GUC-00091442 IP18-00036534
Mrs STELLA MARY .J
05-02-1988 38 Y 5 M 15 D (F)
Dr. SHEELA M

Rainbow Children's Hospital

DISCHARGE TRACKING SHEET

RID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing		21/7/26 @ 6AM					
Activity Sheet update by Pharmacy							

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ACTIVITY RECORD FOR BILLING

Name: Mrs Stella Mary

UHID No: 91442 IP No: B65324 Consultant: Dr. Sheela Dept: LDR

Date of Admission: 19/7/26 Time: 10.11pm Date of Discharge: ..... Time: .....

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
20/7/26	7.30pm	LDR	7th Floor	

CROSS CONSULTATION VISIT

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
19/7/20	RBS [POCT]	26023271	[illegible] /0112
20/7/20	RBS [POCT]	26023287	[illegible]
21/7/20	FBS, CBC	26023378	[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
14/7	CTG (1)			009725	AG/011746
14/7	CTG (2)			009725	AG/011746
2017	CTG (3)			009729	AG/011746
2017	CTG (4)			009729	AG/011746
2017	CTG (5)			009729	AG/011746
	Infusion Pump			1730495	Devi
	CTG. (6)			009314	Devi
	CTG. (7)			009314	Devi
	CTG. (8)			009314	Devi
	CTG. (9)			009314	Devi

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
19/7/26	Iv Placement	(1)	1729406	
19/7/26	Blood reservation Charges	(2)	1729359	

ANY OTHER INFORMATION:

Delivery Details: Vaum assisted vaginal Delivery
Date: 20/7/26.
Duration: 1 Hour
Time: 12pm to 1pm
Dr. Shoola
Dr. Pavithra

Date: 21/7/26 Time: 6AM Prepared By:

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Children's Hospital

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

GUC-00091442 IP18-00036534
Mrs STELLA MARY .J
05-02-1988 38 Y 5 M 15 D (F)
Dr. SHEELA M

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement	21/7/26 at 10am				
	INTIME	OUT TIME			
Arrangement of File by Nursing		21/7 at 10am	Suneel 60353		
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature
19/7/26	10pm	105 mg/dl.	Dr. Vinitha	611796
20/7/26	6AM	96 mg/dl.	Dr. Vinitha	011790

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Birthright 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 : IP18-00036534 **Admit Date** : 19-Jul-2026 **Admit Time** : 10:11 PM **UHID** : GUC-00091442

Patient Details :

Patient Name	: Mrs STELLA MARY .J	**Age**	: 38 Y 5 M 14 D
Guardian	: Mr DHARMAR .M	**DOB**	: 05-02-1988
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 2/188 ragavendva nagar ckikaya puram kovil eb Kunnathur Kunnathur Kanchipuram Chennai Tamil Nadu INDIA 600069	**Phone No**	: 9790449822/ 6380043995
		E-mail	: no@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : ER 102 **Ward Name** : 0F-EMERGENCY

Room No : ER 102 **Admission Type** : First Visit

Contact Details :

Name : Mr DHARMAR .M **Relationship** : Husband

Contact Address : 2/188 ragavendva nagar ckikaya puram kovil eb Kunnathur Kunnathur Kanchipuram Chennai Tamil Nadu INDIA 600069 **Phone No** : 9790449822

Signature

Doctor Details :

Doctor Name Dr. SHEELA M **Specialisation** : OBSTETRICS AND GYNECOLOGY

Referral Doctor Self **Phone No** :

Co-Consultant

Payment Details :

Deposit Amount : 7000.00

Payment Mode : Cash **Payor Name** : SELFPAY

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GENERAL CONSENT FOR TREATMENT

Patient Name:	**Mrs STELLA MARY .J**	**Age :**	**38 Y 5 M 14 D**
IP No:	**IP18-00036534**	**Sex:**	**Female**
Consultant:	**Dr. SHEELA M**	**Ward/Bed No:**	**0F-EMERGENCY/ER 102**

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: > Dharmaraj M

Relationship: > Husband

Date: 19-07-2026 Time: 10:11

Witness Name: Jerwin

Witness Signature:

Patient Address:

2/188 ragavendva nagar ckikaya puram kovil eb Kunnathur Kunnathur Kanchipuram Chennai Tamil Nadu INDIA 600069

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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 : > J. Stellamary	UHID Number : 91442
Self Attendant Name : > Dharmas M	Relation : > Husband
Self Attendant Signature : > M. Dhas Phone Number : > 9790449822	Name & Signature of Financial Counselor

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IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints
Admitted for IOL

LMP: 29/10/25 EDD: 5/8/26
Corrected EDD: GA: 37w 4d

Obstetric Formula:
$G_2P_1L_1$

Menstrual History: Regular: ☑ Yes ☐ No
Married H: 10 yrs; NCM

Obstetric History:
G_1: OI; FTND; Girl | 5.5 yrs | 2.9 kg | PIH; Hypothyroid
G_2: Spont conception;

Obstetric Examination
Fundal Height:

Present Pregnancy Record:
T_1: NT scan - WNL; FTS low risk
T_2: Anomaly scan - WNL

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

RISK FACTORS:
Hypothyroidism
Chronic HTN on Labetalol
GDM on OHA
Anxiety disorder on T. Sertraline 50mg

Per Speculum Examination
Draining: ☐ Present ☑ Absent ☐ Bleeding
Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination 2cm long
Cervix: ☐ Long ☐ Partially effaced ☐ Effaced
Os: Closed _____ Dilated 1 finger loose
Membranes: ☑ Present ☐ Absent
Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained
Presenting Part: ☑ Vertex ☐ Breech ☐ Others
Sutton: BHIM ☑ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2
Pelvis: ☑ Adequate ☐ Doubtful

Height: 158 cm
Weight: 97.2 kg
Allergies: Nil
Breast: ☑ Normal ☐ Abnormal
General Examination:
Consciousness: Conscious Pallor: No
Icterus: No Edema: No
Temp: Afebrile PR: 87/min
BP: 120/70 DTR:
CVS: RS
Liver/Spleen: Urine Output:

DIAGNOSIS
$G_2P_1L_1$ | 37w 4d | Chronic HTN (on Labetalol) | GDM on OHA | Hypothyroidism | Anxiety disorder
Admitted for IOL

Patient Sticker

Family History:

Nil

Surgical History:

Nil

Medical History:

Anxiety disorder
Hypothyroid x 7 yrs.
Chronic HTN
GDM on OHA

Medication History:

T. Ecospirin stopped on 12/7/26
T. Livogen XT 0-1-0
T. Calcimax 500mg 0-0-1
T. Thyronorm 125 mcg 1-0-0
~~T. Glycomet 500mg 1-0-1~~
T. Labetalol 100mg 1-1-1
T. Sertraline 50mg 1-0-0.

Plan of Care: C/D/W Dr. Sheela

- Admission
- Parts preparation
- CTG STAT
- CTG Q4H
- FHR monitoring Q1hourly
- Exercises
- R/A @ 4am
- 2 OPRBC reservation
- CBG @ 6am & inform

Investigations:

RBS - 105 mg/dl

CTG - Reactive

Doctor Name: Dr. Vinitha

Signature: 12:13

Date & Time: 19/7/26

Consultant Name: Dr. Sheela

Signature:

Date & Time: 19/7

Patient Sticke

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RESULT SHEET

Date	15/6	21/7/26				
Time						
Hb	11.5	10.5		A positive		
PCV		31				
RBC		3.58				
WBC	11660	13,760				
N/L		73/20		HbA, C : 5.3		
Platelets	253	3.09				
CRP						
ESR						
PCT						
RBS		FBS: 83		ECG] Normal		
Na				ECHO]		
K						
Cl				15/6 FT3 : 2.6		
Ca/Mg				FT4 : 0.93		
Phosphate				TSH : 1.93		
Urea						
Creatinine				FBS : 70		
ALP	87			PPBS : 110		
SGPT	13					
SGOT	15					
T.Bill/Conj 15/6/26	0.27/0.14					
T.Protein	6.59					
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR 15/6	12.7/0.92					
APTT						
CSF Protein / Sugar						
Cells						
N/L						

16/7/26 18/7/26

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 : .....

.....

.....

.....

Radiology : USG : 16/6/26 32w6d

X-Ray : Cephalic ; PI - Anterior

ECHO : SDP: 5.6 ; AFI: 12

CT : EFW: 2081 g (45 %ile)

MRI Doppler - Normal CPR: 34 %ile

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

11/7/26 36w3d

Cephalic ; PI - Anterior ; SDP: 6 ; Liquor (N)

EFW: 2872 g (48 %ile) Doppler Normal

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/26	S/B Dr. Vinitha	
4am	Pt reviewed ;	c/o mild abdomen pain on & off
	O/E : GC fair ; Afebrile	
	P° / PE°	
BP: 120/70	P/A : Ut term ; Cephalic	
PR: 80/min	2/10"/10' mild contractions	
SpO2: 100% RA	FH good	
	- P/v : Cx: 2cm long ; posterior ;	
	os : admits 2 fingers	
	Vx : brim	
	Memb ⊕	
		c/o/w Dr Sheela
	PGE2 gel kept in PF	
		Adv:
		· CTG @ 5am
		· W/F contractions ; draining P/v ;
[signature] 12/13		· Inform SOS.
	C/D/w Dr Sheela.	
	· CTG Q2H	
	· FH monitoring Q½ hrly	
	· Exercises	
	- R/A by Dr. Sheela mam at 9am	
	· CBG 4 hours after	
[signature] 12/13.		

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/07/2026 9AM	C/S/B Dr. Paridhi.	
	Pt reviewed	
	o/e	Advice
	P/A - Ut term	- CTG 2nd hourly
	mildly acting 2c/15'/10"	- W/f contractions
CTG-Reactive.	cephalic	- CBG 4th hourly.
	FHS good	- FHR ½ hourly
		- To start inj synto
		5 units in 1 @ RL
	124680	@ 12ml/hour.
20/07/2026 10:15AM	C/S/B Dr. Sheela / Dr. Paridhi	
	P/A - Ut term	
	mildly acting 3c/15'/10"	Advice
	cephalic	- Continuous CTG.
	FHS good.	- Sitting position.
CTG-Reactive.	P/V - Cx 1cm long, soft, mid position.	- Titrate synto (12ml/hour)
	OS 4-5 cm dilated	
	memb (+) (BOM(+))	
	Vx @ -2 station	
	↓ SAP ARM done, chronic Grade II Meconium Stained liquor present.	

124680.

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

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PROG[...]SS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/2026 10:20 AM.	Informed Written Consent	
	This is to inform that Mrs. Stella mary / G2P1L1 / 37weeks + 5 days / Chronic HTN on T.Labetalol / GDM on OHA / Hypothyroid admitted for induction of labor. During ARM (Artifical Rupture of membranes) Chronic Grade II Meconium Stained liquor. Patient and attenders have been explained about the complications and risks associated like meconium Aspiration Syndrome, Fetal Distress, ~~Risk of~~ NICU Admission, Caesarean Delivery if in case of fetal Distress, increased / prolonged hospital stay. Patient and attenders are aware of the complications and willing to try for normal vaginal Delivery.	
	[signature]	
	x Patient	x Patient Attendant

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/26 11:30 AM	S/B Dr. Sheela	
	pt. c/o pushing sensation	
	P/A: Wt term 4C / 20 to 25 sec / 10 min cephalic FHS good	Advice - Continuous CTG - W/F progression - Inform SOS.
CTG - Reduced variability 5 BPM No acceleration or deceleration	P/V: Cx 1cm long - Os 5cm dilated. membranes (-) Vx -2 to -1 Grade II MSL scen (+)	- Inj: Pethidine SOS 16/7/26
20/7/26 12 PM	C/S/B Dr. Sheela	
	O/E P/V - Cx well effaced Os 8cm dilated memb (-) Vx @ 0 station.	
CTG - Early Decels (+) Comp		Advice - Active pushing. - Continuous CTG.

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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/2016 12:20PM	C/S/B Dr. Sheela.	
	o/e P/V - Cx well effaced	Advice
	os fully dilated	- Active pushing.
	memb ⊖	
	Vx @ + 2 station	
	[signature]	
20/7/2016 12:28pm.	Vacuum Assisted Vaginal Delivery	
	With Right mediolateral Episiotomy.	
	Ind - Persistent Deceleration.	
	C/B - Dr. Sheela	
	A/B - Dr. Pavithra / Dr. Divyalakshmi	
	↓ SAP, patient in dorsal lithotomy position, local parts painted and draped. With good uterine contraction and full cervical dilatation, 2% lignocaine infiltrated into perineum, vaccum cup applied at vertex, right mediolateral episiotomy given, mother delivered an alive boy baby who cried immediately after birth. Cord clamped and cut. Baby handed over to paediatrician. Inj Synto 10U im & iv added to drip. Placenta & membranes	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	delivered in toto. Episiotomy	wound sutured in
	layers with rapid vicryl. Atonic	PPH of around
	500ml noted. managed	with 2 doses Carboprost,
	Iv Tranexic, misoprostol	800mcg PR stat.
	P/A - Uterus	firm & cont well
	P/V -	No undue Bleeding P/V
	P/R - Rectal	mucosa free & Intact.
		Advice
	B 20/07/2024, 12:28pm	(N) Diet
	A 3.084kg	- Plenty of orals.
	B Boy	- Inj Cupacef 1.5g IV Stat @ 9pm.
	Y 8/10, 9/10	- C. Augmentin 625mg 1-1-1 (tomorrow)
		- T. Paracetamol 1g 1-1-1.
		- C. Pantoprazole 1-0-1.
		- CBC c/m 6AM.
		- BP monitoring 2nd hourly.
		- To give Lobet if BP ≥ 120/85 mmHg
		- FBS/PPBS c/m 6Am
	(signature) 114680	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/20 6:30pm	Alive S/B Dr. Divyalakshmi / Dr. Shreeden Pt. reviewed Nil c/o PND-0 G/E: pt GC fair, afebrile P0 / PEO I- PR- BP- SpO2- CVS RS / NAD P/A: soft wt. firm & contracted voided 400ml PVR ~30ml P/E: Bleeding WNL Epi intact Baby w/s Breasts soft Shift to ward 10/4/20	Advice - N diet. - Plenty of fluids. - monitor vitals. - follow drug chart - BP Q 24 till 12am → 4am - CBC, FBS, PPBS c/n 6am - W/F T bpv - DBF - Inform if BP > 120/85 mmHg & pulse > 100 bpm - Inform SOS.

GUC-00091442 IP18-00036534
Mrs STELLA MARY .J
05-02-1988 38 Y 5 M 15 D (F)
Dr. SHEELA M

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7/26.	S/B Dr. Atshida	
6:55pm	PND #1 / P2L2 / GDM / chronic HTN / hypothyroid	
A the:	pt reviewed	
	voiding freely.	
	passed stools	
BP 110/70mmHg.	O/E afebrile	
PR 72bpm	GC fair	Plan:
SPO2 99% @RA	P°/PE°	- monitor vitals.
temp (N)	P/A uterus wc	- Normal diet
	soft	- plenty of fluids
B/L breast soft	BS (+)	- F/U CBC / FBS.
secretions (+)	L/E BWNL.	- Send PPBS
Baby m/s		- w/f ↑ bleeding P/V
DBF		- ambulate
	128035	- inform if BP > 120/85mmHg
21/07/2026	C/S/B Dr. Pavithra / Dr. Shreedevi	
9Am		
PND -1	Pt reviewed, Nil c/o	Advice
	O/E Pt GC fair, Afebrile	- Normal diet
T-(N)	P°/PE°	- Plenty of oral fluids
PR - 88/min	CVS/	- Vitals Monitoring
BP - 110/53mmHg	RS / NAD	- Follow drug chart
	P/A - Ut well contracted	- W/F ↑ Bleeding PV
Baby - m/s	soft	- Inform if BP > 120/85mmHg
B/L - Breast soft	L/E - BWNL	- Ambulation
Voiding freely	Epi wound Healthy	- Process discharge.
Passed stools. 182217		- To do PPBS & Inform report

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

GUC-00091442 IP18-00036534
Mrs STELLA MARY .J
05-02-1988 38 Y 5 M 14 D (F)
Dr. SHEELA M

(1)

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MEDICATION RECONCILIATION FORM

Drug Allergies: .... ☐ Not known any Drug Allergies

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

Shifting From: .... 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	T. THYRONORM	125mcg	PO	OD		☑C ☐DC
2	T. GLYCOMET	500mg	PO	BD		☐C ☑DC
3	T. LABETALOL	100mg	PO	TDS		☐C ☑DC
4	T. SERTRALINE	50mg	PO	OD		☐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 : [signature] 16428 Dr. Ranjalakshmi

Date & Time : 19/7/26 10pm

Nurse Name & Signature: [signature] Swetha 1011706

Date & Time : 19/7/26 at 10PM

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

Patient Sticker

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MEDICATION RECONCILIATION FORM

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

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

Shifting From: EDR ..... Shifted to: 4th 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	Cap. AUGMENTIN	625mg	PO	BD		☑C ☐DC
2	TAB. PANTOPRAZOLE	40mg	PO	BD		☑C ☐DC
3	TAB. PARACETAMOL	1g	PO	TDS		☑C ☐DC
4						☐C ☐DC
5						☐C ☐DC
6						☐C ☐DC
7						☐C ☐DC
8						☐C ☐DC
9						☐C ☐DC
10						☐C ☐DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Shreedevi 182217

Date & Time : 20/07/2026

Nurse Name & Signature: S/N. Tanishq J 20/7/26

Date & Time : 20/7/26 at 7pm

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

GUC-00091442 IP18-00036534
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DRUG CHART

Date of Admission: 19/7/26 Drug Allergies: ..... ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

DRUG :				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 .....

SUC-00091442 IP18-00036534
Mrs STELLA MARY .J
05-02-1988 38 Y 5 M 14 D (F)
Dr. SHEELA M

REGULAR PRESCRIPTIONS Weight 47.2 Kg Ward. ICU

DRUG : T. LABETALOL

Dose	Route	Frequency	Start Date
100mg	PO	1-1-1	20/7

Name & Signature of the Doctor Starting the Drugs: 12 hrs

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	20/7	
6am	BP MD	
2pm		
10pm		

DRUG : T. THYRONORM

Dose	Route	Frequency	Start Date
125 mg	PO	1-0-0	20/7

Name & Signature of the Doctor Starting the Drugs: 12 hrs

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	20/7	21/7
6am	BP ES	AA ES

DRUG : C. AUGMENTIN

Dose	Route	Frequency	Start Date
625mg	PO	1-0-1	21/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions: 1hr 6hr

Daily Doctor's Endorsement by a Sign

Date / Time	20/7	21/7
8AM		SM PK
2PM		
10PM		
		LA

DRUG : T. PARACETAMOL

Dose	Route	Frequency	Start Date
1g	PO	1-1-1	20/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions: 12 6hr

Daily Doctor's Endorsement by a Sign

Date / Time	20/7	21/7
8AM		SM PK
2PM		
10PM	AA ES	

Patient Sticker

Weight 97.214 Ward. LDR

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
20/7	10.00 am.	Inj: SUPACEF	0.1 ml	ID	16428	MD TJ
20/7	10.40 am.	Inj: PAN	40 mg	IV	16428	MD TJ
20/7	10.40 am	Inj: EMESET	4 mg	IV	16428	MD TJ
20/7	11.00 am.	Inj: EPIDOSIN	2cc in 8ml NS	IV	16428	MD TJ
20/7	11.00 am	Inj: SUPACEF	1.5g	IV	16428	MD TJ
20/7/26	12.40 pm	INJ. SYNTO	10U	IM	18221	MD TJ
20/7/26	12.40 pm	INJ. TRAPIC	1g	IV	18221	MD TJ
20/7/26	12.40 pm	INJ. CARBOPROST	250 mcg	IM	18221	MD TJ
20/7/26	1.15 pm.	INJ. CARBOPROST	250 mcg	IM	18221	MD TJ

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

Patient Sticker

I.V. FLUIDS CHART

Weight. 97-24 Ward. LDR

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
20/7/26	9.30 am	Inj synto 5 units in 1 ⓪ RL	IV	19 ml/hr	182217	ND / SR	20/7/26	164258	ND / SR
20/7/26	9.30 am	INJ. SYNTO 20U in 500ml RL	IV	125 ml/hr	182217	ND / SR	20/7/26	164258	ND / SR
20/7/26	12.30 pm	IVF 1⓪RL	IV	free flow	182217	ND / SR	20/7/26		ND / SR

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

Rainbow Children's Hospital

GUC-00091442 IP18-00036534
Mrs STELLA MARY .J
05-02-1988 38 Y 5 M 15 D (F)
Dr. SHEELA M

Ref. No.: F / HW / DC / RP / INPR / 05.a

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

REGULAR PRESCRIPTIONS

DRUG : CAP PAN D

Dose	Route	Frequency	Start Dt.
1	P/o	1-0-1	20/7/2[illegible]

Name & Signature of the Doctor starting the Drugs: [signature] 128035

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

Date / Time	21/8 [illegible]	22/8
8 am	/	ES/AD
7 pm	ES/AD	

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

CIN : U85110 TG1998 PTC029914

GUC-00091442 IP18-00036534
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05-02-1980 38 Y 5 M 15 D (F)
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STAT / ONCE ONLY DRUGS

Name: .....

Weight: 47.2 kgs

Sheet No: 1

DATE	TIME	MEDICATION	DOSAGE & OTHER INSTRUCTIONS	ROUTE	SIGNATURE		
					Doctor	Nurse-1	Nurse-2
20/7/26	10pm	INJ. EMESET	4mg	IV	82217	MD	SA
20/7/26	9.10pm.	T. MISOPROSTOL	800 mcg	PR	82217	MD	SA
20/7/26	9.20pm.	JUSTIN SUPPOSITORY	100 mcg	PR	82217	MD	SA
20/7/26	9pm.	INJ. SUPACEF	1.5g	IV	82217	BS	AA
20/7/26	9.30pm.	Inj. PARACETAMOL	1gm	IV	16478	MD	SA

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

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Early Warning Observation Score Chart - Obstetrics

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

		Date	19/7/26																						
		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																22		22		19		22		19	
	11 - 20																								
	0 - 10																								
Saturations	94 - 100 %																99%		98%		99%		99%		99%	
	< 94 %																								
Administered O_2 (L/min.)																	RA		RA		RA		RA		RA	
Temp°C	40																								
	39																								
	38																								
	37																98.4		97.1		98.4		98.4		97.4
	36																								
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																94		94		93		84		88
	80																								
	70																								
	60																								
	50																								
	40																								
Systolic Blood Pressure ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120																120		122		120		110		117
	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80																80		74		80		70		74
	70																								
	60																								
	50																								
	40																								
NEURO RESPONSE [✓]	Alert																✓		✓		✓		✓		✓	
	Voice																								
	Pain																								
	Unresponsive																								
URINE mls / hour	> 30																✓		✓		✓		✓		✓	
	< 30																								
Proteinuria	Protein + +																								
	Protein > + +																								
Lochia	Normal																–		–		–		–		–	
	Heavy / Foul																								
Liquor	Clear / Pink																–		–		–		–		–	
	Green																								
TOTAL YELLOW SCORES																	0		0		0		0		0	
TOTAL ORANGE SCORES																	0		0		0		0		0	
Nurse Initial																	MH		MH		MH		MH		MH	

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

FHR Monitoring

12AM : 145 to 150 ~~bpm~~

1AM : 146 to 150

2AM : 140 to 145

3AM : CTG

4AM : ~~CTG~~ 140

5AM : CTG

6AM :

GUC-00091442 IP18-00036534
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(2)

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Early Warning Observation Score Chart - Obstetrics

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

		Date	20/7/20																			
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20		22	2	2		2	22		22			22		20		20		20				20		20	
	0 - 10																									
Saturations	94 - 100 %		99		99		99	99		99			99		99%		96%		96%				97%		99	
	< 94 %																									
Administered O_2 (L/min.)			RA		RA		RA	RA		RA			RA		RA		RA		RA				RA		RA	
Temp°c	40																									
	39																									
	38														98.4 ①		97.2 ②		97.6 ③				98.2 ④		98.8 ⑤	
	37		98		98		98			98			98													
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110														98 BPM ①		80 bpm ②		82 bpm ③				76 bpm ④		84 bpm ⑤	
	100																									
	90		80		80		90	80		80			80													
	80																									
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110		≥110		≥110		≥110	≥130		≥110			≥110		119		119		107				110		108	
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60		70		70		70	70		70			70		64		60		60				70		66	
	50																									
	40																									
															(174)		(73)		(70)				(81)			
NEURO RESPONSE [✓]	Alert		✓		✓		✓	✓		✓			✓		✓		✓		✓				✓		✓	
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30		✓		✓		✓	✓		✓			✓		✓		✓		✓				✓		✓	
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal		-		-		-	-		-			-		✓		✓		✓				✓		✓	
	Heavy / Foul																									
Liquor	Clear / Pink		-		-		-	-		-			-		-		-		-				-		-	
	Green																									
TOTAL YELLOW SCORES			0		0		0	0		0			0		0		0		0				0		0	
TOTAL ORANGE SCORES			0		0		0	0		0			0		0		0		0				0		-	
Nurse Initial																										

GUC-00091442 IP18-00036534
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05-02-1988 38 Y 5 M 15 D (F)
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NURSING CARE RECORD

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

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	7:30 AM	Achieve acceptable Pain control and comfort	8AM	*Assess pain using pain scale * position patient comfortably *Monitor Effectiveness of pain	Reduced Pain to some extend	Reassesment Done	9/6/26
Afternoon	1:30 pm	promote adequate nutriton for healing and Recovery	3pm	* Assess nutritional Status and appetite * provide Balanced diet	promote adequated nutrition to some extend	Reassesment done	Devi
Night	8PM.	Promote adequate Nutriton for healing and Recovery	10pm	* Assess nutritional Status and Appetite * provide Balanced diet.	Promote Adequated Nutrition to some extend.	reassessment done.	9/7/26

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NURSING CARE RECORD

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Date: 19/7/26

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				I			
Night	10pm	Reduce risk of hospital acquired and wound infection	10pm	maintain strict hand hygiene. => Using aseptic technique during procedure and dressing	Patient little signs of tube.	Reassessment done	Aey/01990

Docu. No: RCH /FRM / CLINICAL / 148

GUC-00091442 IP18-00036534
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(1)

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FLUID CHART

Sheet No. : 191726

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
	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	→	on	Admission		←						
	11:00 pm	HW	100							300	NO	NM
	12:00 am	milk	100								NO	NM
	01:00 am	HW	50							200	NM	NM
Total Intake :		250ml				**Total Output :**				500ml		
	02:00 am	HW	100ml								NO	NM
	03:00 am									300	NM	NM
	04:00 am	HW	50ml								0	NM
	05:00 am										0	NM
	06:00 am	HW	100ml							200	0	NM
	07:00 am		250ml								0	NM
Total Intake :						**Total Output :**				500		

Total 24 hrs. Intake	500ml	Total 24 hrs. Output	1000ml

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Mrs STELLA MARY .J
05-02-1988 38 Y 5 M 14 D (F)
Dr. SHEELA M

(2)

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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.

20/7/26

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
20/7/26	08:00 am	Milk	100ml									
	09:00 am			82	1aml							
	10:00 am	Milk	100ml	18	1aml					100ml	0	Devi
	11:00 am			94	1aml						0	Devi
	12:00 pm	Milk	1aml		1aml					150ml	0	Devi
	01:00 pm	Milk	100ml		1aml						0	Devi
Total Intake :	1000ml				1aml						0	Devi
	02:00 pm	Milk	150ml	100ml						100ml	0	Devi
	03:00 pm	Tea	200ml	1aml								
	04:00 pm			1aml							0	Devi
	05:00 pm	Milk	1aml	1aml							0	Devi
	06:00 pm	Milk	1aml								0	Devi
	07:00 pm										0	Devi
Total Intake :	950ml									350ml	0	Devi
	08:00 pm	H2O	150ml								0	Devi
	09:00 pm	H2O	100ml									
	10:00 pm	Milk	100ml								0	~~AA~~
	11:00 pm	H2O	150ml							200ml	0	AA
	12:00 am										0	AA
	01:00 am	H2O	150ml							350ml	0	AA
Total Intake :	650ml										0	AA
	02:00 am	H2O	100ml								0	AA
	03:00 am											
	04:00 am	H2O	100ml							200ml	0	AA
	05:00 am	H2O	100ml								0	AA
	06:00 am	Milk	100ml								0	AA
	07:00 am	H2O	150ml							250ml	0	AA
Total Intake :	600ml										0	AA

Total Output : 350ml

Total Output : 350ml

Total Output : 550ml

Total Output : 450ml

Total 24 hrs. Intake	3,200ml

Total 24 hrs. Output	1,700ml

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NURSES NOTES

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☑ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
19/7	10pm	=> ADMISSION NOTES <=	
		Mrs. STELLA MARY. J 38yrs	
		Female under Dr. Sheela mam.	
		She is G2P1L1 Pre NVD	
		37+4 days, She came c/o for	
		While receiving the patient	
		Conscious and Oriented, afebrile	
		taking Orally and tolerating	
		well. Voided freely. CTG	
		connected reading FHR good.	
		K/C/O Hypothyroidism, Chronic HTN.	
		GDM on OHA. CBG: 105mg/dl.	
		Informed to Dr. Vinitha mam.	
		Patient vital signs stable.	
		General condition fair.	=> [signature]/01F196
	11pm	=> CTG reading FHR good	
		Fetal movement felt by	
		her. CTG disconnected.	=> [signature]/01F196
	11:30pm	=> Under aseptic technique	
		Part's Preparation was good.	
		Patient co-operated well	=> [signature]/01F196
	12AM	=> Cross match sample	
		collected 2 unit PRBC reservation	
		done. orders by Dr. Sheela	
		mam. orders carry out.	=> [signature]/01F196
	1AM	=> FHR Checked: 145 to 150 b/m	
		Patient slept well	=> [signature]/01F196

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

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NURSES NOTES

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☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
cont 20/7/20	2AM	=> FHR 140 to 145 Checked cy recorded, Foetal movement good.	=> [illegible]/07/20
	3AM	=> CTG connected reactive FHR good. Foetal movement good.	=> [illegible]
	4AM	=> Q8/B Dr. [illegible] Advice to under aseptic technique. Cervipril gel, 0.5mg PV done. Patient [illegible] well.	=> [illegible]/0K
	5AM	=> Post gel CTG connected reactive FHR good, Foetal movement good	=> [illegible]/0K
	6AM	=> Patient FHR checked cy recorded, General condition fair => CBG: 96mg/dl.	=> [illegible]
	7AM	=> Patient take a bath cy brushing, Tab thyronorm 125 gm given, Patient will [illegible] [illegible] General condition fair	=> [illegible]
	7³⁰AM	=> Patient report hand over to morning duty [illegible]	=> [illegible]/07/20

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Dr. SHEELA M

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NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
20/7/20	7.30 AM	Morning Duty (20/7/20) patient care Handing over taken from Night duty staff. Monitored vitals and Recorded. watching contractions IV cannula observed. No any other complaints	01/8/20
	8 AM	Monitored vitals and Recorded. Maintained I/o. watching contractions. Pain assessment Done. IV Cannula observed	01/8/20
	9.30 AM	CTG on Connected. FHR Monitoring Maintained I/o. No any other complaints. patient General Condition Fair. IV Cannula observed. Inj. Synto 5 Unit stat	01/8/20
	10.15 AM	CTG on connected. FHR Monitoring Cx 1cm long, Soft Mid position, OS 4-5cm dilated, Membrane present Vx at -2 station. VIS AP, ARM Done, Chronic Grade II Meconium Stained, liquor present.	01/8/20
	11.30 AM	Dr. Sheela mam done PV Examination Cx 1cm long, OS 5cm dilated, Membrane absent, Vx -2 to Grade II MSL	01/8/20

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☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
20/7/25	12pm	Dr Shoba mam done PV Examination	
		Cx well effaced ros 8cm dilated	
		Membrane absent IVx at 0	
		station, CTG on connect.	
		FHR monitoring	01600
		Delivery Notes	
	12.32pm	Vaccum assisted vaginal delivery	
		with RMLE	
		IND: persistant decoleration	
		USAP patient in dorsal lithotomy	
		position local parts painted	
		and draped with good uterine	
		contraction and full cervical	
		dilation 2% lignocaine infiltrated	
		into perineum. vacum cup	
		applied at vertex. Right	
		mediolateral episiotomy given	
		mother delivered an alive boy	
		Baby who cried immediately	
		after birth cord clamped and	
		cut Baby handed over to	
		pediatrician. Inj. synto 10 IU Im	
		and IV added to drip 20 units	
		RL 500ml. placenta and	
		membranes delivered intact	
		episiotomy. wound sutured	
		in layer with Rapid vicryl	

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NURSES NOTES

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☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
20/7/20		Atonic PPH of around 500ml noted. Managed with 2doses Carboprost 1 IV Inj Tranexamic 1g IV given. T-Miso 800mg PR Justin suppository PR Kept by Dr. Sheela.	
		Baby Details	
		B - Alive Girl Baby	
		A - 20/7/20 at 12.22pm	
		B - 3.084kg	
		Y - 8/10, 9/10	[signature] 20/7/20
	1.30pm	Monitored vitals and Recorded. Maintained I/O, Patient General condition fair. PV Bleeding Minimal. No any other complaints	[signature] 20/7/20
	2pm	Monitored vitals & Recorded	
		B - Breast is soft, No engorgement	
		U - Uterus Contracted	
		B - Bladder Not yet voided	
		B - Bowel movement present	
		L - Lochia Rubra No foul smelling	
		E - REEDA Assessment Done	
		H - Homan sign Negative	
		E - Emotional Status good	[signature] 20/7/20
	4pm	Monitored vitals. Maintained I/O, watching PV Bleeding	

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Patient Sticker

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☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
20/7/26		Minimal. No any other	
		complaints	[signature] 01/6/20
	6.30pm	Patient voided [illegible].	
		Informed to Dr Shivya. post	
		Voide scan done 30ml. advised	
		to shift the patient to	
		ward. doctor order	[signature] 01/6/20
	7.30pm	patient shifted from LDR to	
		7th Floor. patient care	
		Handing over given to	
		7th Floor Staff.	
		Receiving Notes.	
20/7/26	7.30pm.	Patient Receiving from LDR to	
		7th floor. Patient details handing	
		Over to LDR Staff. Bed side	
		Assessment done. Conscious & Oriented.	
		IV line ⊕ pattern patient self	
		voided urine. patient taken diet.	[signature]
		patient taken Normal diet.	
	8pm	vitals sig. Checked & Recorded.	
		vitals are stable. I/O chart	
		monitored. P/V Bleeding is Normal.	
	9pm.	Patient due medication & drug	
		given as per drug chart order	
		I/O chart monitored. patient	
		Provided comfortable position.	
		No any other complaints.	[signature]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

UHID: 00091442 IP18-00036534
Mrs STELLA MARY J
05-02-1988 38 Y 5 M 14 D (F)
Dr. SHEELA M

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LABOUR AND DELIVERY NURSING ASSESSMENT

Date of Admission: 19/7/26

Baseline Information:

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

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

Do you require an interpreter? ☐ Yes ☐ No

Source of Information: ☑ Patient ☐ Family ☐ Others

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

handed over to Attender

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

If yes, identify

Doctor Notified on Admission: ☑ Yes ☐ No

Chief Complaints: G2 P1 L1 Post NVD 37+4 days. Cronic HTN, GDM. Hypothyroidism for IOL

Name of the Doctor: Dr. Lalitha

Time Notified: 10pm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Hypothyroid Cronic HTN GDM on OHA Anxiety disorder.	–	–

Blood Group: "A" +ve LMP: 29/10/25 EDD: 5/8/26 Gestational age during admission: 37+4 days

Contractions: Nil Vaginal Discharge: Nil

Obstetric History: G 2 P 1 L 1 A – Previous LSCS Nil

Height: 158 Weight: 97.2 kg BMI: BP: 120/80 SpO₂ 100%

Temp: 98.4°F HR: 84/min RR: 24/min

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

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

(P.T.O)

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Family History: ☑ No Abnormalities Detected

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

☐ Liver disease ☐ Other ..... nil .....

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

Fall Assessment: ☑ Yes ☐ No Score ...10..... (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore: ☑ Yes ☐ No Score ..21..... (complete the Braden Q Sheet)

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

☐ Mobility problem ☐ Walking Problem ☑ No Abnormality Detected

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

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

☐ Under Weight ☐ Diabetes Mellitus ☐ No Abnormality Detected

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

☐ Others .....

Inform consultant for positive criteria

SOCIAL SCREENING:

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

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

Social History: Lives With ..... Husband .....

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. Bilqis Baig .....

Name of Person Orientation was given to: ..... Mrs. Bilqis Baig .....

Orientation not given Reason: .....

Nurse Signature: .....

Nurse Name: ..... S. Nusrat .....

Date & Time: ..... 19/7/26 .....

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Mrs STELLA MARY .J
05-02-1988
Dr. SHEELA M
IP18-00036534
38 Y 5 M 14 D (F)

Patient Stic

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OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 19/7/25 Time of Arrival: 10pm Time Seen by Nurse: 10pm

1) **Level of Consciousness:** ☑ Conscious ☐ Semi-Conscious ☐ UnConscious

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

- ☐ Severe Pain / Moderate Pain
- ☐ Bleeding PV: Slight / Heavy
- ☐ Decreased Fetal Movement
- ☐ No Fetal Movement
- ☐ Preterm rupture of Membranes / Leaking Water PV
- ☐ Preterm Labor/ Labor
- ☐ Spontaneous Rupture of Membrane / Leaking Water PV
- ☐ Other Reason: NIL

3) **Vital Signs:** Temperature: ..... Pulse: ..... RR: ..... SpO_2: ..... BP: ..... Weight: .....

4) **Gestational Criteria:**

Gravida:	G 2	P 1	L 1	A

LMP: 29/10/25 EDD: 5/8/26 Gestational Age: 37 4/7 days

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

5) **Pain Screening:** **Numerical Pain Scale (NPS)**

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

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

6) **Past History:**

a) Surgeries: NIL

b) Medical: Hypothyroid. Chronic HTN. Gestational DM.

Patient Sticker

7) **Allergy:** ☐ Yes ☑ No, If Yes : ....

8) **Current Medications:** ☐ Prenatal Vitamin ☐ None ☐ Others: T. Thyronorm 12.5mg., T.Cab Calcimax 500mg, Tab. Labet 100mg.

9) **Prenatal Medical History:**

- ☐ None
- ☑ Chronic Hypertension
- ☐ Gestational Hypertension
- ☑ Diabetes
- ☐ Gestational Diabetes
- ☐ Low placenta
- ☐ Others if yes, specify Hypothyroidism

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

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

Time seen by Doctor: 10pm

Nurse Name : J.S. Alwetha. Nurse Signature: Alay/011-76

Date: 19/7/26 Time: 10pm.

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RISK ASSESSMENT TOOL FOR DEEP VEIN THROMBOSIS

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

Date:.....

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		1
Family history of unprovoked or estrogen-related VTE in first-degree relative		1
Known low-risk thrombophilia (no VTE)	✓	1
Age (≥35 years)	✓	1 or 2
Obesity		1
Parity ≥ 3		1
Smoker		1
Gross varicose veins		1
Obstetric Risk Factors		
Pre-eclampsia in current pregnancy		1
ART/IVF (antenatal only)		1
Multiple pregnancy		2
Caesarean section in labour		1
Elective caesarean section		1
Mid-cavity or rotational operative delivery		1
Prolonged labour (24 hours)		1
PPH (1 litre or transfusion)		1
Preterm birth 37^{+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	3	
Signature of the Nurse		
Action Plan		

Docu. No. : RCH / GDY /FRM / CLINICAL / 116

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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BRADEN 'Q' SCALE

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				Date : / Time :				
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	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	28	28	28
				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

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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Your Right to a Safe Delivery

GUC-00091442 IP18-00036534
Mrs STELLA MARY .J
05-02-1988 38 Y 5 M 15 D (F)
Dr. SHEELA M

BRADEN 'Q' SCALE

					Date : 8/1/17 Time : M			
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4			
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	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			
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4			
FRICTION-SHEAR **Friction** . Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4			
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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			
				TOTAL SCORE	27			
				Evaluator's Name	PKG			

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

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

GUC-00091442 IP18-00036534
Mrs STELLA MARY .J
05-02-1988 38 Y 5 M 14 D (F)
Dr. SHEELA M

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PAIN ASSESSMENT FORM

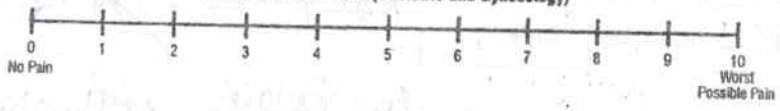
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
19/7/26	10PM	0/10	–	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	No Pain	[illegible] 19/7/26
20/7/26	12AM	0/10	–	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	No Pain	[illegible] 20/7/26
20/7/26	4AM	0/10	–	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	No Pain	[illegible] 20/7/26
20/7/26	6AM	1/10	Low Abdpn	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Comfortable Position.	[illegible] 20/7/26
20/7/26	10 AM	9/10	Lower abdo region	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Comfortable position	Devi 20/7/26
20/7/26	2PM	1/10	Episiotomy site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Comfortable position	Devi 20/7/26
20/7/26	6PM.	1/10	Episiotomy site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Comfortable position	Devi 20/7/26
20/7/26	10PM	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	[illegible]
21/7/26	2AM	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	[illegible]
21/7/26	6AM	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	[illegible]

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

(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

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05-02-1988 38 Y 5 M 15 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
2/17/26	10am	yes	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	N/L	P.K[illegible]
				☐ 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
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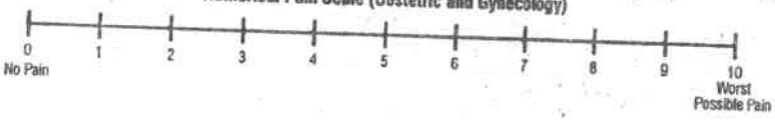
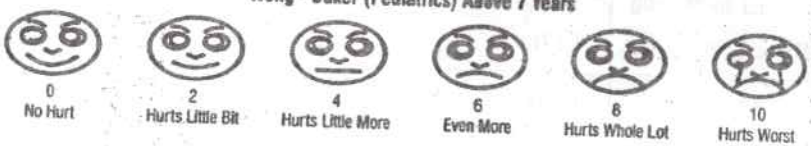
(P.T.O)

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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
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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)
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GUC-00091442 IP18-00036534
Mrs STELLA MARY .J
05-02-1988 38 Y 5 M 14 D (F)
Dr. SHEELA M

Morse Fall Risk Assessment Form

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Choose Highest Applicable Score from each Category		Date / Time	19017	M 20/7/26	T 20/7/26
		Score		35	35
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0		0	
Secondary Diagnosis (more than one diagnosis)	Yes	15	0		0
	No	0		15	15
Ambulatory Aid	Furniture	30	0	0	0
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0			
IV / Heparin Lock or Saline	Yes	20	0	0	0
	No	0		20	20
GAIT / Transferring	Impaired	20	0	0	0
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0	0	0	
Mental Status	Forgets limitations	15			0
	Oriented to own ability	0	0	0	0
Total Morse Fall Scale Score:				35	35
		Signature	[illegible]	[illegible]	[illegible]

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

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	N 20/7/26	M 21/7/26
		Score	35	35
History of Falling (immediately or w/in 3 months)	Yes	25		
	No	0	0	0
Secondary Diagnosis (more than one diagnosis)	Yes	15	15	15
	No	0		
Ambulatory Aid	Furniture	30		
	Crutches, Cane(S), Walker	15		
	None /Bed Rest /Nurse Assist	0	0	0
IV / Heparin Lock or Saline	Yes	20	20	20
	No	0		
GAIT / Transferring	Impaired	20		
	Weak (uses touch for balance)	10		
	Normal /On Bed Rest /Immobile	0	0	0
Mental Status	Forgets limitations	15		
	Oriented to own ability	0	0	0
Total Morse Fall Scale Score:			25	35
		Signature	[signature]	[signature]

Fall Risk Grading		
Risk Level	**Morse Fall Score (MFS)**	**Action**
Low Risk	0 - 24	Standard Fall Precaution
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Risk Level and Interventions

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Patient's Name: GUC-00091442 Mrs STELLA MARY .J IP18-00036534
MRD NO: 05-02-1988 38 Y 5 M 14 D
Age: Dr. SHEELA M (F)
Sex: ☐ M ☐ F
Consultant :

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 20/7/26 Time: 6AM
Location : (L) metacarpal
Size : 18G
Cannula inserted by : Ablay / on-9ac

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
20/7/26	7am	☐Yes ☑No	☐Yes ☑No	Observ	[illegible]
	9am	☐Yes ☑No	☐Yes ☑No	Observ	[illegible]
	11am	☐Yes ☑No	☐Yes ☑No	Observ	[illegible]
	1pm	☐Yes ☑No	☐Yes ☑No	Observ	[illegible]
	3pm	☐Yes ☑No	☐Yes ☑No	Observ	[illegible]
	5pm	☐Yes ☑No	☐Yes ☑No	Observ	[illegible]
	7pm	☐Yes ☑No	☐Yes ☑No	Obs	[illegible]
	10PM	☐Yes ☑No	☐Yes ☑No	Patten	AA
	2AM	☐Yes ☑No	☐Yes ☑No	Patten	AA
	6AM	☐Yes ☑No	☐Yes ☑No	Patten	AA
	10Am	☐Yes ☑No	☐Yes ☑No	obe	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		
		☐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-00091442 IP18-00036534
Mrs STELLA MARY .J
05-02-1988 38 Y 5 M 15 D (F)
Dr. SHEELA M

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BREAST FEEDING HANDOVER AND ASSESSMENT FORM

1. Breastfeeding initiated?
   - ☑ a. Yes
   - ☐ b. No

2. If No, Reason .....

3. Nipple condition:
   - ☑ a. Nipple well formed
   - ☐ b. Flat nipple
   - ☐ c. Inverted nipple
   - ☐ d. Short nipple

4. Milk flow:
   - ☐ a. Good
   - ☑ b. Drops of colostrums
   - ☐ c. Dry

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

Feeding Positions:
Cross Cradle

Feeding Positions:
Football / Clutch

6. Was the position explained:
- ☑ a. Yes
- ☐ b. No

7. For Caesarian mothers:
- ☐ a. Mother is required sit and feed from the 4th feed
- ☐ b. Please explain football hold (N/A)

8. NICU admission:
- ☐ a. Mother needs to stimulate her breast for 2 min every 2 hours (N/A)

9. Additional notes: DBF given

Continuity of Care: Date: 20/7/26

Baby Mothersіde

L – 2	21/7/26
A – 1	L – 2
T – 2	A – 2
C – 2	T – 2
H – 2	C – 1
9	H – 1
	8

P.V 60-261

Handover given by [signature] Handover taken by [signature]

Signature [signature] Signature [signature] 021295

Date & Time: 20/7/26 at 2pm Date & Time: 20/7/26 @ 7.30 pm

PARTOGRAPH

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LABOUR

Labour: ☐ Spont ☐ IOL-PGE 1 ☐ E2 ☐ Others

Indications for IOL-Accel: ☐ None ☐ Oxytocin

Memb. Repture Type: ☐ SROM ☐ PROM ☐ ARM

Presentation: ☐ Vertex ☐ Breech ☐ Others

INTRA PARTUM COMPLICATION

Maternal: ☐ Nome ☐ Pyrexia ☐ HTN ☐ Others — GDM on OHA

Liquor: ☐ Adequate ☐ Oligo ☐ Poly ☐ Clear

☐ Blood ☐ Meconium ☐ Cord: .....

Shoulder Dystocia: ☐ Yes ☐ No

DELIVERY DETAILS

Anesthesia: ☐ None ☐ Epidural

Non-epi: ☐ Local ☐ Spinal ☐ General

Del. Type: ☐ SVD ☐ Asst. Breech ☐ Twins

AVD: ☐ Outlet ☐ Low Forceps ☐ Ventouse (Vaccum)
☐ Trails of Forceps

Indications: Persistent decelerations

Application, Locking & Traction: .....

Duration of Instrumentation: .....

No. of Pulls: .....

Catherised : ☐ Yes ☐ No

Type: ☐ Fileys ☐ Plain

Perineum : ☐ Intact ☐ Episiotomy ☐ Tear

Suture Material Used: Rapid vicryl

STAGE III

Placenta: ☐ Normal ☐ Abnormal ☐ RP Clots
☐ CCT ☐ Retained ☐ MRP

PPH : ☐ Atomic ☐ Traumatic ☐ None

Lacerations: .....

Cervical: .....

Perineal: Episiotomy

Others: .....

Prophylaxis: Synocinon Prostodin
500ml

Blood Loss: .....

Blood Transfusion: No

Other Details (if any): .....

Ractal Examination: Normal

DURATION OF LABOUR

1st Stage: 4hours

2nd Stage: 10min

3rd Stage: 5min

Duration of Active Pushing: .....

No. of VE'S: .....

BABY DETAILS

Gender: Boy

Weight: 3.0kg/kg

APGAR: 8/10, 9/10

Date and Time of Delivery: 20/07/2026; 12:28 pm

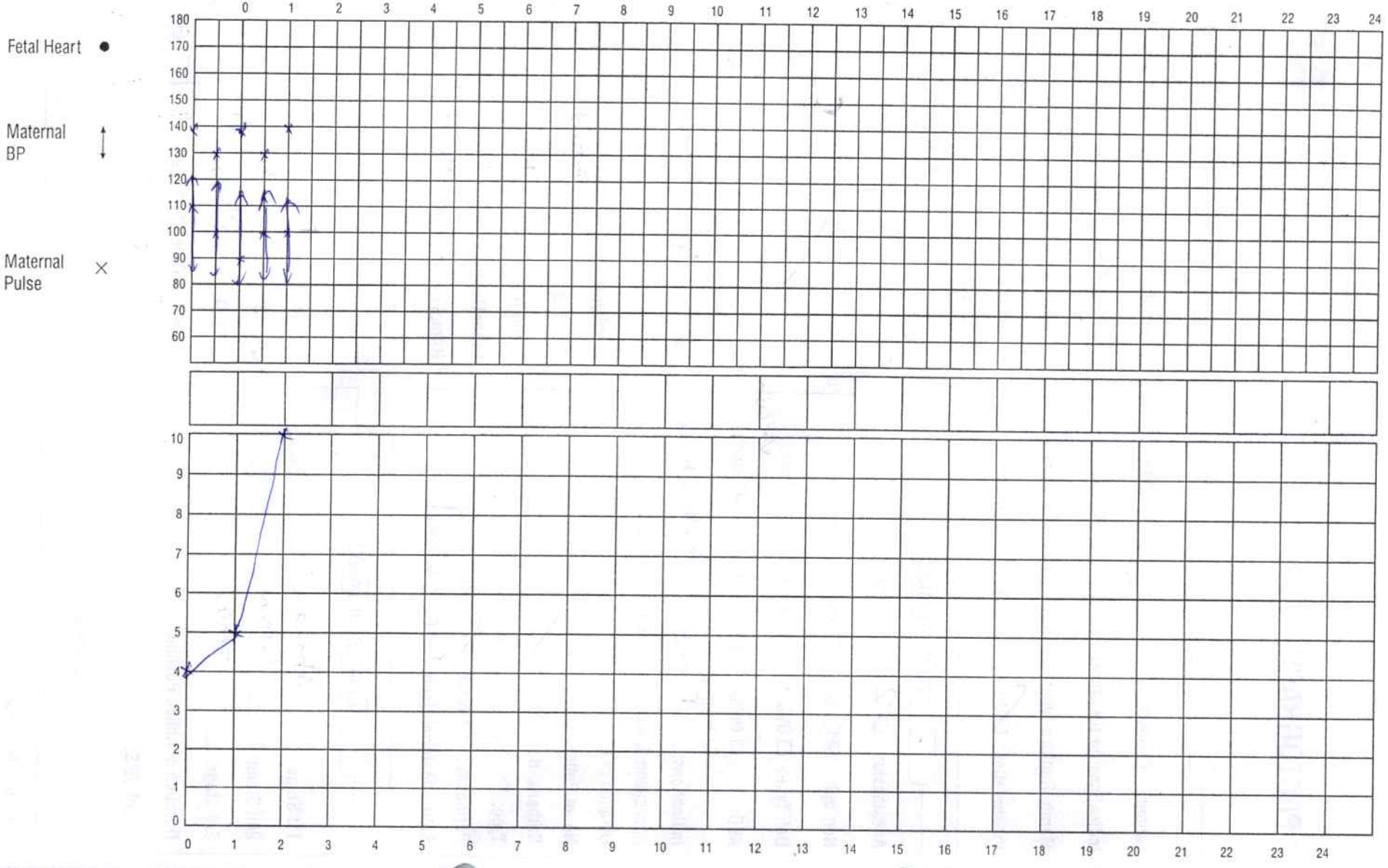
LW Doctor: Dr. Sheela

LW Sister: .....

PARTOGRAPH

Name: Mrs. Stella Obstetrics Formula: G2P1L4 Blood Group Type: A-Positive

Memb. Ruptured: SROM PROM (ARM) Risk Factors: Chronic HTN | GDM on OHA




Time
10:15
11:15
12:15
Signature
182217
182217
182217
Fifths Palpable
3/5
3/5
0/5
Moulding / Caput
N N N N N N
Amniotic Fluid
Grade II msc
Grade II msc
Grade II msc
Position
Cephalic / Breeth
C C C
Oxytocin
12 m/w
12 m/w
24 m/w
Contractions in 10 mins
5
4
3
2
1
Drugs and IV Fluids
10 RL
10 RL
10 RL
Urinalysis
Test
Amount

Record of Labor:

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

Time: ..... Signature: .....

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

Time: ..... Signature: .....

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

Time: ..... Signature: .....

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

Time: ..... Signature: .....

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

Time: ..... Signature: .....

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INSTRUMENTAL DELIVERY PROFORMA

Patient Label Mrs. Stella	OBSTETRICIAN	Dr. Sheela
	ANAESTHETIST	
	ASSISTANT	Dr. Pavithra
	DATE	20/07/2026
	TIME	12:28pm
	PLACE	LABOUR WARD (circled) / THEATRES

CONSENT	EPISIOTOMY	BLADDER EMPTIED?
VERBAL (circled) / WRITTEN	YES (circled) / NO	FOLEY / IN/OUT (circled) / NO

ANALGESIA	CTG	LIQUOR
LOCAL / PUDENDAL (circled) AMOUNT USED 10mMLS OF _____ EPIDURAL / SPINAL / GA	NORMAL / SUSPICIOUS / PATHOLOGICAL (circled) Persistent Decelerations (WRITE FULL DETAILS IN MAIN NOTES IF NOT NORMAL CTG)	CLEAR / BLOOD STAINED / MECONIUM (circled) Grade II
		ABDOMINAL FINDINGS 0 /5 PALPABLE

VAGINAL EXAMINATION

NUMBER OF CMs DILATED
STATION OF PRESENTING PART -1 / 0 / +1 / (+2) / +3

POSITION: DOA / LOA / ROA / ROP / LOP / DOP / (LOT) / ROT

CAPUT	(0)	+	++	+++	
MOULDING	(0)	+	++	+++	

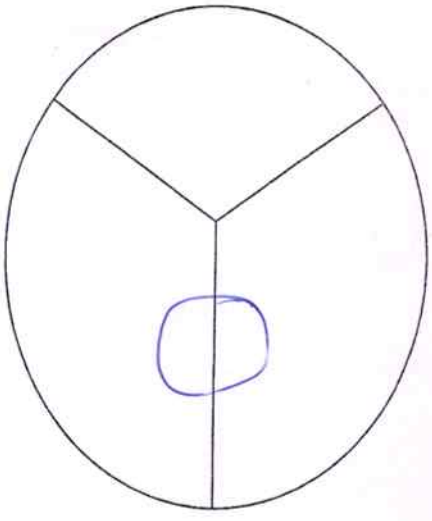
INSTRUMENT USED

Vaccum

KIWI CUP / NEVILLE BARNES / WRIGLEYS / KIELLANDS / SIMPSONS

MANUAL ROTATION	TIME OF APPLICATION	No. OF TRACTIONS
YES / (NO)	12:27pm	-
ABANDONED	**TIME OF DELIVERY**	**LENGTH OF DELIVERY**
YES / (NO) (FULL DETAILS IN NOTES)	12:28pm	—

Brief description of delivery and perineal repair.
(Please mark ventouse position on diagram)



EXTENT OF TEAR

EPISIOTOMY / 1ST degree / 2ND degree / 3A / 3B / 3C / 4TH degree
(If 3rd or 4th, please complete proforma)

SUTURE MATERIAL USED	**SUTURE TECHNIQUE**	**PR**	**PV**
2/0 VICRYL (number.....) 3/0 VICRYL (number.....) OTHER? Rapid vicryl	CONTINUOUS/INTERUPTED SKIN CLOSED? YES/NO	YES / NO	YES / NO

FOLEY CATHETER	**SWAB COUNT**		**ANTIBIOTICS**	**ANALGESIA**
YES NO REMOVE ..... (SHOULD REMAIN IN SITU FOR MIN OF 12HRS IF REGIONAL BLOCK USED)	PRE – REPAIR Correct POST – REPAIR Correct		YES / NO (PRESCRIBE ON DRUG CHART)	YES / NO (PRESCRIBE ON DRUG CHART)
	PARACETAMOL 1GM PR YES / NO	**DICLOFENIC 100MGS PR** YES / NO		

Patient Sticker

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INDUCTION OF LABOR CONSENT

Name: ..... GUC-00091442 IP18-00036534 Mrs STELLA MARY .J 05-02-1988 38 Y 5 M 14 D (F) Dr. SHEELA M ..... Age: ..... Gender: Male ☐ Female ☐

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

You are scheduled for an induction of labor on ..... (date) at ..... (weeks of gestation).

The reason for your induction is .....

The goal of induction of labor is to achieve vaginal delivery by starting uterine contractions before the spontaneous start of labor.

Induction of labor for a medical indication is done when continuation of pregnancy is considered detrimental to the health of the mother or fetus. This can be done at any stage of pregnancy irrespective of fetal maturity if there is a valid indication.

Elective induction of labor (scheduled induction without a medical indication) may not be done until you are at least 39 weeks. This is important so that your newborn does not have complications due to possible prematurity.

The alternative to induction of labor is to wait for labor to start spontaneously.

I have read the information provided and also discussed the process with my doctor.

I understand the risks and benefits of this procedure and wish to proceed.

Patient

Signature: J. [illegible]

Name: [illegible] STELLA MARY

Date & Time: 20/7/26

Patient Attendant:

Signature: M. Dhanam

Name: M. Dhanam

Relationship with Patient: Husband

Date & Time: 20/7/26

Doctor:

Signature: for Dr. Sheela 164288

Name: Dr. Sheela

Date & Time: 20/7/26.

Witness

Signature: .....

Name: .....

Date & Time: .....

INFORMED CONSENT FOR VAGINAL BIRTH

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GUC-00091442 IP18-00036534
Mrs STELLA MARY .J
05-02-1988 38 Y 5 M 14 D (F)
Dr. SHEELA M

Patient Name : ..... UHID No : .....

Gender: ☐ Male ☐ te : ..... Time : .....

I hereby authorized the performance of the following procedure:

- The Procedure has been explained to me in general terms and I understand that:
- The indication requiring the procedure of vaginal birth is pregnancy.
- The purpose of this procedure of vaginal birth pregnancy.
- The purpose of this procedure is to deliver the bay vaginally.

The outcome of the vaginal birth is the delivery of infant through birth canal either naturally or with possible use of force vacuum extraction. An episiotomy (a cut performed for enlarging of the vaginal opening in the space between the vaginal and the rectum) may be performed as part of a vaginal delivery.

Should vaginal delivery be unsuccessful, delivery by cesarean section with an abdominal incision under appropriate anesthesia may be necessary.

In an attempt to deliver the baby either naturally or with the help of instrument i.e. forceps or vacuum, there may be risks of: infection, allergic reaction, scarring, blood loss, need for blood transfusion, pain and discomfort, injury to urinary tract, possible injury to the baby (laceration, hematoma, skull fracture, nerve injury and brain injury) and possible future pelvic floor dysfunction.,

I understand and accept that there are complications, benefits, alternatives including the remote risk of death or serious disability, which exists for me and my baby.

I am aware that in most cases, vaginal delivery results in a healthy mother and baby; however, I realize that there are no guarantees.

I voluntarily consent to the procedures described or otherwise referred to herein. I am aware that they will be performed by a qualified gynecologist.

Name of the Doctor performing the procedure: .....

Consentee :

Signature : J.S.

Name : Mrs. STELLA MARY.

Date & Time : 20/7/26

Witness :

Signature : .....

Name : .....

Date & Time : .....

Patient Attendant :

Signature : M.Dhanam

Name : M.Dhanam

Relationship with Patient: Husband

Date & Time : 20/7/26

Doctor (who is taking the consent):

Signature : for 164285

Name : Dr. Sheela

Date & Time : 20/7/26.

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CONSENT FOR BLOOD TRANSFUSION

Patient Name : Mrs. Stella Mary Age: ..... Gender :.....

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

Type of Blood Product : PRBC

I Mrs Stella Mary 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 .....

J. Sr (J. Stellamary)
Name of Patient / Attendant

J. Sr
Signature of Patient / Attendant

Date 19/7/26

Time :

M. Thomas
Relationship with Patient:

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

GUC-00091442 IP18-00036534
Mrs STELLA MARY .J
05-02-1988 38 Y 5 M 14 D (F)
Dr. SHEELA M

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Part - I.

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

Identified Education Needs:

1. Diagnosis, Plan
2. Treatment and Care
3. Pain Management
4. Informed Consent
5. Medication / Therapy (safety, effects/ side effect, interactions)
6. Discharge Medication
7. Infection Control Measures
8. Diagnostic Test / Procedures
9. Nutrition / Diet
10. Fall Risk Education
11. Safe use of Medical Equipment / Implantable Devices Safety
12. Patient's / Family Rights
13. Risk / Safety

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
19/7	10pm	Yes.	Health education given to Pain management	Patient	Lady barri	Verbal.	none	good	–	
20/7/18	9A	yes	Explain about diet	patient	NO	Oral	none	yes	good	P.Pe 809261

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

PATIENT TRANSFER FORM

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GUC-00091442 IP18-00036534
Mrs STELLA MARY .J
05-02-1988 38 Y 5 M 15 D (F)
Dr. SHEELA M

Treating Consultant Name	Date & Time of Admission	Date & Time of Transfer Order
Dr. Sheela	20/7/26 at 10.11 pm	20/7/26 at 7.30 pm
Transfer Ordered by	**Reason for Transfer**	
Dr. Dhivya	Shifted to ward	
From Unit	**To Unit**	**Information to Attendant**
IDR	7th Floor	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
2P Files		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. Tamilselvi 20-7-26	Dr. Dhivya

Patient & Clinical Records Received by : Rajini 02/7/26

Date & Time of Patient Received : 20/7/26 @ 7.30 pm

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

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

PATIENT TRANSFER FORM

Rainbow® Children's Hospital
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Patient Name & UHID No.	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