GUC-00079923 IP18-00036481
Mrs PRIYADARSHINI SWAMINATHAN
04-02-1997 29 Y 5 M 13 D (F)
Dr. MATHANGI RAJAGOPALAN

Rainbow Children's Hospital

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing	17/7/18 @ 8am.						
Activity Sheet update by Pharmacy							

GUC-00079923 IP18-00036481
Mrs PRIYADARSHINI SWAMINATHAN
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ACTIVITY RECORD FOR BILLING

Name: MRS. PRIYADARSHINI

UHID No: 79923 IP No: 36481 Consultant: Dr. Mathangi Dept: .....

Date of Admission: 15/7/26 Time: ..... Date of Discharge: ..... Time: .....

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
15/7/26	6.45pm	LDR	7th Floor	Sri Pavithra
15/7/26	9pm	7th Floor.	LDR	S/N. Divya
16/7/26	6.40 pm	LDR	7th Floor	S/N. Pavithra

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
15/7/26	RBS	26022819	[signature]
16/7/26	RBS	26022841	[signature]
16/7/26	RBS	26022907	[signature]
17/7/26	FBS, CBC	26022963	[signature]

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
15/7/26	CTG (1)			009520	
	CTG (2)			009520	
	CTG (3)			009562	
	CTG (4)			009562	
	CTG (5).			009570	
	CTG (6)			009573.	
	CTG (7).			009595.	
16/7/26	Infusion pump	8 am.	16/7/26 4 pm	1728374	
	CTG - 8			009606	
	CTG - 9			009606	
	CTG - 10			009606	
	CTG - 11			009606	
	CTG - 12			009606	
	CTG - 13			009606	
	CTG - 14			009606	
	CTG (15)			009612	
	CTG (16)			009612	

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
15/7/26	IV placement	1	1727695	[signature]
15/7/26	Catheterisation	1	1723375	[signature] 10/1960

ANY OTHER INFORMATION:

Delivery Details: Kiwi assisted vaginal Delivery
Date: 16/7/26
Duration: 1 Hour
Time: 2.30pm – 3.30pm
Dr. mathangi
Dr. Akshitha

Date: 17/7/26 Time: 6am Prepared By: [signature]

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
[signature]			

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DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

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ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement	11.15 Am				
	INTIME	OUT TIME			
Arrangement of File by Nursing		11.25 Am	P.Ca 609264		
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

Patient Name: Mrs Priyadharshini UHID No: 79923 Bed Category: 704

AT-ADMISSION DESK:

- Explain about admission process
- Welcome Kit

SERVIGES IN WARD:

- Explain about room facility like how to use the patient COT, Nursing Bell, important contact details.
- Room cleaning and wash room cleaning will be done regularly.
- Patient bed sheet & clothes will be changed every day morning.
- If patient got shifted to OT, please enquire with nursing station to get further updates
- Wash room hot water will be available round the clock
- For patient food please reach to Dietician / F&B Call @ (2203)
- Don't keep waste in the sink or other drains
- Food for the patient strictly as per the advice in-house dietician
- No outside food is allowed for patients
- Fruit juices, coconut water, salads, are available in canteen
- Patients' Rights & Reasonability explain to the family.
- Only 2 attender's allowed inside the room with patient.

BILLING:

- Take billing update on daily basis at ground floor IP Billing Department (09:00AM to 06:00PM) and if any Query please reach to billing manager/IP Manager (+916379905271) (on same time.)
- If any insurance query and corporate information, please reach to ground floor insurance/ corporate desk.
- For Insurance patient give documents after admission.
- Please carry attender pass at the time of visiting patient.
- VISITING HOURS for Pediatrics (08AM -09PM & 4PM -6PM)
- VISITING HOURS for OBG (12PM -01PM & 4PM -6PM)
- Explain about concern department contact details, which mentioned bedside chart.

MANAGEMENT TEAM:

- Team will meet everyday morning to look after the patient welfare and collect patient feedback on hospital services & MOD (+91 6379905263) available round the clock.
- Please give your valuable feedback before leaving the hospital at the time of discharge, it would be helpful to improve our services.

THANK YOU AND GET WELL SOON

Signature of the Introducer

Signature of patient/ patient Attendance

S. venkata krishna

GUC-00079923 IP18-00036481
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BED SIDE CHECK LIST FOR NURSES

Date:	17/7								
Doctor's Orders	yes								
Carried out or not	yes								
Bed Side									
Structured Handover done	yes								
IV Site	yes								
Central Lines	NA								
Arterial Lines	NA								
Feeding Catheter	NA								
Urinary Catheter	NA								
Skin Care	yes								
Eye Care	yes								
Mouth Care	yes								
Sterillum Bottle, Stethoscope	yes								
Suction Bottle (Should be clean & empty)	NA								
Intubation Tray	NA								
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	NA								
Ventilator Tubing,(Any Water, Blood)	NA								
Humidification	NA								
Check all Infusion (Labelling,Correct Preparation)	NA								
Chest Physio & Neb	yes								
Handed Over By Name :	PDS								
Signature :									
Date & Time:	17/7/16 8AM								
Hand Over Taken By Name :									
Signature :									
Date & Time:									

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature
15/7/26	12.30 pm	100 mg/dl	Dr. pavithra	
16/7/2026	6AM.	110 mg/dl	DR. mohana	
16/7/2026	10 am	135 mg/dl.	Dr pavithra	

Docu. No. : RCH /FRM / CLINICAL / 185

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Guindy

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

ADMISSION SHEET

Registration Details :

Admission No : IP18-00036481 **Admit Date** : 15-Jul-2026 **Admit Time** : 11:29 AM **UHID** : GUC-00079923

Patient Details :

Patient Name	: Mrs PRIYADARSHINI SWAMINATHAN	**Age**	: 29 Y 5 M 11 D
Guardian	: Mr VENKATAKRISHNAN .S	**DOB**	: 04-02-1997
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: mayur apartmnet s - f2 7 th main road ags colony Velacheri Chennai Tamil Nadu INDIA 600042	**Phone No**	: 9952296526
		E-mail	: no@gmail.com

Admission Details :

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

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

Contact Details :

Name : Mr VENKATAKRISHNAN .S **Relationship** : Husband

Contact Address : mayur apartmnet s - f2 7 th main road ags colony Velacheri Chennai Tamil Nadu INDIA 600042 **Phone No** : 9952296526

S. Venkata Krishnan
Signature

Doctor Details :

Doctor Name : Dr. MATHANGI RAJAGOPALAN **Specialisation** : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

Payment Mode : Cash **Deposit Amount** : 7000.00

Payor Name : SELFPAY

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

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Mrs PRIYADARSHINI SWAMINATHAN**	**Age :**	**29 Y 5 M 11 D**
IP No:	**IP18-00036481**	**Sex:**	**Female**
Consultant:	**Dr. MATHANGI RAJAGOPALAN**	**Ward/Bed No:**	**8F-OT COMPLEX/MICU 803**

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

Patient, be deemed advisable or necessary.

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

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

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

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

Note:
1 We do not allow use of medication brought from outside by the patient.
2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.
(Receivers Signature: S. Venkata krishna)

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: S. Venkata krishna

Name: Venkatakrishnan . S

Relationship: Husband

Date: 15/07/2026 Time: 11.30 AM

Witness Name: Pavithra

Witness Signature:

Patient Address:

mayur apartmnet s - f2 7 th main road ags colony Velacheri Chennai Tamil Nadu INDIA 600042

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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 : Mrs. Priyadharshini	UHID Number : GUC-0007 9923
Self/Attendant Name : S. Venkata Krishna	Relation : Husband
Self/ Attendant Signature : S. Venkata Krishna Phone Number : 9952296526.	Name & Signature of Financial Counselor

இந்திய அரசாங்கம்
Government of India

பிரியதர்ஷினி சுவாமிநாதன்
Priyadarshini Swaminathan
பிறந்த நாள்/ DOB: 04/02/1997
பெண் / FEMALE

9107 0630 2018

எனது ஆதார், எனது அடையாளம்

Unique Identification Authority of India

முகவரி:
சுவாமிநாதன், நம்பர் 5,
ரானிஜி நகர், ஏ என் ஆர்
வணிக வளகம், மதனந்தபுரம்,
முகலிவாக்கம், காஞ்சிபுரம்,
தமிழ் நாடு - 600125

Address:
D/O,Swaminathan, Nambar 5,
Raniji Nagar, A N R Vaniga
Valagam, Madanandapuram,
Mugalivakkam, Kancheepuram,
Tamil Nadu - 600125

9107 0630 2018

1947

help@uidai.gov.in

www.uidai.gov.in

GUC-00079923 IP18-00036481
Mrs PRIYADARSHINI SWAMINATHAN
04-02-1997 29 Y 5 M 11 D (F)
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IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

* Pt was admitted for IOL
* Able to perceive fetal movements well
* No c/o Lower Abdominal Pain, bleeding or leaking PV

Obstetric Formula: Primi

Obstetric History: G_1 - PP, OI conception

Present Pregnancy Record:
NT Scan - Normal ; FTS - Low risk (↑ risk of PE)
NT - 1.2m
Anomaly Scan - Normal

RISK FACTORS:

GHTN from 13 ~~weeks~~ weeks of gestation
GDm on OHA from 13+4 weeks of gestation / month

Height: ...164..... cm
Weight: .....91.8..... kg
Allergies: .....Nil.....
Breast: ☑ Normal ☐ Abnormal
General Examination:
Consciousness: Conscious Pallor: No
Icterus: No Edema: No
Temp: Normal PR: 100/min
BP: 120/80 mmHg DTR:
CVS: S_1S_2 ⊕ RS : B/L NVBS
Liver/Spleen: Urine Output:

LMP: 15/10/2025 EDD: 22/07/2026
Corrected EDD: GA: 39 weeks
Menstrual History: Regular : ☐ Yes ☐ No

Obstetric Examination

Fundal Height: Term

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

Per Speculum Examination

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

Vaginal Examination

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

DIAGNOSIS

Primi
OI conception
M/e - 3 years
NCM
D +ve

LMP - 15/10/2025
EDD - 22/07/2026
RMP

GA - 39 weeks
GDm on OHA
GHTN
Admitted for IOL

(P.T.O)

Patient Sticker

Family History:

Father. T_2DM, HTN

Surgical History:

HSG done on 21st october 2025

Medical History:

GDm on OHA from 13 weeks

GHTN from 14 weeks

Medication History:

Tab. GLYCOMET 500mg 1-0-1

Tab. LOBET 100mg 1-0-1

Took Tab. ECOSPIRIN 150mg till 36 weeks

Plan of Care:

C/I IT Dr. Mathangi

- Admission
- parts preparation
- Secure IV line
- Informed consent for IOL/ND

3:50pm

↓ SAP, Induction of labour done with 22F Foley's inserted intracervically and bulb inflated with 65ml of distilled water.

- W/F Foley's expulsion
- INJ. SUPACEF 1.5g IV TDS (ATD)
- Post Foley's CTG @4:50pm
- Shift to ward
- Reshift to LDR @ 9pm
- CTG @ 4th hourly

Investigations:

CTG - Reactive

Doctor Name: Dr. Pavithra / Dr. Shreedevi

Signature: [signature]

Date & Time: 15/7/26

Consultant Name: Dr. Mathangi

Signature: for [signature]

Date & Time: 15/7/26.

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RESULT SHEET

Date	21/6/24	17/7/26			O+ POSITIVE
Time					
Hb	10.6	10.6			21/11/25
PCV	34	32			HIV
RBC	3.81	3.71			HCV
WBC	8,610	15,780			HBs Ag } Non-Reactive
N/L	643/25.6	83/12			VDRL
Platelets	3.22	3.39			
CRP					
ESR					21/11/25
PCT					HbA1C - 6.0
RBS	FBS - 88 PPBS - 117	FBS - 96			
Na					Rubella - Positive
K					
Cl					ICT - Negative
Ca/Mg					
Phosphate					Hb Electrophoresis - Normal
Urea					
Creatinine					TSH - 1.78
ALP					TT_4 - 11.07
SGPT					TT_3 - 119.2
SGOT					
T.Bill/Conj					ECG } Normal
T.Protein					ECHO
S.Albumin					Trivial MR
S.Globulin					Trivial TR
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells	18/22/17				
N/L					

Docu. No. : RCH /FRM / CLINICAL / 0138

(P.T.O)

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 : 25/06/2024 SLIUG EFW - 2677 grams (39% 1/2)

X-Ray : 36wks + 1d

ECHO : Liquor - Normal, SDP - 5

CT : Cephalic

MRI : Placenta - Posterior

Others (ECG, Contrast Studies etc.,) : Doppler - Normal

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(1)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/7/24 6pm	C/S/B Dr. Akshitha / Dr. Shreedevi	
	- Post Foley's CTG reactive	
	- W/F Foley's explusion	
	- BP 2nd hourly monitoring	
	- To take night dose of Tab. GLYCOMET	
	- CTG @ 4th hourly	
	- Follow drug chart	
	- Shift to ward	
	- Reshift to LDR @ 9PM	
	Dr. S 2217	
15/7/24 9pm	S/B Dr. Mohana	
	foleys	pt. received in Pre delivery expelled.
39 wks	p/v: Cx 2cm long. OS 2cm dilated. membranes (+) V_x -3 pelvis gynaecoid	C/D/w Dr. Mathangi. Advice:
T: N PR: 80 bpm BP: 120/66 mmHg		- CTG STAT. - Reassess @ 4 AM for Gel induction. - CTG Q4H. - W/F contractions. - Inform SOS.
	16/7/24	

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/7/26	S/B Dr. Mohana	
4 pm	pt reviewed. Able to PFM well.	
39+1 weeks	C/o lower abdominal cramps.	
	P/A: Ut term	
T-N	2c/10sec/10 mins	
PR: 80/min	cephalic	
BP: 124/72 mmHg	FHS good	
CTG - Reactive	P/V: Cx 2cm long os 2cm dilated membranes (+)	
	Vx at -3 station	
	Pelvis gynaecoid	
	↓ ASP, PGE2 gel instilled intracervically.	
		Advice - post gel CTG at 5 pm. - W/F contractions. - Inform SOS.

16/7/26

GUC-00079923 IP18-00036481
Mrs PRIYADARSHINI SWAMINATHAN
04-02-1997 29 Y 5 M 12 D (F)
Dr. MATHANGI RAJAGOPALAN

(2)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/7/26		
5:30 PM	post gel CTG - Reactive	
	c/d/w Dr. Mathangi	
	Advice	
	- To start Inj Synto @ 24 ml/hr @ 8 mm & titrate	
	- Continuous CTG	
	- W/F contractions	
	- Inform SOS	
		16/7/26
16/07/2026	c/s/B Dr. Pavithra / Dr. Shreedevi	
8:30 AM		
	Pt reviewed, N:I c/o	Advice
T - (N)	O/E Pt GC fair, Afebrile	- Liquid diet
PR - 82/min	P° / PE°	- Continuous CTG
BP - 116/72 mmHg	CVS /	- Continue INJ. SYNTO
	RS / NAD	acceleration & titrate
INJ. SYNTO @ 24ml/hr	P/A - Ut @ Term	accordingly
CTG - Reactive	Mildly Acting (2C/20"/10')	- W/F Contractions / Progress
	Cephalic	- Follow
	FHS - good	
	18/7/26	

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/6/2026 9.30 Am.	C/S/B Dr. Mathangi.	
	P/A - Uterus @ Term	
	Mildly acting AC/25"/10"	
	cephalic	
	FHS good.	
CTG-Reactive		
	P/V - Cx - 1.5 cm long	
	OS - 3cm dilated	
	membranes (+)	
USG	vertex @ -2	
- DOP		
- Single loop of cord around the neck	↓ SAP, ARM done clear liquor drained	
	Post ARM	
	18/2/17	Advice
		- All four position
		- INJ. PETHIDINE 50 mg IM
		INJ. PHENERGAN 25mg IM
		- Continuous CTG
		- Continue INJ. SYNTO acceleration and titrate accordingly
		- W/F Contractions
		- Inform(SOS)

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Mrs PRIYADARSHINI SWAMINATHAN
04-02-1997 29 Y 5 M 12 D (F)
Dr. MATHANGI RAJAGOPALAN

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/07/2026 10:30pm	C/S/B Dr. Panithra	
	Pt getting 5 contractions for 30 seconds. Pt asking for epidural pain relief	
CTG-Reactive		Advice C/I/T Dr. Mathangi - To give Epidural for pain relief. - CTG Monitoring.
	Impression	
16/7/26 11PM	Post Epidural → Vitals T- (N)	BP-120/76 PR-86/min.
	Post Epidural → CTG had Decelerations, Syuto Stopped for a while & restarted.	
16/7/2026 1:15PM	C/S/B Dr. Mathangi	
	o/e P/v - Cx well effaced os 5cm dilated membs (-) Vx @ - 2 station.	Advice - To continue Inj Syuto @ 48ml/hour. - Continuous CTG
CTG-Occasional Variable Decels		
	Impression	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/07/2026 2:20pm	C/S/B Dr. Mathangi	
	P/A- Ut @ Term	Advice
	(4C/15"/10')	- Squatting (10')
	Cephalic	- Continuous CTG
CTG- Reactive	FHS-good	- Continuous Monitoring
	P/V- Cx - well effaced	- W/F contractions
	OS- 8cm dilated	
	Membranes - Absent	
	Vertex @ -1	
	Ant. lip of cervix edematous	
	[signature] 182217	
16/07/2026 2:40pm	C/S/B Dr. Mathangi	
		Advice
	P/A- Uterus @ Term	- Position for Labouring
	(4C/15"/10')	- Continuous CTG
CTG- persistent variable decelerations (+)	Cephalic	- Encourage active pushing
	FHS-good	
	P/V- Cx fully effaced	
	OS- fully dilated	
	Membranes Absent	
	~~Vertex~~ @	
	[signature] 182217	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/07/2026 2:57 PM	KIWI ASSISTED VAGINAL MEDIOLATERAL EPISIOTOMY	DELIVERY WITH RIGHT
	INDICATION: PERSISTENT POOR MATERNAL EFFORTS	VARIABLE DECELERATIONS /
	S/B - Dr. Mathangi A/B: Dr. Akshitha, Dr. Shreedevi Under strict aspectic precautions, under epidural analgesia Patient in dorsolithotomy position. local parts painted and draped. With good uterine contractions, full cervical dilation a right mediolateral episiotomy was given under 2% Lignocaine local infiltration. In view of persistent variable decelerations / poor maternal efforts Kiwi cup was applied in vertex at +2 station. Chignon created. An alive term girl baby was delivered. Baby cried immediately after birth. Cord clamped and cut. Baby handed over to pediatrician. Cord blood collected for blood group and typing. Placenta and membranes delivered intoto. Episiotomy inspected and sutured in layers using rapid vicryl and 2-0-vicryl. Hemostasis secured. P/A - Ut firm & well contracted P/V - No undue bleeding PV P/R - Rectal mucosa and sphincter tone Normal	

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	B | 16.07.2026 ; 2:57pm	
	A | Girl	
	B | 3.22 kg	
	Y | 8/10, 9/10	
		Advice
		- Normal diet
		- Plenty of oral fluids
		- Vitals Monitoring
		- Follow drug Chart
		- CBC c/m 6 Am
		- W/F ↑ Bleeding PV
		- FBS, PPBS c/m 6 Am (POD-1)
		- BP 2nd hourly monitoring
		- Inform Pt Measure & void
		- Inform (SOS)
	18221?	

GUC-00079923 IP18-00036481
Mrs PRIYADARSHINI SWAMINATHAN (F)
04-02-1997 29 Y 5 M 12 D
Dr. MATHANGI RAJAGOPALAN

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/7/26 6:15pm	S/B Dr. [illegible]	Dr. Sreedevi.
O/the	PND #0 / P1L1 / B/wi assisted vaginal delivery.	
	• GDM on OHA.	
	• GHTN.	
	pt reviewed.	
BP 122/84mmHg	no sp. complaints.	
PR 82bpm.	O/E: afebrile	Plan:
SpO2 99% @ RA	GC fair	- monitor vitals.
Temp (N)	P° / PE°	- normal diet
	P/A: uterus wc	- hydrate
B/L breast soft	soft	- ambulate.
secretion s (+)	BS (+)	- CBC / FBS / PPBS c/m 6 AM.
Baby m/s	L/E: BUWNL.	- BP Q2hourly.
DBF.		- w/f ↑ bleeding P/V.
	[signature] 128435	- shift to ward.
16/7/26 8:45pM	S/B Dr. Vinitha	
	Pt. reviewed; No c/o	; Passed stools
	O/E: GC fair; Afebrile	
BP: 122/84	P° / PE°	Adv:
PR: 70/min	P/A: Ut WC	• Soft diet; Plenty of fluids
SpO2: 99% RA	Soft; BS (+)	• Vitals monitoring
	L/E: BUWNL	• Ambulation
Baby M/S	Epi wound intact	• CBC, FBS, PPBS
B/L Breasts soft		• BP Q2H
		• w/f Bleeding P/V
	[signature] 12113	• Inform SOS

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

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/07/2024	C/S/B Dr. Pavithra / Dr. Shreedevi	
9 Am	Pt reviewed, N/V/ C/O	Advice
	O/E Pt GC fair, Afebrile	- Normal diet
POD-1	P°/PE°	- Plenty of oral fluids
	CVS /	- Vitals monitoring
T-(N)	RS / NAD	- Follow drug chart
PR- 78/min	P/A- ut well contracted	- W/F ↑ Bleeding PV
BP- 108/66 mm Hg	Soft	- Inform(SOS)
Baby - M/S	L/E - BWNL	- Process discharge
B/L- Breast soft	Epi wound Intact	- To do PPBS & inform the report
Voiding freely	&	
Passed stools	182217	
Hb- 10.6		
FBS- 96		

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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CROSS CONSULTATION FORM

Doctor Name : ..... Date : ..... Time : .....

Diagnosis : .....

Hospital : .....

.....

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

Type of Referral :
☐ Emergency
☐ Urgent
☐ Non Urgent

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

Post natal Exs and advices / Mrs. Priyadharshini

Signature:

Findings and Recommendations : S/B physiotherapist Miss Dr. Mohanapriya (pt).

- Dos and Don'ts advised

OBG & Gyn.

Avoid lifting weights
Avoid lifting Both the legs.
Encourage lying down on the sides
Postural advices Given
Sitting posture educated
Coughing and Huffing technique.

Consultant :

Name : ..... Signature : ..... Date & Time : .....

BE / Abdomen Breathing Ex.

posterior pelvic tilt

Pelvic Bridging Ex

kegels.

Ankle Mobilisation

Knee mobilisation -

Review after 2 weeks.

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04-02-1997 29 Y 5 M 12 D (F)
Dr. MATHANGI RAJAGOPALAN

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MEDICATION RECONCILIATION FORM

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

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

Shifting From: LDR Shifted to: 7th Floor

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Tab. AUGMENTIN	625mg	PO	TDS		☑C ☐DC
2	Tab. PARACETAMOL	1g	PO	TDS		☑C ☐DC
3	C. PAN D	40mg	PO	BD		☑C ☐DC
4	JUSTIN SUPPOSITORY	100 mcg	PR	BD	16/7/26 at 3.20pm	☐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 : 16/07/2026

Nurse Name & Signature: S/N: Tamilselvi 16/7/26

Date & Time : 16/7/26 at 6.40pm

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

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04-02-1997 29 Y 5 M 11 D (F)
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MEDICATION RECONCILIATION FORM

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

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

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

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T. GLYCOMET	500mg	PO	1-0-1		☐C ☐DC
2	T. LOBET	100 mg	PO	1-0-1		☐C ☐DC
3						☐C ☐DC
4						☐C ☐DC
5						☐C ☐DC
6						☐C ☐DC
7						☐C ☐DC
8						☐C ☐DC
9						☐C ☐DC
10						☐C ☐DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Shreeden

Date & Time : 15/7/2026 @ 10.45am

Nurse Name & Signature: S/N Parameswari 16803

Date & Time : 15/7/2026 @ 10.45am

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

GUC-00079923 IP18-00036481
Mrs PRIYADARSHINI SWAMINATHAN
04-02-1997 29 Y 5 M 11 D (F)
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MEDICATION RECONCILIATION FORM

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

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

Shifting From: LDR Shifted to: 7th Floor

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T. GLYCOMET	500mg	P/O	1-0-1		☐C ☐DC
2	T. LOBET	100mg	P/O	1-0-1		☐C ☐DC
3						☐C ☐DC
4						☐C ☐DC
5						☐C ☐DC
6						☐C ☐DC
7						☐C ☐DC
8						☐C ☐DC
9						☐C ☐DC
10						☐C ☐DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : [signature] for Dr. Mohanapriya

Date & Time : 15/7/26 at: 9pm

Nurse Name & Signature: S.N. Tamilselvi [signature]

Date & Time : 15/7/26 at: 9PM

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

GUC-00079923 IP18-00036481
Mrs PRIYADARSHINI SWAMINATHAN
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Dr. MATHANGI RAJAGOPALAN

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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: 7th floor Shifted to: LDR

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T. GLYCOMET	500mg	P/O	1-0-1		☐C ☐DC
2	T. COBET	100mg	P/O	1-0-1		☐C ☐DC
3						☐C ☐DC
4						☐C ☐DC
5						☐C ☐DC
6						☐C ☐DC
7						☐C ☐DC
8						☐C ☐DC
9						☐C ☐DC
10						☐C ☐DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : ..... Dr. Mohanapriya

Date & Time : 15/7/26 @ 9pm

Nurse Name & Signature: ..... S/N. Aswini

Date & Time : 15/7/26 @ 9pm.

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DRUG CHART

Date of Admission: 15/7/26 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 .....

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Mrs PRIYADARSHINI SWAMINATHAN
04-02-1997 29 Y 5 M 11 D (F)
Dr. MATHANGI RAJAGOPALAN

REGULAR PRESCRIPTIONS

Weight. 91.80 kg Ward. LDR

DRUG : T. GLYCOMET

Dose	Route	Frequency	Start Date
500mg	PO	1-0-1	15/7/24

Name & Signature of the Doctor Starting the Drugs: 182217

Additional Instructions: 20 mins after food

Daily Doctor's Endorsement by a Sign

Date/Time	15/7	16/7
8AM		WH
8PM	AA SS	

DRUG : T. LOBET

Dose	Route	Frequency	Start Date
100mg	PO	1-0-1	15/7/24

Name & Signature of the Doctor Starting the Drugs: 182217

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time	15/7	16/7	
8AM		WH	WH
8PM	NJ/AK	WH	

DRUG : INJ. SUPACEF

Dose	Route	Frequency	Start Date
1.5g	IV	1-1-1	15/7/24

Name & Signature of the Doctor Starting the Drugs: 182217

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time	15/7	16/7
8AM	NJ	
2PM	SP	
5PM	TJ	
10PM		

STOP

DRUG : TAB. AUGMENTIN

Dose	Route	Frequency	Start Date
625mg	PO	1-0-1	16/7/24

Name & Signature of the Doctor Starting the Drugs: 182217

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time	16/7	
8AM		SS KH
2PM		
10PM	AA SS	

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04-02-1997 29 Y 5 M 12 D (F)
Dr. MATHANGI RAJAGOPALAN

Weight. 91.80kg Ward. LDR

VARIABLE DOSE	Date / Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
DRUG :		Dose		Dose		Dose		Dose	
Route / Start Date		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.	
		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	
Route / Start Date		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.	
		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
15/7/26	4.15pm	INJ. SUPACEF	0.1 ml	Id	IS2217	SP
16/7/26	11.10 AM	PGE2 Gel	0.5mg	Intracervical	16/7/26	TJ
16/7/26	1.30pm	INJ. DEXA	1 cc	IV	IS2217	SP
16/7/26	~~2.00~~ 2.58pm	INJ. SYNTO	10 U	IM	IS2217	MP / SP
16/7/26	3pm	INJ. TRAP L	1g	IV	IS2217	TJ / SP
16/7/26	3.05pm	INJ. CARBPROST	250mcg	IM	IS2217	TJ / SP
16/7/26	3.20pm	T. MISOPROSTOL	600 mcg	PR	IS2217	TJ / SP
16/7/26	3.20pm	JUSTIN GEL	100 mcg	PR	IS2217	TJ / SP

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

GUC-00079923 IP18-00036481
Mrs PRIYADARSHINI SWAMINATHAN
04-02-1997 29 Y 5 M 12 D (F)
Dr. MATHANGI RAJAGOPALAN

I.V. FLUIDS CHART

Weight. 71-80kg 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
15/7/26	12.30 pm	IVF 1 ⊙ RL	Iv	free flow	182217	SP SA	15/7/26	182217	SP SA
16/7/26	8am	INJ. SYNTO 5U in 500ml RL	Iv	24 ml/hr	182217	MD SA	16/7/26	182217	SW MD
16/7/26	8am.	IVF 1 ⊙ RL	Iv	free flow	182217	MD SA	16/7/26	182217	SA
16/7/26	11.00 am.	IVF 1 ⊙ RL	Iv	free flow	182217	MD SA	16/7/26	182217	MD SA
16/7/26	12.30 pm	IVF 1 ⊙ RL	Iv	free flow	182217	MD SA	16/7/26	182217	TJ SP
16/7/26	3pm	INJ. SYNTO 20 U in 500ml RL	Iv	125 ml/hr	182217	TJ SP	16/7/26		TJ SP

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

GUC-00079923 IP18-00036481
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04-02-1997 29 Y 5 M 12 D (F)
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Sheet No: .....

REGULAR PRESCRIPTIONS

Weight 9/.30 Ward 2DR

DRUG : C. PAN D

Dose	Route	Frequency	Start Dt.
40mg	PO	1-0-1	16/7/26

Name & Signature of the Doctor Starting the Drugs: 182217

Additional Instructions: Before food

Daily Doctor's Endorsement by a Sign

Date/Time	16/7	17/7
7AM	✓	AA/SS
7PM	SM	KH

DRUG : Tab. PARACETAMOL

Dose	Route	Frequency	Start Dt.
1g	PO	1-1-1	16/7/26

Name & Signature of the Doctor Starting the Drugs: 182217

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time	16/7	17/7
8AM	✓	S.S/KH
2PM	✓	
10PM	AA/SS	

DRUG : JUSTIN SUPPOSITORY

Dose	Route	Frequency	Start Dt.
100mg	PR	1-0-1	16/7/26

Name & Signature of the Doctor Starting the Drugs: 182217

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time	16/7	17/7
9AM	✓	S.S/K.H
9PM	AA/SS	

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time	

Signature .....

VERIFIED BY : Name .....

Patient Sticker

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

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

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

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

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

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

GUC-00079923 IP18-00036481
Mrs PRIYADARSHINI SWAMINATHAN
04-02-1997 29 Y 5 M 11 D (F)
Dr. MATHANGI RAJAGOPALAN

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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

15/7/26	Date																						
	Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																								
	21 - 30																								
	11 - 20				20	20				18				20		20	20	20	18	20		20		20	
	0 - 10																								
Saturations	94 - 100 %				99	99				99				99		99	99	99	99	99		99		99	
	< 94 %																								
Administered O2 (L/min.)					RA	RA				RA				RA		RA	RA	RA	RA	RA		RA		RA	
Temp °C	40																								
	39																								
	38				98F		98F			98F				99.6F											
	37																								
	36																								
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110				160																				
	100						98			90				95											
	90																								
	80																								
	70																								
	60																								
	50																								
	40																								
Systolic Blood Pressure ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120				120		124			126				111		110		117		110		120		118	
	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80				80		76			76				66		68		66		60		78		72	
	70																								
	60																								
	50																								
	40																								
NEURO RESPONSE [✓]	Alert				✓		✓			✓				✓		✓		✓		✓		✓		✓	
	Voice																								
	Pain																								
	Unresponsive													✓											
URINE mls / hour	> 30				✓		✓			✓				✓		✓		✓		✓		✓		✓	
	< 30																								
Proteinuria	Protein + +																								
	Protein > + +																								
Lochia	Normal				—		—			—				—		—		—		—		—		—	
	Heavy / Foul																								
Liquor	Clear / Pink				—		—			—				—		—		—		—		—		—	
	Green																								
TOTAL YELLOW SCORES					0		0			0				0		0		0		0		0		0	
TOTAL ORANGE SCORES																									
Nurse Initial																									

Admission

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

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

16/7/2026

		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20		20		22		22		18	20	20		16		16		20		16		22		22			
	0 - 10																									
Saturations	94 - 100 %		99		98%		99%		98%	98%	98%		99%		99		98%		99		98%		99%			
	< 94 %																									
Administered O_2 (L/min.)			RA		RA		RA		RA	RA	RA		RA		2L		RA		2L		RA		RA			
Temp °c	40																									
	39																									
	38								98.8	98.8	98.8		98.8		98.6		98.6		97.6		96.8		97.6			
	37		98		98		98																			
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100								96										100							
	90		88		90		90		88	90	90				78		84				78		76			
	80												80													
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130								130																	
	120		116		140		130			128	124		122		107		112		102		108		99			
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70		70		80		80		72	70-72	72		84		66		80		66		66		66			
	60																									
	50																									
	40																									
NEURO RESPONSE [✓]	Alert		✓		—		—		✓	✓	✓		✓		∟		∩		∟		∩		∩			
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30		✓		—		—		✓	✓	✓		✓		∟		∩		∟		∩		∩			
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal		T		—		—		—	—	✓		✓		∟		∩		—		—		∩			
	Heavy / Foul																									
Liquor	Clear / Pink		+		—		—		✓	—	—		—		—		—		—		—		—			
	Green																									
TOTAL YELLOW SCORES			0		0		0		0	0	0		0		0		0		0		0		0			
TOTAL ORANGE SCORES			2		0		0		0	0	0		0		0		0		0		0		0			
Nurse Initial																										

GUC-00079923 IP18-00036481
Mrs PRIYADARSHINI SWAMINATHAN
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FLUID CHART

Sheet No. : 1

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

15/7/2026		Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am	——	—— admission ——							——		
	11:00 am	H20	150ml							100ml	NO IV line	
	12:00 pm	H20	100ml									
	01:00 pm	H20	100ml	RL 500ml							0	
Total Intake :		850ml				Total Output :				100ml		
	02:00 pm	H20	150							200ml	0	
	03:00 pm	H20	100								0	
	04:00 pm	H20	100							250ml	0	
	05:00 pm										0	
	06:00 pm	Juice	100							150ml	0	
	07:00 pm											
Total Intake :		450ml				Total Output :				600ml		
	08:00 pm	H20	100ml								0	
	09:00 pm	H20	100ml							200ml	0	
	10:00 pm									200	0	
	11:00 pm	H20	100ml								0	
	12:00 am	H20	100ml								0	
	01:00 am									200	0	
Total Intake :		400ml				Total Output :				600ml		
	02:00 am	H20	100ml							200	0	
	03:00 am									150ml	0	
	04:00 am	H20	100ml							150ml	0	
	05:00 am	H20	100ml							200	0	
	06:00 am										0	
	07:00 am	H20	100ml							50ml	0	
Total Intake :		400ml				Total Output :				750ml		

Total 24 hrs. Intake	2.100ml.	Total 24 hrs. Output	2.050ml.

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FLUID CHART

Sheet No. : 2

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

16/7/26		Intake				Output					IV Site Thrombo-phlebitis Score	
Date	Time	Nature of Fluid	Route		84 Nto	NG	Diarrhoea	Vomit	Drainage	Urine		Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am	H2O	100	500	24					100	0	Dm
	09:00 am			100ml	48						0	Dm
	10:00 am	TC	100ml	100ml	72ml					100ml	0	Dm
	11:00 am			500ml	46ml						0	Dm
	12:00 pm	TC	100ml	500ml	40ml					100ml	0	Dm
	01:00 pm			100ml	40ml					50ml	0	Dm
Total Intake : 1538ml				RL	Inj-synto			Total Output : 350ml				
	02:00 pm	H2O	100	100	24	[illegible]				100	0	[illegible]
	03:00 pm	H2O	100	100	125						0	[illegible]
	04:00 pm	H2O	150		125						0	[illegible]
	05:00 pm	Juice	150		125						0	[illegible]
	06:00 pm	H2O	150ml							350	0	[illegible]
	07:00 pm						✓				0	
Total Intake : H2O - 750ml								Total Output : U - 450ml M - 1				
	08:00 pm	H2O	150ml								0	AA
	09:00 pm	H2O	100ml							300ml	0	AA
	10:00 pm	H2O	150ml							150ml	0	AA
	11:00 pm	Milk	100ml								0	AA
	12:00 am	H2O	150ml							250ml	0	AA
	01:00 am									150ml	0	AA
Total Intake : 650ml								Total Output : 850ml				
	02:00 am	H2O	100ml								0	AA
	03:00 am	H2O	100ml							250ml	0	AA
	04:00 am										0	AA
	05:00 am									200ml	0	AA
	06:00 am	Milk	100ml								0	AA
	07:00 am	H2O	150ml							300ml	0	AA
Total Intake : 450ml								Total Output : 750ml				

Total 24 hrs. Intake	3,438		Total 24 hrs. Output	2400ml

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: Primi / GA 39w+0D / GHTN GDM ON OHA / IOL			Any Infection: ☐ Yes ☐ No ☑ Not Known If Yes Specify:			
	Surgery / Procedure:			Post OP Day:			
BACKGROUND	Date / Shift	15/7/26 Morning	15/7/26 E	15/7/26 N	15/7/2026 N	16/7 M	16/7/26 E
	Medical Condition (Any special condition to be noted):	GDM on OHA GHTN	GDM on OHA / GHTN	GDM on OHA / GHTN	GDM on OHA / GHTN	GDM on OHA	GDM on OHA GHTN
	Diet:	Diabetic Diet	Diabetic	Diabetic Diet	Diabetic diet	Diebetic Diet	Diabetic
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Ventilation (RA, NP, NIV, VENTI):	RA	NA	NA	NA	NA	NA
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Vital Signs: Temp:	98°F	98 F	97.6F	98.1F	98 F	98F
	Res:	20 bpm	20 b/m	20 b/m	20 b/m	24 b/m	20 b/m
	SpO_2:	99%	99%	99%	99%	99%	99%
	Pulse:	100 bpm	100 b/m	85 b/m	80 b/m	84 b/m	80 b/m
	BP:	120/80 mmHg	126/76	111/66	110/70	110/70	110/70
	LOC:	conscious	conscious	conscious	conscious	conscious	conscious
	Fall Risk Score:	0	20	20	20	20	35
	Pain Score:	0	01/10	0/10	2/10	2/10	1/10
	Skin Integrity	Intact	Intact	Intact	Intact	Intact	Intact
Recommendations	Safety Needs:	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No
	Physiotherapy:	NA	NA	NA	NA	NA	NA
	Others Specify:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Special Diet:	Diabetic Diet	Diabetic	Diabetic Diet	Diabetic	D D	Diabetic
	Critical Lab Test / Values:	–		–	–	–	
	Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	ADL (Dependent / Non Dependent):	Non Dependent	Dependent	Dependent	Dependent	NA	Dependent
Post Operative Procedure Special Orders:		–	–	–	–	–	–
Handed Over By Name :		S/N parameswari		[illegible]	[illegible]	[illegible]	S/N [illegible]
Signature / ID :		[signature] 016808	[signature]	[signature] 021240	[signature]	[signature] 0157	[signature] 016120
Date:		15/7/26	15/7/26	15/7/26	16/7/2026	16/7	16/7/26
Time:		11am	7.30pm	9.00pm	7.30am	8am	at 8pm
Taken Over By Name :		S/N [illegible]	[illegible]	[illegible]	[illegible]	S/N [illegible]	[illegible]
Signature / ID :		[signature] 016120	[signature] 021240	[signature]	[signature] 0157	[signature] 016120	[signature]
Date:		15/7/26	15/7/26	15/7/26	16/7/26	16/7/26	16/7/26
Time:		1.30pm	7.3pm	9pm	8AM	1.30pm	8p

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NURSING CARE RECORD

Date: 15/7/2021

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	12pm	Reduce risk of Infection	12:30 pm	Maintain strict hand hygiene Use aseptic techniques	patient maintain hand hygiene	FHR good	01:00
Afternoon	1.30 pm	Reduce pain and discomfort	2pm	* Assess pain by using pain scale * position comfortably	Reduced Pain and discomfort to some extend	Reassessment done	01:00
Night	9.30 pm	Reduce risk of Infection and pain discomfort.	8pm	Assess pain by using Pain scale * position comfortably	Reduced Pain and discomfort to some extad	Reassessment done.	02:00

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NURSING CARE RECORD

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Date: 16/07/26

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	8 am.	Relieve pain and discomfort.	8.30 am.	Assess pain using pain scale regularly Position patient comfortably Maintain accurate documentation.	Pt free from pain.	Reassessment was done.	
Afternoon	1.30 pm	Achieve acceptable pain and discomfort	2pm	* Assess pain using pain scale * Provide comfortable position * Administer analgesic	Reduced pain to some extend	Reassessment Done	
Night	8pm	To maintain fluid balance.	8pm	To ass the general condition To monitor vital signs. To maintain IV/O chart.	maintained fluid volume.	Treatment was done	

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(1)

NURSES NOTES

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
15/7/2022	10.45am	ADMISSION NOTES: Patient Admission on 15/7/2022. patient came for Induction of labour. patient general condition fair. Vitals are checked & recorded. patient voided. CTG connected. FHR good. Fetal movements well. patient diagnosis primi/ GA 39wks / GDM on OHA / GHTN / IOL. parts preparation done. There is no allergic history. patient medical history of GHTN and GDM on OHA. There is no past surgical history.	
	11am		S/N paramesvari 016808
	12pm	Dr. pavithra gave the patient checked PV CTG advised IVF RL 500ml stat. IV SNP, IV line stat in left cephalic vein. RL connected.	S/N paramesvari 016808
	12.30pm	CTG continue monitor. RBS-100mg/dl Informed to Dr. pavithra.	S/N paramesvari 016808
	12.50pm	CTG disconnected as per doctor advice.	S/N paramesvari 016808

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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NURSES NOTES

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☑ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		patient had normal diet	S/N [illegible] 016808
15/7/26	1:30pm	vaginal birth consent, Induction consent uptained.	
		patient side no complaints of pain.	[illegible] 016808
	2pm	Maintained I/O. Monitored Vitals and Recorded. Pain assessment Done. PV [illegible] Examination Done by Dr-mathangi mam advised for Foleys Induction	[illegible] 016120
	3.50pm	Dr. mathangi mam done Foleys Induction of labour done with 22F Foleys inserted intracervically and bulb inflated with 65ml of distilled water. Post Foleys CTG at 4.50pm	[illegible] 016120
	4pm	Inj. Supacef 0.1ml ID given as per doctor order. No any other complaints. IV cannula observed	[illegible] 016120
	4.50pm	post Foleys CTG connected. FHR Monitoring. Maintained I/O. patient dosent have any allergic Reaction of Inj. Supacef test dose. Inj. Supacef 1.5g IV given. No any other complaints	[illegible] 016120

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00079923 IP18-00036481
Mrs PRIYADARSHINI SWAMINATHAN (F)
04-02-1997 29 Y 5 M 11 D
Dr. MATHANGI RAJAGOPALAN

(2)

NURSES NOTES

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☑ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
15/7/20	6pm	post Foley CTG disconnected. FHR Monitored, Maintained, I/O. Monitored vitals and Recorded. No any other complaints	[signature] 15/7/20
	6.15PM	Patient Shifted from LDR to 7th Floor. Patient care Handing over given to 7th Floor Staff	[signature] 15/7/20
		Receiving Nurses:	
	6²⁰ pm	Patient Received from LDR to 7th floor. She was conscious & oriented well talking orally & breathing well. Vitals are checked & found maintained. Ambulating no LPV / BPV FM (+) FHR ↑ checked general condition is fair —	[signature]
	7³⁰ pm	Patient report handing over to (N) duty staff	[signature]
		Night duty Notes.	
15/7/20	7:30PM.	Patient details handing Over taken from Evening duty Staff. Bed side Assessment done. Conscious & Oriented. IV line (+) pattern. 22F Foley's (+). CTG to continue 9.20 PM to do. Patient c/o mild pain. provide comfortable position	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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☑ No Known Drug Allergies
☐ Drug Allergies Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
15/7/26	8pm.	Patient vitals sig Checked & Recorded. vitals are Stable. I/O Chart monitored. BP-111/66 mmHg Inform the Dr. W/H the BP tablet. No any Other. Complain provide Comfortable position	[signature]
	9pm.	patient details Handing over to LDR Staff.	[signature]
		Receiving Note (15/07/2026).	
	9pm	patient Receiving 4th Floor to LDR patient concious and oriented General condition fair patient Foley expelled. CTG connecting FHR ⊕ 144b/m patient concious and oriented General & No complaints	[signature] 07
	10pm	S/B DR. mohana advice to CTG disconnecting FHR ⊕ 140b/m patient concious and oriented patient 4th hrs CTG Next CTG 02AM	[signature] 07
	10.30 pm	patient General condition Fair patient 9pm Foley expelled inform to DR. mohana p/v examination 2cm long 2cm dilations advice to 4th hrs CTG continue	[signature] 07

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

UHC-00079923 IP18-00036481
Mrs PRIYADARSHINI SWAMINATHAN
04-02-1997 29 Y 5 M 12 D (F)
Dr. MATHANGI RAJAGOPALAN

(3).

NURSES NOTES

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☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
16/7/26	12 AM	patient checked vital are stable patient consious and oriented general condition fair patient Next CTG 2AM	[signature] 07/7/18
	2 AM	patient checked vital are stable patient CTG connecting FHR ⊕ 140 b/m patient general condition fair	[signature] 07/7/18
	2:30 AM	S/B DR. mohana mam advice to CTG stop order patient CTG disconnecting FHR ⊕ 143 b/m	[signature] 07/7/
	3.45 AM	patient mouning care given patient bath done. patient CTG connecting FHR ⊕ 140 b/m	[signature] 07/7/
	4.10 AM	S/B DR. mohana p/v examination 2cm long 2cm dilation advice kept gel. ✓ ASP PGE2 gel 0.5 mg instilled Intra... patient 5.10 AM post gel CTG	[signature] 07/7/
	5.10 AM	patient post gel CTG connecting FHR ⊕ 140 b/m patient consious and oriented general condition	[signature] 07/7/18

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Patient Sticker

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DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
16/7/26	5.30 AM	patient on going on FHR(+) 138b/m SB Dr. mohana mam advice to on Reactivity disconnected order care out	[signature] 07/7/26
	6 AM	patient Checked vital are stable patient Checked CBG - 110mg/dl inform to Dr. mohana patient Cheked Contraction 10 mins 3 contraction 15 to 20 sec Inform to Dr. mohana	[signature] 07/7/26
	7AM	patient General Condition fair, patient conscious and oriented General Condition fair patient mild pain admin walking something	[signature]
	7.30 AM	Patient handing over given morning duty staff Nurse	[signature] 07/7/26
		Morning duty 16/7/26	
	7.30 AM	Hand over taken from Night duty staff, patient conscious and oriented, Iv line pattern IVF RL on flow, FHR is 160, FM(+) felt by mother vitals are checked and	

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(5)

NURSES NOTES

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16/7/26	pm. 1-10	SVD for Priyadharshini mam	
		PV examination 5 cm dilation Inj-Synto	
		stop order by Dr Mathangi mam.	
		Pt continue FHR is dropping SIB	
		Dr Mathagi mam 5 cm dilation.	
		All four position Inj Synto	
		ml on flow pt general condition	
		is good. pt c/o in Itching	Dmi/01/760
	1.30 pm	patient nifor chunl & received.	
		Dr Pavithra mam order Inj Drug	
		slow to given as per	
		doctor order. Pt continue FHR is	
		dropping. Inj. Synto 24 ml on flow	
		Pt handling over to evening	
		duty staff to be followed	
		doctor order	Dmi/01/760
		Evening Duty (16/7/26)	
	1.30pm	Patient care Handing	
		over taken from Morning	
		duty staff. Monitored vitals	
		and Recorded. Maintained	
		I/O. watching contractions	
		Pain assessment Done Inj- synto	
		48ml/hr on connected. IV	
		cannula observed	[signature] 01/5/20
	2pm	Monitored vitals and Recorded.	
		Maintained I/O. watching	

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Patient Sticker

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☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
16/7/26		Contractions. Pain assessment done. Inj. Synto stopped as per doctor order. No any other complaints	
	2.20pm	Dr. Mathangi mam done PV Examination Cx-well effaced os 2cm dilated, Membrane absent, Vertex at -1 Station anterior lip of cervix edematous. advised to do Squatting. CTG on connect. FHR monitoring	
	2.40pm	Dr. Mathangi mam again done PV Examination Cx-fully effaced, os fully dilated, Membrane absent, CTG on Connect. FHR monitoring. No any other complaints	
	2.57pm	Delivery Notes Kiwi assisted vaginal delivery with RMLE IND: persistant variable Decelerations / poor maternal efforts under strict aseptic precautions under Epidural analgesia patient in dorsolithotomy position. local parts painted and draped	

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NURSES NOTES

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☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
16/7/20		with good uterine contractions full cervical dilation a right mediolateral episiotomy was given under 2% lignocaine local infiltration. in view of persistant variable decelerations poor maternal efforts kiwi cup was applied in vertex +2 station. Chignon created an alive term girl baby was delivered. Baby cried immediately after birth. cord clamped and cut. Baby handed over to pediatrician cord blood collected for Blood group and typing. Placenta and membranes delivered intoto. Episiotomy inspected and sutured in layers using Rapid vicryl and 2-0 vicryl Hemostasis achieved. Inj-Synto 10 unit Im, Inj. Synto 20 unit c RL 500ml IV given. Inj Taxim 1g IV 500ml given. Inj-carboprost 250mg Im, T-Miso 600mg PR/ Justin Suppository 100mg PR Kept by Dr-mathangi mam —	[signature] 16/7/20

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

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DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
16/7/20	4pm	Monitored vitals and Recorded. Maintained Dlo. Pv Bleeding Minimal. Peri assessment Done. Duj-synto Drnulhron Connected	[signature] 16/7/20
	5pm	Monitored vitals and Recorded. Maintained Dlo. Pv Bleeding Minimal. Watching contraction 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] 16/7/20
	6.15pm	Maintained Dlo. Monitored vital and Recorded. Patient voided 350ml Informed to Dr. Akshitha Done post void scan. Bladder Collapsed. advised to shift the patient to ward, doctor order carried out	[signature] 16/7/20
	6.45pm	patient Shifted from LDR to 7th Floor. patient care Handing over given to 7th Floor Staff	[signature] 16/7/20

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LABOUR AND DELIVERY NURSING ASSESSMENT

Date of Admission: 15/7/26

Baseline Information:

Admission From: ☐ ER ☐ OPD ☐ Admission Desk ☐ Others: specify IDR

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 Husband

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

If yes , identify

Chief Complaints: came for induction of labour

Doctor Notified on Admission: ☐ ~~Yes~~ ☐ No

Name of the Doctor: Dr. pavithra

Time Notified: 11 am

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

Past Medical History	Past Surgical History	Previous Hospital Admission
GDM on OHA GHTN	NIL	NIL

Blood Group: 'O' positive LMP: 15/10/25 EDD: 22/7/26 Gestational age during admission: 39 wks

Contractions: NIL Vaginal Discharge: NIL

Obstetric History: G 1 P — L — A — Previous LSCS —

Height: 164 cm Weight: 91.8 kg BMI: 34.13 kg/m²

Temp: 98°F HR: 100 bpm RR: 20 bpm BP: 120/80 mm Hg SpO2 99 %

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

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

Patient Sticker

Family History: ☐ No Abnormalities Detected

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

☐ Liver disease ☐ Other Father - Diabetic / Hypertension

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

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

Risk of Pressure Sore: ☑ Yes ☐ No Score 0 (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. priyadharshini

Name of Person Orientation was given to: Mrs. priyadharshini

Orientation not given Reason: -

Nurse Signature: [signature] 010808

Nurse Name: S.M. parameswari

Date & Time: 15/7/2026 @ 11am

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Pa

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OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 15/7/2026 Time of Arrival: 10:45am Time Seen by Nurse: 10:45am

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: Induction cof labour

3) **Vital Signs:** Temperature: 98°f Pulse: 100 bpm RR: 20 bpm SpO_2: 99% BP: 120/80 mmHg Weight: 91.80 kg

4) **Gestational Criteria:**

Gravida:	G 1	P —	L —	A —

LMP: 15/10/2025 EDD: 22/7/2026 Gestational Age: 39 wks

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: GDM. O.D. aHA / GHTN

Patient Sticker

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

8) **Current Medications:** ☐ Prenatal Vitamin ☐ None ☑ Others: T. Labet 100mg TDS / T. Glycomet 500mg BD

9) **Prenatal Medical History:**

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

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

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

Time seen by Doctor: 11 am

Nurse Name : S/N parameswari Nurse Signature: [signature] 016808

Date: 15/7/2026 Time: 11.05am

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RISK ASSESSMENT TOOL FOR DEEP VEIN THROMBOSIS

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

Date: 15/7/2026

Pre - Existing Risk Factors	Tick	Score
Previous VTE (except a single event related to major surgery)		4
Previous VTE provoked by major surgery		3
Known high-risk thrombophilia		3
Medical comorbidities e.g. cancer, heart failure; active systemic lupus erythematosus, inflammatory polyarthropathy or inflammatory bowel disease; nephrotic syndrome; type I diabetes mellitus with nephropathy; sickle cell disease; current intravenous drug user		3
Family history of unprovoked or estrogen-related VTE in first-degree relative		1
Known low-risk thrombophilia (no VTE)		1
Age (≥35 years)		1
Obesity	✓	1 or 2
Parity ≥ 3		1
Smoker		1
Gross varicose veins		1
Obstetric Risk Factors		
Pre-eclampsia in current pregnancy		1
ART/IVF (antenatal only)		1
Multiple pregnancy		1
Caesarean section in labour		2
Elective caesarean section		1
Mid-cavity or rotational operative delivery		1
Prolonged labour (24 hours)		1
PPH (1 litre or transfusion)		1
Preterm birth 37^{+0} weeks in current pregnancy		1
Stillbirth in current pregnancy		1
Transient Risk Factors		
Any surgical procedure in pregnancy or puerperium except immediate repair of the perineum, e.g. appendectomy, postpartum sterilization		3
Hyperemesis		3
OHSS (first trimester only)		4
Current systemic infection		1
Immobility, dehydration		1
Total		01
Signature of the Nurse	Sfn parameshwari 01/6/26	
Action Plan		

RISK ASSESSMENT FOR VENOUS THROMBOEMBOLISM (VTE)

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

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

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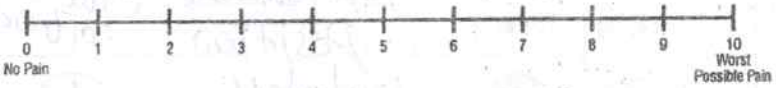
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
15/7/26	11am	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	No pain	
15/7/26	2pm	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	No pain	
15/7/26	6pm	1/10	Abdomen	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☐ Yes ☐ No	Comfortable Position	
15/7/26	8pm	1/10	Abdomen	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☑ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	Comfortable position	
15/7/26	10pm	2/10	Lower abdomen pain	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☑ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	Comfortable position	
16/7/26	2AM	2/10	Lower abdomen	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☑ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☐ Yes ☐ No	Comfortable position	
16/7	2AM	2/10	Lower abdomen	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	Comfortable position	
16/7	4AM	2/10	Lower abdomen pain	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☐ Dull ☑ Aching ☐ Burning	☑ Increasing ☐ Decreasing	☐ Yes ☐ No	Comfortable position	
16/7	6AM	2/10	Lower abdomen pain	☐ Continuous ☑ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☑ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☐ Yes ☐ No	comfortable position	
16/7	8AM	2/10	Lower abdomen pain	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Comfort Positi	

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

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

GUC-00079923 IP18-00036481
Mrs PRIYADARSHINI SWAMINATHAN
04-02-1997 29 Y 5 M 12 D (F)
Dr. MATHANGI RAJAGOPALAN

Rainbow® Children's Hospital
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BirthRight
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PAIN ASSESSMENT FORM

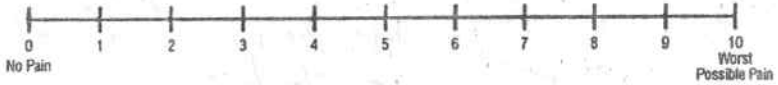
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
16/7/26	2pm	3/10	lower abdomen	☐ Continuous ☑ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Breathing Exercise	[illegible]
16/7/26	4pm	1/10	Episiotomy site	☐ Continuous ☑ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Pharmacological therapy	[illegible]
16/7/26.	10pm	1/10	Episioto site	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☑ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	tab para. 1gm given	[illegible]
17/7/26	4Am	1/10	Episioty site	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☑ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	comfortable position.	[illegible]
17/7/26	8Am	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☑ No	NIL	[illegible] 607261
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

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

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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Mrs PRIYADARSHINI SWAMINATHAN
04-02-1997 29 Y 5 M 11 D (F)
Dr. MATHANGI RAJAGOPALAN

BRADEN 'Q' SCALE

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date : 15/7/26	15/7/26	15/7/26	16/7/26
					Time : 11am	2pm	8pm	8am
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.	3	3	3	3
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR **Friction** . Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
				TOTAL SCORE	27	27	27	27
				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

Patient ID

BRADEN 'Q' SCALE

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

BirthRight BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

				Date :	16/7	17/7		
				Time :	8pm	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	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	3		
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4		
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4		
FRICTION-SHEAR **Friction** . Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4		
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings 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		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4		
				TOTAL SCORE	23	27		
				Evaluator's Name				

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

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

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-00079923 IP18-00036481
Mrs PRIYADARSHINI SWAMINATHAN
04-02-1997 29 Y 5 M 11 D (F)
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It takes a lot to treat the little.

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	11am 15/7/26	2 pm 15/7/26	8PM 15/7/26
		Score	15	~~35~~	~~35~~
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0	0	0	0
Secondary Diagnosis (more than one diagnosis)	Yes	15	15	15	15
	No	0			
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0	0	0	0
IV / Heparin Lock or Saline	Yes	20		20	20
	No	0	0		
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0	0	0	0
Mental Status	Forgets limitations	15			
	Oriented to own ability	0	0	0	0
Total Morse Fall Scale Score:			15	35	35
		Signature			

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

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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04-02-1997 29 Y 5 M 12 D (F)
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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	10/8/26	16/8/26	16/8/26
		Score	35	35	35
History of Falling (immediately or w/in 3 months)	Yes	25	0		
	No	0	0	0	0
Secondary Diagnosis (more than one diagnosis)	Yes	15	15	15	15
	No	0	0		
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0	0	0	0
IV / Heparin Lock or Saline	Yes	20	20	20	20
	No	0	0		
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0	0	0	0
Mental Status	Forgets limitations	15			
	Oriented to own ability	0	0	0	0
Total Morse Fall Scale Score:			35	35	35
		Signature			

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

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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- ☐ Assist and/or supervise ambulation. Reinforce to always call for assistance
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- ☐ 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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04-02-1997 29 Y 5 M 13 D (F)
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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	N 17/26		
		Score			
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0	0		
Secondary Diagnosis (more than one diagnosis)	Yes	15	15		
	No	0			
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0	0		
IV / Heparin Lock or Saline	Yes	20	20		
	No	0			
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0	0		
Mental Status	Forgets limitations	15			
	Oriented to own ability	0	0		
Total Morse Fall Scale Score:			35		
		Signature			

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

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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- ☐ 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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Patient's Na GUC-00079923 IP18-00036481
Mrs PRIYADARSHINI SWAMINATHAN
04-02-1997 29 Y 5 M 11 D (F)
Dr. MATHANGI RAJAGOPALAN

MRD NO:....

Age :.................. ☐ M ☐ F

Consultant :..

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 15/7/26 Time: 12pm

Location : Left cephalic vein

Size : 18G

Cannula inserted by : S/N parameswari 016808

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
15/7	12.30pm	☐Yes ☐No	☐Yes ☐No	Observ	[illegible]
	2pm	☐Yes ☐No	☐Yes ☐No	Observ	fO
	4pm	☐Yes ☐No	☐Yes ☐No	obsev	fO
	6pm	☐Yes ☐No	☐Yes ☐No	Observ	fO
	8pm	☐Yes ☐No	☐Yes ☐No	Observing	[illegible]
	10pm	☐Yes ☐No	☐Yes ☐No	OBS	[illegible]
16/7	12AM	☐Yes ☐No	☐Yes ☐No	OBS	[illegible]
	2AM	☐Yes ☐No	☐Yes ☐No	OBS	[illegible]
	4AM	☐Yes ☐No	☐Yes ☐No	OBS	[illegible]
	6AM	☐Yes ☐No	☐Yes ☐No	Ob	D
	8AM	☐Yes ☐No	☐Yes ☐No	"	[illegible]
	10AM	☐Yes ☐No	☐Yes ☐No	Observ	Dm
	12pm	☐Yes ☐No	☐Yes ☐No	Obser	m
	2pm	☐Yes ☐No	☐Yes ☐No	Observ	fu
	4pm	☐Yes ☐No	☐Yes ☐No	observ	fO
	6pm	☐Yes ☐No	☐Yes ☐No	observ	fO
	8pm	☐Yes ☐No	☐Yes ☐No	pat	[illegible]
	10PM	☐Yes ☐No	☐Yes ☐No	path	[illegible]
17/7	12A	☐Yes ☐No	☐Yes ☐No	path	[illegible]
17/7	6AM	☐Yes ☐No	☐Yes ☐No	patton	[illegible]
	10AM	☐Yes ☐No	☐Yes ☐No	Obser	PO
		☐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.

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

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

GUC-00079923 IP18-00036481
Mrs PRIYADARSHINI SWAMINATHAN
04-02-1997 29 Y 5 M 11 D (F)
Dr. MATHANGI RAJAGOPALAN

Rainbow® Children's Hospital
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Part - I.

Patient's / Learner Language: Tamil Patient / Learner Literacy: ☐ Read ☐ Write ☐ Spe No Healthcare Literacy: Yes ☐ No ☐

Identified Education Needs:

1. Diagnosis — Primi / GA 39 wks
2. Treatment and Care

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
15/7/26	11am	yes	Educate & Inform about plan of treatment	Patient	None	oral	Teach family	yes	good	
16/7	8AM	yes	Educate about during Pain Deep breating Exercis	Patient	none	oral	NO	verbal	good	
17/7/26	8AM	yes	Explain about Nutrition	Patient	None	oral	NO	verbal	good	

Part - III: CODES

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

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

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

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

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

PATIENT TRANSFER FORM

Rainbow® Children's Hospital — It takes a lot to treat the little.
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GUC-00079923 IP18-00036481
Mrs PRIYADARSHINI SWAMINATHAN
04-02-1997 29 Y 5 M 12 D (F)
Dr. MATHANGI RAJAGOPALAN

	Date & Time of Admission	Date & Time of Transfer Order
	15/7/26, 11:29 AM	16/7/26 at 6.40 pm
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr. Mathangi	Dr. Akshitha	Shifted to ward for further care
From Unit	**To Unit**	**Information to Attendant**
LDR	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**
IP files	CTG - (16)	Yes ☑ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	T-Acton 1g	(10)
2.	C-Pan D 40mg	(40)
3.	Justin Suppository	(5)
4.	T-Augmentin 625	(10)
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
S/N. Janakshi 016-120	Dr. Akshitha

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

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

PATIENT TRANSFER FORM

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GUC-00079923 IP18-00036481
Mrs PRIYADARSHINI SWAMINATHAN
04-02-1997 29 Y 5 M 11 D (F)
Dr. MATHANGI RAJAGOPALAN

Treating Consultant Name: Dr. Mathangi	Date & Time of Admission: 15/7/2026 @	Date & Time of Transfer Order: 15/7/2026 @ 6.15PM
	Transfer Ordered by: Dr. Akshitha	Reason for Transfer: further mgt
From Unit: LDR	To Unit:	Information to Attendant: Yes ☑ No ☐
Number of Sheets in Clinical File: casesheet	Number of Imaging Films: CTG - (3)	Personal belongings including clinical documents. If any handed over to attendant: Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
S/N parameswari 016808	Dr. Akshitha

Patient & Clinical Records Received by : Srimathi

Date & Time of Patient Received : Monster 15/7/26 at 6.20 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

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GUC-00079923 IP18-00036481
Mrs PRIYADARSHINI SWAMINATHAN
04-02-1997 29 Y 5 M 11 D (F)
Dr. MATHANGI RAJAGOPALAN

	Date & Time of Admission	Date & Time of Transfer Order
	15/07/2026 @ 1:29am	15/07/2026 @ 9pm.
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr. Mathangi	Dr. Mohana Priya	Further management
From Unit	**To Unit**	**Information to Attendant**
7th floor	LDR.	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
S/N. Aswini 021295	

Patient & Clinical Records Received by : D. Sobekcay 017178 15/7/2026.

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

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

INFORMED CONSENT FOR VAGINAL BIRTH

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GUC-00079923 IP18-00036481
Patient Nam Mrs PRIYADARSHINI SWAMINATHAN
04-02-1997 29 Y 5 M 11 D (F)
Dr. MATHANGI RAJAGOPALAN

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

Gender: ☐

Date : ..... 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: Dr. Mathangi

Consentee :

Signature : S. Priyadarshini

Name : S. PRIYADARSHINI

Date & Time : 15/7/26 at 5pm

Witness :

Signature : .....

Name : .....

Date & Time : .....

Patient Attendant :

Signature : S. Venkata krishnan

Name : S. Venkata krishnan

Relationship with Patient: Husband

Date & Time : 15/7/26 at 5pm

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. Sneedevi

Date & Time : .....

GUC-00079923 IP18-00036481
Mrs PRIYADARSHINI SWAMINATHAN
04-02-1997 29 Y 5 M 11 D (F)
Dr. MATHANGI RAJAGOPALAN

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INDUCTION OF LABOR CONSENT

GUC-00079923 IP18-00036481
Mrs PRIYADARSHINI SWAMINATHAN
04-02-1997 29 Y 5 M 11 D (F)
Dr. MATHANGI RAJAGOPALAN

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

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

You are scheduled for an induction of labor on 15/07/2026 (date) at 39 weeks (weeks of gestation).

The reason for your induction is Term

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: S Priyadarshini

Name: S. PRIYADARSHINI

Date & Time: 15/7/26 at 5pm

Patient Attendant:

Signature: S. venkata krishnan

Name: S. venkata krishnan

Relationship with Patient: Husband

Date & Time: 15/7/26 at 5pm

Doctor:

Signature: 18221

Name: D. Shreedevi

Date & Time: 15/07/2026

Witness

Signature: .....

Name: .....

Date & Time: .....

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INSTRUMENTAL DELIVERY PROFORMA

Patient Label

GUC-00079923 IP18-00036481
Mrs PRIYADARSHINI SWAMINATHAN
04-02-1997 29 Y 5 M 12 D (F
Dr. MATHANGI RAJAGOPALAN

OBSTETRICIAN	Dr. Mathangi	
ANAESTHETIST		
ASSISTANT	Dr. Akshitha	
DATE	16/07/2021	
TIME	2:57 pm	
PLACE	(LABOUR WARD)	THEATRES

CONSENT	EPISIOTOMY	BLADDER EMPTIED?
(VERBAL) / WRITTEN	(YES) / NO	FOLEY IN/OUT (NO)
ANALGESIA (LOCAL) / PUDENDAL AMOUNT USED 10ml MLS OF _____ (EPIDURAL) / SPINAL GA	**CTG** (NORMAL) / SUSPICIOUS / PATHOLOGICAL Persistent variable decelerations (WRITE FULL DETAILS IN MAIN NOTES IF NOT NORMAL CTG)	**LIQUOR** (CLEAR) / BLOOD STAINED / MECONIUM **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)	+	++	+++

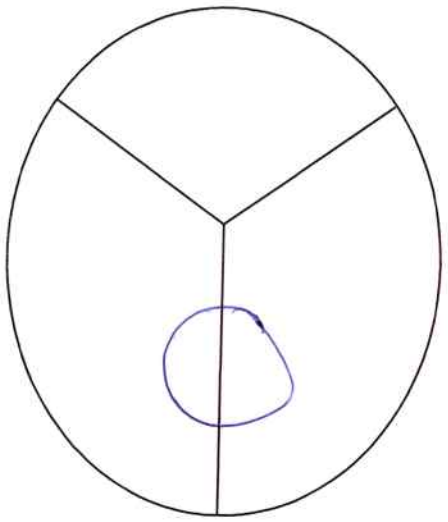
INSTRUMENT USED

(KIWI CUP) / NEVILLE BARNES / WRIGLEYS / KIELLANDS / SIMPSONS

MANUAL ROTATION	TIME OF APPLICATION	No. OF TRACTIONS
YES / (NO)	2:56 pm	1
ABANDONED YES / (NO) (FULL DETAILS IN NOTES)	**TIME OF DELIVERY** 2:57 pm	**LENGTH OF DELIVERY** –

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		

PARTOGRAPH

GUC-00079923 IP18-00036481
Mrs PRIYADARSHINI SWAMINATHAN
04-02-1997 29 Y 5 M 12 D (F)
Dr. MATHANGI RAJAGOPALAN

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LABOUR

Labour: ☐ Spont ☐ IOL-PGE 1 ☑ E2 ☑ Others Foley's

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 Kiwi
☐ Trails of Forceps

Indications: Persistent variable deceleration / Poor maternal efforts

Application, Locking & Traction: .....

Duration of Instrumentation: .....

No. of Pulls: .....

Catherised : ☑ Yes ☑ No

Type: ☑ Fileys ☐ Plain

Perineum : ☐ Intact ☑ Episiotomy ☐ Tear

Suture Material Used: RAPID VICRYL & 2-OVICRYL

STAGE III

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

PPH : ☐ Atomic ☐ Traumatic ☑ None

Lacerations: .....

Cervical: .....

Perineal: Episiotomy

Others: .....

Prophylaxis: (Synocinon) Prostodin

Blood Loss: 350ml

Blood Transfusion: No

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

Ractal Examination: Normal

DURATION OF LABOUR

1st Stage: 6 hours

2nd Stage: 10 mins

3rd Stage: 5 mins

Duration of Active Pushing: .....

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

BABY DETAILS

Gender: Girl

Weight: 3.22 kg

APGAR: 8/10, 9/10

Date and Time of Delivery: 16.07.2020 @ 2.57 pm

LW Doctor: Dr. Mathangi

LW Sister: .....

(P.T.O.)

PARTOGRAPH

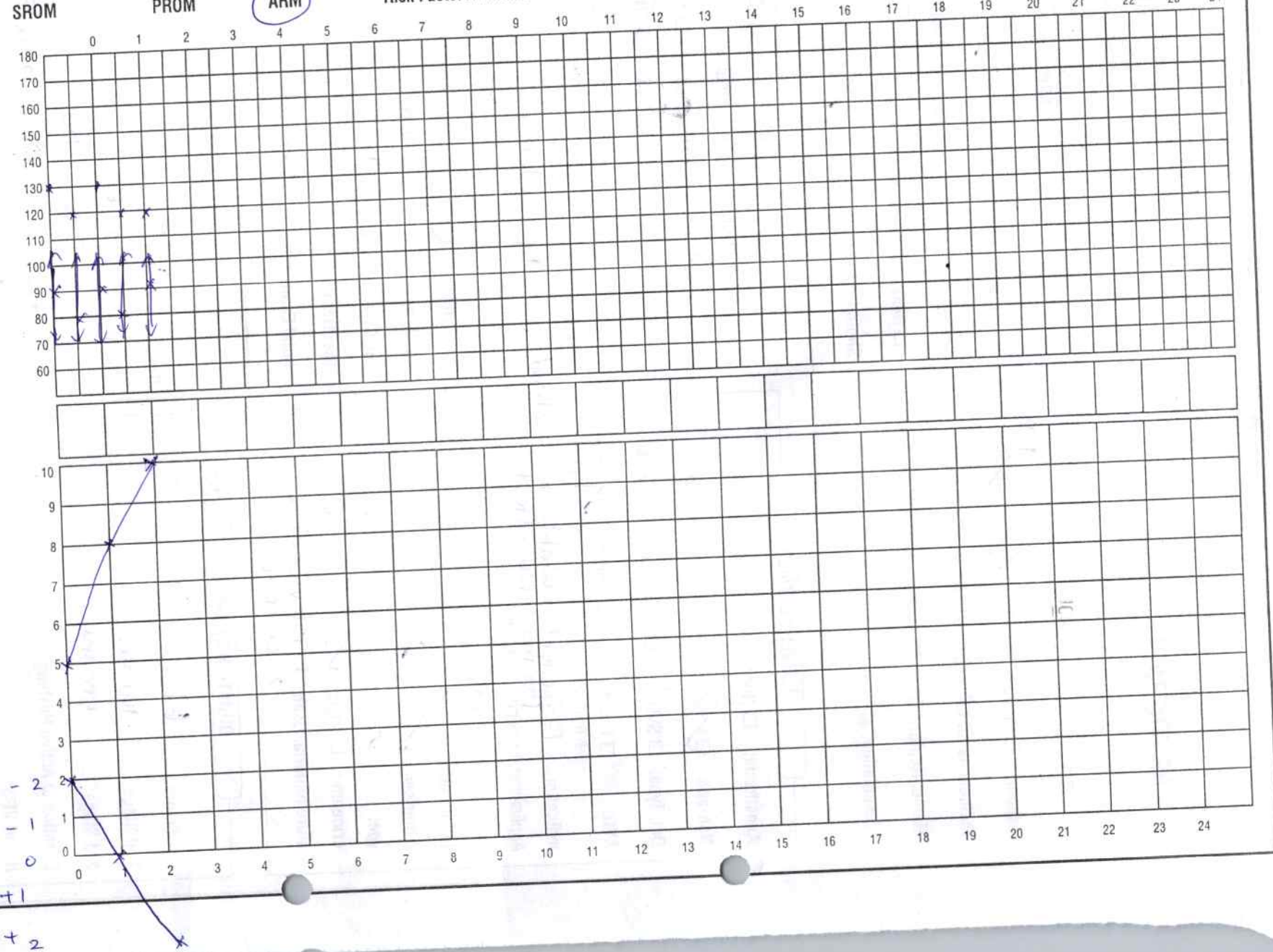
Name: Mrs. Priyadharshini Obstetrics Formula: Primi Blood Group Type: O- POSITIVE

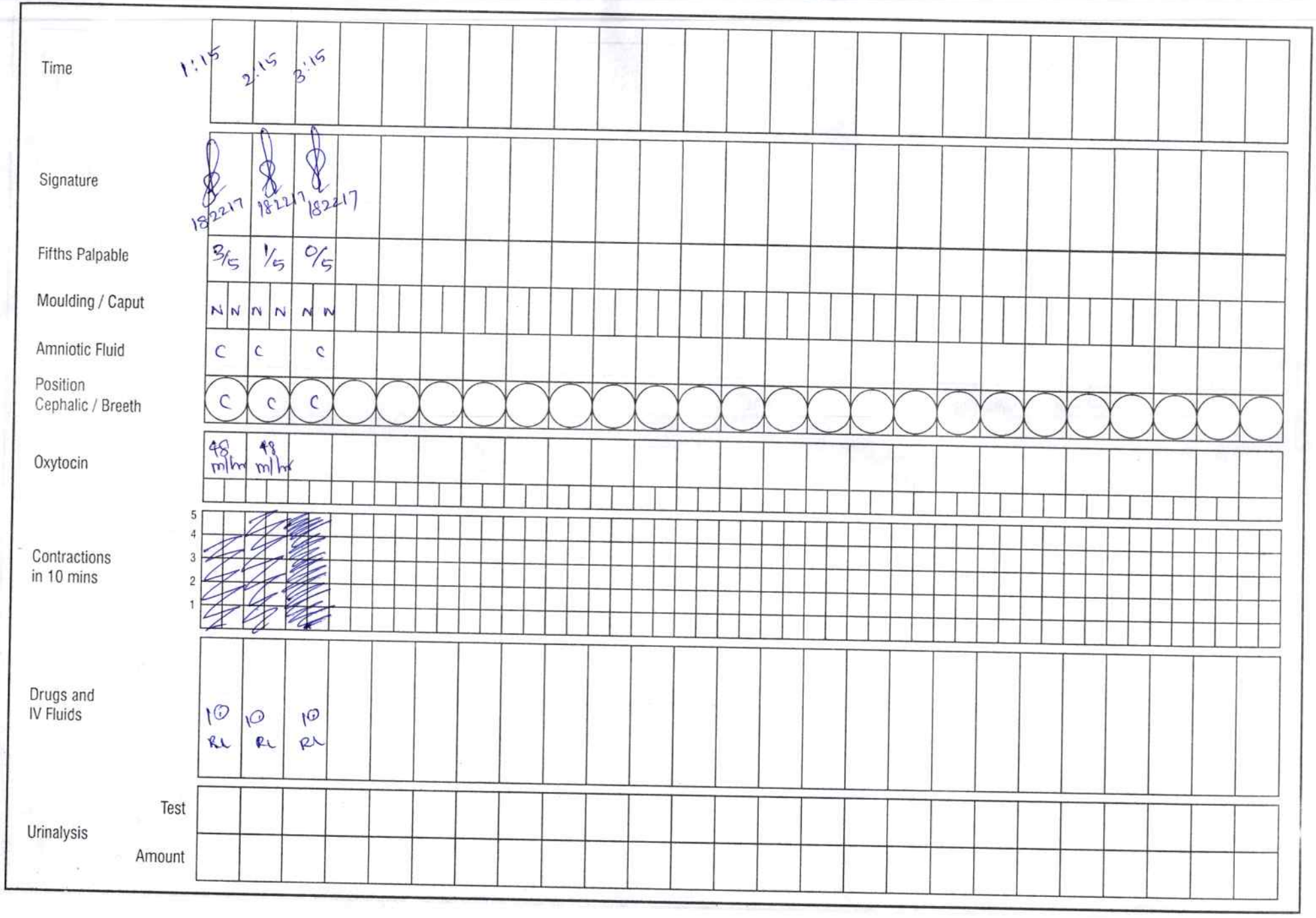
Memb. Ruptured: SROM PROM ARM Risk Factors: GDM on OHA, GHTN

Fetal Heart ●

Maternal BP ↕

Maternal Pulse ×




Time
1:15
2:15
3:15
Signature
18/2/17
18/2/17
18/2/17
Fifths Palpable
3/5
1/5
0/5
Moulding / Caput
N N N N N N
Amniotic Fluid
C C C
Position
Cephalic / Breeth
C C C
Oxytocin
4g m/hr
4g m/hr
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: .....

Mrs PRIYADARSHINI SWAMINATHAN
04-02-1997 29 Y 5 M 12 D (F)
Dr. MATHANGI RAJAGOPALAN

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URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 16/7/26 Date of Removal: 16/7/26

Parameters	Date / Shift Time	16/7/26 Morn	16/7/26 E					
Need for the Catheter		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hand Hygiene		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Usage of Sterile Equipment		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the Collection bag below the level of bladder		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Check the Tube for Obstruction (Free of Kinking)		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Catheter dated as policy		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Collecting bag is been emptied regularly?		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Maintenance of closed system for the catheter		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing clean and dry?		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the line removed as Policy?		☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Performance of Perineal Care		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Onset of New Fever		☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Asses for the leakage at the site of insertion		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Nurse		Devi	Shiv Pandey					
Signature of the Nurse								

Removed

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

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CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MAC

GUC-00079923 IP18-00036481
Mrs PRIYADARSHINI SWAMINATHAN
04-02-1997 29 Y 5 M 12 D (F)
Dr. MATHANGI RAJAGOPALAN

Patient Name : .... Age : .....
Gender : M☐ F☐ ..... Consultant : .....
Ward / Bed No. : ... iologist : .....
Operative procedure planned : .....

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

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

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

☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure
☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma / RTA
☐ Incapacitating COPD ☐ Others : .....

Comments : .....

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

DECLARATION BY PATIENT / GUARDIAN / PROXY

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

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

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

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

I authorize the anaesthetic team to perform any additional procedures (for example, CVP line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter in need arises.

I understand that the above mentioned consultant anesthesiologist or occasionally a colleague deputed by him I her will administer the Anaesthesia.

Pregnant: ☐ Yes ☐ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

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

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

Patient / Patient Attendant :

Signature : S. Priyadarshini

Name : priyadarshini

Relationship with Patient: Self

Date & Time : 16/7/26 at 11Am

Witness :

Signature : S. venkata krishna

Name : S. venkata krishna

Date & Time : 16/7/26 at 11Am

Doctor (who is taking the consent) :

Signature :

Name :

Date & Time :

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Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: ..... Age: ..... Sex: ..... UHID.No : .....

Date: ..... Time: ..... Proposed Operation: .....

Diagnosis: .....

B.P / CRT: ..... H.R: ..... Weight: ..... ASA Physical Status: ☐1 ☐2 ☐3 ☐4 ☐5

Laboratory Data:

Hgb:	Glucose:	Protein:	HIV:	X-Ray: .....
PCV:	Urea:	Alb:	HBS Ag:	ECG: .....
WBC:	Creat:	Total Bill:	HCV:	2D Echo: .....
Plate:	Na:	Dir. Bill:	Blood group:	Stress/Anglo: .....
PT:	K:	LDH:	T3	Other: .....
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH	
	Cl -:	SGOT/SGPT:	**Allergies:**	

Medical History: CVS :

RESP : Diabetes :

CNS :

Renal :

Hepatic / GE : Physical Activity:

Others :

Past Anaesthetic History:

Physical Exam:

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

Lungs :

Heart:

CNS:

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

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

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

.....

.....

Signature: ..... Name: .....

Patient Sticker

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☐ No		Fasting Status:	
Physical Status:	Patient Identified	☐ Consent Present	☐ Chart Reviewed

H.R:	B.P / CRT:	SpO_2:	R.R:	Last Feed:

Pre-OP Diagnosis: ..... Operation: ..... Date : .....

Surgeon: ..... Anaesthesiologist: ..... Technician: .....

TIME

N_2O /AIR /O_2 LPM

HALO /SO /SEVO

Drugs:

FIO_2 / SaO_2

$ETCO_2$

ECG

Temperature

Urine Output

Fluids

Blood

Antibiotic

Suppository

Blood Loss

NOTES

B.P
V Systolic
Λ Diastolic
X Mean
• Heart Rate

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

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

LAB Values

ABG

GRBS

Others

☐ Equipment Checked and Functional
☐ BP
☐ Cuff Site: .....
☐ Art Site: .....
☐ EKG Lead
☐ Temp Site
☐ FIO_2 Monitor
☐ Agent Monitor
☐ Pulse Oximeter
☐ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position:
☐ Pressure Points Checked

Eye Care:
☐ Oint
☐ Tape
☐ Padding
☐ Awake

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

Times:
Anaes Start: .....
OP Start: .....
OP End: .....
Leave OR: .....

Anaesthesia:
☐ GA
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP: .....
☐ ART: .....
☐ IV: .....
☐ IV .....
☐ IV: .....

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

☐ Mask ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
ETT# ..... at ..... cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug: .....

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

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

Regional:
Extremity Specify: .....
☐ Spinal ☐ Epidural ☐ Caudal
Others: .....
Position: .....
Site: .....
Needle Size: ..... Depth: .....
Parasthesia ☐ Yes ☐ No
Catheter at skin ..... cm
Drug Name & Conc: .....
Bolus: .....
Infusion: .....
Block Level: .....
Comments: .....

Transportation to
☐ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☐ NA

Name of the Doctor : .....
Signature of the Doctor : .....

Patient Sticker

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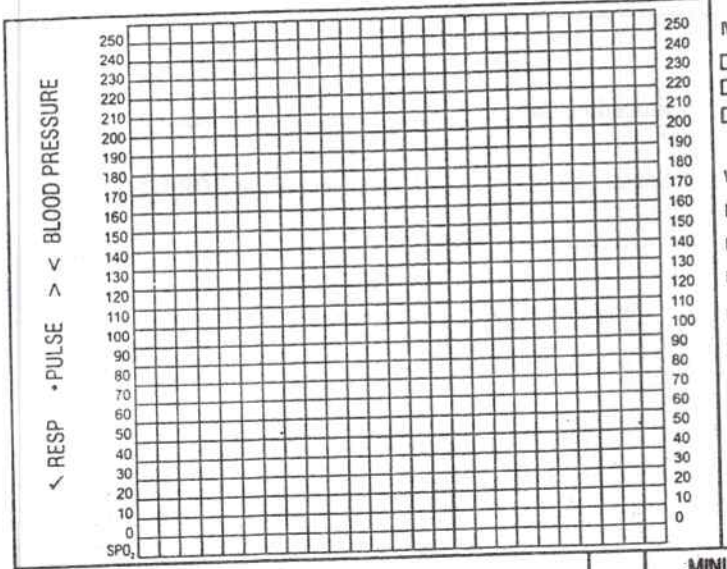
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : ..... Time Received : ..... Time Discharged : .....



IV Cannula Site : .....

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

Vomiting : ☐ Yes ☐ No Drug: .....

NG Tube : ☐ Yes ☐ No

Drain: ☐ Yes ☐ No

Urinary Catheter: ☐ Yes ☐ No

Chest Tube: ☐ Yes ☐ No

Nil Oral ☐ Yes ☐ No

IV Fluids: .....

Oral Feeds: .....

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature

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

Reassessment Frequency:

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

Anaesthesiologist Name : .....

Anaesthesiologist Signature: .....

Date & Time: .....

PACU Nurse Name : .....

PACU Nurse Signature: .....

*Date & Time: .....

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

Date & Time: .....

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : .....

Any other issues :

a) .....

b) .....

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

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

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

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....