GUC-00092680 IP18-00036608
Mrs DHANALAKSHMI .S
03-05-1970 56 Y 2 M 22 D (F)
Dr. PRIYADHARSHINI S M

ACTIVITY RECORD FOR BILLING

BirthRight BY RAINBOW HOSPITALS Your Right to a Safe Delivery

Name: Mrs: DHANALAKSHMI

UHID No: 92680 IP No: 36608 Consultant: Dr. priyadharshini Dept: LDR

Date of Admission: 25/7/26 Time: Date of Discharge: Time:

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
25/7/26	9:45 Am	LDR	OT	S/N Akalya 0805
25/7/26	11:10 Am	OT	MLW	[signature] 25-7-26

CROSS CONSULTATION VISIT

	Doctor Name	Date	Order No.	Signature
1.	PAC (OP)	22/7/26	OP	S/N Akalya 0805
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
25/7/26	RBS	26023870	Abalg 01850
25/7/26	Endometrial polyp	26023885	Blessing

EDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
25/7/26	Laparoscopy	10:04 am	10:40 am	1732812	
25/7/26	Infusion pump	11:30 am	4pm	1739841	

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
25/7/26	IV placement	(1)	1732729	
25/7/26	Catheterization	(1)	IP (OT)	

ANY OTHER INFORMATION:

25/7/26 Procedure : Hysteroscopic polypectomy

Surgeon : Dr. Priyadharshini

Anesthetist : Dr. Mohan

Assist. surgeon : Dr. Akshitha

Starting time : 10:04 am

Ending time : 11:00 am

Date: 25/7/26 Time: 5pm Prepared By:

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Sr Lipoy			

GUC-00092680 IP18-00036608
Mrs DHANALAKSHMI .S
03-05-1970 56 Y 2 M 22 D (F)
Dr. PRIYADHARSHINI S M

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SURGERY DETAILS

Date : 25/7/26

Patient Name: Mrs. Dhanalakshmi Date of Birth: 8/5/1970 Age: 56y

Gender: F Ward : OT UHID No.: 92680/36608

Date of Surgery: 25/7/26 ☑ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : hysteroscopy polypectomy

Time in : 9:50Am Time Out : 11:10Am

	NAME	AMOUNT
1. Surgeon	: Dr. Priyadharshini	
2. Anaesthetist	: Dr. mohan	
3. Assistant Surgeon	: Dr. Akshitha, Dr. Lucita	
4. OT Technician	: mr. Thangadurai	
5. Circulating Nurse	: c/N Risns	
6. Assistant Nurse	: S/N Agalya.	

(10:04Am - 10:40Am) 1732812

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

Rewd finalised by S/N. Sangi. 607721

Signature of the Surgeon Signature of Circulating Nurse

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

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

Patient Sticker

Hysteroscopy

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CONSUMABLES OF OT

Circulating staff : Rigna .... Technician : Thenge .... Date : .... Time : ....

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			~~Major~~ Pack Hysteroscopy		1	Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : (A) / P / N		3				Suction Catheter		
HME filter : A / P / N						Feeding Tube		
Syringes : 10 cc		4+2				Vaccum Suction Set		1
05 cc		4	Gloves 6½ PF		3	Surgical Gloves		
02 cc		6	7 PF		1	Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade			Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL		3	Cautery pencil			Atropine		(1)
NS : 10ml / 100ml / 500ml / 1000ml		1	Koochies			Ephedrine		(1)
NS 31		1	Ointments			D. water 10ml		3+2
			Suction Catheter			Atracil		(1)
Fentanyl		1	Cap, Mask			Para 100ml		(1)
Morphine			Gauze Pack RO		2	Laxicard 50ml		(1)
Ketamine			Mop Pack		1	Quick fix cheat		1
Propofol		2	Steristrip			proto gown		1
Rocuronium			Underpad		1	Neo mom pad		1
Glycopyrolate			Draw sheet			New mom fixator		1
Myopyrolate		1	Abgel			K-90		1
Ondansetron			Foleys catheter 14F		1	Irrigation		1
Pencan 25g/ Spinal Needle 22			Uro~~bag~~ meter		1	VASOCON		1
Bupivacaine 0.25%			Chest Drainage Catheter			CALCIUM Gluconate		1
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
			Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set		✓			
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution		1			
			Microshield					
			Cotton Balls					
			Latex Gloves		10P			
			Ramdione Scrub					
			Saral					

Surgeon   Anaesthesiologist   Nurse   OT Technician

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

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

RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

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

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

DL NO :

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

INPATIENT ISSUES AGAINST ORDERS

IP No	IP18-00036608		
Patient Name	Mrs DHANALAKSHMI .S	**Ward**	8F-OT COMPLEX
Age/Sex	56 Y 2 M 22 D / Female	**Bed Name**	MICU 801
Date	25/07/2026 12:34	**Order No**	18-0001732838
Payor	SELFPAY	**Prescription No**	PRIP18-0629121
UHID	GUC-00092680	**Dispensed Date**	25/07/2026 12:38

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	AMNEPARA 100ML GLASS BOTTLE		H	L0016006	12/27	1	787.00	787.00
2	ARTACIL 25MG 2.5ML INJ	Neon Laboratories Ltd	H	1303356	07/27	1	45.30	45.30
3	CALCIUM GLUCONATEINJ10ML-SWISSCRITICURE	SWISS CRITICURE	H	0548	08/27	1	7.13	7.13
4	DSYRINGE 10ML (NIPRO)	NIPRO	GENERAL	26E02K29	04/31	6	28.13	168.78
5	DSYRINGE 5ML.(NIPRO)	NIPRO	GENERAL	26C13K17	02/31	4	21.56	86.24
6	DSYRINGS 2.5ML(NIPRO)	NIPRO	GENERAL	26B12K44	01/31	4	11.25	45.00
7	D WATER 10 ML AMPULE	Aculife Health Care Pvt.Ltd(Nirlif	H	2254585	11/28	5	2.58	12.90
8	E.C.G ELECTRODES (ADULT)	JMS	GENERAL	20326S08G	05/28	3	32.34	97.02
9	EFIPRES INJ 30 MG 1 ML	NEON LABORATORIES LTD	H	1231096	02/28	1	45.90	45.90
10	LOXICARD INJ 2% 50 ML	Neon Laboratories Ltd	H	KM238100	11/28	1	55.48	55.48
11	MCT-ROF 100MG 10ML	Neon Laboratories Ltd	H	NA1353004	10/27	2	69.10	138.20
12	MYOPYROLATE-INJ-5ML	NEON LABORATORIES LTD	H	V350487	11/27	1	140.20	140.20
13	RL 500 ML CLOSED SYSTEM	Fresenius Kabi India Pvt Ltd		1D262104	03/29	3	69.84	209.52
14	TROPINE INJ AMP0.6MG1ML	NEON LABORATORIES LTD	H	KM038118	11/27	1	7.30	7.30
15	VASOCON INJ 1MG1ML	NEON LABORATORIES LTD		KP85439	02/27	1	13.04	13.04
						Total :	**1,336.15**	**1,859.01**

Receiver Name

for RAINBOW CHILDREN'S MEDICARE LIMITED

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

Printed Time : 25-07-2026 12:38

RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

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

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

DL NO :

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

INPATIENT ISSUES AGAINST ORDERS

IP No	IP18-00036608		
Patient Name	Mrs DHANALAKSHMI .S	**Ward**	8F-OT COMPLEX
Age/Sex	56 Y 2 M 22 D / Female	**Bed Name**	MICU 801
Date	25/07/2026 12:34	**Order No**	18-0001732839
Payor	SELFPAY	**Prescription No**	PRIP18-0629122
UHID	GUC-00092680	**Dispensed Date**	25/07/2026 12:39

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	Encore Microptic gloves-6.5		H	2603019005	03/29	3	128.00	384.00
2	ENCORE MICROPTIC GLOVES-7 PF	ANSEL		2604014105	04/29	1	128.00	128.00
3	FOLEYS CATHETER 14FR POLYMED	Polymed	C1	2516836N	11/30	1	249.00	249.00
4	GAUZ SWAB 10 X 10 CM 12PLY 5S X-RAY	Bapuji Surgicals	GENERAL	M2645010	03/29	2	123.00	246.00
5	HYSTEROSCOPY PACK	Amaryllis		1010626	05/29	1	1,255.00	1,255.00
6	IRRIGATTO(T.U.R SET)	ROMSONS	GENERAL	K26D010015	03/31	1	532.00	532.00
7	K-90 URETRAL CATHETER	Blue neem		19032026	12/30	1	84.00	84.00
8	MOPS 30X30 8PLY 5S X-RAY	DATT MEDI PRODUCTS	H	M2642SF029	03/30	1	949.00	949.00
9	NEW MOM DISP MATERNITY PADS MAXIPAD	DYNAMIC TECHNO		0153715	03/31	1	204.00	204.00
10	NEWMOM DISPOSABLE PADFIXATOR-XXLARGE	DYNAMIC TECHNO		1486O5	03/31	1	221.00	221.00
11	NITRILE EXAMINATION GLOVES P F- MEDIUM	ELITE MEDICALS	GENERAL	ENPF030020	11/28	20	25.00	500.00
12	NS 1000 ML ACCULIFE-EH	Aculife Health Care Pvt.Ltd(Nirlif	H	2C26O729	02/30	1	105.22	105.22
13	NS 3 LTRS BOTTLE	Aculife Health Care Pvt.Ltd(Nirlif		5A260064	04/28	1	747.00	747.00
14	PROTO GOWN (ADULT)	Diamond Medicare	GENERAL	1010626	05/29	1	250.00	250.00
15	QUICKSUITE OT TABLE SHEET MIDLINE SUITEL		H	260616I	06/31	1	775.00	775.00
16	RAMADINE SOLUTION 10% 100 ML	RAMAN & WEIL PVT LTD		RC126036	04/28	1	103.00	103.00
17	UNDERPADS CARE 60 X 90 (FRIENDS)			07072026	12/30	1	205.00	205.00
18	UROMETER ADULT-MEASUREXX		GENERAL	K26E010304	04/31	1	978.00	978.00
19	VACCUME SUCTION SET	ROMSONS	GENERAL	K26D010296	03/31	2	811.00	1,622.00
						Total :	**7,872.22**	**9,537.22**

Receiver Name

for RAINBOW CHILDREN'S MEDICARE LIMITED

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

Printed Time : 25-07-2026 12:39

GUC-00092680 IP18-00036608
Mrs DHANALAKSHMI .S
03-05-1970 56 Y 2 M 22 D (F)
Dr. PRIYADHARSHINI S M

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DISCHARGE TRACKING SHEET

DATE : 25/4/20

Name of Consultant :

Floor : 1 DR UHID :

S.NO	Activity	TIME		Name & Signature	Remarks
		IN TIME	OUT TIME		
1	Dr. Announce Time	5pm		Sd/	
2	Arrangement of File by Nurses		Sd/		
3	Pharmacy Clearance				
4	Provisional Billing				
5	Audit Check				
6	Final Bill Prepared				
7	Sent to Insurance & Approval Received				
8	Handing Over & Bill Clearance				
9	Discharge Summary				
10	Physical Check Out				
11	Activity Sheet updated by Nursing				
12	Activity Sheet updated by Pharmacy				

GUC-00092680 IP18-00036608
Mrs DHANALAKSHMI .S
03-05-1970 56 Y 2 M 22 D (F)
Dr. PRIYADHARSHINI S M

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OPERATION NOTES

Surgeon : DR. PRIYADHARSHINI.	Asst. Surgeon : DR. LUCETTA / DR ~~ANKITA~~
Anesthetist : DR. MOHAN.	OT Nurse :
Pre-Operative Diagnosis: 53yrs/ P1L1 / NYD / T2DM on OHA / Dyslipidemia / Thickened ET / postmenopausal	
Surgical Procedure : HYSTEROSCOPIC POLYPECTOMY.	

Weight :	Date : 25/7/26.	Start Time :	End Time :

Post Operative Diagnosis: P1L1 / POD #0 / hysteroscopic polypectomy.

Peri-Operative Complications: NIL.

Operation Notes: ↓ SAP, ↓ GA, dorsolithotomy position,

Findings: parts painted and draped, Anterior & posterior vaginal walls retracted c sim's, anterior lip of cervix held c allis', serial dilatation done c hegar's dilator. hysteroscope introduced with normal saline as distension medium, 3×2 cm pedunculated polyp noted arising from (R) lateral wall, stalk cut and polyp removed

Procedure Notes: with resectoscope, sent for HPE. Fundus and B/L ostia visualised & normal. Hemostasis secured. Bladder catheterised with 14 Fr Foley's, clear urine drained, no undue bleeding noted.

Amount of Blood Loss: minimal.	Blood Transfused (in ML) –

Name and Number of Surgical Specimen sent for examination:
Endometrial Polyp.

(P.T.O.)

Patient Sticker

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POST-SURGICAL CARE PLAN FORM

Post-Operative Monitoring Parameters /Frequency:

- NPO x 2hours.
- strict I/O charting.
- w/f breathlessness/abdominal distension/shoulder tip pain.
- chest auscultation.
- BP, PR, SpO_2 monitoring q2H.

Wound Care:

- CBD till 6pm.
- IVF @100ml/hr.
- Mobilisation.

Drain /Special Lines/Catheters:

- INJ TAXIM 1gm IV BD (HH D/S).
- TAB PAN. 40mg P/O BD.
- TAB ~~PARA~~ 1gm P/O 1-1-1.

Special Patient Positioning and Requirements:

- follow drug orders
- w/f bleeding P/R.
- AG charting q4H.

Nutritional Instructions:

When to Start Mobilization:

Special Referrals:

The new order for all required medications documented in the doctor order/medication sheet:

☐ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

Name of the Surgeon: DR. PRIYADHARSHINI. S.M.

Signature of the Surgeon: (FOR) 128435

Date & Time: 25/12/26, 11:50PM

GUC-00092680 IP18-00036608
Mrs DHANALAKSHMI .S
03-05-1970 56 Y 2 M 22 D (F)
Dr. PRIYADHARSHINI S M

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Priyadharshini
Asst. Surgeon : Dr. Akshitha
Anaesthetist : Dr. Mohan
Scrub Nurse : S/Sr. Agalya

..... Age : ..... Gender : .....
Surgery Name : Hysteroscopy
Date : 25/7/26 In-time : 9:50Am Out-time : 11:10Am

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 9:55Am

Patient Has Confirmed
- Identity ☑Yes ☐No
- Site ☑Yes ☐No
- Procedure ☑Yes ☐No
- Consent ☑Yes ☐No

Site Marked ☐Yes ☐No ☑NA

Anaesthesia Safety Check Completed ☑Yes ☐No

Pulse Oximeter on Patient & Functioning ☑Yes ☐No

Does Patient have a:
- Known Allergy? ☐Yes ☑No

Difficult Airway / Aspiration Risk?
- Yes, & Equipment / Assistance Available ☑Yes ☐No

Risk of > 500ml Blood Loss (7ml/kg In Children)?
- Yes, and Adequate Intravenous Access and Fluids Planned ☑Yes ☐No ☐NA
- Blood Units Reserved ☐Yes ☑No ☐NA

Has Antibiotic Prophylaxis been given within the last 60 minutes? ☑Yes ☐No ☐NA

Signature : .....
Name : Dr. Mohan

Before Skin Incision ➤➤

TIME OUT Time: 10:00Am

Confirm all team members have introduced themselves by Name and Role ☑Yes ☐No

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm
- Correct Patient (Check ID Band) ☑Yes ☐No
- Correct Site ☑Yes ☐No
- Correct Procedure ☑Yes ☐No

Anticipated Critical Events

Surgeon Reviews:
- What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? ☑Yes ☐No ☐NA

Anaesthesia Team Reviews:
- Are There Any Patient-specific Concerns? ☑Yes ☐No ☐NA

Nursing Team Reviews:
- Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☐Yes ☑No ☐NA
- **Is Essential Imaging Displayed?** ☐Yes ☑No ☐NA
- Power Supply, Earthing, Power Backup and functioning of equipment checked. ☑Yes ☐No

Signature : 12/7/26
Name : Dr. Akshitha

Before Patient Leaves Operating Room

SIGN OUT Time: 11:00Am

Nurse Verbally Confirms with the Team:
- The Name of the Procedure Recorded ☑Yes ☐No
- That Instrument, Sponge and Needle Counts are Correct (or Not Applicable) ☑Yes ☐No ☐NA
- The Specimen is Labelled (including patient name) ☑Yes ☐No ☐NA
- Whether there are any Equipment Problems to be addressed ☐Yes ☑No ☐NA

To Surgeon, Anaesthetist and Nurse:
- What are the key concerns for recovery and management of this patient? ☑Yes ☐No

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

Signature : .....
Name : Rene

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 : IP18-00036608 **Admit Date** : 25-Jul-2026 **Admit Time** : 07:26 AM **UHID** : GUC-00092680

Patient Details :

Patient Name	: Mrs DHANALAKSHMI .S	**Age**	: 56 Y 2 M 22 D
Guardian	: Mr SENGOETAIYAN PERIYANNA GOUNDAR	**DOB**	: 03-05-1970
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: casagrand savoye Karapakkam Karapakkam Kanchipuram Tamil Nadu INDIA 600097	**Phone No**	: 9994600233
		E-mail	: NO@gmail.com

Admission Details :

Bed Type : MICU **Bed No** : MICU 801 **Ward Name** : 8F-OT COMPLEX

Room No : MICU 801 **Admission Type** : First Visit

Contact Details :

Name : Mr SENGOETAIYAN PERIYANNA **Relationship** : Husband

Contact Address : casagrand savoye Karapakkam Karapakkam Kanchipuram Tamil Nadu INDIA 600097 **Phone No** : 9994600233

Signature

Doctor Details :

Doctor Name : Dr. PRIYADHARSHINI S M **Specialisation** : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Dr. Priyadharshini S M **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Guindy

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

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Mrs DHANALAKSHMI .S**	**Age :**	**56 Y 2 M 22 D**
IP No:	**IP18-00036608**	**Sex:**	**Female**
Consultant:	**Dr. PRIYADHARSHINI S M**	**Ward/Bed No:**	**8F-OT COMPLEX/MICU 801**

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

Patient, be deemed advisable or necessary.

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

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

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

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

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

3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.
4 Financial and billing counseling has been done to me.

Signature of Patient/Relative: > S.Dhinesh Kumar.S

Name: > Dhinesh Kumar.S

Relationship: > Mother

Date: 25-07-2026 Time: 7:26

Witness Name: Aswin.

Witness Signature:

Patient Address:

casagrand savoye Karapakkam
Karapakkam Kanchipuram Tamil Nadu
INDIA 600097

Rainbow Children's Hospital | BirthRight BY RAINBOW HOSPITALS

BILLING POLICY

- Billing Cycle: - Bed charges will be calculated based on 12PM to 12PM checkout. Settlement post 12PM, room rent will be charged for half day extra & post 6PM, it will be charged for full day. Less than 24 hours stay will be considered as one day.
- Room Rent inclusive of Bed, Nursing, Consultation Charges and all other charges, like Diet, Investigations, IP or OP Procedures, Equipment, Cross Consultations, Blood/ Blood Products, Implants, Ward Consumables, Infection Preventive Measure Charges, Pharmacy and Consumables will be charged extra.
- 5% GST Charges applicable on more than INR 5,000/- Bed Charges which was effective from 18.07.2022 as per the GST Council.
- As per the G.O.I. guidelines, we can collect Rs 1,99,999/- only in cash mode, balance patient can pay through Credit Card/ Debit Card/ NEFT / RTGS / Demand Draft and Online Payment.
- In the event of TPA / Cashless denial or approval not received due to any reason then hospital tariff will be applicable and any discount or special rates given to TPA's / Corporate won't 9eapplicable.
- If the Surgery/ Procedures performed in emergency hours (8PM-6AM), Public Holiday and on Sunday will be charged 30% extra.
- Asst. Surgeon and Anesthetist Charges will be charged 30% on the Surgeon Charges.
- Admission will be done according to the ward category chosen by the patient; charges will be applicable as per the ward category. All charges vary as per Room category, except Pharmacy and consumables.
- Patient / Guardian Self Attested Government ID proof is mandatory to submit at the admission.
- TPA/Insurance Processing Fee applicable for all Insurance Cases.
- In our hospital there is "No Discounts Policy". Kindly co-operate.
- No Duplicate/ Second copy of OP or IP bill will be issued.
- In case the patient is shifted from lower category to higher category, all the charges like consultant visits, investigations, operations and procedures etc. from the date of admission will be charged according to the higher category.
- If the patient is shifted to the ICU, the attendant should vacate the room. If the attender occupies the room, it will be charged as per dual occupancy.
- Room eligibility is purely subject to TPA approval. Proportionate difference of the bill amount is applicable in case the patient opts for higher category higher than the TPA approved, which has to paid by the patient and may not be reimbursed by the TPA / Insurance Company at later stage.
- For Non - Medicals, Disposables, Consumables, Infusion Pump, Taxes, Implants, HIV/ HbsAg, Medical Records, Insurance Processing Fee, Double Occupancy and Registration Charges, Etc., credit cannot be extended. These items are not payable to us as per insurance company norms (Depends on the TPA/Insurance Co. T&C).
- It takes time for cash discharge is a minimum 3-4hrs. and in the case of insurance, it will take a minimum 6-7hrs.
- Difference, if any between the final bill amount arid amount permitted / approved by the TPA or total bill amount in case of denial from TPA, has to be paid by the patient.
- Two attendants are permitted with patients in Deluxe, Private Rooms and only one is permitted in the rest of the categories of rooms. No attendant is permitted in ICU's.
- All the refunds more than Rs.5,000/- will be refunded through NEFT within 7 Bank working days.
- Patient attendant can collect for Interim/provisional bill of the patient from the billing section on daily basis. Interim Bill shall be based on the acknowledged services in HIS. Final Bill of the patient may vary from the Interim bill based on actual update taken on the day of discharge. It is requested that patients/attendants enquire daily about the bill amount from billing section and pay the outstanding as on that day. You are requested to clear your outstanding amount on daily basis before 12 PM. **Patient bill outstanding should not be increase more than 10,000/-**

DECLARATION

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

Patient Name : - Dhanalakshmi	UHID Number : 92680
Self/Attendant Name : - Dhinesh kumar S	Relation : - Mother
Self/ Attendant Signature : - S.D.L. Phone Number : - 9952604666	Name & Signature of Financial Counselor

GUC-00092680 IP18-00036608
Mrs DHANALAKSHMI .S
03-05-1970 56 Y 2 M 22 D (F)
Dr. PRIYADHARSHINI S M

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URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 25/7/26 @ 11:00Am (OT) Date of Removal: .....

Parameters / Date / Shift Time	25/7/26 11Am	25/7/26 2pm					
Need for the Catheter	☑Yes ☐No	☑Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Hand Hygiene	☑Yes ☐No	☑Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Usage of Sterile Equipment	☑Yes ☐No	☑Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Is the Collection bag below the level of bladder	☑Yes ☐No	☑Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Check the Tube for Obsiruction (Free of Kinking)	☑Yes ☐No	☑Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Is Catheter dated as policy	☐Yes ☐No	☑Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Collecting bag is been emptied regularly?	☐Yes ☐No	☑Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Maintenance of closed system for the catheter	☑Yes ☐No	☑Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Dressing clean and dry?	☐Yes ☐No	☑Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Is the line removed as Policy?	☐Yes ☐No	☑Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Performance of Perineal Care	☑Yes ☐No	☑Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Onset of New Fever	☐Yes ☑No	☐Yes ☑No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Asses for the leakage at the site of insertion	☑Yes ☐No	☑Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Name of the Nurse	Risna	Pooja					
Signature of the Nurse	[signature]	[signature]					

GUC-00092680 IP18-00036608
Mrs DHANALAKSHMI .S
03-05-1970 56 Y 2 M 22 D (F)
Dr. PRIYADHARSHINI S M

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature
25/7/26	8:20Am	130mg/dl	Dr: Arshitha	S/N Abalya 018082

GUC-00092680 IP18-00036608
Mrs DHANALAKSHMI .S
03-05-1970 56 Y 2 M 22 D (F)
Dr. PRIYADHARSHINI S M

PRE - OPERATIVE CHECK LIST

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Date: 25/7/26

Patient's Name : MRS. DHANALAKSHMI Age : 56/F Gender : ☐ M ☑ F

Blood Group : .... UHID : 92680

Planned Surgery : Hysteroscopy & Endometrial Biopsy Surgeon : Dr Priyadharshini

Anesthetist : Dr. Aishwarya Date & Time of Operation : 25/7/26

Tick Appropriate Boxes

To be filled by Nurse Incharge / Senior Nurse :

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

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

Billing Clearance taken

Billing Executive Name : Dellibalu. C

Billing Executive Signature : [signature]

Date & Time : 25/07/26 @ 8:42 Am

Nurse In-Charge Name : S. Nithya 01808

Signature of Nurse In-Charge : [signature] 018080

Date & Time : 25/7/26

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

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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GUC-00092680 IP18-00036608
Mrs DHANALAKSHMI .S
03-05-1970 56 Y 2 M 22 D (F)
Dr. PRIYADHARSHINI S M

Patient Name : .....

UHID No : .....

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

.. Date : .....

Instruction:

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

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

..... Hysteroscopy and Endometrial Biopsy .....

..... upon .....

..... (Name of the Patient) .....

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

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

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

..... Bleeding, infection, Blood transfusion, Anaesthesia complication, Air Embolism, MICU Stay. .....

.....

.....

My signature on this form indicates that

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

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

Consentee :

Signature : .....

Name : MRS. DHANALAKSHMI

Date & Time : 25/7/2026

Patient Attendant :

Signature : .....

Name : Dhinesh Kumar. S

Relationship with Patient: Mother

Date & Time : 25/7/2026

Witness :

Signature : .....

Name : .....

Date & Time : .....

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. Pavithra.

Date & Time : 25/07/2026.

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Ref. No. : F / HW / CON / ANES / 02

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MAC

Patient Name : .....
GUC-00092680 IP18-00036608
Mrs DHANALAKSHMI .S
03-05-1970 56 Y 2 M 22 D (F)
Dr. PRIYADHARSHINI S M
Gender : M☐ F☐ - IP ..... Age : .....
Ward / Bed No. : ..... Consultant : Dr. Priyadharshini.
Operative procedure plan... t: Dr. Mohan / Dr. Sathish
Hysteroscopy + endometrial biopsy

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 : HYPOTENSION / BRADYCARDIA / PONV

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 MRS. DHANALAKSHMI. the above mentioned operation I Diagnostic I Therapeutic procedures HYSTEROSCOPY + BIOPSY

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 / 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. Boonlare

Name : MRS: DHANALAKSHMIA

~~Relationship with~~ Patient: patient

Date & Time : 25/7/26

Witness :

Signature : S. [signature]

Name : Dhinesh kumar

Date & Time : 25/07/2026.

Doctor (who is taking the consent) :

Signature : [signature]

Name : DR. ASHWINI. S

Date & Time : 25/7/26 8:30Am

GUC-00092680 IP18-00036608
Mrs DHANALAKSHMI .S
03-05-1970 56 Y 2 M 22 D (F)
Dr. PRIYADHARSHINI S M

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Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

UHID.No : 92680

Name: Mrs Dhanalakshmi Age: 56 yrs Sex: female

Date: 22/7/26 Time: 1:15PM Proposed Operation: Hysteroscopy + biopsy

Diagnosis: ? watery discharge from Vagina / thickened endometrium

B.P / CRT: 129/80mmHg H.R: .... Weight: 56 Kg ASA Physical Status: ☐1 ☑2 ☐3 ☐4 ☐5

Laboratory Data:

23/6/26

Hgb: 12.6g %	Glucose: 111	Protein: 7.52g %	HIV:	X-Ray:
PCV: 37.4	Urea: 32.74	Alb: 4.44g %	HBS Ag:	ECG: NSR, HR 75/mi
WBC:	Creat: 0.54	Total Bili: 0.45	HCV:	2D Echo: Mild AR
Plate: 2.53L	Na:	Dir. Bili: 0.07	Blood group:	Stress/Angio: Trivial MR, TR
PT:	K:	LDH:	T3:	Other: (N) EF.
PTT:	Ca++: 10.04	Alk phos: 84.71	T4: 1.07	HbA1C = 5.8 %
INR:	Mg++:	Amylase:	TSH: 1.68	
	Cl-:	SGOT/SGPT: 18/13		

Allergies: NKDA.

Total cholesterol/HDL = 6.

Medical History: CVS: dyslipidemia x 4 yrs. Diabetes: K/c/o type II DM x 4 yrs - on OHA

RESP: post menopausal.

CNS:

Renal: Physical Activity: (N) exercise tolerance >5METS.

Hepatic / GE:

Others:

Past Anaesthetic History: H/o PS done ↓GA - uneventful.

Physical Exam: (N) built

Airway: MP 1 (2) 3 4 Mouth Opening: adequate Mentohyoid Distance: (N) Neck: movts (N) Teeth: No loose tooth

Lungs: B/L NVBS(+), clear

Heart: S1S2(+), No murmur

CNS: NFND

Pregnant: ☐ Yes ☐ No ☑ N/A Venous Access Site: 18G/20G Spine Exam for regional: (N)

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

CBG at 8:30AM - 130 mg/dl.

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

CURRENT MEDICATIONS	DOSAGE
T. Metformin 250mg OD	
T. Rosuvastatin 5mg OD	

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:
6) To stop T. Metformin 250mg on the previous day of surgery
7) CBG at 6AM
8) continue T. Rosuvas.

Signature: S. Ashwini 101348 Name: DR. ASHWINI.S

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

Patient Sticker

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☐ No | Fasting Status:

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 : .....

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Mrs DHANALAKSHMI .S
03-05-1970 56 Y 2 M 22 D (F)
Dr. PRIYADHARSHINI S M

Patient Sticker

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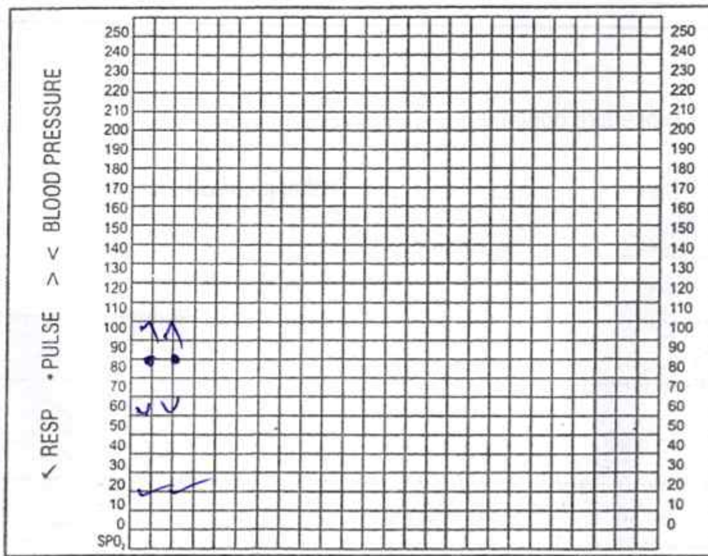
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Resme Time Received : 11:10 Am Time Discharged : 11:10Am



IV Cannula Site : ....

☐ O₂ Mask ☐ Nasal Prongs
☐ Tracheostomy ☐ T-Piece
☐ Oral Airway ☐ Nasal Airway

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

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

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
			NPO as per Dr's order	
			IVF @ 100 ml/hr RL Dx,	
			2. Para [illegible]	

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

Anaesthesiologist Name : [illegible]

Anaesthesiologist Signature: [signature]

Date & Time: 25/7/26 10 Am

PACU Nurse Name : Resmi

PACU Nurse Signature: [signature]

*Date & Time: 25/7/20

Reassessment Frequency:

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

Transferred to Unit by (PACU): MW

Date & Time: 25/7/26 @ 11:10Am

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : .....

Any other issues :

a) .....

b) .....

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

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 : .....

Ref. No. : F/GYNIC/18

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I.P. ADMISSION SHEET FOR GYNECOLOGY

GUC-00092680 IP18-00036608
Mrs DHANALAKSHMI .S
03-05-1970 56 Y 2 M 22 D (F)
Dr. PRIYADHARSHINI S M

Date of Admission : _____

Time of Admission : _____

PERSONAL DETAILS

Name : Mrs. Dhanalakshmi. Age _____ Date of Birth _____

UHID No.: GUC-92680 IP No.: _____

Department : OBG. Consultant : _____

PRESENTING COMPLAINTS

56 yrs
P1L1
Prev FTNVD
LCB - 37 wks
ST done

Postmenopausal by > 10 years.

Watery Vaginal Discharge F/2 | Diabetic on OHA.

→ Pt came with c/o lower abd pain along with backache on & off.

→ c/o watery Discharge from vagina for past 1 year on & off,

↑ Discharge for past 1 month.

→ Discharge NOT related to urination.

→ Bowel and Bladder habits Normal.

MENSTRUAL HISTORY

Year of Marriage : 40 yrs

Previous Periods :

LMP : (-)

Contraception :

OBSTETRIC HISTORY

Parity : P1L1

Mode of Delivery Prev FTNVD, ♂, 37 wks, A & H.

Last Child Birth :

ST ~~done~~ done.

MEDICAL HISTORY	SURGICAL HISTORY
Type II DM → K/c/o Diabetic on OHA for past 3-4 years on T. metformin 250mg 0-0-1 → Hyperlipidemia on Rosuvastatin 5mg 0-0-1 for 1/2 years on & off.	Sterilisation done. PS done & GA.

FAMILY HISTORY	NOTES / ALLERGIES
Nil	Nil

INITIAL ASSESSMENT :

Date 25	**Breasts**	**Local / Speculum Examination**
Ht. 155 Wt. 56.4	Soft.	P/S- Cervix healthy mild Discharge (+).
BMI 23.4.		
B.P 121/85 mmHg.		**Bimanual Pelvic Examination**
Pallor No.	**Abdominal Examination**	P/V- Cervix feels normal Uterus (N) size. mobile, No ff
CVS S1S2 (+)	Soft.	
Respiratory System NVBS (+)		
Thyroid		
PR- 75/min Spo2- 98% RA.		

PROVISIONAL DIAGNOSIS : P1L1 / Post Menopausal / Watery vaginal Discharge F/E

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT	PRESCRIPTION
	HYSTEROSCOPY AND ENDOMETRIAL BIOPSY.	- NPO - INF 1 © RL - Inj TAXIM 1g IV Stat - Inj PAN 40mg IV Stat - Inj EMESET 4mg IV Stat

Name of the Doctor : Dr. Pavithra.

Date : 25/07/2026 Time : 25/07/2026 @ 7:30 AM Signature of Doctor

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Mrs DHANALAKSHMI .S
03-05-1970 56 Y 2 M 22 D (F)
Dr. PRIYADHARSHINI S M

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RESULT SHEET

Date	23/6/26					
Time						
Hb	12.6					
PCV	37.4				HIV } Nonreactive.	
RBC					HBsAg }	
WBC						
N/L						
Platelets	2.53					
CRP					Bld (	
ESR						
PCT						
RBS	111				TSH -	1.68
Na						
K				15/7/26	Echo -	EF 76%.
Cl					Gr I diastolic dysfn.	
~~Ca/Mg~~	10.04				mild AR	PR / Trivial MR
Phosphate					HbA1C -	5.8%
Urea	32					
Creatinine	0.54					
ALP	84.71				LBC -	Trichomonas Vaginalis (+)
SGPT	13					
SGOT	18					
T.Bill/Conj	0.45/0.07				Ca 19.9 -	12.1
T.Protein	7.52				Ca 125 -	5.97
S.Albumin	4.44					
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
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 : .....

.....

.....

.....

16/6/2020.

Ut - Av, 5.1 x 3.4 x 2.6cm.
Thickened ET - 7.3mm.

Radiology : USG : .....

X-Ray : (R) ovary atrophic, (L) ovary not visualised.

ECHO : Ovarian / Para ovarian cyst → 4.5 x 4.4 x 3.7cm in (L) adnexa.

CT : .....

MRI .....

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

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Pati

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/7/26. 8:50 AM.	S/B Dr. Athelila	
	pt reviewed	
	no sp. complaints.	
	o/E: afebrile	Plan:
	GC fair	- NPO.
CBG 130	P°/PE°	- hysteroscopy +
	P/A: soft.	endometrial Biopsy.
BP 121/85mmHg.		@ 9:30 AM today.
PR 75bpm.		- follow preop orders.
SpO2 98% @ RA		
temp (N)		128435.
25/7/26. 9 AM.	c/o/w Dr Priyadharshini	
	- no need for BC G/T.	

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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/7/26. 11:15AM	S/B Dr. Abslitei	
	pt received in MICU.	
	O/E afebrile CVS] RS] NAD.	
BP 130/80mmHg	GC fair	Plan:
PR 80bpm	P° /PE°	- NPO x 2hours.
SpO2 99% @RA.	P/A: soft.	- CBD till 6pm
temp (N)		- I/o charting.
	L/E: no bleeding P/V.	- AG charting Q4H.
AG= 81cms	CBD in situ	- IVF @ 100ml/hr.
	clear urine	- w/f breathlessness/
	LHLD = 150ml.	distension/shoulder tip pain
	(signature)	- w/f bleeding P/V.
	122435	- follow anes orders.
		- BP/PR/SpO2 chart
		Q1hrly.
		- chest auscultation
		- for d/s tomorrow.
25/7/26	S/B Dr. Priyadharshini	
4:45PM	Pt reviewed; No c/o	
	CBD removed @ 3:30pm; Voided freely (not measured)	
	O/E: GC fair; Afebrile	
BP: 140/82	P° /PE	
PR: 80/min	P/A: soft	Adv:
SpO2: 100% -RA	L/E: No bleeding	· Process Discharge
		· Follow drug orders

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

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DOCTOR'S SHIFT CHANGE HANDOVER FORM

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

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

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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

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

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Mrs DHANALAKSHMI .S
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Dr. PRIYADHARSHINI S M

Patient St

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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. METFORMIN	250mg	PO	0-0-1	23/7	☐ C ☑ DC
2	T. ROSUVASTATIN.	5mg	PO	0-0-1	24/7	☐ 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. Pavithra [signature] TN4682

Date & Time : 25/07/2026 @ 7Am

Nurse Name & Signature: S. NAKalya 018080 SA 018080

Date & Time : 25/7/26 at 7Am

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

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Dr. PRIYADHARSHINI S M

(2)

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MEDICATION RECONCILIATION FORM

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

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

Shifting From: LDR Shifted to: OT

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	INJ PAN	40mg	IV.		25/7/26 at 8:30Am	☑C ☐DC
2	INJ EMESET	4mg	IV.		25/7/26 8:30Am	☑C ☐DC
3	INJ TAXIM	0.1ML	ID.		25/7/26 8:30Am	☑C ☐DC
4	INJ TAXIM	1GM	IV.		25/7/26 9:45Am	☑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. Harshita [signature]

Date & Time : 25/07/2026 12:45

Nurse Name & Signature: S.N.Akalya 018080

Date & Time : 25/7/26

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

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Mrs DHANALAKSHMI .S
03-05-1970 56 Y 2 M 22 D (F)
Dr. PRIYADHARSHINI S M

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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: OT Shifted to: MICU

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	2. PARACETAMOL	1gm	IV	SOS	25/7/26 @10:40am	☐C ☐DC
2						☐C ☐DC
3						☐C ☐DC
4						☐C ☐DC
5						☐C ☐DC
6						☐C ☐DC
7						☐C ☐DC
8						☐C ☐DC
9						☐C ☐DC
10						☐C ☐DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. mohan

Date & Time : 25/7/26

Nurse Name & Signature: Renu

Date & Time : 25/7/26

Patient Sti

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Mrs DHANALAKSHMI .S
23-05-1970 56 Y 2 M 22 D (F)
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DRUG CHART

Date of Admission: 25/7/26 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:				

Signature .....

VERIFIED BY : Name .....

GUC-00092680 IP18-00036608
Mrs DHANALAKSHMI .S
03-05-1970 56 Y 2 M 22 D (F)
Dr. PRIYADHARSHINI S M

REGULAR PRESCRIPTIONS

Weight 56.4 kgs. Ward. .....

DRUG : INJ TAXIM	Dose	Route	Frequency	Start Date	Date / Time
	1gm	IV	1-0-1	25/7/24	10AM
Name & Signature of the Doctor Starting the Drugs: 128435					
Additional Instructions: till d/s.					10pm
Daily Doctor's Endorsement by a Sign					

DRUG : TAB PAN	Dose	Route	Frequency	Start Date	Date / Time
	40mg	P/o	1-0-1	25/7/24	7AM
Name & Signature of the Doctor Starting the Drugs: 128435					
Additional Instructions:					7pm
Daily Doctor's Endorsement by a Sign					

DRUG : TAB PARA	Dose	Route	Frequency	Start Date	Date / Time
	1gm	P/o	1-1-1	25/7/24	8AM
Name & Signature of the Doctor Starting the Drugs: 128435					
Additional Instructions:					2pm
Daily Doctor's Endorsement by a Sign					10pm

DRUG : TAB METFORMIN	Dose	Route	Frequency	Start Date	Date / Time
	250mg	P/o	0-0-1	25/7/24	
Name & Signature of the Doctor Starting the Drugs: 128435					
Additional Instructions: After dinner.					
Daily Doctor's Endorsement by a Sign					

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Dr. PRIYADHARSHINI S M

Patient Stic

Weight 56-4/9 Ward DR

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

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

Signature

VERIFIED BY : Name

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
25/7	8:30 AM	Inj TAXIM	0.1ml	i d		SA / SP
25/7	9:45 AM	Inj TAXIM	1g	IV		SA / SP
25/7	8:30 AM	Inj PANTOPRAZOLE	40mg	IV		SA / SP
25/7	8:30 AM	Inj EMESET	4mg	IV		SA / SP
25/7	10:40 AM	2. PARACETAMOL	1gm	IV		BS / AS

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03-05-1970 56 Y 2 M 22 D (F)
Dr. PRIYADHARSHINI S M

I.V. FLUIDS CHART

Weight. 56.4kg Ward. .....

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
25/7/26	8 AM	IVF 1 DRL	IV	100ml/hr		SA / SP	25/7		SA / SP
25/7/26	10:00 AM	INF 2 DRL	IV			RS / AS	25/7/26		RS / AS

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

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REGULAR PRESCRIPTIONS

Sheet No: .... Weight .... Ward ....

DRUG : TAB ROSUVASTATIN

Dose	Route	Frequency	Start Dt.
5mg	P/O	0-0-1	25/7/26

Name & Signature of the Doctor Starting the Drugs: 128435

Additional Instructions:

Date / Time: 9PM

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

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 ....

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

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 ....

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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

25/7/26	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	20	20	16																		
	0 - 10																								
Saturations	94 - 100 %	100		99	100	100	100																		
	< 94 %																								
Administered O_2 (L/min.)		RA		RA	RA	RA	RA																		
Temp°c	40																								
	39																								
	38																								
	37	98.6		98.6																					
	36																								
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90	75		75	76	80	76																		
	80																								
	70																								
	60																								
	50																								
	40																								
↑ Systolic Blood Pressue	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130	121		130	136	125	130	132	140																
	120																								
	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
↓ Diastolic Blood Pressure	130																								
	120																								
	110																								
	100																								
	90																								
	80			80	80	91	90	80	80	80															
	70																								
	60	85																							
	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	1	0	0	0															
TOTAL ORANGE SCORES		0		0	0	0	0	0	0	0															
Nurse Initial		A					A	P	P	P															

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

25/7/2026 AVI chart

12pm - 81 cm

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Dr. PRIYADHARSHINI S M

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FLUID CHART

Sheet No. : 1

25/7/2006

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

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	~~I.V~~ RL	N.G							
	08:00 am	N		RL 500ml						200	0	SA
	09:00 am									–	0	SA
	10:00 am	P								–	0	SA
	11:00 am	O		~~500ml~~ RL 500ml						50ml	0	RS
	12:00 pm			100						150	0	SA
	01:00 pm			100						150	0	SA
Total Intake :		1800ml				**Total Output :**				450ml		
	02:00 pm	H20	100	100						250	0	SA
	03:00 pm	TC water	200ml	100ml						150	0	SA
	04:00 pm			100							0	SA
	05:00 pm	100	200ml	100						~~200~~	0	SA
	06:00 pm										0	
	07:00 pm											
Total Intake :						**Total Output :**				400+ 1 Time		
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

GUC-00092680 IP18-00036608
Mrs DHANALAKSHMI .S
03-05-1970 56 Y 2 M 22 D (F)
Dr. PRIYADHARSHINI S M

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: P1L1 post menopause d PMB NUD			Any Infection: ☐ Yes ☐ No ☑ Not Known If Yes Specify:			
	Surgery / Procedure: Hysteroscopy Endometrial Biopsy			Post OP Day:			
BACKGROUND	Date / Shift	25/7/20 M	25/7/20 9pm				
	Medical Condition (Any special condition to be noted):	Type II DM	T2DM.				
	Diet:	Npo	Liquid.				
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	N/A	RA.				
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98F	98F				
	Res:	20b/m	18				
	SpO_2:	100%.	100				
	Pulse:	80b/m	82.				
	BP:	121/80	130/80				
	LOC:	conscious	conscious				
	Fall Risk Score:	20	30				
	Pain Score:	0/10	1/10				
	Skin Integrity	Normal	Normal				
Recommendations	Safety Needs:	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	–	–				
	Others Specify:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	NPO	Liquid				
	Critical Lab Test / Values:	N/A	–				
	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):	NonDepe	Depend				
Post Operative Procedure Special Orders:		–	–				
Handed Over By Name :		S/N Akalyaniban	Pooja				
Signature / ID :		RAD18057	Pooja.				
Date:		25/7/20	25/7/20				
Time:		1:30pm					
Taken Over By Name :		Pooja					
Signature / ID :		Pooja					
Date:		25/7/20					
Time:		2pm					

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Mrs DHANALAKSHMI .S IP18-00036608
03-05-1970 56 Y 2 M 22 D (F)
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NURSING CARE RECORD

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Date: 05/7/2026

Goals

- ☐ Maintain [illegible]
- ☐ Maintain Personal Hygiene
- ☐ Identify Potential Complications
- ☐ Relieve Pain & Discomfort
- ☐ Prevent Infection
- ☐ 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
- ☐ Any Others. Specify.....

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM	prevent falls & Injury	8:30 AM	keep Bed in low position with side rails up. Ensure call bell is within reach	patient was stable	Reassessment was Done	[illegible] 01800
Afternoon		Improve knowledge and promote self-care.		Teach medication regimens follow up-care Educate regarding diet.	Improved patient knowledge about self care	Reassessment is done	[illegible]
Night							

Patient Sticker

NURSING CARE RECORD

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Date: .....

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							

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03-05-1970 56 Y 2 M 22 D (F)
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(1)

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NURSES NOTES

(USE BALL POINT PEN ONLY)

☐ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		Admission Notes
25/1/26	07 AM	⇒ Mrs: DHANALAKSHMI come for Admission under Dr: priyadharshini complaints of post menopaused water vaginal discharge. She is P1L1 previous NVD, known case of Type II DM / Diabetic on OHA for past 3-4 years, surgical History of ST done. VUA checked for vital signs recorded patient vital are stable parts preparation was done patient morning care & bath done provided proto gown, patient general condition fair ⟶ S/N Akalya 018080
	8 AM	⇒ IV placement was done IV fluids RL 500ml connected on flow pt is NPO from yesterday Night. pt was stable No complaints ⟶ S/N Akalya 01808
	8:30 AM	⇒ Inj: Taxim 1gram after dilution 0.1ml ID given Inj pan 40mg & Inj Emeset 4mg IV given to patient To checked for CBG 130mg/dl Informed Dr: Akshini / Dr: Akshitha pt care hand over given to OT staff Nurse ⟶ S/N Akalya 01808

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Docu. No. : RCH /FRM / CLINICAL / 089

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Mrs DHANALAKSHMI .S
03-05-1970 56 Y 2 M 22 D (F)
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NURSES NOTES

(USE BALL POINT PEN ONLY)

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
25/7/26	9:45 Am	⇒ No Allergic reaction S/Inj: Taxim 1gram full Dose given to pt shifted to OT. Dr: Akshitha Advised to No need pt Blood grouping S/N Healthy
		OT shifting Note
25/7/26	9:50 Am	Patient received from LDR to OT-I. Patient is conscious & stable. Iv line is present patient vital signs are stable.
	09:55 Am	GA given positioning done. Iv fluid connected. vital signs are stable.
	10:00 Am	Painting and draping done.
	10:05 Am	Procedure started. no active bleeding is present. Patient vital signs are stable. Iv fluid on flow.
	10:50 Am	Specimen taken and sent to lab.
	10:55 Am	procedure done no bleeding is present. Patient vital signs are stable. Foley's Catheterization done.
	11:00 Am	Extubation done. patient is awaked. vital signs are stable Iv fluid on flow.
	11:10 Am	Patient shifted to recovery given to recovery staff

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00092680 IP18-00036608
Mrs DHANALAKSHMI .S
03-05-1970 56 Y 2 M 22 D (F)
Dr. PRIYADHARSHINI S M

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NURSES NOTES

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
25/7/26	11:15 AM	Receiving Notes Patient is receiving from OT to MICU patient care hand over taken from OT Staff Nurse patient was stable conscious & oriented IV line present & patent. connected vital signs maintained No chest secretions output Nil Informed Dr. Akshitha IV fluids connected 125ml/hr RL 500ml in general condition fair catheter @ IV line @ NAD other compliants	Akshitha 01808
	1pm	patient was stable IV fluids 125ml/hr ongoing maintained No chest & clear output patient general condition fair	Akshitha 01808
	1:30	⇒ Dr. Akshitha advised to checked Abdomen girth Nil is 81cm Informed Dr. Akshitha at 2pm patient care hand over given to Evening duty staff Nurse	Akshitha 01808

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NURSES NOTES

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Evening duty	
05/7/26	1.30pm	pt care hand over taken from morning duty staff. pt consciously oriented. IV line ⊕ c̄ pattern. CBD ⊕ urine draining clear. she is on liquid diet. Encourage to take adequate oral fluid. pt have no c/o pain.	[signature]
	2pm	pt vital signs checked & recorded. maintain Leo chart provide comfortable bed position. PVI, Braden, Q, morse fall risk assessment done.	S/N [signature]
	3.30pm	Dr. Vinitha advice to Remove CBD after mobilization pt mobilization done. pt walking. CBD removed as per doctor order.	S/N [signature]
	4.45pm	Dr. priyadharshini advice to do discharge process pt voided urine freely not measured. Informed to Dr. vinitha advice to do discharge process.	[signature]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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☑ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
25/7	11:05pm	File sent to billing.	
		[illegible] sent to pharmacy	
		as per doctors order.	[illegible]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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OBSTETRICS / GYNECOLOGY
NURSING INITIAL ASSESSMENT FORM

Date of Admission: 25/7/25

Baseline Information:

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

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

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

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

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

If yes, identify —

Chief Complaints: Pt came for postmenopassed water vaginal discharge

Doctor Notified on Admission: ☑ Yes ☐ No

Name of the Doctor: Dr. Pavithra

Time Notified: 7AM

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Type II DM Diabetic 3 to 4 years	ST Done	—

Gynecology Assessment: ☑ Not Applicable

Menstrual History: Regular

Onset of Menarche: —

Menstrual Cycle: ☑ Regular ☐ Irregular

Last Menstrual Period: —

Gynecology Surgical History:

Caesarean Section: ☑ No ☐ Yes

Cervical Cerclage: ☑ No ☐ Yes

Ectopic Pregnancy: ☑ No ☐ Yes

Myomectomy: ☑ No ☐ Yes

Others: —

Gynecological History:

Contraceptives: ☑ No ☐ Yes

Vaginal Discharge: ☑ No ☐ Yes

Post-Coital Bleeding: ☑ No ☐ Yes

Infertility: ☑ No ☐ Yes

If Yes Type: ☐ Primary ☐ Secondary

Obstetric History: G — P 1 L 1 A —

Previous LSCS: NO

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

Family History: ☐ No Abnormalities Detected

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

☐ Liver disease ☐ Other —

Vital Signs / Measurements: Temp: 98 F HR: 75 bpm RR: 20 bpm

BP: 120/85 mmHg Weight: 56.4 kg Height: 155 cm BMI: 24.1

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

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Dr. PRIYADHARSHINI S M

PHYSICAL ASSESSMENT

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

Fall Assessment: ☑ Yes ☐ No Score ...25..... (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore: ☑ Yes ☐ No Score ...27..... (complete the Braden Q Sheet)

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

☐ Mobility problem ☐ Walking Problem ☑ No Abnormality Detected

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☐ No Abnormality Detected

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

☐ Under Weight ☑ Diabetes Mellitus ☐ Hyperemesis Gravidarum

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

☐ Others .....

Inform consultant for positive criteria

SOCIAL SCREENING:

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

Social History: Lives With ...Son/family.....

Orientation has been given regarding the following aspects:

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

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

Above information given to ...patient.....

Name of Person Orientation was given to: ...mrs. Dhanalakshmi.....

Orientation not given Reason: .....-.....

Nurse Signature: S/N Akalya ...18088

Nurse Name: SA 01808

Date & Time: 25/7/26 at 7:40 AM

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RISK ASSESSMENT TOOL FOR DEEP VEIN THROMBOSIS

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

Date: 25/7/26

Pre - Existing Risk Factors	Tick	Score
Previous VTE (except a single event related to major surgery)		4
Previous VTE provoked by major surgery		3
Known high-risk thrombophilia		3
Medical comorbidities e.g. cancer, heart failure; active systemic lupus erythematosus, inflammatory polyarthropathy or inflammatory bowel disease; nephrotic syndrome; type I diabetes mellitus with nephropathy; sickle cell disease; current intravenous drug user		3
Family history of unprovoked or estrogen-related VTE in first-degree relative		1
Known low-risk thrombophilia (no VTE)		1
Age (≥35 years)	✓	1
Obesity		1 or 2
Parity ≥ 3		1
Smoker		1
Gross varicose veins		1
Obstetric Risk Factors		
Pre-eclampsia in current pregnancy		1
ART/IVF (antenatal only)		1
Multiple pregnancy		1
Caesarean section in labour		2
Elective caesarean section		1
Mid-cavity or rotational operative delivery		1
Prolonged labour (24 hours)		1
PPH (1 litre or transfusion)		1
Preterm birth 37^{+0} weeks in current pregnancy		1
Stillbirth in current pregnancy		1
Transient Risk Factors		
Any surgical procedure in pregnancy or puerperium except immediate repair of the perineum, e.g. appendectomy, postpartum sterilization		3
Hyperemesis		3
OHSS (first trimester only)		4
Current systemic infection		1
Immobility, dehydration		1
Total		1
Signature of the Nurse	S/ N.Akalya 018058	
Action Plan		

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

RISK ASSESSMENT FOR VENOUS THROMBOEMBOLISM (VTE)

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

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

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Score	Date / Time	25/7/26	25/7/26	
History of Falling (immediately or w/in 3 months)	Yes	25				
	No	0	0	0		
Secondary Diagnosis (more than one diagnosis)	Yes	15	15	15		
	No	0	0			
Ambulatory Aid	Furniture	30				
	Crutches, Cane(S), Walker	15				
	None /Bed Rest /Nurse Assist	0				
IV / Heparin Lock or Saline	Yes	20	20	20		
	No	0				
GAIT / Transferring	Impaired	20				
	Weak (uses touch for balance)	10		10		
	Normal /On Bed Rest /Immobile	0	0			
Mental Status	Forgets limitations	15				
	Oriented to own ability	0	0	0		
Total Morse Fall Scale Score:			35	45		
		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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BRADEN 'Q' SCALE

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	1	2	3	4				
				Date :	M 25/7	A 25/7		
				Time :	8Am	2pm		
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.	[illegible] 1	2		
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	24	24		
				Evaluator's Name	[illegible] 018008	[illegible]		

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	⓫ Regular Turning Schedule ⓫ Enable as much activity as possible ⓫ Protect the heels ⓫ Use pressure redistribution surfaces ⓫ Manage moisture, friction and shear ⓫ 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	⓫ Use the Same Protocol as for **"At Risk"** Patients ⓫ 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	⓫ Follow the same protocol as for **"Moderate Risk"** Patients ⓫ In addition to regular turning schedule ⓫ 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	⓫ Use same protocol as for **"High Risk"** Patients ⓫ Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

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Patient's GUC-00092680 IP18-00036608
Mrs DHANALAKSHMI .S
MRD NO 03-05-1970 56 Y 2 M 22 D (F)
Dr. PRIYADHARSHINI S M
Age :.... Sex: ☐ M ☐ F
Consultant :

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 25/7/26 Time: 8Am
Location : left mal cephalic vein
Size : 18G
Cannula inserted by : S/N Akalya 018082

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
25/7	8:30Am	☐Yes ☐No	☐Yes ☐No	Obser	SA
	10AM	☐Yes ☐No	☐Yes ☐No	Obser	SA
	12pM	☐Yes ☐No	☐Yes ☐No	Obse	SA
	2pm	☐Yes ☐No	☐Yes ☐No	obser	[illegible]
	4pm	☐Yes ☐No	☐Yes ☐No	obser	[illegible]
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

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

CANNULA 2

Date : Time:
Location :
Size :
Cannula inserted by :

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

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

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

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

PHLEBITIS ASSESSMENT AND MANAGEMENT RECORD

CANNULA 3

Date : Time:

Location :

Size :

Cannula inserted by :

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

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

CANNULA 4

Date : Time:

Location :

Size :

Cannula inserted by :

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

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

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

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

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

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PAIN ASSESSMENT FORM

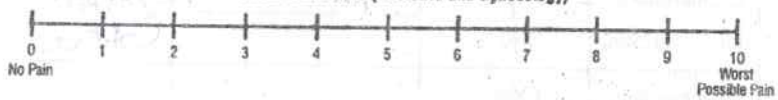
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
25/7/26	8Am	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	no pain	Abalya 01800
25/7/26	12pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	no pain	Abalya 01800
25/7/26	2pm	0/10	nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	nil	[illegible] 01800
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

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

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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INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III: Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding	Comments	Designation / Signature
25/7	8Am	YES	Educated about the NPO status	pt	No learning barriers	orally	None	YES	good	[illegible] 01800

Part - III: CODES

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

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

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

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

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

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Dr. PRIYADHARSHINI S M

(2)

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PATIENT TRANSFER NURSING HANDOVER CHECKLIST

Date & Time of Transfer: 25/7/26 @ 11:10 Am OT **TRANSFERRED TO :** MLW

		YES/NO	REMARKS
1	**Patient Identification**		
	a.Patient Identification Patient name, age, UHID/hospital number confirmed	Yes	
	b.Surgical procedure & correct site verified	Yes	
2	**Airway & Breathing**		
	a.Oxygen delivery (mask/cannula/ventilator) secured	Yes	
	b.SpO_2 within safe range	Yes	
	c.If ETT: position confirmed, ties secure, cuff inflated	NA	
3	**Circulation & Hemodynamic Stability**		
	a.IV lines secured & infusion running correctly	Yes	
	b.No active uncontrolled bleeding	Yes	
	c.Last vitals recorded before transfer	Yes	
	d.Central line hubs are closed	NA	
	e.Dressing Intact	NA	
4	**Pain Assessment**		
	a.Pain score assessed & analgesia given	Yes	
	b.Reassessment done	Yes	
5	**Wound, Dressings & Drains**		
	a.Surgical dressing intact	NA	
	b.All drains fixed, output noted	NA	
	c.Catheter secure & urine output recorded	NA	
	d.Splints/casts/traction devices stabilized		
6	**Medications Pre & Post-Op Orders**		
	a.Medications due time noted	Yes	
	b.Pre & Post-op instructions (NPO, position, mobilization) communicated	Yes	
	c.Emergency meds given in OT (time & dose documented)	Yes	
7	**Equipment Safety & Transport Preparedness**		
	a.Oxygen cylinder full & ambu bag at bedside	NA	
	b.Bed/side rails up and brakes applied	Yes	
	c.Special positioning maintained as per surgery	NA	
8	**High-Risk Patient Safety (if applicable)**		
	a.Chest tube: underwater seal below chest level	NA	
	b.Epidural catheter secure, infusion checked	NA	
	c.Pressure areas protected (heels/elbows)	NA	
9	**BLOOD AND BLOOD PRODUCTS TRANSFUSED**	NA	
10	**REPORTS AND LABS HANDED OVER**	NA	
11	**BIOPSY/HPE SENT**	Yes	
12	**Documentation**		
	a.Documentation completeness	Yes	
	Transferring Nurse:		
	Receiving Nurse :		
	Signature of Incharge:	For Risw 60731	

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Mrs DHANALAKSHMI .S
03-05-1970 56 Y 2 M 22 D (F)
Dr. PRIYADHARSHINI S M

BirthRight Rainbow Children's Hospital

PATIENT TRANSFER NURSING HANDOVER CHECKLIST

TRANSFERRED TO : OT

	Date & Time of Transfer: 25/7/26 LDR	YES/NO	REMARKS
1	**Patient Identification**	yes	
	a.Patient Identification Patient name, age, UHID/hospital number confirmed	yes	
	b.Surgical procedure & correct site verified		
2	**Airway & Breathing**	yes	
	a.Oxygen delivery (mask/cannula/ventilator) secured	yes	
	b.SpO_2 within safe range	No	
	c.If ETT: position confirmed, ties secure, cuff inflated		
3	**Circulation & Hemodynamic Stability**	yes	
	a.IV lines secured & infusion running correctly	No	
	b.No active uncontrolled bleeding	yes	
	c.Last vitals recorded before transfer	No	
	d.Central line hubs are closed	No	
	e.Dressing Intact		
4	**Pain Assessment**	yes	
	a.Pain score assessed & analgesia given	yes	
	b.Reassessment done		
5	**Wound, Dressings & Drains**	No	
	a.Surgical dressing intact		
	b.All drains fixed, output noted	No	
	c.Catheter secure & urine output recorded	No	
	d.Splints/casts/traction devices stabilized		
6	**Medications Pre & Post-Op Orders**	yes	
	a.Medications due time noted	yes	
	b.Pre & Post-op instructions (NPO, position, mobilization) communicated	yes	
	c.Emergency meds given in OT (time & dose documented)		
7	**Equipment Safety & Transport Preparedness**	yes	
	a.Oxygen cylinder full & ambu bag at bedside	yes	
	b.Bed/side rails up and brakes applied	No	
	c.Special positioning maintained as per surgery		
8	**High-Risk Patient Safety (if applicable)**	No	
	a.Chest tube: underwater seal below chest level	No	
	b.Epidural catheter secure, infusion checked	No	
	c.Pressure areas protected (heels/elbows)	No	
9	**BLOOD AND BLOOD PRODUCTS TRANSFUSED**	No	
10	**REPORTS AND LABS HANDED OVER**	No	
11	**BIOPSY/HPE SENT**		
12	**Documentation**	yes	
	a.Documentation completeness		
	Transferring Nurse: S/N Deepa 01800 60771		
	Receiving Nurse : S/N Anusya		
	Signature of Incharge:		

RCH/GDY/FRM/CLINICAL/598

(1)

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PATIENT TRANSFER FORM

GUC-00092680 IP18-00036608
Mrs DHANALAKSHMI .S
03-05-1970 56 Y 2 M 22 D (F)
Dr. PRIYADHARSHINI S M

...lo.	Date & Time of Admission	Date & Time of Transfer Order
	25/7/26 at 7Am	25/7/26 at 9:45Am
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr: priyadharshini	Dr Akshitha	Hysteroscopy & Endometrial Biopsy
From Unit	**To Unit**	**Information to Attendant**
LDR	07	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
whole IP File	—	Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

Shifting Summary / Notes Written by Doctor : Yes ☑ No ☐
pt shifted to OT

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
S/N Akalya 018050	Dr. Akshitha

Patient & Clinical Records Received by : Reshma 6007121

Date & Time of Patient Received : 25/7/26 @ 9:50am

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

(2)

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PATIENT TRANSFER FORM

GUC-00092680 IP18-00036608
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03-05-1970 56 Y 2 M 22 D (F)
Dr. PRIYADHARSHINI S M

Date & Time of Admission	Date & Time of Transfer Order
25/7/26 @ 7:26 Am	25/7/26 @ 11:10 Am

Treating Consultant Name	Transfer Ordered by	Reason for Transfer
Dr. Priyadharshini	Dr. mohan	For further management

From Unit	To Unit	Information to Attendant
OT	mcw	Yes ☑ No ☐

Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant
1 Ip file	—	Yes ☑ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
609721	Dr. mohan

Patient & Clinical Records Received by : Shabaliya 018080

Date & Time of Patient Received : 25/7/26 at 4:13 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