented — (signature)
		patient vital sign's checked 018950
		and Recorded vital are stable —
	5.30am	patient part preparation done.
		Patient Iv cannula insert — (signature)
		patient NPO On morning 1am — 018950
		patient Blood requestion given.
		patient complaint's of heavy
		menstrual bleeding 1year during cycles
		On 2/3 days changes 1pad every
		2hour patient clots ⊕ no dysmonorrhea
		patient inj 7cm twice On 1st and
		10th july taken HB:7g/dl Repeat
		HB: 9.9g/dl today plan for (signature)
	6AM	total Laparoscopic Hysterectomy — 018950
		patient reservation ② PRBC, 1unit
		FFP
	6:30AM	Patient inj Supceff 0.1ml given -
		inj pan 40mg and inj Emeset 4mg
		given as per doctor's Order — (signature)
		Patient vital are stable — 018950

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

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NURSES NOTES

(USE BALL POINT PEN ONLY)

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		→ continue 21/4/26 ←
21/4/26		Flo chart Maintained —
		Patient inj. Suceff. 1.5gm given no Adv any allergic reaction. — 018950
		patient Shifted to OT.
		Patient Report hand Over given to OT staff — Adv 018950
		OT Notes
21/4/26	8:10Am	=> patient received From LDR to OT. While receiving patient ID Band, Consent checked.
		=> Anaesthesia given by Dr. Sathish. Dr priyadharsini under General Anaesthesia.
		=> Foleys catheter insitu urine drain clear.
		=> painting and draping done under Aseptic precautions.
		=> Surgery done by Dr. Vaishnavi and Dr. Kisore reddy.
		=> Specimen collected and Sended to lab. Vaginal pack to be kept.
		=> Instrument count, Gauze count, mops count checked and correct. — 6-18
		=> patient had No allergic reaction during Blood Transfusion.

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00093943
Mrs ARUNA.K
25-10-1983
Dr. SELF
IP18-00036552
42 Y 8 M 26 D (F)

(2)

NURSES NOTES

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

☐ No Known Drug Allergies

☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
21/7/26			

ANNAI TERESA BLOOD BANK & APHERESIS CENTRE
(Run by Little Roses Trust)
LICENCE No.: 506/28C
No.946, 1st Floor, Bazaar Road, Ram Nagar (South) Madipakkam, Chennai - 91.
Ph.: 044-22580803 Mobile : 9840143108 / 9840333108 / 9566468884
E.mail : annaiteresabloodbank@gmail.com web: www.annaiteresabloodbank.com

CONCENTRATED HUMAN RED BLOOD CELLS I.P.
Prepared From Blood Collected with anticoagulant citrate phosphate dextrose solution. Whole blood 350 ml / 450 ml (IP 49ml / 63 ml)

BA	COLLECTION DATE	EXPIRY DATE	VOLUME
2984	18.7.26	29.8.26	280ml

INSTRUCTIONS :
1. Do not use if there is any visible evidence of deterioration.
2. Storage temperature 2°to 6°
3. Administer with warming.
4. Mix well before use and do not vent
5. Do not add any Medication.
6. Use a Fresh clean, Sterile Transfusion set with filter
7. Do not Dispense without Prescription.
8. Check blood group on the label and recipients blood group. before administration and properly identify intended recipient.
9. No Atypical antibodies detected
10. Shelf life 35 days / SAGM 42 Days.
11. Transfusion Criteria ABO and Rh Specific X-match compatible

BLOOD GROUP **B**
Rh. (D) POS

SCREENED : NEGATIVE / NON REACTIVE FOR : HBsAg, Anti HCV Anti HIV I & II, MP, VDRL, Irr, Ab - By CLIA METHOD
PREPARED FROM A VOLUNTARY BLOOD DONOR

Bag No: 2984.
Start time: 11:15 am.
End time: 12:40pm
Date of collection 18/7/24 Date of Expiry: 29/8/26.
Blood group: B+ve.

21/7/26.	1:30 pm	⇒ patient shifted To MICU and patient handover to MICU Staff.	

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NURSES NOTES

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☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Receiving Notes	
21/7/26	1:30pm	patient is receiving from	
		OT to MICU patient care	
		hand over taken from OT	
		Staff Nurse patient was	
		stable conscious & oriented	
		IV line present & pattern	
		catheter was present a uses	
		Output No Bleeding PV	
		patient general condition	
		fair No complaints →	Akalya
	3pm	patient was stable	01808
		conscious & oriented IV fluids	
		On going RL 500ml 100ml/h	
		ongoing No complaints →	Akalya
	4pm	patient vitals are stable	01808
		No Bleeding patient is sleeping	
		pt NPO 6hrs →	Akalya
	6pm	Dr: Vinitha DD removed	01808
		vaginal ball patient vital	
		are stable maintained TPO	
		chart →	Akalya
	7pm	⇒ Dr: Vinitha Advised to	01808
		start sips 100ml water given to	
		pt No vomiting so TC water	
		100ml given to patient	
		Inj: Supacef 1.5 gm given →	Akalya 01808

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(3)

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NURSES NOTES

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☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
21/7/26	7:30 pm	⇒ patient care hand over given to Night duty staff Nurse	D. Akalya 018080
		⇒ Night Duty ⇐	
21/7/26	7.30pm	Patient report hand over taken from evening duty staff. She is conscious & oriented, afebrile. Dealing & tolerating well. CBD urine drained clear & adequate.	
	8pm	⇒ Patient vital signs stable - General condition fair	⇒ [illegible] 011726
	8.25pm	⇒ S/B Dr. Divya Advice to plan shift to ward. Orders carry out. Pt complaints of mild abdominal pain. Inf to Dr. Dhivya mam. Advice Inj Pcm 1gm IV given. Orders carry out	⇒ [illegible] 011726
	9pm	⇒ Patient shift to ward. hand over to 7th floor staff	⇒ [illegible] 011726
		Receiving Notes 21/7/2026	
		Patient Conditions and details handing Over taken from LDR staff Nurse pt on Conscious	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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☑ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
21/7/20		Arnemeded, forges present	
		at clear. I v line present	
	10PM	IVF:- DNS 125ml started	
		oral Encourage 2nd hourly	
		taken liquids flows	
	11PM	patient same more pain	
		inj:- Phethine 50mg	
		and inj: phegradron 1ml	[signature]
		IM given done for	
		long sleeping	
22/7/20	12AM	vital signs are Mornitored	
		and Recorded done H.D stable	
	1AM	due Medications given	
		and To fallow drug chart	
	2AM	patient have sleeping	
		well and provide comfortable	
		positioning	[signature] 021875
	4AM	Recheck the vital signs	
		H.D stable and continue	
		IV fluids	
	6AM	ReAdsu the the pain Manage	
		ment, and moonitoure	
	7AM	Medication given as per order	
	7-30AM	patient Details handing	
		Over given to Morning	
		duty staff Nurse	[signature]

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OPERATION NOTES

Surgeon : Dr VAISHNAVI	Asst. Surgeon : Dr Kishore Reddy
Anesthetist : Dr Priya	OT Nurse : S/N. Sasi, S/N. Siva.

Pre-Operative Diagnosis: Fibroid uterus

Surgical Procedure : TLH

Weight :	Date : 21/7/26	Start Time : 8.45am	End Time : 12 30 pm

Post Operative Diagnosis:

Peri-Operative Complications: Blood loss

Operation Notes: UGETA, Parts painted and draped, bladder catheterised

Findings: Pneumoperitoneum created using Veress needle. Uterus ~16-18w gravid size. Hysterectomy proceeded by coagulating and cutting round ligament, ovarian ligament, uterine vessels. Specimen removed after by partial uterosacral, McKendles ligament

Procedure Notes: morcelation and vaginally Vault closure done. Complete hemostasis achieved. Specimen sent for HPE.

Findings - Uterus enlarged
B/L tubes, ovaries (N)

Amount of Blood Loss: 200 - 250 ml	Blood Transfused (in ML) 1(1) PRBC

Name and Number of Surgical Specimen sent for examination:
Uterus with tubes

(P.T.O.)

Doc. No. : RCH / FRM / CLINICAL / 099

Patient Sticker

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POST-SURGICAL CARE PLAN FORM

Post-Operative Monitoring Parameters /Frequency:	- Npox 6hrs - IVF 1/5 20 NS 10 K / 10% / D / 100ml / hr
Wound Care:	
Drain /Special Lines/Catheters:	- CBD / I/O chart / PTR charting
Special Patient Positioning and Requirements:	- Inj. Supacef 1.5g iv bd (night dose)
Nutritional Instructions:	- Inj Pan 40mg iv bd
When to Start Mobilization:	Inj Neomol 1g iv tds - Inj Emeset 1cc + Inj Phenergan 1cc / iv HS.
Special Referrals:	- Anfemin fres
The new order for all required medications documented in the doctor order/medication sheet: ☐ Yes ☐ No	
Any Other Post-Operative Care Needed including Required Follow Up	- Vaginal pack to be removed @ 6 pm today

Name of the Surgeon: Dr VAISHNAVI

Signature of the Surgeon: [signature]

Date & Time: 21/3/26; 1pm 1030095

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	21/7/26	21/7/26	21/7/26
		Score			
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			
	No	0	0		
GAIT / Transferring	Impaired	20		20	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	0	0
Total Morse Fall Scale Score:				20	20
		Signature	21/7/26	21/7/26	

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

Patient Sticker

GUC-00093943 IP18-00036552
Mrs ARUNA.K
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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	M 22/7/26		
		Score			
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		
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0	0		
IV / Heparin Lock or Saline	Yes	20	20		
	No	0			
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			
Total Morse Fall Scale Score:			20		
		Signature	PV 60726		

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

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Risk Level and Interventions

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Mrs ARUNA.K
25-10-1983 42 Y 8 M 26 D (F)
Dr. SELF

BRADEN 'Q' SCALE

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					Date : 21/7/26	21/7	21/7	21/7
					Time : N	M	E	N
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	3	3	3
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR **Friction** . Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
				TOTAL SCORE	28	27	27	27
				Evaluator's Name	[illegible] 018900.	[illegible]	[illegible]	[illegible]

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

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

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

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BRADEN 'Q' SCALE

(2)

				Date :	22/7			
				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.	4			
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				TOTAL SCORE	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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PHLEBITIS ASSESSMENT

Patient's Name:..

MRD NO:.......... GUC-00093943 IP18-00036552
Mrs ARUNA.K
25-10-1983 42 Y 8 M 26 D (F)
Dr. SELF

Age :................ M ☐ F

Consultant :..

CANNULA 1

Date : 21/7/26 Time: 5.30am
Location : (1) metacarpal.
Size : 18g
Cannula inserted by : S/N. Nivitha.

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
21/7	8am	☐Yes ☐No	☐Yes ☐No	Observed	Ofy
	10AM	☐Yes ☐No	☐Yes ☐No	Obs	SP
	12pm	☐Yes ☐No	☐Yes ☐No	Obs	SP
	2PM	☐Yes ☐No	☐Yes ☐No	Obs	SP
	4pm	☐Yes ☐No	☐Yes ☐No	Obs	SP
	6pm	☐Yes ☐No	☐Yes ☐No	Obs	Sp2
	8pm	☐Yes ☐No	☐Yes ☐No	OM	[illegible]
	10PM	☐Yes ☐No	☐Yes ☐No	patten	[illegible]
22/8/26	12AM	☐Yes ☐No	☐Yes ☐No	patten	[illegible]
	2AM	☐Yes ☐No	☐Yes ☐No	path	[illegible]
	4AM	☐Yes ☐No	☐Yes ☐No	path	[illegible]
	6AM	☐Yes ☐No	☐Yes ☐No	path	M
	8AM	☐Yes ☐No	☐Yes ☐No	pattern	[illegible]
	10AM	☐Yes ☐No	☐Yes ☐No	Clee	P.G
	12PM	☐Yes ☐No	☐Yes ☐No	Clee	P.G
		☐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:

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		

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

PHLEBITIS ASSESSMENT AND MANAGEMENT RECORD

CANNULA 3

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		

Cannula removed : ☐Yes ☐No, if yes date and time :

RX any initiated : ☐Yes ☐No ☐NA If Yes specify-

Phlebitis score:

CANNULA 4

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		

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)

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

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BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient's Name:..

MRD NO:.............................Room No.:..................

Age :..................... Weight :...............Sex: ☐ M ☐ F

Consultant :..

PHLEBITIS ASSESSMENT

CANNULA 1

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		

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

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		

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

PHLEBITIS ASSESSMENT AND MANAGEMENT RECORD

CANNULA 3

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		

Cannula removed : ☐Yes ☐No, if yes date and time :

RX any initiated : ☐Yes ☐No ☐NA If Yes specify-

Phlebitis score:

CANNULA 4

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		

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)

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

GUC-00093943 IP18-00036552
Mrs ARUNA.K
25-10-1983 42 Y 8 M 26 D (F)
Dr. SELF

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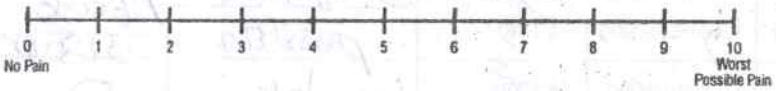
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
21/7/26	5am	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	Nil	[signature] 018950
21/7/26	8Am	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	[illegible]	[signature]
21/7/26	2pm	1/10	Back pain	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☑ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	comfortable position	[signature] 01808
21/7/26	8pm	1/10	leg pain	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☑ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	Comfort position	[signature]
22/7/26	2AM	1/10	back pain	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☑ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☐ Yes ☐ No	Inj: pethidine given IM	[signature]
22/7/26	8AM	1/10		☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☑ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☐ Yes ☑ No	positioning	[signature] 02875
20				☐ 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.

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

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

GUC-00093943
Mrs ARUNA.K
25-10-1983
Dr. SELF
IP18-00036552
42 Y 8 M 26 D (F)

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PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
				☐ 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:

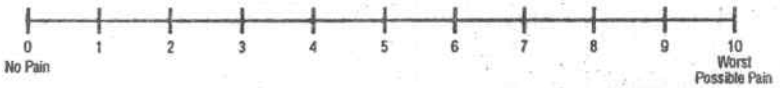
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
   a) At least every 2 hours for the first 24 hours
   b) Then every 4 hours.
   c) Prior to pain pain-relieving intervention.
   d) Within 30 – 60 minutes after pain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

Docu.No: RCH /FRM / CLINICAL / 152

(P.T.O)

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

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

GUC-00093943 IP18-00036
Mrs ARUNA.K
25-10-1983 42 Y 8 M 26 D (F)
Dr. SELF

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INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECO

Part - I.
Patient's / Learner Language: Tamil, English Patient / Learner Literacy: ☒ Read ☐ Write ☐ Speak Willingness to Learn: Yes ☐ No ☐ Healthcare Literacy: Yes ☐ No ☐

Identified Education Needs:

1. Diagnosis
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		
21/11/26	5am	treatment care	Explain about treatment care	Patient	No learning Barriers	Oral	None	Verbalized understanding	good	018950
22/11/26	10 Am	yes	Explian about Drugs Intake	patient	NO	Oral	None	yes	Good	Pfizer

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

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Vaishnavi
Asst. Surgeon : Dr. Kisore
Anaesthetist : Dr. Sathish, Dr. priyadh
Scrub Nurse : S/N. sasi, S/N. siva

GUC-00093943 IP18-00036552
Mrs ARUNA.K
25-10-1983 42 Y 8 M 26 D (F)
Dr. SELF

..... Age : ..... Gender : .....
jery Name : .....
8:10AM Out-time : 1:30pm

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 8:15AM

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 : 15/10/25
Name : Dr Priyadharshini

Before Skin Incision ➤➤

TIME OUT Time: 8:40AM

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 : 10/10/25
Name : Dr. Vaishnavi

Before Patient Leaves Operating Room

SIGN OUT Time: 1:30pm

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

6 Type ISO 11140 | STEAM | Green = Sterilized | Man.: 2025 - 06 | Exp.: 2030 - 06 | Ref.: 106.303.0500 | Lot.: 14176 | SV: 121°C - 15 min. 134°C - 3,5 min. | Sterintech

Signature : Sasi 01322
Name : S/N. Sasi, S/N. Siva

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

INFORMED CONSENT FOR SPECIAL PROCEDURE

GUC-00093943
Mrs ARUNA.K
25-10-1983
Dr. SELF
IP18-00036552
42 Y 8 M 26 D (F)

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Patient Name : ARUNA. ☑ Female Age : 42yrs.

UHID No : G.U.C-00093943. Date : 21/7/26.

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

I hereby authorize the performance of the following operation (s) or procedure (s) (use no abbreviation / Avoid technical terms)
TOTAL LAPAROSCOPIC HYSTERECTOMY WITH OR WITHOUT BILATERAL SALPINGO-OOPHORECTOMY
upon ARUNA.
(Name of the Patient)

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

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

I have been explained that the following complications though rare are possible and will not hold Surgeon, Anesthesiologist or the hospital staff responsible for any untoward event thereof.
INFECTION, BLEEDING, BOWEL, BLADDER INJURY,
BLOOD TRANSFUSION, HIGH RISK DUE TO ANEMIA,

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

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

Consentee :
Signature : K. Aruna
Name : Aruna
Date & Time : 21/7/26.

Patient Attendant :
Signature :
Name : JAYARAJ
Relationship with Patient: husband
Date & Time : 21/7/26.

Witness :
Signature :
Name :
Date & Time :

Doctor (who is taking the consent) :
Signature : 128935
Name : Dr. Vaishnavi
Date & Time : 21/7/26

Dr. VAISHNAVI

Docu. No. : RCH /FRM / CLINICAL / 027

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CONSENT FORM FOR GENERAL / REGIONAL ANESTHESIA / MAC

GUC-00093943
Mrs ARUNA.K
25-10-1983
Dr. SELF
IP18-00036552
42 Y 8 M 26 D (F)

Patient Name : ..... Age : .....

Gender : M ☐ F ☐ - IP No : ..... Consultant : .....

Ward / Bed No. : ..... Anaesthesiologist : DR SATHISH / DR PRIYA

Operative procedure planned : TOTAL LAPAROSCOPIC HYSTERECTOMY

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

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

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

☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure

☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma / RTA

☐ Incapacitating COPD ☐ Others : .....

Comments : HYPOTENSION, BRADYCARDIA, 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 I my patient ..... the above mentioned operation I Diagnostic I Therapeutic procedures .....

I authorize and give consent for anaesthesia (☐ Regional / ☑ General Anesthesia / ☐ Monitored anesthesia care (MAC)) as considered appropriate by the anaesthetic team.

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

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

I authorize the anaesthetic team to perform any additional procedures (for example, CVP 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 I her will administer the Anaesthesia.

Pregnant: ☐ Yes ☐ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

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

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

Patient / ~~Patient Attendant~~ :

Signature : .....

Name : ..... Mrs. ARUNA.K .....

Relationship with Patient: ..... Patient .....

Date & Time : ..... 21/7/26. .....

Witness :

Signature : .....

Name : ..... MR. JAHARAT (HUSBAND) .....

Date & Time : .....

Doctor (who is taking the consent) :

Signature : .....

Name : ..... Dr. Brijesh Sharma .....

Date & Time : ..... 21/7/26 7.20am .....

GUC-00093943 IP18-00036552
Mrs ARUNA.K
25-10-1983 42 Y 8 M 26 D (F)
Dr. SELF

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Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

Name: ARUNA Age: 42 Y Sex: F UHID.No :

Date: 16/7/26 Time: 12pm Proposed Operation: ~~Endometrial biopsy~~ & TLH

Diagnosis:

B.P / CRT: 100/70 H.R: 74/min Weight: 64kg ASA Physical Status: ☑1 ☐2 ☐3 ☐4 ☐5

Laboratory Data:

Hgb: 8.3 → 9.9	Glucose	9% Protein:		HIV:		X-Ray:	
PCV:		Urea: 17	Alb:	HBS Ag:		ECG:	Echo NAD
WBC:		Creat: 0.7	Total Bili:	HCV:		2D Echo:	
Plate: 4.6		Na: 142	Dir. Bili:	Blood group: B +ve		Stress/Angio:	
PT:		K: 4.7	LDH:	T3		Other:	
PTT: 34		Ca++:	Alk phos:	T4		Inves pend	
INR: 0.97		Mg++:	Amylase:	TSH 2.48			
		Cl -:	SGOT/SGPT:	**Allergies:** Nil			

Medical History: CVS :

RESP : Diabetes :

CNS : · No H/o DM / HT / CAD / prev surg / Fits

Renal :

Hepatic / GE : Physical Activity:

Others : No H/o Fever / cold /

Past Anaesthetic History:

Physical Exam: On Iron Infusion

Airway: MP 1 2 3 4 Mouth Opening: Nil Mentohyoid Distance: NL Neck: Teeth:

Lungs : BAE (P)

Heart: S1S2 (+)

CNS: NAD

Pregnant: ☐ Yes ☐ No ☐ NA | Venous Access Site : | Spine Exam for regional :

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours; → Others 6 Hours
3. Informed Consent: ☐ Standard ☐ High Risk
4. Post Operative Pain Management: ☐ Discussed with Patient
5. Other Instructions:

To Reserve 2 PRBC
1 FFP

Signature: [signature] Name: CESAT4YA CUTANDay

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

Patient Sticker

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No — Fasting Status: > 6 hrs

Physical Status: Patient Identified ✓ — ☐ Consent Present — ☑ Chart Reviewed

H.R: 80/min | B.P / CRT: 110/70 | SpO_2: 100 % | R.R: 16/min | Last Feed:

Pre-OP Diagnosis: AUB - L | Operation: TLH +/- BSO | Date :

Surgeon: Dr Kishore / Dr Vaishnavi | Anaesthesiologist: Dr Rathish / Dr Preeja | Technician: MM Anwar

TIME: 8am 9am 10am 11am 12pm 1.15pm

N_2O /AIR/O_2 LPM: 0.3: 0.7

HALO /ISO /SEVO: 2%

Drugs:
Inj Fentanyl 100mg IV + 50+50mg IV
Inj Propofol 150mg IV
Inj Atracurium 25mg IV
Inj Paracip 1g IV
Inj Dexa 8mg IV
Inj Teapic 1g IV
4 s/lb 16mg/hr IV infusion

FIO_2 / SaO_2: 0.5
$ETCO_2$: 35-40
ECG: sinus rhythm
Temperature
Urine Output

Antibiotic
Suppository
Blood Loss
NOTES

Fluids: 10 RL, 20 RL, 30 RL, 10 PRBC, 40 RL

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

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

LAB Values: ABG, GRBS, Others

☑ Equipment Checked and Functional
☑ BP
☑ Cuff Site: (R) arm
☐ Art Site:
☑ EKG Lead
☐ Temp Site
☑ FIO_2 Monitor
☑ Agent Monitor
☑ Pulse Oximeter
☐ Capnograph
☐ Ventilator
☑ Nerve Stimulator

Position: low lithotomy
☐ Pressure Points Checked

Eye Care:
☐ Oint
☑ Tape
☐ Padding
☐ Awake

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

Times:
Anaes Start: 8 am
OP Start: 8.40 am
OP End: 1.00 pm
Leave OR: 1.20 pm

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP:
☐ ART:
☐ IV: 18 Gr (L) VL
☐ IV
☐ IV:

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

☐ Mask ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
☑ ETT# 7 at 21 cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug:

☐ Awake ☑ Direct Vision
☐ Video Laryngoscopy ☑ Stylette / Bougie
☐ Fiberoptic
Blade# 3 Attempts: 1
Difficulty Why?

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

Regional:
Extremity Specify:
☐ Spinal ☐ Epidural ☑ Caudal
Others: ↓ APP
Position: USG guided
Site: B/L TAP
Needle Size: Depth:
Parasthesia ☐ Yes ☐ No
Catheter at skin
Drug Name & Conc: with 20ml
Bolus:
Infusion: 0.2% ROPIN
Block Level:
Comments: on each side
Transportation to
☐ PACU ☑ ICU ☐ Other
Relaxant Reversed ☑ Yes ☐ No ☐ NA
Name of the Doctor: Dr Pujari R
Signature of the Doctor:
15/6/22

Patient Sticker

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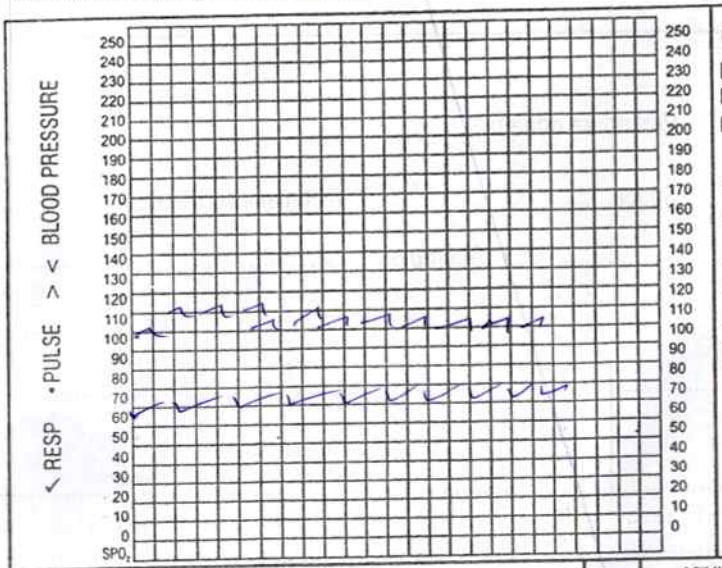
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Thanu Time Received : 1:34pm Time Discharged : 1:34pm



IV Cannula Site : .....

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

Vomiting : ☐ Yes ☐ No Drug: .....
NG Tube : ☐ Yes ☐ No
Drain: ☐ Yes ☐ No
Urinary Catheter: ☐ Yes ☐ No
Chest Tube: ☐ Yes ☐ No
Nil Oral ☐ Yes ☐ No

IV Fluids: .....
Oral Feeds: .....

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
21/7/26	1.25pm	0/10	NPO x 6 hours	1:34pm
			Repeat- CBC	

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

Anaesthesiologist Name : Dr Puja R

Anaesthesiologist Signature: 1:34pm

Date & Time: 21/7/26 1.25pm

PACU Nurse Name : Thanu

PACU Nurse Signature:

*Date & Time: 21/7/26 @ 1:20pm

Reassessment Frequency:

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

Transferred to Unit by (PACU): .....

Date & Time: 21/7/26 @ 1:34pm

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: ..... Time: ..... Procedure done by .....

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

Depth: ..... Catheter at Skin: ..... Attempts : .....

Parasthesia : Yes/No if yes details : .....

Solution Composition : .....

Any other issues :

a) .....

b) .....

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

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

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

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

GUC-00093943 IP18-00036552
Mrs ARUNA.K
25-10-1983 42 Y 8 M 26 D (F)
Dr. SELF

PRE - OPERATIVE CHECK LIST

Date: 21/7/26

Patient's Name : Mrs. Aruna Age : 42year Gender : ☐ M ☑ F

Blood Group : B+ve UHID : 93943

Planned Surgery : D&C Surgeon : Dr. Vaishnavi

Anesthetist : Dr. Ranjith Date & Time of Operation : 21/7/26

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 :

Billing Executive Signature : [signature]

Date & Time :

Nurse In-Charge Name : S. Nath

Signature of Nurse In-Charge : 011746

Date & Time : 21/7/26

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

Pati GUC-00093943 IP18-00036552
Mrs ARUNA.K
25-10-1983 42 Y 8 M 26 D (F)
Dr. SELF

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RICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 21/7/18

Baseline Information:

Admission From: ☐ ER ☐ OPD ☑ Admission Desk ☐ Others, specify IOL

Primary Language: ☐ Telugu ☑ English ☐ Hindi ☐ Others, specify ....

Do you require an interpreter? ☐ Yes ☑ No If Yes specify ....

Source of Information: ☑ Patient ☐ Family ☐ Others, specify ....

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

If yes, identify ....

Chief Complaints: B... NVD LCB 10yrs. AUB-2 TLH.

Doctor Notified on Admission: ☐ Yes ☐ No
Name of the Doctor: ....
Time Notified: ....

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Nil	Nil	Nil

Gynecology Assessment: ☐ Not Applicable	Gynecology Surgical History:	Gynecological History:
Menstrual History:	Caesarean Section: ☐ No ☐ Yes	Contraceptives: ☐ No ☐ Yes
....	Cervical Cerclage: ☐ No ☐ Yes	Vaginal Discharge: ☐ No ☐ Yes
Onset of Menarche:	Ectopic Pregnancy: ☐ No ☐ Yes	Post-Coital Bleeding: ☐ No ☐ Yes
Menstrual Cycle: ☑ Regular ☐ Irregular	Myomectomy: ☐ No ☐ Yes	Infertility: ☐ No ☐ Yes
Last Menstrual Period:	Others: ______	If Yes Type: ☐ Primary ☐ Secondary

Obstetric History: G — P 2 L 2 A —

Previous LSCS: Nil

Current Medication: ☑ None ☐ Yes, If Yes, Fill the reconciliation form

Family History: ☐ No Abnormalities Detected

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

☐ Liver disease ☐ Other ....

Vital Signs / Measurements: Temp: 98°F HR: 84/min RR: 24/min
BP: 110/70 Weight: 85 kgs. Height: 162cm BMI: ....

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

Patient Sticker

PHYSICAL ASSESSMENT

General Appearance: ☑ Healthy ☐ ill looking ☐ Anxious ☐ Agitated ☐ Others: .....

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

Risk of Pressure Sore: ☑ Yes ☐ No Score ..0/10..... (complete the Braden Q Sheet)

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

☐ Mobility problem ☐ Walking Problem ☑ No Abnormality Detected

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☐ No Abnormality Detected

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

☐ Under Weight ☐ Diabetes Mellitus ☐ Hyperemesis Gravidarum

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

☐ Others .....

Inform consultant for positive criteria

SOCIAL SCREENING:

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

Social History: Lives With ..... Family .....

Orientation has been given regarding the following aspects:

Call Bell in Reach : ☑ Yes ☐ No Waste Disposal Explained: ☑ Yes ☐ No

Infusion Pump : ☑ Yes ☐ No Hand Hygiene Explained: ☑ Yes ☐ No ☐ Others

Above information given to ..... Mrs. Aruna .....

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

Orientation not given Reason: .....

Nurse Signature: ..... 21/7/26 .....

Nurse Name: ..... B. NIVETHA .....

Date & Time: ..... 21/7/26 .....

Patient GUC-00093943 IP18-00036552
Mrs ARUNA.K
25-10-1983 42 Y 8 M 26 D (F)
Dr. SELF

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RI[illegible]OOL FOR DEEP VEIN THROMBOSIS

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

Date: 21/7/26

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		
Signature of the Nurse		
Action Plan		

RISK ASSESSMENT FOR VENOUS THROMBOEMBOLISM (VTE)

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

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

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PATIENT TRANSFER FORM

GUC-00093943 IP18-00036552 Mrs ARUNA.K 25-10-1983 42 Y 8 M 26 D (F) Dr. SELF	Date & Time of Admission 21/7/26 @6am	Date & Time of Transfer Order 21/7/26 at 8:40Am
Treating Consultant Name Dr. Vaishnavi	Transfer Ordered by Dr. Akstha	Reason for Transfer [illegible]
From Unit 2102	To Unit OT	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File [illegible]	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
S/N [illegible] / 011740	Dr. Akstha

Patient & Clinical Records Received by : [signature] 007891

Date & Time of Patient Received : 21/7/26 @ 8:35

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

Docu. No. : RCH /FRM / CLINICAL / 102

PATIENT TRANSFER FORM

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GUC-00093943 IP18-00036552
Mrs ARUNA.K
25-10-1983 42 Y 8 M 26 D (F)
Dr. SELF

	Date & Time of Admission	Date & Time of Transfer Order
	21/7/26 @ 4:20 Am	21/7/26 @ 1:30 pm
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr. Vaishnavi	Dr. Salthish	For Further Management
From Unit	**To Unit**	**Information to Attendant**
OT	NICU.	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
1 Ipfile	—	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
GG1671	Dr. Salthish

Patient & Clinical Records Received by : S/N Akalya 018088

Date & Time of Patient Received : 21/7/2026

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-00093943 IP18-00036552
Mrs ARUNA.K
25-10-1983 42 Y 8 M 26 D (F)
Dr. SELF

FORM

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	Date & Time of Admission	Date & Time of Transfer Order
Treating Consultant Name	Transfer Ordered by	Reason for Transfer
From Unit	To Unit	Information to Attendant Yes ☐ No ☐
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

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

Patient & Clinical Records Received by :

Date & Time of Patient Received :

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

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

GUC-00093943 IP18-00036552
Mrs ARUNA.K
25-10-1983 42 Y 8 M 26 D (F)
Dr. SELF

6 Type ISO 11140 | STEAM | Green = Sterilized | Man.: 2025 - 06 | Exp.: 2030 - 06 | Ref.: 106.303.0500 | Lot.: 14176 | SV: 121°C - 15 min. 134°C - 3,5 min. | Sterintech

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URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 21/7/26 Date of Removal: 22/7/26

Parameters	Date / Shift Time	21/7/26	21/7/26 E	21/7/26 N	22/7/26			
Need for the Catheter		☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hand Hygiene		☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Usage of Sterile Equipment		☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the Collection bag below the level of bladder		☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Check the Tube for Obstruction (Free of Kinking)		☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Catheter dated as policy		☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Collecting bag is been emptied regularly?		☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Maintenance of closed system for the catheter		☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing clean and dry?		☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the line removed as Policy?		☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No
Performance of Perineal Care		☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Onset of New Fever		☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Asses for the leakage at the site of insertion		☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Nurse		Thanu	Abdulla					
Signature of the Nurse		60727	61808	21/7/26				

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

RAINBOW CHILDREN'S MEDICARE LIMITED
157 - 160, Anna Salai, Guindy, Chennai - 600 015.

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Sl.No. 2554

NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name : Ms. ARUNA K		Age: 42y	Gender: F
UHID No: 93743	IP No: 36552	Date: 21/07/26	Date: 21/07/26
Diagnosis: P2L2 / POST [illegible] / DUB / [illegible]			Time: 8:45pm

PRESCRIPTION DETAILS (Tick only one of the following)

S.No.	Drug Name	Dosage / No. Vials / Ampoule	Remarks
1.	Inj Fentanyl Citrate (100 mcg/2ml)		
2.	Fentanyl Citrate 25 mcg patch		
3.	Morphine Inj 10 MG / ML		
4.	Pethidine 50 MG / 1ML	50mg (1)	

Doctor Name: Dr. ANANDHALSWARI

Doctors Medical Council Registration No. 126007

Signature:

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

IP Registration No: 18-00036552

Date: 21/07/26

Aadhaar No. of the patient(optional):

		Remarks
1.	**Name**	
2.	Complete postal address (with contact number, if any)	10/3A, [illegible] Street, Jafferkanpet, Ashok Nagar, Chennai
3.	Brief description of the illness	P2L2 / POST [illegible] / DUB [illegible]
4.	Whether registered with any other registered medical practioner / recognized medical institution (if yes, details to be recorded)	
5.	Details of essential narcotic drugs dispensed	

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient	Remarks, if any
21/07/26	Inj PETHIDINE 50mg	(1)		

Dispensed by (Name & ID No.): [illegible] 070772

Received by (Name & ID No.): Punyamgai E

Time: 10:1 pm

Signature:

Signature:

Docu. No: RCHBH /FRM / CLINICAL / 133

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Sl.No. 2554

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BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Ref. No. : F / HW / BTM / NSG / 03

GUC-00093943 IP18-00036552
Mrs ARUNA.K
25-10-1983 42 Y 8 M 26 D (F)
Dr. SELF

Name of the patient : Mrs. Aruna. K UHID : 93943 I.P. No. : 36552

Age : 49 y Gender : Female Department : OT Ward : OT

Blood group of the patient : B+ve Blood group on the Blood bag : B+ve

Blood bank issue no : 2924 Date of collection : 18/7/26 Date of expiry : 29/8/26

Date & Time of starting transfusion : 21/7/26 @ 11:15AM Planned duration of transfusion : 21/7/26 @ 12:40pm

PLEASE MONITOR THE FOLLOWING EVERY 30 MINUTES

Time	HR	Temperature	Blood pressure	SpO_2	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
11 AM	70 b/m	98.2°F	120/90 mmHg	100%	✓	—	—	—
11:15 AM	70 b/m	98.2°F	120/80 mmHg	100%	-	-	—	—
11:30 AM	72 b/m	98.4°F	120/90 mmHg	100%	-	-	-	-
11:45 AM	76 b/m	98.4°F	120/80 mmHg	100%	-	-	-	-
12 pm	72 b/m	98.2°F	100/60 mmHg	100%	-	-	-	-
12:15 PM	62 b/m	98.4°F	100/60 mmHg	99%	-	-	-	-
12:30 PM	62 b/m	98.4°F	110/70 mmHg	99%	-	-	-	-
12:40 PM	62 b/m	98.4°F	100/60 mmHg	99%	-	-	-	-

Comments : No Allergic Reaction

Nurse Name : Thanushya. Nurse Signature :

ANNAI TERESA BLOOD BANK & APHERESIS CENTRE

(Run by Little Roses Trust)

LICENCE No.: 506/28C

No.946, 1st Floor, Bazzar Road, Ram Nagar (South) Madipakkam, Chennai - 91. Ph.: 044-22580803, 48616108
Mobile : 9840143108, 9840333108 E.mail : annaiteresabloodbank@gmail.com web : www.annaiteresabloodbank.com

COMPATIBILITY REPORT

Patient's Name: Mrs. ARUNA Age: 42 Sex: F

Patient's Blood Group & Rh Typing: B pos IP No: — Ward: —

Hospital Name: Pain bow Hospital (Chennai)

Bag Blood Group & Rh Typing: B pos DATE: 21.07.26 TIME: 7.10 Am

S.No.	BAG NUMBER	COMPONENTS	DATE OF COLLECTION	DATE OF EXPIRY	SEG.No.
1	2984	PRBC	18.7.26	29.8.26	bE209790

Major X Matching : Saline / Alb / AHG / Column (Gel)

Minor X Matching : Saline / Alb / AHG / Column (Gel)

COMPATIBLE

Cross Matched by K. Vani Checked by

Dr. C. FLORENCE, MBBS
(Reg. No. 127546)
Medical Officer

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GUC-00093943
Mrs ARUNA.K
25-10-1983
Dr. SELF
IP18-00036552
42 Y 8 M 26 D (F)

CONSENT FOR BLOOD TRANSFUSION

Patient Name : ....1..1..... Age: ..... Gender :.....

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

Type of Blood Product : .....

I ..... hereby give my consent for whole blood transfusion / blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for HIV antibodies, Hepatitis B surface antigens, Hepatitis C antibodies, Malaria and Syphilla. I have also been explained that transfusion transmitted infections can vary rarely occur even with screened blood, especially if it is in the "window period" and also due to various other infections which have not been screened for. I also understand that any blood component transfusions carry risk of transfusion associated reactions.

All the above-mentioned risks have been explained to me by the doctor treating me / my patient in the language that I fully understand and I accept the same and give my consent for the whole blood component transfusion to me / my Patient named .....

R.JAYARAJ
Name of Patient / Attendant

Signature of Patient / Attendant

Date 21/7/26

Time : 11 Am.

Relationship with Patient: -

GUC-00093943 IP18-00036552
Mrs ARUNA.K
25-10-1983 42 Y 8 M 26 D (F)
Dr. SELF

BirthRight | Rainbow Children's Hospital

PATIENT TRANSFER NURSING HANDOVER CHECKLIST

Date & Time of Transfer: 26/8 **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	NO	
	c.Catheter secure & urine output recorded	NO	
	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	NO	
	b.Bed/side rails up and brakes applied	No	
	c.Special positioning maintained as per surgery	Yes	
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**	Yes	
10	**REPORTS AND LABS HANDED OVER**	Yes	
11	**BIOPSY/HPE SENT**	NO	
12	**Documentation**		
	a.Documentation completeness	Yes	
	Transferring Nurse: _____	Mary	
	Receiving Nurse : _____	[illegible]	
	Signature of Incharge:	Anu.	

GUC-00093943 IP18-00036552
Mrs ARUNA.K
25-10-1983 42 Y 8 M 26 D (F)
Dr. SELF

BirthRight | Rainbow Children's Hospital

PATIENT TRANSFER NURSING HANDOVER CHECKLIST

Date & Time of Transfer: 21/7/26 @ 1:30pm **TRANSFERRED TO :** NICU

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

GUC-00093943 IP18-00036552
Mrs ARUNA.K
25-10-1983 42 Y 8 M 26 D (F)
Dr. SELF

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NUTRITIONAL ASSESSMENT FOR GYNEC PATIENTS

Date: 22/07/2026 Time: 12:20PM.

Origin: — Height: 162 Cm. Weight: 65 Kgs. BMI: 24.8 Kg/M²

Food Allergies: NIL.

Diagnosis: TOTAL LAPAROSCOPIC HYSTERECTOMY WITH OR WITHOUT BILATERAL SALPINGO-OOPHORECTOMY.

Medical History: NIL

Surgical History: NIL.

☐ Vegetarian ☑ Non-Vegetarian ☐ Vegan

Diet Advised: - Patient is on clear liquid diet. Patient is Stable. Oral intake is Better. Further Orders — Advised to take easy-digest foods — Mashed rice, Well-cooked Vegetables, Curd (etc.); Plenty of Oral fluids. Consume Small — frequent meals. Avoid Spicy, oily, Salty, Sugary, fried & Junk foods

Patient's / Attendant's

Signature: AC/Arun

Name: K. Aruna

Date & Time: 22/07/26 @ 12:20 PM.

Dietician's

Signature: A. Sadiya Parveen (61833.6)

Name: A. Sadiya Parveen

Date & Time: 22/07/26 @ 12:20 PM.

(P.T.O)

GUC-00093943 IP18-00036552
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SURGERY DETAILS

Date : 21/7/26

Patient Name: Mrs. Aruna.K Date of Birth: 25/10/1983 Age: 42y

Gender: Female Ward : OT UHID No.: 93943/36552

Date of Surgery: 21/7/26 ☒ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : TLH

Time in : 8:10 AM Time Out : 1:25pm

		NAME	AMOUNT
1.	Surgeon	: Dr. Vaishnavi	
2.	Anaesthetist	: Dr. Sathish, Dr. Priyadharshini	
3.	Assistant Surgeon	: Dr Kishore Reddy →	
4.	OT Technician	: Mr. Thangam	
5.	Circulating Nurse	: C/N. Thanushya	
6.	Assistant Nurse	: S/N. Sasi, S/N. Siva.	

Start time: 8:45AM End time: 12 PM order no → 1730823 Start time: 11:15AM End time: 11:40AM

Special Equipment: ☒ Laparascopy ☐ Broncoscope ☐ Harmonic ☒ Morcelator 5th use from Annanagar

☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa

☐ Neuro Cusa ☒ Others ..... order no : 1730822

Ligasure start time: 8:55AM End time: 10:55AM.

Signature of the Surgeon

mail sent for charges

Signature of Circulating Nurse

Order No: Record finalized done by Priya Order by:

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

Patient Sticker

TLH

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CONSUMABLES OF OT

Circulating staff : Thanam Technician : Thangam Date : 21/7/26 Time :

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube 7, 6, Cuffed		4+1	Major Pack		1	Inj Vit.K		
LMA			Sutures 5062		1	Cord Clamp		
ECG leads : A / P / N		6	2347		2	Suction Catheter 14F		1
HME filter : A / P / N			Surgicare 7		2	Feeding Tube		
Syringes : 10 cc		2+4	Surgicare 8		2	Vaccum Suction Set		
05 cc		4	Gloves 7.5 P.F		4	Surgical Gloves		
02 cc		4	6.5 P.F		1+3	Gauze Pack		
01 cc			7 P.F		2	Syringe 1ml / 2ml		
Cautery plate : A / P / N		1	Surgical blade 11/22		1+1	Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL		4	Cautery pencil			Quick Table		
NS : 10ml / 100ml / 500ml / 1000ml		1+1	Koochies			Sheet		1
3 Litre NS		01	Ointments			D'Water 10ml		2
			Suction Catheter					
Fentanyl		2	Cap, Mask			Aknacil		4+1
Morphine			Gauze Pack 20		3	Blood Set		1
Ketamine			Mop Pack		2	Amnepara 100ml		1
Propofol		2	Steristrip			Atropin		1
Rocuronium			Underpad		1	Ephedrin		1
Glycopyrolate			Draw sheet			D. Water 10ml		5+2
Myopyrolate		1	Abgel			Dexa		1
Ondansetron			Foleys catheter 14FR		1	Bioxamic		2
Pencan 25g/ Spinal Needle 22			Urobag meter		1	20ml Syringe		1
Bupivacaine 0.25%			Chest Drainage Catheter			200 CM HP		1
Bupivacaine 0.25%(Heavy)			Romodrain bag			100 cm Ex		1
Antibiotics			Bandage			D.water 1000ml		2
			Tegaderm 8582		05	Airway 2 size		1
Suppositories			~~Tobac~~ Tegaderm 8582		2	N95 mask		4
Anamol : 80mg / 250mg / 170 mg			Double J Stent			protogown		2
Supridol : 100mg			Vaccum Suction set		3	ROPin 0.2%		2
Justin : 12.5 mg / 25mg / 100mg		1	Plastic ~~Bed Sheet~~ Apron		2	Sonopiex 2gm		1
Tab. Misoprost : 200mg			Betadine Solution		2	needle 20x1		1
mom pad		1	Microshield			10cm Ex		3
mom fixator		1	Cotton Balls			Pixies Tube 14F		1
			Latex Gloves		10pair			
			Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician

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	IP18-00036552	**Ward**	8F-OT COMPLEX
Patient Name	Mrs ARUNA.K	**Bed Name**	MICU 805
Age/Sex	42 Y 8 M 26 D / Female	**Order No**	18-0001730838
Date	21/07/2026 14:04	**Prescription No**	PRIP18-0628386
Payor	SELFPAY	**Dispensed Date**	21/07/2026 14:05
UHID	GUC-00093943		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	DISPOSABLE APRONS STERILE XL	Mediblue		1010726	06/29	2	120.00	240.00
2	D WATER IV 1000 ML BOTTLE	Aculife Health Care Pvt.Ltd(Nirlif	H	1D262317	03/29	1	107.61	107.61
3	Encore Microptic gloves-6.5		H	2603019005	03/29	4	128.00	512.00
4	ENCORE MICROPTIC GLOVES-7 PF	ANSEL		2604014105	04/29	2	128.00	256.00
5	FOLEYS CATHETER 14FR POLYMED	Polymed	C1	2516836N	11/30	1	249.00	249.00
6	GAUZ SWAB 10 X 10 CM 12PLY 5S X-RAY	Bapuji Surgicals	GENERAL	M2645010	03/29	3	123.00	369.00
7	JUSTIN SUPPOSITORIES 100 MG 5 S	Neon Laboratories Ltd	H	BLNP274055	12/28	1	18.74	18.74
8	MAJOR PACK	Mediblue		1010626	05/29	1	2,800.00	2,800.00
9	MERSILK 1-0 NW 5062	ETHICON SUTURES-J&J	C1	V4007	07/29	1	337.00	337.00
10	MOPS 30X30 8PLY 5S X-RAY	DATT MEDI PRODUCTS	H	M2642SF029	03/30	2	949.00	1,898.00
11	N95 MASK KARE-ROMSONS	ROMSONS		16032026	12/30	2	56.00	112.00
12	N95 MASK KARE-ROMSONS	ROMSONS		G26B036120	12/30	2	57.00	114.00
13	NEW MOM DISP MATERNITY PADS MAXIPAD	DYNAMIC TECHNO		0153715	03/31	1	204.00	204.00
14	NEWMOM DISPOSABLE PADFIXATOR-XXLARGE	DYNAMIC TECHNO		1486O5	03/31	1	221.00	221.00
15	NITRILE EXAMINATION GLOVES P F- MEDIUM	ELITE MEDICALS	GENERAL	ENPF030020	11/28	20	25.00	500.00
16	NS 100ML ACCULIFE - EH	Aculife Health Care Pvt.Ltd(Nirlif		1B260029	04/28	2	21.01	42.02
17	NS 3 LTRS BOTTLE	Aculife Health Care Pvt.Ltd(Nirlif		5A260048	03/28	1	747.00	747.00
18	PROTO GOWN (ADULT)	Diamond Medicare	GENERAL	1010626	05/29	2	250.00	500.00
19	QUICKSUITE OT TABLE SHEET MIDLINE SUITEL		H	260616I	06/31	1	775.00	775.00
20	RAMADINE SOLUTION 10% 100 ML	RAMAN & WEIL PVT LTD		RC126036	04/28	2	103.00	206.00
21	SGLOVE # 7.0(SURGICARE)	ICARE (KANAM LATEX)	GENERAL	26B5016M	01/31	2	91.00	182.00
22	SGLOVE # 7.5 POWDER FREE	ANSEL	GENERAL	260300891T	05/29	4	128.00	512.00
23	SGLOVE # 8.0 (SURGI CARE)	KANAM LATEX	GENERAL	22C3394KV	02/27	2	75.00	150.00
24	SURGICAL BLADE 11	Surgeon	GENERAL	O030925	08/30	1	7.10	7.10
25	SURGICAL BLADE 22	Surgeon	GENERAL	22C010126	12/30	1	7.67	7.67
26	TEGADERM WITH PAD 5X7CMS (3582)(8582)	3M HEALTHCARE	GENERAL	R03260912	02/29	7	175.00	1,225.00
27	UNDERPADS CARE 60 X 90 (FRIENDS)			07072026	12/30	1	205.00	205.00
28	UROMETER ADULT-MEASUREXX		GENERAL	K26E010304	04/31	1	978.00	978.00
29	VACCUME SUCTION SET	ROMSONS	GENERAL	K26D010294	03/31	3	811.00	2,433.00
30	VICRYL PLUS 1 VP - (2347)	ETHICON SUTURES-J&J	C1	T5O72	10/30	2	951.00	1,902.00

RAINBOW CHILDREN'S MEDICARE LIMITED

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VAT TIN : 33AABCR4014M1ZK **CIN :** L85110TG1998PLC029914

DL NO :

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INPATIENT ISSUES AGAINST ORDERS

IP No	IP18-00036552	**Ward**	8F-OT COMPLEX
Patient Name	Mrs ARUNA.K	**Bed Name**	MICU 805
Age/Sex	42 Y 8 M 26 D / Female	**Order No**	18-0001730838
Date	21/07/2026 14:04	**Prescription No**	PRIP18-0628386
Payor	SELFPAY	**Dispensed Date**	21/07/2026 14:05
UHID	GUC-00093943		

Total :	**10,848.13**	**17,810.14**

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
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INPATIENT ISSUES AGAINST ORDERS

IP No	IP18-00036552	**Ward**	8F-OT COMPLEX
Patient Name	Mrs ARUNA.K	**Bed Name**	MICU 805
Age/Sex	42 Y 8 M 26 D / Female	**Order No**	18-0001730837
Date	21/07/2026 14:04	**Prescription No**	PRIP18-0628385
Payor	SELFPAY	**Dispensed Date**	21/07/2026 14:04
UHID	GUC-00093943		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	AMNEPARA 100ML GLASS BOTTLE		H	L0016006	12/27	1	787.00	787.00
2	ARTACIL 25MG 2.5ML INJ	Neon Laboratories Ltd	H	1303356	07/27	4	45.30	181.20
3	BIOXAMIC 500 MG INJ	Biocare Pharmaceuticals	H	C3BIO004	01/28	2	73.23	146.46
4	BLOOD SET WITH LUER LOCK	Bbraun Medical PvtLtd	GENERAL	G25I020367	08/30	1	208.00	208.00
5	DEXAMETHASONE INJ 2 ML	PENTA PHARMA	H	VDDUI0O8	10/27	1	10.78	10.78
6	DSYRINGE 10ML (NIPRO)	NIPRO	GENERAL	26C30K60	02/31	6	28.13	168.78
7	DSYRINGE 20 ML WITH LEUR LOCK	NIPRO	GENERAL	25B05K11	01/30	1	42.00	42.00
8	DSYRINGE 5ML.(NIPRO)	NIPRO	GENERAL	26C13K17	02/31	4	21.56	86.24
9	DSYRINGS 2.5ML(NIPRO)	NIPRO	GENERAL	26B12K44	01/31	4	11.25	45.00
10	D WATER 10 ML AMPULE	Aculife Health Care Pvt.Ltd(Nirlif	H	2254216	10/28	7	2.58	18.06
11	E.C.G ELECTRODES (ADULT)	JMS	GENERAL	12226S08G	03/28	6	32.34	194.04
12	EFIPRES INJ 30 MG 1 ML	NEON LABORATORIES LTD	H	1231095	01/28	1	45.90	45.90
13	ET TUBE - 6.0 MM WITH CUFFED-HELMIER		GENERAL	G26A010216	12/30	1	399.00	399.00
14	ET TUBE - 7.0 MM WITH CUFFED-ADLISC			G26D010769	03/31	1	437.00	437.00
15	HIGH PRESSUR EXTENTION 200CM-ROMSONS	ROMSONS	GENERAL	K26E01O376	04/31	1	435.00	435.00
16	MCT-ROF 100MG 10ML	Neon Laboratories Ltd	H	NA1353004	10/27	2	69.10	138.20
17	MYOPYROLATE-INJ-5ML	NEON LABORATORIES LTD	H	V350487	11/27	1	140.20	140.20
18	NEEDLE 20 G	Dispovan		50532D	11/30	1	2.66	2.66
19	PREGELLED SURGICAL PLATES(ADULT)	Erbee	GENERAL	2510302409	10/27	1	1,275.00	1,275.00
20	RL 500 ML CLOSED SYSTEM	Fresenius Kabi India Pvt Ltd		1D262104	03/29	4	69.84	279.36
21	ROPIN INJ 0.2 % 20 ML	Neon Laboratories Ltd		1435130	12/27	2	189.30	378.60
22	RYLES TUBE 14 POLYMED	Polymed	H	2415045K	08/29	1	90.00	90.00
23	SONOPLEX STIM CANNULA 21G X 100MM	pajunk	GENERAL	1592	06/30	1	1,754.00	1,754.00
24	SUCTION CATHETER 14 ROMSONS	ROMSONS	GENERAL	K24L010887	11/29	1	83.44	83.44
25	TROPINE INJ AMP0.6MG1ML	NEON LABORATORIES LTD	H	SM038138	11/27	1	7.30	7.30
26	VEIN-O-LINE 100CM ROMSONS	ROMSONS		G26A010292	12/30	1	442.00	442.00
27	VEIN-O-LINE 10CM ROMSONS		GENERAL	K26E010512	04/31	2	460.00	920.00

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Patient Name	Mrs ARUNA.K	**Bed Name**	MICU 805
Age/Sex	42 Y 8 M 26 D / Female	**Order No**	18-0001730837
Date	21/07/2026 14:04	**Prescription No**	PRIP18-0628385
Payor	SELFPAY	**Dispensed Date**	21/07/2026 14:04
UHID	GUC-00093943		

Total :	**7,161.91**	**8,715.22**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN