GUC-00085644 IP18-00036512
Mrs KANIMOZHI L
19-03-1997 29 Y 3 M 30 D (F)
Dr. MATHANGI RAJAGOPALAN

Rainbow Children's Hospital

DISCHARGE TRACKING SHEET

HID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing		19-1-24 6 AM					
Activity Sheet update by Pharmacy							

ACTIVITY RECORD FOR BILLING

GUC-00085644
Mrs KANIMOZHI L
19-03-1997
Dr. MATHANGI RAJAGOPALAN
IP18-00036512
29 Y 3 M 29 D (F)

Rainbow® Children's Hospital

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: Mrs. Kanimozhi L.

UHID No: KNL-85644 IP No: 18-36512 Consultant: Dr. mathangi Dept: LDR

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
18/7/2026	10.20pm	LDR	7TH Floor	

CROSS CONSULTATION VISIT

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
18/7/24	CBC, CRP	26023086	[illegible]
19/7/24	CBC	26023198	[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
18/7	CTG - (1)			009675	[illegible]
18/7	Infusion pump	8Am	18/7/26 4pm	1729181	[illegible]
	CTG - (2)			009719	Atalya 018080
	CTG - (3)			009719	Atalya 018080
	CTG - (4)			009719	Atalya 018080
	CTG - (5)			009719	Atalya 018080
	CTG (6)			009720	Atalya 018080
	CTG (7)			009720	Atalya 018080
	CTG (8)			009720	Atalya 018080
	CTG (9)			009720	AT 018080

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
18/7/26	IV placement	(1)	1729132	[illegible]
18/7/26	catheterization	(1)	1729563.	S/N [illegible],

ANY OTHER INFORMATION:

Delivery Details : Kiwi assisted Delivery
Date : 18/7/26
Duration : 1 Hour
Time : 1.30pm – 2.30pm
Dr. Mathangi
Dr. Vinitha

Date: 19/7/26 Time: 6am Prepared By: [signature]

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

GUC-00085644 IP18-00036512
Mrs KANIMOZHI L
19-03-1997 29 Y 3 M 30 D (F)
Dr. MATHANGI RAJAGOPALAN

Rainbow Children's Hospital | BirthRight

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement	20/7/26 at 11:00pm				
	INTIME	OUT TIME			
Arrangement of File by Nursing		20/7/26 at 11:00am	S.meal 0073pm		
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

705

Rainbow Children's Hospital

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 : IP18-00036512 **Admit Date** : 18-Jul-2026 **Admit Time** : 07:24 AM **UHID** : GUC-00085644

Patient Details :

Patient Name	: Mrs KANIMOZHI L	**Age**	: 29 Y 3 M 29 D
Guardian	: Mr KARTHIKEYAN P	**DOB**	: 19-03-1997
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: G2, 2ND FLOOR, CHANDRA APARTMENTS, VGP ROAD Saidhapet North Chennai Tamil Nadu INDIA 600015	**Phone No**	: 9345455498/ 8489895709
		E-mail	: NO@GMAIL.COM

Admission Details :

Bed Type : MICU **Bed No** : MICU 804 **Ward Name** : 8F-OT COMPLEX

Room No : MICU 804 **Admission Type** : First Visit

Contact Details :

Name : Mr KARTHIKEYAN P **Relationship** : Husband

Contact Address : G2, 2ND FLOOR, CHANDRA APARTMENTS, VGP ROAD Saidhapet North Chennai Tamil Nadu INDIA 600015 **Phone No** : 9345455498

Signature

Doctor Details :

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

Referral Doctor : Dr. Mathangi Rajagopalan **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

Rainbow Children's Hospital

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 KANIMOZHI L**	**Age :**	**29 Y 3 M 29 D**
IP No:	**IP18-00036512**	**Sex:**	**Female**
Consultant:	**Dr. MATHANGI RAJAGOPALAN**	**Ward/Bed No:**	**8F-OT COMPLEX/MICU 804**

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 a 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: > P. Kar

Name: > Karthikeyan P

Relationship: > Husband

Date: 18-07-2026 Time: 07.24

Witness Name: ASWIN

Witness Signature:

Patient Address:

G2, 2ND FLOOR, CHANDRA APARTMENTS, VGP ROAD Saidhapet North Chennai Tamil Nadu INDIA 600015

Rainbow Children's Hospital | BirthRight BY RAINBOW HOSPITALS

BILLING POLICY

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

DECLARATION

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

Patient Name : Kanimozhi . L	UHID Number : 85644
Self/Attendant Name : Karthikeyan . P	Relation : Husband
Self/ Attendant Signature : Phone Number : 9345455498	Name & Signature of Financial Counselor

आधार

భారత ప్రభుత్వం
Unique Identification Authority of India
Government of India

నమోదు సంఖ్య/ Enrolment No.: 0651/10123/00350

To
లక్ష్మణ కనిమొళి
Lakshmanan Kanimozhi
D/O M Lakshmanan
9-303
mangalam
settypalli
Tirupati (Urban)
Chittoor Andhra Pradesh - 517507
8489895709

Enrolment Date: 21/11/2018
Generation Date: 11/04/2019

Signature valid
Digitally signed by UNIQUE IDENTIFICATION AUTHORITY OF INDIA
Date: 2019.04.11 12:43:02 IST

మీ ఆధార్ సంఖ్య / Your Aadhaar No. :
9169 3339 5712
VID : 9152 6063 8709 6340
నా ఆధార్, నా గుర్తింపు

భారత ప్రభుత్వం
Government of India

లక్ష్మణ కనిమొళి
Lakshmanan Kanimozhi
పుట్టిన తేదీ/DOB: 19/03/1997
స్త్రీ/ FEMALE

9169 3339 5712
VID : 9152 6063 8709 6340
నా ఆధార్, నా గుర్తింపు

Government of India

AADHAA

సమాచారం

- ఆధార్ గుర్తింపుకు రుజువుగా, పౌరసత్వానికి కాదు.
- గుర్తింపును ధృవీకరణ ఆన్‌లైన్ ఆథెంటికేషన్ ద్వారా పొందవచ్చు.
- ఇది ఎలక్ట్రానిక్ పద్ధతిలో రూపొందిన లేఖ.

INFORMATION

- Aadhaar is a proof of identity, not of citizensh
- To establish identity, authenticate online.
- This is electronically generated letter.

- ఆధార్ దేశమంతటా ఆమోదించబడుతుంది.
- ఆధార్ భవిష్యత్తులో ప్రభుత్వ మరియు ప్రభుత్వేతర సేవలు అందచేయడంలో సహాయ పడుతుంది.
- Aadhaar is valid throughout the country.
- Aadhaar will be helpful in availing Governme and Non-Government services in future.

ఆధార్ — భారత విశిష్ట గుర్తింపు ప్రాధికార సంస్థ
Unique Identification Authority of India

చిరునామా:
W/O యం లక్ష్మణన్, 9-303, మంగళం, సెట్టిపల్లి, తిరుపతి,
ర్, చిత్తూర్ జిల్లా - 517507

Address:
/O M Lakshmanan, 9-303, mangalam,
ttypalli, Tirupati (Urban), Chittoor,
dhra Pradesh - 517507

9169 3339 5712
VID : 9152 6063 8709 6340

Patient Sticker

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INDUCTION OF LABOR CONSENT

GUC-00085644 IP18-00036512
Mrs KANIMOZHI L
19-03-1997 29 Y 3 M 29 D (F)
Dr. MATHANGI RAJAGOPALAN

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

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

You are scheduled for an induction of labor on 18/07/2026 (date) at 37 weeks + 2 days (weeks of gestation).

The reason for your induction is Term | PROM

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

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

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

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

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

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

Patient
Signature: L Kanimozhi
Name: L. Kanimozhi
Date & Time: 18/7/26

Patient Attendant:
Signature: P. Kanthikapan
Name: Kanthikapan. P
Relationship with Patient: Husband
Date & Time: 18/7/26

Doctor:
Signature: 182217
Name: Dr. Shreedevi
Date & Time: 18/07/2026

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

INFORMED CONSENT FOR VAGINAL BIRTH

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GUC-00085644 IP18-00036512
Mrs KANIMOZHI L
19-03-1997 29 Y 3 M 29 D (F)
Dr. MATHANGI RAJAGOPALAN

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

Gen Date : ..... Time : .....

I hereby authorized the performance of the following procedure:

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

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

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

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

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

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

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

Name of the Doctor performing the procedure: Dr. Mathangi

Consentee :

Signature : .....

Name : L. Kanimozhi

Date & Time : 18/7/26

Patient Attendant :

Signature : .....

Name : Koothirayan. P

Relationship with Patient: Husband

Date & Time : 18/7/26

Witness :

Signature : .....

Name : .....

Date & Time : .....

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. Shreederi

Date & Time : 18/07/2026

GUC-00085644 IP18-00036512
Mrs KANIMOZHI L
19-03-1997 29 Y 3 M 29 D (F)
Dr. MATHANGI RAJAGOPALAN

Patient Stick

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IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints PFM well.
Leaking PV since 5:30 AM
No pain/bleeding PV.

Obstetric Formula:
Primigravida.

Obstetric History:
spontaneous conception.
hypothyroid.
M/S 3 yrs; NCM;
moderate anemia – corrected c 1gm FCM.

Present Pregnancy Record:
Dating
NT
Anomaly
Growth
} (N).

RISK FACTORS:
- hypothyroid (Thyronorm 25mcg OD)
- mild anemia.
- Inj. FCM 1gm given @ 32w.

Height: 164 cm
Weight: 67.7 kg
Allergies: NKA
Breast: ☑ Normal ☐ Abnormal
General Examination:
Consciousness: conscious Pallor: (-)
Icterus: (-) Edema: (-)
Temp: (N) PR: 92 bpm.
BP: 102/62 mmHg DTR:
CVS: S1S2 (+) RS BAE (+).
Liver/Spleen: Urine Output:

LMP: 30/10/25 EDD: 6/8/26.
Corrected EDD: GA: 37w2D

Menstrual History: Regular : ☑ Yes ☐ No

Obstetric Examination

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

Per Speculum Examination

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

Vaginal Examination

Cervix: 1.75 cms ☑ Long ☐ Partially effaced ☐ Effaced
Os: Closed _____ Dilated 2 cms dilated.
Membranes: ☐ Present ☑ Absent
Liquor: ☑ Clear ☐ Meconium ☐ Blood Stained
Presenting Part: ☑ Vertex ☐ Breech ☐ Others
Sutton: ☑ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2
Pelvis: ☑ Adequate ☐ Doubtful

DIAGNOSIS

29yrs | Primigravida | 37w2D | hypothyroid | mild anemia (Hb 9.7) |
PROM.

Patient Sticker

Family History: Father } DM/SHTN. Mother }	**Surgical History:** Open appendectomy @ 13yrs of age
Medical History: Gestational hypothyroid.	**Medication History:** Thyronorm 25mcg.
Plan of Care: C/D/W Dr. Mathangi. R Prepare parts Secure IV line Send CBC, CRP. CTG QAHRLY DFMC w/f pain abdomen/bleeding P/V ~~Refer~~ SVP for observation. . If CTG Reactive ↓ - Tab. misoprostol 50mcg P/O. - Inj. syntocinon @ 9AM.	**Investigations:** - CTG - Reactive - CBC/CRP.

Doctor Name: Dr. Akshitha

Signature: 127435

Date & Time: 18/12/25

Consultant Name: Dr. Mathangi. R.

Signature: 127435

Date & Time: 18/12/25

GUC-00085644 IP18-00036512
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Dr. MATHANGI RAJAGOPALAN

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RESULT SHEET

Date	7/7/26.	9/6/26.	18/7/26			
Time				B POSITIVE.		
Hb	9.7.	8.6.	11.2			
PCV			34	ECG } (N)		
RBC			3.87.	2DECHO }		
WBC	8410.	9750.	8,561			
N/L			74/18	6/5/26.		
Platelets	1.71.	2.06.	2.28	TSH = 2.610.		
CRP			5			
ESR				9/12/26		
PCT				HbA1C = 4.8.		
RBS		F 84				
Na		PP 107.				
K				HIV } Nonreactive		
Cl				HBSAg }		
Ca/Mg				VDRL }		
Phosphate				HCV }		
Urea						
Creatinine				ECG } Normal		
ALP				ECHO }		
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L			182			

(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 : 9/7/26.

SLIVB @ 36 W.

P/a (P)

cephalic

FH (+).

Radiology : USG : SDP 5-3cms.

X-Ray : EFW = 2.852kgs. @ 34%ile

ECHO : (N) doppler.

CT :

MRI

Others (ECG, Contrast Studies etc.,) :

GUC-00085644 IP18-00036512
Mrs KANIMOZHI L (F)
19-03-1997 29 Y 3 M 29 D
Dr. MATHANGI RAJAGOPALAN

(1)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/7/26	S/B Dr. Mathangi	
9:15AM	Pt reviewed;	
	O/E: P/A: Ut term;	
	3/25"/10'	
	FH good.	
USG:	P/V: Cx: 1cm long	
ROP to ROT	OS: 2 fingers	
1 loop of cord around neck	Vx: -3 station	
1 loop near neck	↓SAP, ARM done - Clear liquor	
		Adv:
		- Continue synto
		- Continuous CTG
		- All four's position
		- W/F contractions
		- Inform (SOS)
18/07/2026	C/S/B Dr. Vinitha	C/I/T Dr. Mathangi
12pm		Advice
	P/V Cx 0.5 cm long	- Continuous CTG
CTG - Reactive	OS - 4cm dilated	- Continue INJ. SYNTO
	Membranes Absent	accelerations
	Vertex @ -2	- To give INJ. PETHIDINE 50mg
		INJ. PHENERGAN 25mg
	[signature] 18 22	

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

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/07/2026	C/S/B Dr. Mathangi	
1:30pm	..	
	Pt reviewed, Pt C/o pushing sensation	
	P/A - uterus @ Term	Advice
	Moderately Acting (5C/30"/10')	- Squatting
CTG - Reactive	Cephalic	- Continuous CTG
	FHS - good	- Continue INJ. SYNTO
		acceleration
	P/V -	- Inform (SOS)
	Cx - fully effaced	
	OS - fully dilated, Membranes - Absent	
	Vertex @ 0 station	
	18/07/26	
18/07/2026	C/S/B Dr. Mathangi	
1:30pm		
	P/V - Cx - fully effaced	
	OS - fully dilated	
	Membranes - Absent	
CTG - Variable Decelerations	Vertex @ +2 Station	
		Advice
		- Position for Labouring
		- Kiwi cup.
	18/07/26	

GUC-00085644 IP18-0003651
Mrs KANIMOZHI L
19-03-1997 29 Y 3 M 29 D
Dr. MATHANGI RAJAGOPALAN

(2)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/07/2026 1:46pm	KIWI ASSISTED VAGINAL DELIVERY WITH RIGHT MEDIOLATERAL EPISIOTOMY INDICATION: POOR MATERAL EFFORTS / VARIABLE DECELERATIONS S/B : Dr. Mathangi A/B : Dr. Vinitha / Dr. Dhuiyalakshmi / Dr. Shreedevi	
	↓ SAP, Patient in dorsolithotomy position, Local parts painted and draped. With good uterine contractions, full cervical dilation. 2% lignocaine local infiltration given. In view of poor maternal efforts / variable decelerations kiwi cup was applied in vertex @ +2 station. Chignon created. A right medio lateral episiotomy given. An alive term boy baby with single loop of cord around the neck delivered. Baby cried immediately after birth. cord clamped and cut. Baby handed over to pediatrician. Cord blood collected for Blood grouping and typing. Placenta and membranes delivered intoto. Mild Atonic PPH noted medically managed. Episiotomy inspected and sutured in layers using rapid vicryl & 2-0 vicryl. A left lateral vaginal wall tear noted and the same sutured using rapid vicryl. Hemostasis secured.	
	P/A - uterus firm & well contracted P/V - No undue bleeding PV P/R - Rectal mucosa and sphincter tone Normal	

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	B | 18.07.2026, 1:46 pm	
	A | Boy	
	B | 3.086 kg	
	Y | 8/10, 9/10	
		Advice
		- Normal diet
		- Plenty of oral fluids
		- vitals Monitoring
		- Follow drug chart
		- W/F ↑ Bleeding PV
		- CBC C/M6Am
		- Measure & Inform 1st void
		- Inform SOS)
		- INJ TRAPIC 1g IV Stat (1dose) @ 8pm
	B/152217	
18/7/26 6:30pm	S/B Dr. Divyalakshmi	
	PVR ~ Pt. voided 200ml urine / 110ml	
		Advice
		- Measure next void & inform

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

164288

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Dr. MATHANGI RAJAGOPALAN

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/07/2026 8:45 PM	C/S/B Dr. Panithra	
	Pt reviewed	
	o/e	Advice
	Pt a/c fair	(N) Diet
T- (N)	afebrile	- Plenty of orals.
BP- 100/60mmHg	P̄ / Pa	- Vitals monitoring.
PR- 96/min	CVS / RS NAD	- Follow drug chart.
		- CBC c/m 6AM
Baby-m/s	P/A - Ut firm & cont well	
B/L Breast soft.	L/E - Epi wound intact	
		[signature]
18/07/2026. 9:15 PM	O/E/B Dr. Panithra	
	Pt reviewed	
Pt voided, normal.	o/e Pt a/c fair	Advice
USG		- (N) Diet
PVR- 500ml	afebrile	- Plenty of orals
↓ Catheterised @ 9:15PM.	P̄ / Pa	- Vitals monitoring
	CVS / RS NAD	- Follow drug chart.
830ml drained		CBC c/m 6Am
	P/A - Ut firm & cont well.	- Bladder drilling c/m 8Am
	L/E - Epi wound intact.	
	Shift to ward	

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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/7/26 11am	S/B Dr. Vinitha	
	Pt reviewed;	
	Bladder drilling – 10am 1st sensation 350 ml	
	No other C/O	
	O/E: GC fair; Afebrile	
	BP: 100/60	
Hb: 7.7	PR: 110/min	
	SpO_2: 100% RA	
Plt: 251	P/A: Ut contracted well;	
	C/E: BWNL; Epi wound healthy	
		Adv:
		C/D/W Dr Mathangi
		- Shift to LDR for
	0113	1U PRBC transfusion
19/7/26 12pm	S/B Dr. Vinitha	
	Pt received in LDR	
	for Blood	transfusion
	O/E: GC fair; Afebrile	
	P/A: Ut contracted	
	Soft; BS(+)	
	C/E: BWNL	
		Adv:
		1U PRBC cross match
	3rd sensation 2pm	
	Prevoid USG: 500 ml	; Voided 520 ml
	Post void USG: Nil; Bladder collapsed	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/7/26	Blood grp B positive Date of Collection: 6/7/26 Date of Expiry 17/8/26 Starting time 19/7/26 @ 3 PM Ending time 19/7/26 @ 6:00 PM. Post transfusion: BP: 90/50 mmHg PR: 87/min SpO₂: 99% RA No transfusion/allergic reaction	

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/7/26	S/B Dr. Vinitha	
6:30 PM		
	Pt reviewed, No c/o	
	1 U PRBC transfusion done	
	Pt comfortable	
BP: 90/50 mmHg	O/E: GC fair ; Afebrile	
PR: 87/min	P/A: Ut contracted well	
SpO_2: 99% RA	soft ; BS ⊕	
	L/E: BWNL	
	Epi intact	
		C/D/W Dr Mathangi
		Adv:
		Shift to ward
[signature] 12443		w/f Bleeding P/v
		Follow drug chart
		Inform SOS

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/07/2026	C/S/B Dr. Pavithra / Dr. Shreeden'	
9 AM	Pt reviewed, Nil c/o	
PND - 2		Advice
	O/E G/C fair, Afebrile	- Normal diet
T - (N)	Mild pallor (+) / PE°	- Plenty of oral fluids
PR - 108/min	CVS	- Vitals Monitoring
BP - 103/73 mmHg	RS / NAD	- W/F ↑ Bleeding PV
SpO_2 - 98% ↓RA	P/A - ut well contracted	- Process discharge
Baby - m/s	Soft	- Inform SR)
B/L - Breast Soft	L/E - BWNL	
voiding freely	Epiwound Healthy	
Stools Passed		
	182217	

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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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Dr. MATHANGI RAJAGOPALAN

(1)

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MEDICATION RECONCILIATION FORM

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

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

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

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T. THYRONORM	25mcg	PO	OD		☑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. Shreedevi 182217

Date & Time : 18/07/2024

Nurse Name & Signature: S. Pooja

Date & Time : 18th July 24 7am

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

GUC-00085644 IP18-0003651
Mrs KANIMOZHI L
19-03-1997 29 Y 3 M 29 D
Dr. MATHANGI RAJAGOPALAN

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MEDICATION RECONCILIATION FORM

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

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

Shifting From: LDR. Shifted to: 7th floor.

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T. THYRONORM	25mcg	PO	OD		☑C ☐DC
2	INJ. SUPACEF	1.5g	IV	TDS		☑C ☐DC
3	C. PAN D	40mg	PO	BD		☑C ☐DC
4	T. PARACETAMOL	1g	PO	TDS		☑C ☐DC
5	JUSTIN SUPPOSITORY	100mg	PR	BD		☑C ☐DC
6						☐C ☐DC
7						☐C ☐DC
8						☐C ☐DC
9						☐C ☐DC
10						☐C ☐DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Shreedevi 182217

Date & Time : 18/07/2021

Nurse Name & Signature: S. Pooja

Date & Time : 18/7/21 10:20pm

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

GUC-00085644 IP18-00036512
Mrs KANIMOZHI L
19-03-1997 29 Y 3 M 29 D (F)
Dr. MATHANGI RAJAGOPALAN

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DRUG CHART

Date of Admission: 13/3/20 Drug Allergies: ..... ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As required Medication)

DRUG :				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-00085644 IP18-00036512
Mrs KANIMOZHI L
19-03-1997 29 Y 3 M 29 D (F)
Dr. MATHANGI RAJAGOPALAN

REGULAR PRESCRIPTIONS

Weight. 67 Ward. ICU

DRUG : T. THYRONORM

Dose	Route	Frequency	Start Date
25mcg	PO	1-0-0	19/7/26

Name & Signature of the Doctor Starting the Drugs: 18/7/26

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	19/7	20/7
6AM	ES / AA	ES / AA

DRUG : INJ. SUPACEF

Dose	Route	Frequency	Start Date
1.5g	IV	1-1-1	18/7/26

Name & Signature of the Doctor Starting the Drugs: 18/7/26

Additional Instructions: x (3) doses

Daily Doctor's Endorsement by a Sign

Date / Time	18/7	19/7
8AM	/	ES / AA
9PM	J.T / MD	S.A
12AM	AA / ES	DL / DL

DRUG : C. PAN D

Dose	Route	Frequency	Start Date
40mg	PO	1-0-1	18/7/26

Name & Signature of the Doctor Starting the Drugs: 18/7/26

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	18/7	19/7	20/7
7AM	/	ES / AA	ES / AA
7PM	DS	S.S / K.H	

DRUG : T. PARACETAMOL

Dose	Route	Frequency	Start Date
1g	PO	1-1-1	18/7/26

Name & Signature of the Doctor Starting the Drugs: 18/7/26

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	18/7	19/7	20/7
8AM	/	SM / VA	ES / AA (6AM)
2PM	/	S	
10PM	DS	AA / ES	

Patient Sticker

Weight. 67.7 Ward. LDR

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
18/7/26	7AM	INJ. SUPACEF	0.1ml	Id	182217	SP DS
18/7/26	7.30AM	INJ. SUPACEF	1.5g	IV	182217	SP DS
18/7/26	12:30pm	INJ. PETHIDINE	50mg	IM	182217	SA SP
18/7/26	12:30pm	INJ. PHENERGAN	25mg	IM	182217	SA SP
18/7/26	1.43pm	INJ. SYNTO	10U	IM	182217	MD TJ
18/7/26	1.50pm	INJ. TRAPIC	1g	IV	182217	MD TJ
18/7/26	1.55pm	INJ. CARBOPROST	250 MCG	IM	182217	MD TJ
18/7/26	2.30pm	TAB. MISOPROSTOL	600 MCG	PR	182217	MD TJ
18/7/26	2.30pm	TAB. JUSTIN SUPPOSITORY	100mg	PR	182217	MD TJ

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Mrs KANIMOZHI L
19-03-1997 29 Y 3 M 29 D (F)
Dr. MATHANGI RAJAGOPALAN

I.V. FLUIDS CHART

Weight. 67.7 Ward. I.DR

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
18/7/26	8AM	IVF 1 ORL	Iv	free flow	182217	SA / SP	18/7		SA / SP
18/7/26	8AM	INJ. SYNTO 5U in 500ml RL	IV	24 ml/hr	182217	SA / SP	18/7/26		TJ / MD
18/7/26	1pm	IVF 10 RL	Iv	free flow	182217	SA / SP	18/7/26		MD / TJ
18/7/26	1.50 pm	INJ. SYNTO 20 U in 500ml RL	Iv	125 ml/hr	182217	MD / TJ	18/7/26		MD / TJ

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

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Mrs KANIMOZHI L
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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight 67.7 kg Ward LDR

DRUG : JUSTIN SUPPOSITORY				Date / Time	18/7	19/7	20/7
Dose	Route	Frequency	Start Dt.	9AM		SM/VA	
100mcg	PR	1-0-1	18/7/21				
Name & Signature of the Doctor Starting the Drugs: 82247							
Additional Instructions:				9PM	DS/EP	AA/ES	
Daily Doctor's Endorsement by a Sign							

DRUG : T. URIMAX				Date / Time	18/7	19/7	20/7
Dose	Route	Frequency	Start Dt.	10 AM		SM/VA	
0.4mg	PO	1-0-1	18/7				
Name & Signature of the Doctor Starting the Drugs: 124682							
Additional Instructions:				10PM	ES/AA	AA/ES	
Daily Doctor's Endorsement by a Sign							

DRUG : T. AUGMENTIN				Date / Time	19/7	20/7
Dose	Route	Frequency	Start Dt.	8am		SM/VA
625mg	P/O	1-1-1	19/7			
Name & Signature of the Doctor Starting the Drugs: 121113				2pm		
Additional Instructions:				10pm	AA/ES	
Daily Doctor's Endorsement by a Sign					D1	D2

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 ....

Patient Sticker

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

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

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				

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Mrs KANIMOZHI L
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STAT / ONCE ONLY DRUGS

Name: .....

Weight: 6.7 kgs

Sheet No: 1

DATE	TIME	MEDICATION	DOSAGE & OTHER INSTRUCTIONS	ROUTE	SIGNATURE		
					Doctor	Nurse-1	Nurse-2
18/7/24	8pm	INJ. TRAPIC	1g	IV	S2217	DS	SP

GUC-00085644
Mrs KANIMOZHI L
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Dr. MATHANGI RAJAGOPALAN
IP18-00036512

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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

18/7/26

	Date	18/7																								
	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	18	19	19	20					20				18				20				20				
	0 - 10																									
Saturations	94 - 100 %	100	100	100	99%					99%				100				98%				97%				
	< 94 %																									
Administered O_2 (L/min.)		RA		RA		RA												RA				RA				
Temp °C	40																									
	39																									
	38																									
	37																									
	36	98.4	98.6	98.6	98.8	98.8								98				98.6				98.8				
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90	92	89	80		96		94						96				98				96				
	80																									
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110	102	100	118	110	112								100				110				107				
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60	62	60	58	70	80								60				72				68				
	50																									
	40																									
NEURO RESPONSE [✓]	Alert	✓	✓	✓	✓	✓								✓				✓				✓				
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30	✓	✓	✓	✓	✓								✓				✓				✓				
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal	–	–	–	–	✓								✓				✓				✓				
	Heavy / Foul																									
Liquor	Clear / Pink	✓	–	–	–	–								–				–				–				
	Green																									
TOTAL YELLOW SCORES		0	0	0	0	0								0				0				0				
TOTAL ORANGE SCORES		0	0	0	0	0								0				0				0				
Nurse Initial																										

(84) (110)

GUC-00085644 IP18-00036512
Mrs KANIMOZHI L
19-03-1997 29 Y 3 M 30 D (F)
Dr. MATHANGI RAJAGOPALAN

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Early Warning Observation Score Chart - Obstetrics

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

9/7/26	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	22				22			20					20				20				20		
	0 - 10																							
Saturations	94 - 100 %	100%				99%			98					99%				98%				99%		
	< 94 %																							
Administered O2 (L/min.)		RA				RA			RA					RA				RA				(A)		
Temp°C	40																							
	39																							
	38	97.6F																						
	37					98.2F			98					97.8F				98F				97.4F		
	36																							
	35																							
	< 35																							
Heart Rate	170																							
	160																							
	150																							
	140																							
	130																							
	120																							
	110																							
	100																							
	90	96bpm				88bpm			98					84bpm				88bpm				81bpm		
	80																							
	70																							
	60																							
	50																							
	40																							
Systolic Blood Pressure ↑	190																							
	180																							
	170																							
	160																							
	150																							
	140																							
	130																							
	120	110				112			100					108				98				100		
	110																							
	100																							
	90																							
	80																							
	70																							
	60																							
	50	(66)				(74)								(70)				(60)				(78)		
Diastolic Blood Pressure ↓	130																							
	120																							
	110																							
	100																							
	90																							
	80																							
	70																							
	60	60				62			60					62				60				58		
	50																							
	40																							
NEURO RESPONSE [✓]	Alert	✓				✓			✓					✓				✓				✓		
	Voice																							
	Pain																							
	Unresponsive																							
URINE mls / hour	> 30	✓				✓			✓					✓				✓				✓		
	< 30																							
Proteinuria	Protein + +																							
	Protein > + +																							
Lochia	Normal	✓				✓			✓					✓				✓				✓		
	Heavy / Foul																							
Liquor	Clear / Pink	-				-			✓					-				-				-		
	Green																							
TOTAL YELLOW SCORES		0				0			0					0				0				0		
TOTAL ORANGE SCORES		0				0			0					0				0				0		
	Nurse Initial																							

Blood culture

17 29808.

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FLUID CHART

Sheet No. : 6

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

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
	08:00 am	H2O	100ml	RL 500ml	24ml					200	0	
	09:00 am				95ml						0	
	10:00 am	H2O	100ml		70ml					200	0	
	11:00 am	TC	100ml	RL	120ml						0	
	12:00 pm	TC	100	500	190ml					200	0	
	01:00 pm	H2O	100		192						0	
Total Intake : 2192ml						Total Output : 600ml						
	02:00 pm	H2O	100		125						0	
	03:00 pm	Juice	100		125						0	
	04:00 pm	H2O	100		125						0	
	05:00 pm	H2O	150		125						0	
	06:00 pm	Juice	150ml							200	0	
	07:00 pm	H2O	100						4.30pm	500ml	0	
Total Intake : 1050ml						Total Output : 200ml + 500ml						
	08:00 pm	H2O	100ml							500ml	0	
	09:00 pm	H2O	100ml						(BD)	830ml	0	
	10:00 pm	Milk	100ml							250ml	0	
	11:00 pm	H2O	100ml							100ml	0	AA
	12:00 am	H2O	150ml							250ml	0	AA
	01:00 am									100ml	0	AA
Total Intake : 600ml						Total Output : 2030ml						
	02:00 am									150ml	0	AA
	03:00 am	H2O	100ml							150ml	0	AA
	04:00 am	H2O	100ml							200ml	0	AA
	05:00 am									100ml	0	AA
	06:00 am	Milk	100ml							100ml	0	AA
	07:00 am	H2O	150ml							50ml	0	AA
Total Intake : 450ml						Total Output : 750ml						

Total 24 hrs. Intake	4298 ml

Total 24 hrs. Output	4080 ml

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FLUID CHART

Sheet No. : .....

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

19/4/26		Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G					CBD done	0	
	08:00 am	H2O	30ml								0	V.A
	09:00 am	H2O	30ml								0	V.A
	10:00 am	H2O	300ml							1st sample	0	V.A
	11:00 am	H2O	30ml								0	V.A
	12:00 pm	H2O	200ml							2nd sample	0	V.A
	01:00 pm	H2O	100ml								0	V.A
Total Intake : 500ml						Total Output : 1040ml						
	02:00 pm	H2O	100ml							500ml	0	S
	03:00 pm										0	S
	04:00 pm	H2O	200ml								0	S
	05:00 pm	H2O	100ml								0	S
	06:00 pm										0	S
	07:00 pm	H2	100ml								0	S
Total Intake : 500ml						Total Output : 500 ml + 1 urine						
	08:00 pm										0	S
	09:00 pm	H20	100ml							200ml	0	S
	10:00 pm	H20	50ml								0	S
	11:00 pm										0	S
	12:00 am	H20	50ml							250ml	0	S
	01:00 am										0	S
Total Intake : 200ml						Total Output : 450ml						
	02:00 am										0	S
	03:00 am	H20	100ml								0	S
	04:00 am										0	S
	05:00 am									500ml	0	S
	06:00 am	H20	150ml								0	S
	07:00 am										0	S
Total Intake : 450ml						Total Output : 500ml						

Total 24 hrs. Intake	2450ml	Total 24 hrs. Output	2290ml

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NURSING CARE RECORD

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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

Date: 18/7/26

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am	Achieve acceptable Pain control & comfort	8.30 am	Assess Pain using Pain scale regularly Position patient comfortably.	patient feel better	patient pain level reduced	
Afternoon	2pm	Achieve Acceptable pain control & comfort	2:30 pm	Assess pain using pain scale regularly possion patient	Reduced pain to some extend	Reassesment Done	
Night	8pm	Achieve. Acceptable. pain control & comfort.	8.30 pm	Assess pain using pain scale. Regulus position patein Comforten.	Patient Feel better.	Reassessment done	

Patient

GUC-00085644 IP18-00036512
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NURSING CARE RECORD

Rainbow® Children's Hospital
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BirthRight BY RAINBOW HOSPITALS
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Date: 19/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am	Achieve acceptable pain control & Comfort	9AM	Assess pain using pain scale regularly Position patient Comfortable	Pt feel Better	Re-assessed every 6hrs	
Afternoon	2pm	⇒ To Maintain Nutritional Status.		⇒ To encourage high rich protein diet.	⇒ To improved nutritional Status	The child vitals sign stable	
Night	9pm	- Assess the patient clinical condition - provide painkiller as per Doctor's Ord	12Am	- Assessed the patient clinical conditions - provide painkiller as per Doctor's Order	provided painkillers as per Doctor's Ord	Pt feel better	

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NURSES NOTES

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		On admission notes	
18/7/20	7 AM	pt mrs. Kanimozhi 30y/F. she is primi/37w+2d/Hypothyroid/PPROM/pt came c clo leaking pv at 5.30AM. pt was got admitted under Dr. mathangi. vital signs checked & recorded. BP - 102/68 P/R - 92b/m. R/R - 18b/m. CTG connected FHR ⊕. Reported to Dr. Akshitha soon the pt. she to called did pv examination cx 1.5cm long os 2 finger membrane absent. Advice to start Inj. supacef. order carried out. Parts preparation done. IV placement done c 18G venflon back flow ⊕. Inj supacef 0.1ml test dose ID given as per doctor order.	[signature]
	7.30AM	Dr. Akshitha advice to send CBC, CRP order carried out. CBC, CRP sample collected. pt have no c/o allergy, itching. Inj supacef 1.5gm IV given as per doctor order.	[signature]
	7.40AM	pt care hand over given to morning duty staff.	[signature]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
18/7/26	7.45pm	morning duty notes. patient details handed over taken from Night Duty staff. patient conscious & oriented. Vitals are checked & recorded. FHR good. CTG continue monitor. patient had Idly.	S/N parameshwari 016808
	8am	Dr. Akshitha saw the patient advised to Inj: Synto 24ml stat. Doctors order carried out.	S/N parameshwari 016808
	8.30 am	contraction checked 3 contraction 25sec In 10min. early deceleration present Informed to Dr. Vinitha	S/N parameshwari 016808
	9am	Dr. Vinitha adviced to Inj: Synto 36ml/hr continue. CTG continue monitor.	S/N parameshwari 016808
	9:20 AM	Dr: mathangi Do PV Examination findings was she is 1cm/long 2cm dilatation do ~~ARM~~ ~~was~~ Advised to put All fores posision a clear only syntocin ongoing To Encourage Adequate walls	S/N Akalya 018057

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Mrs KANIMOZHI L
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NURSES NOTES

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☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
18/7/26	11Am	⇒ patient was stable Inj syntocin 12ml/hr ongoing To give Ball Excercise FHR is good (+) patient general condition fair pt have a 3 contraction for 30 seconds.	→ Akalya 018059
	12pm	⇒ Dr Vinitha DO p/v Examination findings was she is 3cm dilatation FHR is good (+) Show was present	→ Akalya 018059
	12:30 pm	⇒ pt want to pain killer Informed Dr: mathangi Advised to Inj pethidin 1ml ̄c Inj: phenergan 1ml Im given to pt compliants of pain Pt shifted to LDR II	→ Akalya 018059
	1pm	⇒ Dr: mathangi DO p/v Examination findings was she is full dilatation Advised to squatting FHR is good (+) Syntocin 12ml/hr ongoing	→ Akalya 018059
	1:30pm	⇒ patient care hand over given to Evening duty staff nurse	→ Akalya 018059
		Evening Duty (18/7/26)	
	1:40pm	Kiwi assisted vaginal Delivery with RMLE IND: poor maternal efforts *SAP: patient in dorsolithotomy position local parts painted and draped. with good uterine contractions full cervical dilation 2% Lignocaine	

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
12/7/26		local infiltration given. In view	
		of poor maternal efforts / variable	
		decelerations kiwi cup was applied	
		in vertex at +2 station. Chignon	
		created. a right mediolateral	
		episiotomy given. an alive term	
		boy Baby with single loop of	
		cord around the neck. Baby cried	
		immediately after birth. cord	
		clamped and cut. Baby handed	
		over to pediatrician. cord blood	
		collected for Blood Grouping	
		and typing. placenta and membrane	
		delivered intoto. mild atonic PPH	
		noted medically managed. Episiotomy	
		inspected and sutured in layer	
		using Rapid vicryl 2-0 vicryl. A left	
		lateral vaginal wall tear noted	
		and the same sutured using	
		Rapid vicryl. Hemostasis secured	
		Baby Details	
		B - Alive Boy Baby	
		A - 12/7/26 at 1.46pm	
		B - 3.086kg	
		Y - 8/10, 9/10	[signature] 01b120
	3pm	Monitored vitals and Recorded.	
		Maintained I/O. PV Bleeding	

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19-03-1997 29 Y 3 M 29 D
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(3)

NURSES NOTES

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☑ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
8/7/20		Minimal. No any other complaints	
		B - Breast is soft, No encouragement	
		U - Uterus Contracted	
		B - Bladder Not yet voided	
		B - Bowel movement present	
		L - Lochia Rubra No foul smelling	
		E - REEDA Assessment Done	
		H - Homan Sign Negative	
		E - Emotional Status good	[signature] 01/6/20
	4pm	Monitored vitals. Maintained	
		I/O. PV Bleeding Minimal	
		Dr. Dhivya done PV Examination	
		No other Complaints	[signature] 01/6/20
	6pm	Patient voided 200ml	
		Informed to Dr. Dhivya,	
		post voide scan done 60ml	
		Balance - advised to Measure	
		2nd voide. doctor order	
		carried out	[signature] 01/6/20
	7pm	Maintained I/O, Monitored	
		Vitals and Recorded, Pain	
		assessment Done. No any	
		other complaints	[signature] 01/6/20
	7.30pm	Patient care Handing	
		over given to Night duty	
		Staff	[signature] 01/6/20

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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
18/7/26	7:30 pm	Night duty (18/7/2026). Patient handing over taken by evening duty staff Nurse patient consious and oriented p/v bleeding minimal other. No complaint. ———	(signature)
	7:40 pm	patient voided 500ml. Bed side usg scan bladder was 150 ml advice DR. Dime Next voided measuring ———	(signature)
	8.00 pm	patient checked vital are stable p/v bleeding minimal patient Inj: Taxpic 1g in 100ml NS given patient given dinner ———	(signature)
	8.30 pm	patient urine voided 500ml inform to DR. Paulthar advice Bed usg scan was done 550ml ———	(signature)
	9pm	B - Breast was both soft.	
		U - uterus well contraction	
		B - Bowement present	
		B - patient self voided present	

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NURSES NOTES

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☑ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
18/7/26	contin	L- lochi Rubra	
		present.	
		E- REEDA Assessment	
		present Episiotomy healthy	
		only.	
		H- Homan sign Negative	
		E- Emotion status	
		good	[signature] 01/7/18
	9.15 pm	S/B DR. Pavithra advice	
		to patient catheterisation	
		DR. pavithra patient cathe-	
		16 F, inline patient urine	
		draining 830 ml DR. pavi	
		advice patient shifted to	
		ward	[signature] 01/7/18
	10.20 pm	patient handing over	
		given 7th floor staff Nurse	
		[illegible] patient conscious,	
		and oriented General condition	
		fair	[signature] 01/7/18
		Receiving Notes.	
18/7/26	10.30pm	Patient Receiving from LDR to	
		7th floor. Patient handing over	
		taken from LDR Staff. →	[signature]
		Bed side Assessment done. Conscious	
		& Oriented. Patient IV line ⊕.	
		CBD ⊕ pattern. Urine colour is Normal.	[signature]

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Patient Sticker

NURSES NOTES

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☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
18/7/26.		Patient vitals Sign checked & Recorded. vitals are Stable. Flo chart monitored. P/V Bleeding is Normal.	
		B- Breast Soft. No Engorgement.	
		U- Uterus Contracted.	
		B- Bladder CBD @ Urine on flow.	
		B- Bowel movement present.	
		L- Lochia rubra present	
		E- RBDD Assessment done.	
		H- Homan's Sign Negative.	
		E- Emotional Status good. →	
	11PM.	Patient Normal diet, Follow the drug Chart, CBC clm 6AM, Bladder drilling clm 8AM, to the flow.	
19/7/26.	12AM.	Patient vitals Sign checked & Recorded. vitals are Stable. Flo Chart monitored. No any other Complaints. Give medication & → drug given. as per drug Chart Order.	
	2AM	Patient Sleeping Pattern is good. P/V Bleeding is Normal.	
	4AM	vitals Sig checked & Recorded. vitals are Stable. Flo Chart monitored. P/V Bleeding is Normal.	

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NURSES NOTES

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
19/7/26	6Am.	Patient Today Morning CBC taken Send the Lab. Report due. Morning care done. No any other complaints. →	[signature]
		due medication & drug given as per drug chart order.	
	7:30AM	Patient details handing over to Morning duty staff →	[signature]
		MORNING DUTY	
19/7/26	7:30Am	Pt's details Hand over, taken from Night Duty staff. Pt's CBD ⊕ drilling plan at 8Am, IV line ⊕, Pt's have ⓝ diet, CBD ⓟ plan, 3rd sensation. M/Not passed. →	[signature] 6437m
	8Am	Pt's vital signs checked and recorded. vitals are stable. maintained the chart. Due medication given as per order. CBD drilling done. →	[signature] 6437m.
		B - Breast is soft, no engorgement	
		U - Uterus contraction well	
		B - Bowel movement ⊕	
		B - urine drained well.	
		L - Lochia rubra ⊕	
		E - Reeda scale none,	
		H - Homan's sign negative	
		E - Emotional status good →	[signature] 6435?

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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

Patient Sticker

NURSES NOTES

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☐ Drug Allergies ..... Nil.

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
19/7/26	10AM	Pt's c/o 1st sensation Inform to Dr. Vinitha mam A/B CBD release U/O - 375ml. after that CBD clamped	S/- 607373.
	11AM	Dr. Vinitha mam come and seen assessed the pt's condition A/B Hb-7.7 D/W Dr. Mattangi mam. →	S/- 607373.
	12pm	pt's vitals are stable maintained i/o chart. Dr. Vinitha mam A/B pt's shifted to LDR Now. pt's details Hand over given to LDR staff. →	S/- 607
19/7/26	12.30pm	MICU received Notes. Patient received from 7th floor. Patient conscious & oriented. Vitals are checked & recorded. IV line patent. catheter present. Catheter clamped. To do blood transfusion, cross match sample sended	S/- paramesvari 01608
	1pm	PV bleeding normal. patient side no complaints. Vitals are stable.	S/- parameswari 01608
		→ The patient is visit Dr. Vinitha mam advice to bed side scan. CBC removal [illegible] [illegible] [illegible]. Inform to	

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GUC-00085644 IP18-00036512
Mrs KANIMOZHI L
19-03-1997 29 Y 4 M 0 D (F)
Dr. MATHANGI RAJAGOPALAN

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NURSES NOTES

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		vinhu mam.	
19/7/26	3.00pm	=> The patient, RRBC (1) unit 250ml Blood checking Dr. vinhu mam.	
		=> The patient vital sign chesy Recorded.	S. [signature] 2/933.
		=> The patient RRBC sample 50ml start 30mins.	
	3.30pm	=> The patient is no any allergy reaction. The Blood 80ml hr. Maintainy document	[signature] 0/2938
	4.00pm	=> The patient vital sign chesy Recorded.	
		=> The patient Blood 120ml maintaining document	[signature]
		Blood group. O+ve Bag No: 2906 Date of collection 6/7/26 Date of expiry 17/8/26 Start time 19/7/26 at 3.00pm End time: 19/7/26 6.00pm	S. [signature]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies ..Nil.....

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

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

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

BAG NO.	COLLECTION DATE	EXPIRY DATE	VOLUME
2906	06.07.26	17.08.26	240 ml

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

BLOOD GROUP: **B**

Rh₀ (D): Pos

SCREENED : NEGATIVE / NON REACTIVE FOR : HBsAg. Anti HCV Anti HIV I & II, MP, VDRL, Irr, Ab - By **CLIA METHOD**

PREPARED FROM A VOLUNTARY BLOOD DONOR

	6.00pm	⇒ The patient is Blood transfusion done. The patient vital signs stable.	
	6.20pm	⇒ The patient hand over from 7th floor staff nurse.	
	7pm	⇒ Pt received from the MICU to 7th floor and check the vitals are monitoring and reported. pt vital are stable. pt handing over done	
	7.30pm	pt side there is no c/o of fever and other complaints.	
	7.30pm	pt details carefully handing over taken from the evening to night duty staff.	

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BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 19/7/26 Time: 8.00pm.

Blood Group of the Patient: B+ve Blood Group on the Blood Bag: B+ve

Blood Bank Issue No: 2906 Date of Collection: 6/7/26 Date of Expiry: 15/8/26

Date & Time of Starting Transfusion: ..... Planned duration of Transfusion: .....

Check for Correct Unit: ✓ Correct Patient: ✓

Blood products cross checked by: Nurse 1: ..... Nurse 2: .....

Before starting transfusion vitals: Temp: 98.2F HR 98bm RR: 22bm BP: 100/60 SpO_2 99%

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO_2	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
19/7	15 Min	98bm	98.2F	100/60	99%.	-	-	-	-
19/7	15 Min	96bm	98.2F	100/52	98%.	-	-	-	-
19/7	30 Min	96bm	98.	99/52	99%.	-	-	-	-
19/7	30 Min	98bm	98.2.	110/60	98%.	-	-	-	-
19/7	30 Min	86bm	98.	102/62	99%.	-	-	-	-
19/7	1 Hr	86bm	98.F	100/60	98	-	-	-	-
19/7	1 Hr	86h.	98.2F	100/60	99	-	-	-	-

Comments: The Patient is and other compaces Patient Vitals Stable.

Name of the Incharge-Nurse: ..... Name of the Nurse: S. Anusha

Signature of the Incharge-Nurse: ..... Signature of the Nurse: [signature]

Date & Time: ..... Date & Time: 19/7/26 at 6.00pm

Ref. No. : F / HW / BTR / NSG / 02

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BLOOD TRANSFUSION REACTION FORM

Name of the patient : Mrs. Kanimozhi UHID : 8544 I.P. No. 8644

Age : 29 y Gender : F Department : LDR Ward : LDR

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

Blood bank issue no : 2706 Date of collection : 6/7/26 Date of expiry : 17/8/26

Date & Time of starting transfusion : 19/7/26 at 2.00pm. Date & Time of stopping transfusion : 19/7/26 at 6.00p.

PLEASE TICK MARK IF ANY DURING THE TRANSFUSION

Was the patient monitored during transfusion and the monitoring form filled completely ? ☐ Yes ☐ No

Fever : ☐ Yes ☑ No ; Hypotension : ☐ Yes ☑ No ; Jaundice : ☐ Yes ☑ No

Chills : ☐ Yes ☑ No ; Hypertension : ☐ Yes ☑ No ; Shock : ☐ Yes ☑ No

Rigor : ☐ Yes ☑ No ; Breathlessness : ☐ Yes ☑ No

Cyanosis : ☐ Yes ☑ No ; Hematuria : ☐ Yes ☑ No

Comments : The reaction is no ans other complaints. Patient vital sign stable.

Nurse Name : S. Anu Nurse Signature : S. Anu

NOTE: 1. Please send this duely filled form to laboratory along with empty blood bag.

2. In case of transfusion reaction, stop the transfusion immediately keeping the I.V line patent.

3. In case of suspected transfusion reaction please send the following immediately to the laboratory along with the blood bag i.e. patient's urine sample and patient blood sample in EDTA.

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CONSENT FOR BLOOD TRANSFUSION

Patient Name : Mrs. Kanimozhi Age: 29y Gender : F

UHID No.: 85644 :IP No.: Ward/Bed No. LDR

Type of Blood Product : 1 UPRBC

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

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

L. Kanimozhi
Name of Patient / Attendant

Signature of Patient / Attendant

Date 19/7/26

Time : 3.00pm

Relationship with Patient:

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LABOUR AND DELIVERY NURSING ASSESSMENT

Date of Admission: 18/6/25

Baseline Information:

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

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

Do you require an interpreter? ☐ Yes ☑ No

Source of Information: ☑ Patient ☐ Family ☐ Others

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

handed over to —

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

If yes, identify

Chief Complaints: Pt came c c/o leaking PV

Doctor Notified on Admission: ☑ Yes ☐ No

Name of the Doctor: Dr. Akshitha

Time Notified: 7 AM

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Hypothyroid	Open appendicectomy ~~###~~	### I

Blood Group: B+ve LMP: 30/6/25 EDD: 6/3/26 Gestational age during admission: 37 wks 2d

Contractions: Yes Vaginal Discharge: —

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

Height: 164 Weight: 67.7 BMI: 26

Temp: 98°F HR: 90 RR: 18 BP: 102/62 SpO_2 100%

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

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

Patient Sticker

Family History: ☐ No Abnormalities Detected

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

☐ Liver disease ☐ Other .....

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

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

Risk of Pressure Sore: ☑ Yes ☐ No Score ..22.. (complete the Braden Q Sheet)

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

☐ Mobility problem ☐ Walking Problem ☑ No Abnormality Detected

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

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

☐ Under Weight ☐ Diabetes Mellitus ☐ No Abnormality Detected

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

☐ Others .....

Inform consultant for positive criteria

SOCIAL SCREENING:

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

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

Social History: Lives With ..Husband..

Orientation has been given regarding the following aspects:

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

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

Above information given to ..Patient..

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

Orientation not given Reason: .....

Nurse Signature: .....

Nurse Name: ..Poonam..

Date & Time: ..18.4.16..

Rainbow Children's Hospital

Blood Storage Center

No, 157, Annasalai, Guindy, Chennai - 600015

Compatibility Report

Patient's Name :	Mr. Kanimozhi	Age/Sex	29y/F		
Patient's Blood Group & Rh Typing	B POSITIVE				
GUC No	85644	Ward	MCW	Order No	26023224
Bag Blood Group & Rh Typing	B POSITIVE	Date	19/7/26	Time	1.30pm

S.No	Bag Number	Components	Date of Collection	Date of Expiry	Seg No
1.	2906	PRBC	6/7/26	17/8/26	60158707

Major X Matching :	Saline/Alb/AHG/Colum (Gel) ✓	Minor X Matching :	Saline/Alb/AHG/Colum (Gel) ✓

Cross Matched By: Divya B 19/7/26 Medical Officer: Divya D 19/7/26

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OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 18/4/26 Time of Arrival: 4pm Time Seen by Nurse: 4:10pm

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

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

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

3) **Vital Signs:** Temperature: 98° Pulse: 92 RR: 18 SpO_2: 100 BP: 102/68 Weight: 67.7

4) **Gestational Criteria:**

Gravida:	G	P	L	A

LMP: 30/6/2025 EDD: 06/03/2026 Gestational Age: 37 wk 2d

Uterine Contraction	☑ Yes	☐ No	☐ NA	Onset 18/4/26	Time 5:30pm	Frequency: 2 figures in 10 mins
Membrane Rupture	☑ Yes	☐ No	☐ NA	Onset 18/4/26	Time 5:30pm	Fluid Color: Clear
Vaginal bleeding	☐ Yes	☑ No	☐ NA	Onset	Time	Amount:
Pre Eclampsia Symptoms	☐ Yes	☑ No	☐ NA	If Yes specify: Headache / Visual Symptoms / Pain Abdomen / Vomiting		
Good fetal Movement	☑ Yes	☐ No	☐ NA	If No specify:		

5) **Pain Screening:**

Numerical Pain Scale (NPS)

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

- Location: lower abdomen
- Duration: 10 secs (Days / Weeks/ Months (Strike out which is not applicable)
- Character: tightening
- Frequency: 2 in 10 mins
- Interventions: comfortable bed position

6) **Past History:**

a) Surgeries: .....

b) Medical: Hypothyroid

Patient Sticker

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

8) **Current Medications:** ☐ Prenatal Vitamin ☐ None ☐ Others: Thyronorm .....

9) **Prenatal Medical History:**

☐ None
☐ Chronic Hypertension
☐ Gestational Hypertension
☐ Diabetes
☐ Gestational Diabetes
☐ Low placenta
☐ Others if yes, specify Hypothyroid

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

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

Time seen by Doctor: 7:10AM

Nurse Name : S. Pooja Nurse Signature: .....

Date: 18/7/20 Time: 7:30AM

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RISK ASSESSMENT TOOL FOR DEEP VEIN THROMBOSIS

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

Date: 18/7/20

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

RISK ASSESSMENT FOR VENOUS THROMBOEMBOLISM (VTE)

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

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

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BRADEN 'Q' SCALE

					Date : 18/7 18/7 18/7 18/7
					Time : 1 AM 8 am E N
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4 4 4 4
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	3 3 3 3
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4 4 4 4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4 4 4 4
FRICTION-SHEAR **Friction** . Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4 4 4 4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4 4 4 4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4 4 4 4
				TOTAL SCORE	27 27 27 27
				Evaluator's Name	

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

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

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BRADEN 'Q' SCALE

				Date : 19/7	20/7	20/7	20/7
				Time : M	E	N	M
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	3	3	3	3
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
				TOTAL SCORE	27	27	27	27
				Evaluator's Name				

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

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

29 Y 3 M 29 D (F)

HANG RAJAGOPALAN

Patient Sticker

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PAIN ASSESSMENT FORM

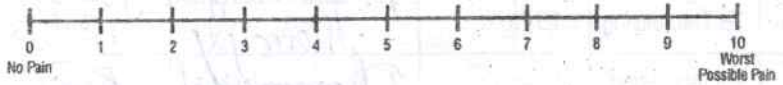
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
18/7/26	7 am	1/10	lower abdomen	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Comfortable position	
18/7/26	8am	2/10	lower abdomen pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Provide comfortable position	
18/7/26	12pm	3/10	lower abdomen	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Pharmacological therapy	
18/7/26	4pm	1/10	Episiotomy site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Pharmacological therapy	
18/7/26	8pm	2/10	Episiotomy site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Comfortable position	
19/7/26	8AM	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	
19/7/26	8am	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	
19/7	2pm	0/6	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	
19/7/26	8pm	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	
20/7/26	2am	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	

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 drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

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

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

GUC-00085644 IP18-00036512
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PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
20/7/26	8am	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	Nil	60774
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

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2. For post-surgical patients, patients with chronic pain, patient with severe pain:
   a) At least every 2 hours for the first 24 hours
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PAIN ASSESSMENT TOOLS

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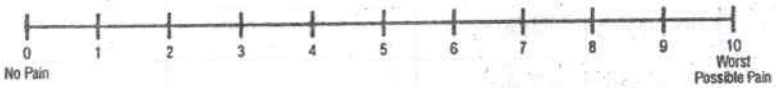

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	18/7/26 7am	18/7/26 M	18/7/26 E
		Score			
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0	0	0	0
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0	0	0	0
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0	0	0	0
IV / Heparin Lock or Saline	Yes	20		20	20
	No	0	0		
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10	10	10	10
	Normal /On Bed Rest /Immobile	0			
Mental Status	Forgets limitations	15			
	Oriented to own ability	0	0	0	0
Total Morse Fall Scale Score:			10	30	30
		Signature	[illegible]	[illegible]	[illegible]

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

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	N 18/7/26	M 19/7/26	D 19/7
		Score			
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0	0	0	0
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0	0	0	0
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0	0	0	0
IV / Heparin Lock or Saline	Yes	20	20	20	20
	No	0			
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0	0	0	0
Mental Status	Forgets limitations	15			
	Oriented to own ability	0	0	0	0
Total Morse Fall Scale Score:			20	20	20
		Signature	[illegible]	602271	[illegible]

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

Tick (✓) whichever precaution taken.

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- ☐ Assess patient after visitors, leave to ensure safety measures in place

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	N 29/7	M 20/2/26	
		Score			
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0	0	0	
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0	0	0	
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0	0	0	
IV / Heparin Lock or Saline	Yes	20	20	20	
	No	0			
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0	0	0	
Mental Status	Forgets limitations	15			
	Oriented to own ability	0	0	0	
Total Morse Fall Scale Score:			20	20	
		Signature			

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

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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- ☐ Assist and/or supervise ambulation. Reinforce to always call for assistance
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Patient's
MRD NO
Age :......
Consultant :..........

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19-03-1997 29 Y 3 M 29 D (F)
Dr. MATHANGI RAJAGOPALAN

ex: ☐ M ☐ F

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 18/7/18 Time: 7.00AM
Location : (L) metacarpal
Size : 18G
Cannula inserted by : S/N Poojai

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
18/7	7.30A	☐Yes ☑No	☐Yes ☑No	observ	Pooja
	9.30am	☐Yes ☑No	☐Yes ☑No	observ	[illegible]
	12PM	☐Yes ☑No	☐Yes ☑No	observ	[illegible]
	2pm	☐Yes ☑No	☐Yes ☑No	observ	[illegible]
	4pm	☐Yes ☑No	☐Yes ☑No	observ	[illegible]
	6pm	☐Yes ☑No	☐Yes ☑No	observ	[illegible]
	8pm	☐Yes ☑No	☐Yes ☑No	OBS	[illegible]
	10pm	☐Yes ☑No	☐Yes ☑No	OB	[illegible]
19/7	2AM	☐Yes ☑No	☐Yes ☑No	obsv	[illegible]
	6AM	☐Yes ☑No	☐Yes ☑No	obv	[illegible]
	8AM	☐Yes ☑No	☐Yes ☑No	obsn	[illegible]
	2pm	☐Yes ☑No	☐Yes ☑No	obse	[illegible]
	4pm	☐Yes ☑No	☐Yes ☑No	obs	[illegible]
19/7	8PM	☐Yes ☑No	☐Yes ☑No	obsv	[illegible]
	12AM	☐Yes ☑No	☐Yes ☑No	obv	[illegible]
	4AM	☐Yes ☑No	☐Yes ☑No	obsv	[illegible]
	6AM	☐Yes ☑No	☐Yes ☑No	obsv	[illegible]
	8AM	☐Yes ☑No	☐Yes ☑No	obsv	[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		

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

MAS. Kanimozh. L.
GUC - 8564H.

Patient Sticker

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 18/7/2026 at 9.15pm Date of Removal: 19/7/26 at 2-30 pm

Parameters	Date / Shift Time	18/7/26 N	18/7/26 E					
Need for the Catheter		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hand Hygiene		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Usage of Sterile Equipment		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the Collection bag below the level of bladder		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Check the Tube for Obstruction (Free of Kinking)		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Catheter dated as policy		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Collecting bag is been emptied regularly?		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Maintenance of closed system for the catheter		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing clean and dry?		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the line removed as Policy?		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Performance of Perineal Care		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Onset of New Fever		☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Asses for the leakage at the site of insertion		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Nurse		Dsabitha 0/7/26	S. [illegible]					
Signature of the Nurse		[signature] 0/7/26	[signature]					

GUC-00085644 IP18-00036512
Mrs KANI[redacted] L
[redacted]-03-1997 29 Y 3 M 29 D (F)
Dr. MATHANGI RAJAGOPALAN

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
18/7/26	7AM	Yes	Educate about fall risk safety needs (bed side rails)	Patient	No learning barriers	oral	None	Yes	Good	
19/7/26	8 AM	yes	educate about fall risk safety needs (bed side rails)	patient	no barrier	oral	none	yes	Good	[redacted]
20/7/26	8AM	yes	educate about fall risk safety needs (bed side rails)	patient	no barrier hearing	oral	none	yes	Good	[redacted]

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