GUC-00094461 IP18-00036750
Mrs SAHAR SHANAZ
02-08-2002 24 Y 0 M 2 D (F)
Dr. MATHANGI RAJAGOPALAN

ACTIVITY RECORD FOR BILLING

BirthRight BY RAINBOW HOSPITALS Your Right to a Safe Delivery

Name: Mrs. Sahar Shanaz

UHID No: 9446 IP No: 36750 Consultant: Dr. Mathangi Dept: OBG

Date of Admission: 4/8/26 Time: Date of Discharge: Time:

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
4/8/26	9.40 AM	OBG	OT	
4/8/26	10:30 AM.	OT	MICU	

CROSS CONSULTATION VISIT

	Doctor Name	Date	Order No.	Signature
1.	PDC	4/8/26	1736908	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
4/8/26	medium Biopsy	2/6024918	[signature] 020328

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
4/8/20	Hysteroscope	9:55am	10:20am	1737031	[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
4/8/26	IV placement	1	1736900	

ANY OTHER INFORMATION:

Procedure : Hysterosurgery & polypectomy
Surgeon : DR. Mathangi
Asst Surgeon : DR. Priyadharsini / DR. Vinutha
Anaesthetist : DR. Sathish / DR. Priyadharsini
Time in : 9:45 AM Time out : 10:30 AM
04/8/26 Infusion pump not used

Date: 04/8/26 Time: 2pm Prepared By:

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
S/N Pooja			

GUC-00094461 IP18-00036750
Mrs SAHAR SHANAZ
02-08-2002 24 Y 0 M 2 D (F)
Dr. MATHANGI RAJAGOPALAN

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SURGERY DETAILS

Date : 4/8/26

Patient Name: mrs Sahar Shanaz Date of Birth: 02/08/2002 Age: 24y

Gender: Female Ward : OT UHID No.: 94461/36TJD

Date of Surgery: 4/8/26 ☑ OT-1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Hysteroscopy and polypectomy ↓ GA

Time in : 9:45AM Time Out : 10:30Am

	NAME	AMOUNT
1. Surgeon	: DR. mathangi / DR. priyadharsini	
2. Anaesthetist	: DR. Sathesh / DR. priyadharsini	
3. Assistant Surgeon	: DR. Vinitha	
4. OT Technician	: mr. Raja	
5. Circulating Nurse	: SIN. Sangeetha	
6. Assistant Nurse	: SIN Agalya	(1737031)

Hystroscopy (9:55Am – 10:20Am)

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

DR. mathangi
Signature of the Surgeon

Signature of Circulating Nurse

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

Docu. No. : RCH /FRM / GENERAL / 114 Record finalized dongle Agalya
02432

Patient Sticker

Hystroscopy

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CONSUMABLES OF OT

Circulating staff :.................................... Technician : MR. Sudharsan Date : 4/8/26........ Time :..............................

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			~~Major~~ Pack hysteroscope		1.	Inj Vit.K		
~~LMA~~ 2g...		1.	Sutures			Cord Clamp		
~~ECG~~ leads (A)/P/N		3				Suction Catheter		
HME filter : A / P / N						~~Feeding~~ Tube GFr		1
~~Syringes~~ : ~~10~~ cc		3	PF 6.		02	Vaccum Suction Set		
~~05~~ cc		2	Gloves P.F 6.5		4	Surgical Gloves		
~~02~~ cc		2	SC 6.5		1	Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade			Surgical Blade # 20		
~~IV set~~			NG tube			Koochies (S)		
~~RL~~		1.	Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml			Koochies			Atracil		01
NS 3 litres		1	Ointments			Amnepara 1gm		1
			Suction Catheter			D water		2
~~Fentanyl~~		1	Cap, Mask			D water 1000 ml		1
Morphine			Gauze Pack R/O		2	Rioxamic		2
Ketamine			Mop Pack			Mean Mop pad		01
~~Propofol~~		2	Steristrip			" " Fixator		01
Rocuronium			Underpad					
Glycopyrolate			Draw sheet					
~~Myopyrolate~~		01	Abgel					
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
			Tegaderm					
Suppositories			~~Ioban~~ TURP Set		1			
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set					
Justin : 12.5 mg / 25mg / 100mg			Plastic ~~Bed Sheet~~ Apron		2			
Tab. Misoprost : 200mg			Betadine Solution		1			
Proto gown		2	Microshield					
			Cotton Balls					
			Latex Gloves		5P			
			Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician

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

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

RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

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

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

DL NO :

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

INPATIENT ISSUES AGAINST ORDERS

IP No	IP18-00036750	**Ward**	8F-OT COMPLEX
Patient Name	Mrs SAHAR SHANAZ	**Bed Name**	MICU 804
Age/Sex	24 Y 0 M 2 D / Female	**Order No**	18-0001737027
Date	04/08/2026 12:30	**Prescription No**	PRIP18-0630861
Payor	SELFPAY	**Dispensed Date**	04/08/2026 12:36
UHID	GUC-00094461		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	AMNEPARA 100ML GLASS BOTTLE		H	L0016006	12/27	1	787.00	787.00
2	ARTACIL 25MG 2.5ML INJ	Neon Laboratories Ltd	H	130359	08/27	1	45.30	45.30
3	BIOXAMIC 500 MG INJ	Biocare Pharmaceuticals	H	C3BIO004	01/28	2	73.23	146.46
4	DSYRINGE 10ML (NIPRO)	NIPRO	GENERAL	26E02K29	04/31	3	28.13	84.39
5	DSYRINGE 5ML.(NIPRO)	NIPRO	GENERAL	26C13K17	02/31	2	21.56	43.12
6	DSYRINGS 2.5ML(NIPRO)	NIPRO	GENERAL	26B12K44	01/31	2	11.25	22.50
7	D WATER 10 ML AMPULE	Aculife Health Care Pvt.Ltd(Nirlif	H	2254585	11/28	2	2.58	5.16
8	E.C.G ELECTRODES (PAED)	Adilase	GENERAL	0716O326	02/28	3	40.00	120.00
9	INFANT FEEDING TUBE-9	ROMSONS	GENERAL	G25K010618	10/30	1	63.00	63.00
10	LMA 3.0 (Auragain)			11F25F0296	06/28	1	3,770.00	3,770.00
11	MCT-ROF 100MG 10ML	Neon Laboratories Ltd	H	NA1353005	10/27	2	69.10	138.20
12	MYOPYROLATE-INJ-5ML	NEON LABORATORIES LTD	H	V350487	11/27	1	140.20	140.20
13	RL 500 ML CLOSED SYSTEM	Fresenius Kabi India Pvt Ltd		1E262785	04/29	1	69.84	69.84
						Total :	**5,121.19**	**5,435.17**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

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

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

DL NO :

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

INPATIENT ISSUES AGAINST ORDERS

IP No	IP18-00036750	**Ward**	8F-OT COMPLEX
Patient Name	Mrs SAHAR SHANAZ	**Bed Name**	MICU 804
Age/Sex	24 Y 0 M 2 D / Female	**Order No**	18-0001737026
Date	04/08/2026 12:30	**Prescription No**	PRIP18-0630862
Payor	SELFPAY	**Dispensed Date**	04/08/2026 12:37
UHID	GUC-00094461		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	DISPOSABLE APRONS STERILE XL	Mediblue		15072026	06/29	2	120.00	240.00
2	D WATER IV 1000 ML BOTTLE	Aculife Health Care Pvt.Ltd(Nirlif	H	2602074015	05/28	1	258.80	258.80
3	Encore Microptic gloves-6.5		H	2604O1201T	03/29	4	128.00	512.00
4	GAUZ SWAB 10 X 10 CM 12PLY 5S X-RAY	Bapuji Surgicals	GENERAL	M2545O21	11/29	2	123.00	246.00
5	HYSTEROSCOPY PACK	Amaryllis		1010626	05/29	1	1,255.00	1,255.00
6	IRRIGATTO(T.U.R SET)	ROMSONS	GENERAL	G26D010632	03/31	1	532.00	532.00
7	NEW MOM DISP MATERNITY PADS MAXIPAD	DYNAMIC TECHNO		0153715	03/31	1	204.00	204.00
8	NEWMOM DISPOSABLE PADFIXATOR-XXLARGE	DYNAMIC TECHNO		1486O5	03/31	1	221.00	221.00
9	NITRILE EXAMINATION GLOVES P F- MEDIUM	ELITE MEDICALS	GENERAL	011	12/28	10	18.75	187.50
10	NS 3 LTRS BOTTLE	Aculife Health Care Pvt.Ltd(Nirlif		5A260064	04/28	1	747.00	747.00
11	PROTO GOWN (ADULT)	Diamond Medicare	GENERAL	1010726	06/29	2	250.00	500.00
12	RAMADINE SOLUTION 10% 100 ML	RAMAN & WEIL PVT LTD		RC126048	06/28	1	103.00	103.00
13	SGLOVE # 6.5 (SURGICARE)	ICARE (KANAM LATEX)	GENERAL	6F103	05/31	1	91.00	91.00
14	SGLOVE # 6 (POWDER FREE)	ANSEL		260301001T	03/29	2	128.00	256.00
						Total :	**4,179.55**	**5,353.30**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

GUC-00094461 IP18-00036750
Mrs SAHAR SHANAZ
02-08-2002 24 Y 0 M 2 D (F)
Dr. MATHANGI RAJAGOPALAN

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DISCHARGE TRACKING SHEET

DATE : 02/8/20

Name of Consultant :

Floor : IPR, UHID :

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

GUC-00094461 IP18-00036750
Mrs SAHAR SHANAZ
02-08-2002 24 Y 0 M 2 D (F)
Dr. MATHANGI RAJAGOPALAN

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OPERATION NOTES

Surgeon : DR. mathangi	Asst. Surgeon : DR Priyadharshini / DR Vinutha
Anesthetist : DR. Sathish	OT Nurse : SIN Agalya
Pre-Operative Diagnosis:	
Surgical Procedure : Hysteroscopy and polypectomy ↓ GA	

Weight : 72 KG	Date : 4/8/26	Start Time : 9:45Am	End Time : 10:30Am

Post Operative Diagnosis: Nulligravida.

Peri-Operative Complications: Nil

Operation Notes:

Findings: A sessile polyp of 1x1 cm noted in the left lateral wall just below the cornua.
Polypoidal endometrium.
Bilateral ostia visualised.

Procedure Notes: ↓Sterile aseptic precautions, pt in lithotomy position. ↓GA, parts painted and draped. Ant lip of cervix held with vulsellum after visualising with sims speculum
Routine saline hysteroscopy done without cervical dilatation.
A polyp 1x1 cm visualised on the left lateral wall of uterus just below cornua. Polypoidal endometrium noted. Polyp removed using scissors. ~~Rx~~ Gentle curettage done without dilatation
Specimen (polyp + endometrial curettings) sent for HPE

Amount of Blood Loss: Minimal.	Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:
1 - Endometrial Polyp + Endometrial curettings.

(P.T.O.)

Patient Sticker

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POST-SURGICAL CARE PLAN FORM

Post-Operative Monitoring Parameters /Frequency:	Post op orders: • NPO x 3 hours
Wound Care:	• Inj. Supacef 1.5g 2nd dose (before discharge) • T. Augmentin 625mg 1-1-1 x 7 days
Drain /Special Lines/Catheters:	• T. Pan D40mg 1-0-1 x 7 days • T. Paracetamol 1g P/O 1-1-1 • Diclofenac suppository 1 tab P/R (if Pt complains pain) SOS
Special Patient Positioning and Requirements:	• Encourage to void
Nutritional Instructions:	• Inform SOS.
When to Start Mobilization:	
Special Referrals:	
The new order for all required medications documented in the doctor order/medication sheet: ☐ Yes ☐ No	
Any Other Post-Operative Care Needed including Required Follow Up	

Name of the Surgeon: (FOR) Dr. Mathangi

Signature of the Surgeon: V.M.D

Date & Time: 12/11/13

IP18-00036750
IAZ
24 Y 0 M 2 D (F)
RAJAGOPALAN

SAFETY CHECKLIST

Surgeon : DR. mathangi
Ast. Surgeon : DR. priyadharsini
Anaesthetist : Dr. R. Sathish
Scrub Nurse : S.N. Agalya

Patient Name : Mrs. Sahar Shaw Age : 24 Y Gender : F
UHID No. : 94461 Surgery Name : Hysteroscopy & Polypectomy
Date : 4/8/26 In-time : 9:45Am Out-time : 10:30pm

Rainbow Children's Hospital

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 9:50Am

Patient Has Confirmed ☑Yes ☐No
Identity ☑Yes ☐No
Site ☑Yes ☐No
Procedure ☑Yes ☐No
Consent ☐Yes ☐No ☑NA
Site Marked ☑Yes ☐No
Anaesthesia Safety Check Completed ☑Yes ☐No
Pulse Oximeter on Patient & Functioning
Does Patient have a:
Known Allergy? ☐Yes ☑No
Difficult Airway / Aspiration Risk?
Yes, & Equipment / Assistance Available ☑Yes ☐No
Risk of > 500ml Blood Loss (7ml/kg In Children)?
Yes, and Adequate Intravenous Access and Fluids Planned ☐Yes ☑No ☐NA
Blood Units Reserved ☐Yes ☑No ☐NA
Has Antibiotic Prophylaxis been given within the last 60 minutes? ☑Yes ☐No ☐NA

Signature : [signature] 1 subr
Name : Dr Raja-R

Before Skin Incision ➤➤

TIME OUT Time: 9:55Am

Confirm all team members have introduced themselves by Name and Role ☑Yes ☐No
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm
Correct Patient (Check ID Band) ☑Yes ☐No
Correct Site ☑Yes ☐No
Correct Procedure ☑Yes ☐No
Anticipated Critical Events
Surgeon Reviews:
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? ☐Yes ☑No ☐NA
Anaesthesia Team Reviews:
Are There Any Patient-specific Concerns? ☐Yes ☑No ☐NA
Nursing Team Reviews:
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☐Yes ☑No
Is Essential Imaging Displayed? ☐Yes ☑No
Power Supply, Earthing, Power Backup and functioning of equipment checked. ☑Yes ☐No

Signature : for [signature] 18221
Name : DR. mathangi

Before Patient Leaves Operating Room

SIGN OUT Time: 10:30Am

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

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

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

Signature : For [signature] 003?8.
Name : S.N. Agalya

Rainbow Children's Hospital

BirthRight

PATIENT TRANSFER FORM

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

Medications / Consumables / Surgicals / Handover

S.No.	Item Name	Quantity

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Patient & Clinical Records Received by :	
Date & Time of Patient Received	

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

☐ Nurse not Available ☐ Available Bed not ready

Docu. No. :

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...ATION FORM

☑ Not known any Drug Allergies

...one at the time of admission and also whenever there is change ...ating team or shifting from one unit to another unit.
...at the time of admission shifting from ICU to Ward, or Ward to ICUs)

... OT ... Shifted to: MICU

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	INJ PARACIP	1g	IV	stat	4/8	☐C ☐DC
2	INJ TRAMIC	1g	IV	stat	4/8	☐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 Ruby

Date & Time : ... 4/8/26 10.20 am.

Nurse Name & Signature: ... SIN. Sangeetha Punyakoti

Date & Time : ... 4.8.26 at 10:20 Am

...RCH /FRM / GENERAL / 090

GUC-00094461 IP18-00036750
Mrs SAHAR SHANAZ
02-08-2002 24 Y 0 M 2 D (F)
Dr. MATHANGI RAJAGOPALAN

BirthRight | Rainbow Children's Hospital

PATIENT TRANSFER NURSING HANDOVER CHECKLIST

Date & Time of Transfer: **TRANSFERRED TO :**

1	**Patient Identification**	**YES/NO**	**REMARKS**
	a.Patient Identification Patient name, age, UHID/hospital number confirmed	Yes	
	b.Surgical procedure & correct site verified	Yes	
2	**Airway & Breathing**		
	a.Oxygen delivery (mask/cannula/ventilator) secured	Yes	
	b.SpO₂ within safe range	Yes	
	c.If ETT: position confirmed, ties secure, cuff inflated	No	
3	**Circulation & Hemodynamic Stability**		
	a.IV lines secured & infusion running correctly	Yes	
	b.No active uncontrolled bleeding	No	
	c.Last vitals recorded before transfer	Yes	
	d.Central line hubs are closed	No	
	e.Dressing Intact	No	
4	**Pain Assessment**		
	a.Pain score assessed & analgesia given	Yes	
	b.Reassessment done	Yes	
5	**Wound, Dressings & Drains**		
	a.Surgical dressing intact	Yes	
	b.All drains fixed, output noted	Yes	
	c.Catheter secure & urine output recorded	Yes	
	d.Splints/casts/traction devices stabilized	No	
6	**Medications Pre & Post-Op Orders**		
	a.Medications due time noted	Yes	
	b.Pre & Post-op instructions (NPO, position, mobilization) communicated	Yes	
	c.Emergency meds given in OT (time & dose documented)	No	
7	**Equipment Safety & Transport Preparedness**		
	a.Oxygen cylinder full & ambu bag at bedside	Yes	
	b.Bed/side rails up and brakes applied	Yes	
	c.Special positioning maintained as per surgery	No	
8	**High-Risk Patient Safety (if applicable)**		
	a.Chest tube: underwater seal below chest level	No	
	b.Epidural catheter secure, infusion checked	No	
	c.Pressure areas protected (heels/elbows)	No	
9	**BLOOD AND BLOOD PRODUCTS TRANSFUSED**	Yes	
10	**REPORTS AND LABS HANDED OVER**	Yes	
11	**BIOPSY/HPE SENT**	No	
12	**Documentation**		
	a.Documentation completeness	Yes	
	Transferring Nurse: ____________	[signature]	
	Receiving Nurse : ____________	[signature]	
	Signature of Incharge:	[signature]	

GUC-00094461 IP18-00036750
Mrs SAHAR SHANAZ
02-08-2002 24 Y 0 M 2 D (F)
Dr. MATHANGI RAJAGOPALAN

PRE - OPERATIVE CHECK LIST

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: 4/3/26

Patient's Name : Mrs. SAHAR SHANAZ Age : 24 yrs Gender : ☐ M ☑ F

Blood Group : B⁺ Positive UHID : 94461

Planned Surgery : Hysteroscopy + Polypectomy Surgeon : Dr. Mathangi

Anesthetist : Dr. Aswini Date & Time of Operation : 4/3/26

Tick Appropriate Boxes

To be filled by Nurse Incharge / Senior Nurse :

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

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

Billing Clearance taken

Billing Executive Name : Dolli Kalai. C

Billing Executive Signature : [signature]

Date & Time : 04/03/26 @ 04/03/26

Nurse In-Charge Name : S. Nivetha

Signature of Nurse In-Charge : [signature]

Date & Time : 4/3/26

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

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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BirthRight BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

GUC-00094461 IP18-00036750
Mrs SAHAR SHANAZ
02-08-2002 24 Y 0 M 2 D (F)
Dr. MATHANGI RAJAGOPALAN

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

UHID No : .... Date : 4/8/26

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

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

HYSTEROSCOPY GUIDED ENDOMETRIAL POLYPECTOMY

(Ind: Endometrial polyp) upon (Name of the Patient) Mrs. SAHAR

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

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

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

Bleeding, infection, injury to adjacent structures, anaesthesia related complications, ICU stay

My signature on this form indicates that

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

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

Consentee :
Signature : S
Name : MRS. SABAR SHANAZ
Date & Time : 4/8/26

Patient Attendant :
Signature : S. Shanaz (Mother)
Name : S. Basiriya
~~Relationship with~~ Patient: MOTHER
Date & Time : 4/8/26

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

Doctor (who is taking the consent) :
Signature for
Name : Dr. Mathangi
Date & Time : 04/08/26 @ 7:30am

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

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CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MAC

GUC-00094461 IP18-00036750
Mrs SAHAR SHANAZ
02-08-2002 24 Y 0 M 2 D (F)
Dr. MATHANGI RAJAGOPALAN

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

Gender: M☐ F☐ - ..... Consultant : Dr. Mathangi

Ward / Bed No. : ..... Anaesthesiologist : Dr. Lathish

Operative procedure planned : Hysteroscopy + polypectomy

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

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

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

☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure

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

☐ Incapacitating COPD ☐ Others : .....

Comments : .....

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

DECLARATION BY PATIENT / GUARDIAN / PROXY

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

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

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

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

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

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

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

Pregnant: ☐ Yes ☑ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

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

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

Patient / Patient Attendant :

Signature : .....

Name : S. SAHAR SHANAZ

~~Relationship with~~ Patient: Patient

Date & Time : 4/2/26

Witness :

Signature : S. Basiriya (Mother)

Name : S. BASIRIYA

Date & Time : 4/2/26

Doctor (who is taking the consent) :

Signature : .....

Name : DR. Aravindha

Date & Time : 4/2/26 7:30AM

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: Mrs SAHAR SHANAZ 02-08-2002 24 Y 0 M 2 D (F) Dr. MATHANGI RAJAGOPALAN

Date: .....

ge: 23Y Sex: ..... UHID.No : .....

..... Proposed Operation: HYSTEROSCOPY

Diagnosis: .....

B.P / CRT: ..... H.R: 80/m Weight: 74Kg ASA Physical Status: ☑1 ☐2 ☐3 ☐4 ☐5

Laboratory Data:

Hgb: 10.9	Glucose: 92	Protein:	HIV:	X-Ray:
PCV:	Urea: 17	Alb:	HBS Ag:	ECG:
WBC:	Creat: 0.5	Total Bill:	HCV:	2D Echo:
Plate:	Na:	Dir. Bill:	Blood group:	Stress/Anglo:
PT:	K:	LDH:	T3	Other: Inferi pend
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH 2.95	
	Cl -:	SGOT/SGPT:		

Allergies: Nil

Medical History: CVS :

RESP :

CNS :

Renal :

Hepatic / GE :

Others :

Diabetes : No H/o DM/HT/Prev Surg/Fits

Physical Activity:

Past Anaesthetic History: No H/o Br Asthma

Physical Exam: No H/o cough/Runny nose.

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

Lungs : BAE (P)

Heart: S_1S_2 (P)

CNS: NAD (P)

Pregnant: ☐ Yes ☐ No ☐ NA

Venous Access Site :

Spine Exam for regional :

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

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

.....

.....

.....

Signature: ..... Name: CSATHYA CHANU

Patient Sticker

ANAESTHESIA CHART

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Pre Induction Assessment:

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

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

H.R: 80/min | B.P / CRT: 130/80 | SpO_2: 100% | R.R: 20/min | Last Feed: Date: 4/8

Pre-OP Diagnosis: Endometrial polyp | Operation: Hysteroscopic polypectomy

Surgeon: Dr Mathangi | Anaesthesiologist: Dr Sathish / Dr Peyush | Technician:

TIME
N_2O /AIR /O_2 LPM
HALO /SO /SEVO
Drugs:

9.50am
2-1
Inj Fent 100mcg IV
Inj Propofol 150mg IV
Inj Atracurium 10mg IV

10.20am
Inj Paracip 1g IV
Inj Glycopyrrolate 2ml
Inj Tropin 1g IV

FIO_2 / SaO_2 0.5
ETCO$_2$ >35 mmHg
ECG Sinus rhythm
Temperature
Urine Output

Fluids 100ml
Blood

Antibiotic
Suppository
Blood Loss
NOTES

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

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

ABG
GRBS
Others

LAB Values

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

Position: Supine
☐ Pressure Points Checked

Eye Care:
- ☐ Oint
- ☑ Tape
- ☐ Padding
- ☐ Awake

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

Times:
Anaes Start: 9.50am
OP Start:
OP End:
Leave OR: 10.20am

Anaesthesia:
- ☑ GA
- ☐ Monitored Anaesthesia Care
- ☐ Regional

Line (Size & Location)
- ☐ CVP:
- ☐ ART:
- ☐ IV: 18G (L) UL
- ☐ IV:
- ☐ IV:

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

- ☐ Mask
- ☑ SGA 3
- ☐ Airway ☐ Oral ☐ Nasal
- ETT# ... at ... cm
- ☐ Oral ☐ Nasal ☐ Cuff
- ☐ Tracheostomy ☐ Topical
- ☐ Drug:

- ☐ Awake
- ☐ Direct Vision
- ☐ Video Laryngoscopy
- ☐ Stylette / Bougie
- ☐ Fiberoptic

Blade# ... Attempts:
Difficulty Why?

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

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

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

Name of the Doctor: Dr Riya
Signature of the Doctor:
15 Nov

Patient Sticker

POST-ANAESTHESIA CARE UNIT RECORD

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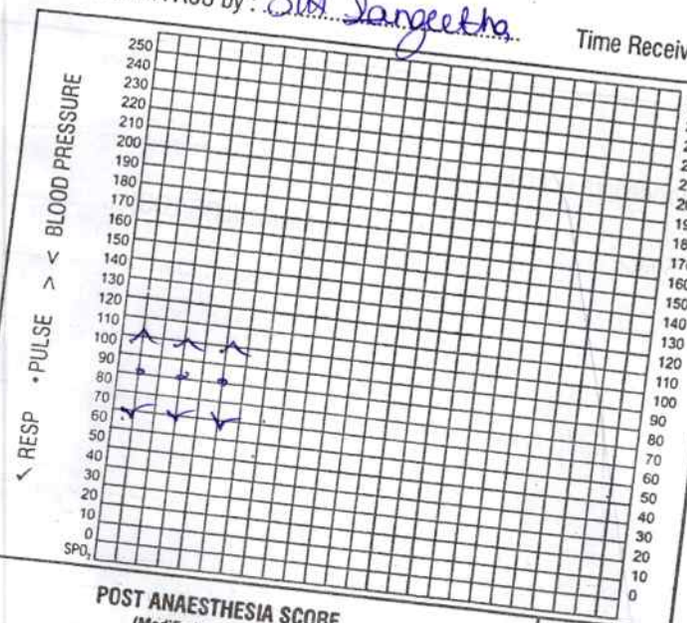
Received in PACU by : SIN Sangeetha Time Received : 10:20m Time Discharged : 10:30m



IV Cannula Site : .....

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

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

POST ANAESTHESIA SCORE
(Modified Aldrete Score)

		IN	MINUTES 30	60	90	OUT
Able to move 4 extremities voluntary or on command Able to move 2 extremities voluntary or on command Able to move 0 extremities voluntary or on command	= 2 = 1 = 0 ACTIVITY	2				2
Able to deep breathe & cough freely Dyspnea or limited breathing Apneic	= 2 = 1 = 0 RESPIRATION	2				2
BP ± 20 of Pre Anaesthetic leve BP ± 20-50 of Pre Anaesthetic leve BP ± 50 of Pre Anaesthetic leve	= 2 = 1 = 0 CIRCULATION	2				2
Fully awake Arousable on calling Not responding	= 2 = 1 = 0 CONSCIOUSNESS	2				2
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0 COLOR	2				2
	TOTAL	10				10

SCORING INTERPRETATION

A Minimum Total Score of 8 is Required for Discharge

Exceptions to this, are to be explained in the space below by the Discharging Physician:

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
4/8		0/10	NRM x 2 hours	

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

Anaesthesiologist Name : Dr Divya. R

Anaesthesiologist Signature: .....

Date & Time: 4/8/26

PACU Nurse Name : SIN Sangeetha

PACU Nurse Signature: .....

Date & Time: 4/8/26 at 10:20m

Reassessment Frequency:

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

Transferred to Unit by (PACU): SIN Sangeetha

Date & Time: 4/8/26 at 10:30m

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : .....

Any other issues :

a) .....

b) .....

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

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

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

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Guindy

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

ADMISSION SHEET

Registration Details :

Admission No : IP18-00036750 **Admit Date** : 04-Aug-2026 **Admit Time** : 06:44 AM **UHID** : GUC-00094461

Patient Details :

Patient Name	: Mrs SAHAR SHANAZ	**Age**	: 24 Y 0 M 2 D
Guardian	: Mr MEERAN MOHIDEEN M	**DOB**	: 02-08-2002
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: NO 7/1 NARAYANA 3RD LANE,PUDUPET Anna Road Chennai Tamil Nadu INDIA 600002	**Phone No**	: 7708643795/ 9962659768
		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 MEERAN MOHIDEEN M **Relationship** : Husband

Contact Address : NO 7/1 NARAYANA 3RD LANE,PUDUPET Anna Road Chennai Tamil Nadu INDIA 600002 **Phone No** : 7708643795

Signature

Doctor Details :

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

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

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

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

Rainbow Children's Hospital
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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 SAHAR SHANAZ**	**Age :**	**24 Y 0 M 2 D**
IP No:	**IP18-00036750**	**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 also consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

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

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

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

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

3 I 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: → Sameema.S

Name: > SAMEEMA FATHIMA

Relationship: > SISTER

Date: 04-08-2026 Time: 6:44

Witness Name: Aswin

Witness Signature:

Patient Address:

NO 7/1 NARAYANA 3RD LANE, PUDUPET Anna Road Chennai Tamil Nadu INDIA 600002

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BILLING POLICY

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

DECLARATION

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

Patient Name : > SAHAR SHANAZ	UHID Number : 94461
Self/Attendant Name : > SAMEEMA FATHIMA	Relation : > SISTER
Self/ Attendant Signature :> Phone Number : > 6380797929	Name & Signature of Financial Counselor

RCH/GDY/FRM/CLINICAL/426

Ref. No. : F/GYNIC/18

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I.P. ADMISSION SHEET FOR GYNECOLOGY

GUC-00094461 IP18-00036750
Mrs SAHAR SHANAZ
02-08-2002 24 Y 0 M 2 D (F)
Dr. MATHANGI RAJAGOPALAN

Date of Admission : 4/8/26
Time of Admission :

PERSONAL DETAILS

Name : Mrs. Sahar Shanaz Age 23 Date of Birth
UHID No.: GUC-94461 IP No.:
Department : OG Consultant : Dr. Mathangi

PRESENTING COMPLAINTS :

Nulligravida | B positive | RMP | LMP: 23.07.26 | Dysmenorrhea | Endometrial polyp

- Pt. is trying for pregnancy since 1 year.
- Has regular cycles.
- H/O dysmenorrhea since January 2026.
- H/O Follicular study
  ↓
  incidental finding of endometrial polyp 11 x 7 mm on Day 11.

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : 1 year	Parity : Nulligravida
Previous Periods : Regular	Mode of Delivery
LMP : 23.07.2026	Last Child Birth : -
Contraception : -	

MEDICAL HISTORY	SURGICAL HISTORY
NIL Taking Tab. LIVOGEN and Tab. FOLIC ACID	NIL
FAMILY HISTORY	**NOTES / ALLERGIES**
NIL	NIL

INITIAL ASSESSMENT :

Date 04.08.26
Ht. 163 Wt. 74 kg
BMI 27.85 kg
B.P 104/60 mmHg
Pallor Absent
CVS S_1S_2 (+)
Respiratory System B/L AE (+)
Thyroid
PR - 90/min

Breasts
Clinically normal

Abdominal Examination
soft, non tender
NO organomegaly

Local / Speculum Examination
—

Bimanual Pelvic Examination
—

PROVISIONAL DIAGNOSIS : Nulligravida B+ve | Regular cycles | Dysmenorrhea | Endometrial polyp

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT	PRESCRIPTION
NIL	Hysteroscopy + Polypectomy	- NPO - IVF @ 125ml/hr - Tab. MISO 400mcg PV - Informed consent - Inform OT - monitor vitals - follow strict aseptic

Name of the Doctor : Dr. Mohana / Dr. Durgalakshmi
Date : 4/8/26 Time :
16/7/87
Signature of Doctor

GUC-00094461 IP18-00036750
Mrs SAHAR SHANAZ
02-08-2002 24 Y 0 M 2 D (F)
Dr. MATHANGI RAJAGOPALAN

Patie

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RESULT SHEET

Date	21/6/26				B POSITIVE	(oral)
Time						
Hb	10.9					
PCV					HIV, HBsAg, HCV } NR	
RBC						
WBC						
N/L						
Platelets					TSH - 2.95	
CRP						
ESR						
PCT						
RBS	96.4	F-92 PP-107			FSH - 5.65	
Na					LH - 7.34	
K						
Cl					Testosterone - 0.16ng/ml	
Ca/Mg						
Phosphate						
Urea					HbA1C - 4.3	
Creatinine		17 0.5				
ALP						
SGPT						
SGOT						
T.Bill/Conj					CXR - (N)	
T.Protein						
S.Albumin						
S.Globulin					ECG, 2D Echo } (N)	
A/G Ratio					EF - 63%	
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L		16/6/26				

(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 : .....

.....

.....

.....

27/7/26

Radiology : USG : ut. anteverted 9.1 x 4.1 cm

ET - 3.6 mm

X-Ray : .....

ECHO : endometrial polyp @ 0.9 x 0.7 x 0.5 cms (Vol. 0.2 cc)

CT : seen in left cornua. A vascular pedicle seen

MRI in the polyp.

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

GUC-00094461 IP18-00036750
Mrs SAHAR SHANAZ
02-08-2002 24 Y 0 M 2 D (F)
Dr. MATHANGI RAJAGOPALAN

Docu. No. : RC

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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Your Right to a Safe Delivery

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

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

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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

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

GUC-00094461 IP18-00036750
Mrs SAHAR SHANAZ
02-08-2002 24 Y 0 M 2 D (F)
Dr. MATHANGI RAJAGOPALAN

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
04/08/2026	Patient received in MICU	
10:30 Am	C/S/B Dr. Vinitha / Dr. Shreedevi	
	Pt reviewed, Nil c/o	Advice
T-(N)	O/E Pt GC fair, Afebrile	- NPO x 3 hours
PR- 82/min	P° / PE°	- Vitals Monitoring
BP- 102/65mmHg	CVS /	- IVF 10 Rl @ 100ml/hr
	RS / NAD	- Inj. SUPACEF 1.5g IV
	P/A - Soft	2nd dose (before discharge)
	L/E - NAD	- Diclofena Suppository
		1 tab PR (SOS) if Pt c/o pain
	18/2/17	- Measure & inform 1st void
		- Inform (SOS)
04/08/2026	C/S/B Dr. Vinitha / Dr. Shreedevi	
2pm	Pt tolerating liquids well	
	Pt reviewed, Nil c/o	Advice
	Patient voided 220ml	- Liquid diet
T-(N)	O/E Pt GC fair, Afebrile	- Vitals Monitoring
PR- 80/min	P° / PE°	- Follow drug chart
BP- 110/60mmHg	CVS /	- Inform (SOS)
	RS / NAD	- process discharge
	P/A - Soft	
	L/E - NAD	
	18/2/17	

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

30

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

GUC-00094461 IP18-00036750
Mrs SAHAR SHANAZ
02-08-2002 24 Y 0 M 2 D (F)
Dr. MATHANGI RAJAGOPALAN

Patient

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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	-	-	-	-	-	☐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. Dhyalakshmi

Date & Time : ..... 4/8/26 @ 6.30 am

Nurse Name & Signature: 016808

Date & Time : ..... 4/8/26 @ 6.30 am

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

GUC-00094461 IP18-00036750
Mrs SAHAR SHANAZ
02-08-2002 24 Y 0 M 2 D (F)
Dr. MATHANGI RAJAGOPALAN

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DRUG CHART

Date of Admission: 4/8/20 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:				

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

Patient Sticker

REGULAR PRESCRIPTIONS

Weight. 74kg Ward. 202

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

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

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

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

Patient Sticker

Weight. 74 kg Ward. ICU

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
4/8/26	6:30 AM	Tab. MISOPROSTOL	400mcg	PV	16428	SP IJ
4/8	9AM	Inj. SUPACEF	01 ml	ID	16428	SND SP
4/8	9AM	Inj. PAN	40 mg	IV	16428	SND SP
4/8	9AM	Inj. EMESET	4 mg	IV	16428	SND SP
4/8	9:30 AM	Inj. SUPACEF	1.5 g	IV	16428	SND SP
4/8	9:50AM	INT RANA	1g	IV	15402	R 020322
4/8	10:20AM	INJ TRAMIC	1g	IV	15402	R 020322.

Patient Sticker

I.V. FLUIDS CHART

Weight. 74 kg .... Ward. ....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
4/8	7:30 Am	IVF 10 RL	IV	125 ml/hr	[illegible] 16428	SP / TJ	4/8	[illegible]	
4/8	9:45am to 10:30am	RL 10	IV	[illegible]	[illegible]	[illegible] / 0205am	4/8	[illegible]	[illegible] 0205am

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

GUC-00094461 IP18-00036750
Mrs SAHAR SHANAZ (F)
02-08-2002 24 Y 0 M 2 D
Dr. MATHANGI RAJAGOPALAN

Patie

(1)

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Early Warning Observation Score Chart - Obstetrics

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

Date: 4/8/26	Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																								
	21 - 30																								
	11 - 20	20		20	22	20		20																	
	0 - 10																								
Saturations	94 - 100 %	97%		99	99	99		100																	
	< 94 %																								
Administered O_2 (L/min.)		RA		RA	RA	RA		RA																	
Temp °c	40																								
	39																								
	38																								
	37	98.6F		98.4	98.2	98		98°F																	
	36																								
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90	88/m						82																	
	80			78	82	80																			
	70																								
	60																								
	50																								
	40																								
Systolic Blood Pressue ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130	118		110	102	110		108																	
	120																								
	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70			70	65	60		62																	
	60	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																	
TOTAL ORANGE SCORES		0		0	0	0		0																	
Nurse Initial		[illegible]		[illegible]	[illegible]	[illegible]		[illegible]																	

Discharge

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

GUC-00094461 IP18-00036750
Mrs SAHAR SHANAZ
02-08-2002 24 Y 0 M 2 D (F)
Dr. MATHANGI RAJAGOPALAN

(C)

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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.

9/8/26		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							
	08:00 am	N		125						200ml	0	[signature]
	09:00 am	P		RL 500ml.						200ml	0	[signature]
	10:00 am	O		125						-	0	[signature]
	11:00 am	N		125							0	[signature]
	12:00 pm	P		125							0	[signature]
	01:00 pm	O		125						220	0	[signature]
Total Intake :		1125 ml.						Total Output :		620 ml		
	02:00 pm	H2O feed	200	125ml							0	[signature]
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :								Total Output :				
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :								Total Output :				
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :								Total Output :				

Discharge

Total 24 hrs. Intake		Total 24 hrs. Output	

Docu. No. : RCH /FRM / CLINICAL / 092

GUC-00094461 IP18-00036750
Mrs SAHAR SHANAZ (F)
02-08-2002 24 Y 0 M 2 D
Dr. MATHANGI RAJAGOPALAN

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: Nulligravida/ Hysteroscopy		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:				
	Surgery / Procedure:		Post OP Day:				
BACKGROUND	Date / Shift	4/8/26 7am	4/8/26				
	Medical Condition (Any special condition to be noted):	–	–				
	Diet:	NPO	liquid				
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	RA	RA				
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98°F	98F				
	Res:	20bpm	18				
	SpO_2:	99%	100%				
	Pulse:	90bpm	80				
	BP:	104/70	104/66				
	LOC:	Conscious	Conscious				
	Fall Risk Score:	20	30				
	Pain Score:	0	1/10				
	Skin Integrity	Intact	Normal				
Recommendations	Safety Needs:	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	NA	–				
	Others Specify:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	NPO	Liquid				
	Critical Lab Test / Values:	–	–				
	Other Special Orders / Medications:	☐ Yes ☑ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	Non Dependent	Depen				
Post Operative Procedure Special Orders:		–	–				
Handed Over By Name :		S/ Iparameshwari	4200?				
Signature / ID :		01680	01080				
Date:		4/8/26	4/8/26				
Time:		7:30am	2PM				
Taken Over By Name :		Aarthi					
Signature / ID :		011796					
Date:		4/8/26					
Time:		8AM					

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NURSING CARE RECORD

Date: .....

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM	Achieve acceptable Pain control & Comfort	8AM	=> Assess the pain using pain Scale regularly => position changed. => Administered analgesics	Patient Vital Signs Stable.	Reassessment done	02/01/22
Afternoon							
Night							

Patient Sticker

NURSING CARE RECORD

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Date: .....

Goals

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

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

GUC-00094461 IP18-00036750
Mrs SAHAR SHANAZ
02-08-2002 24 Y 0 M 2 D (F)
Dr. MATHANGI RAJAGOPALAN

NURSES NOTES

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☑ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
4/8/26	6.30 am	ADMISSION NOTES:	
		patient Admission on	
		4/8/26. patient came for	
		Hysteroscopy + polypectomy.	
		patient general condition	
		fair. Vitals are checked &	
		recorded. patient diagnosis	
		Nulligravida / Dysmenorrhea	
		endometrial polyp. parts	
		preparation done. There is	
		no past medical & surgical	
		history. patient maintain	
		NPO. patient voided.	
		Dr. Dhivyalakshmi saw the	
		patient & SAP, T. Zitotec	
		400mcg PV kept.	S/N paravengan 016808
		surgery consent obtained.	
	7.30 PM	patient details, files handed	
		over given to morning duty	
		staff.	S/N paravengan 016808
4/8/26	7.30 AM	Morning Duty:	
		Patient report hand	
		over taken from Night	
		duty staff. Patient is	
		Conscious & Oriented, afebrile.	
		NPO. IV fluid. RL 12ml/hr	
		on flow.	[signature] 01174

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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

BirthRight BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

☑ No Known Drug Allergies

☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
4/8/26	8AM	⇒ Patient Vital Signs Checked & recorded, General Condition Fair	⇒
	9AM	⇒ Inj Pan 40mg IV, Inj Emeset 4mg IV, Inj Supact 0.1mg IM given as per Drug Orders	⇒
	9:30AM	⇒ Inj Supact 1.5gm IV Fair dose given. Patient Shifted to OT head over to OT Staff	⇒
	9:40AM	OT Notes:	
4/8/26	9:45AM	patient hand over taken from ICDR staff while receiving the patient is conscious & oriented. vitals on monitor: pulse: 80bpm, RR = 20bpm, BP = 100/70mmHg	
	9:50AM	Temp @, SpO2 = 100%. General Anaesthesia given by DR. Sathish	
	9:55AM	procedure started by DR. Mallangi. Procedure went on well. HPE sent to lab. procedure done patient shifted to micu.	
	10:30AM	patient documents & details hand over given to micu staff.	
		Recovery Notes	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

IP18-00036750

Mrs SAHAR SHANAZ
02-08-2002 24 Y 0 M 2 D (F)
Dr. MATHANGI RAJAGOPALAN

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NURSES NOTES

UHID-94461

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
4/2/26	10.30 AM	Receiving Notes (2/2/2026) patient from OT done Hysteroscopy and polypectomy V.C.H.A. patient conscious and oriented. General condition Fair	Y. DSG
	11 AM	patient Checked vitals are stable patient Conscious and oriented Hasone patient can also complaints patient is continue patient Other No complaint	Y. DSG
	12 pm	Patient Checked vitals are stable patient Back pain, complaint from to DR. Venitha Mam	Y. DSG
	1 pm	patient wheeled room from to DR. Venitha Mam patient General conditions Fair	Y. DSG
	1.30 pm	patient patient oral given patient Conscious and oriented General conditions Fair	Y. DSG
	2 pm	DR. Vinitha advice to do discharge process. orders carried out.	DSG

NOTE : DO NOT WRITE OUTSIDE THE MARGS

GUC-00094461 IP18-00036750
Mrs SAHAR SHANAZ
02-08-2002 24 Y 0 M 2 D (F)
Dr. MATHANGI RAJAGOPALAN

☐ ~~No Known Drug Allergies~~
☐ Drug Allergies ....

NURSES NOTES

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DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
04/8/26	2pm	File sent to billing.	
		Activity sent pharmacy	
		as per doctor order.	[signature]

DO NOT WRITE OUTSIDE THE MARGINS

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Patient Sticker

NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies ....

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

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies ....

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

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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

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OBSTETRICS / GYNECOLOGY
NURSING INITIAL ASSESSMENT FORM

Date of Admission: 4/8/26

Baseline Information:

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

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

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

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

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

If yes, identify .....

Chief Complaints: Came for hysteroscopy

Doctor Notified on Admission: ☐ Yes ☑ No

Name of the Doctor: 6.30am Dr. mohana

Time Notified: Dr. 6.30am

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

Past Medical History	Past Surgical History	Previous Hospital Admission
NIL	NIL	NIL

Gynecology Assessment: ☐ Not Applicable

Menstrual History: Regular

Onset of Menarche: 15 yrs

Menstrual Cycle: ☑ Regular ☐ Irregular

Last Menstrual Period: 23/7/26

Gynecology Surgical History:

Caesarean Section: ☑ No ☐ Yes

Cervical Cerclage: ☑ No ☐ Yes

Ectopic Pregnancy: ☑ No ☐ Yes

Myomectomy: ☑ No ☐ Yes

Others: _____

Gynecological History:

Contraceptives: ☑ No ☐ Yes

Vaginal Discharge: ☑ No ☐ Yes

Post-Coital Bleeding: ☑ No ☐ Yes

Infertility: ☑ No ☐ Yes

If Yes Type: ☐ Primary ☐ Secondary

Obstetric History: G — P — L — A —

Previous LSCS: —

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

Family History: ☑ No Abnormalities Detected

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

☐ Liver disease ☐ Other .....

Vital Signs / Measurements: Temp: 98°F HR: 90bpm RR: 20bpm

BP: 163 cm Weight: 74kg Height: 163 cm BMI: .....

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

(P.T.O.)

Patient Sticker

PHYSICAL ASSESSMENT

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

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

Risk of Pressure Sore: ☐ Yes ☑ No Score ..25.. (complete the Braden Q Sheet)

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

☐ Mobility problem ☐ Walking Problem ☑ No Abnormality Detected

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☐ No Abnormality Detected

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

☐ Under Weight ☐ Diabetes Mellitus ☐ Hyperemesis Gravidarum

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

☐ Others .....

Inform consultant for positive criteria

SOCIAL SCREENING:

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

Social History: Lives With ..Husband..

Orientation has been given regarding the following aspects:

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

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

Above information given to ..Mrs. Sabar Sbanat..

Name of Person Orientation was given to: ..Mrs. Sabar Sbanat..

Orientation not given Reason: ..-..

Nurse Signature: .....

Nurse Name: .....

Date & Time: .....

Patient Sticker

GUC-00094461 IP18-00036750
Mrs SAHAR SHANAZ
02-08-2002 24 Y 0 M 2 D (F)
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RISK ASSESSMENT TOOL FOR DEEP VEIN THROMBOSIS

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

Date: 4/8/26

Pre - Existing Risk Factors	Tick	Score
Previous VTE (except a single event related to major surgery)		4
Previous VTE provoked by major surgery		3
Known high-risk thrombophilia		3
Medical comorbidities e.g. cancer, heart failure; active systemic lupus erythematosus, inflammatory polyarthropathy or inflammatory bowel disease; nephrotic syndrome; type I diabetes mellitus with nephropathy; sickle cell disease; current intravenous drug user		1
Family history of unprovoked or estrogen-related VTE in first-degree relative		1
Known low-risk thrombophilia (no VTE)		1
Age (≥35 years)	✓	1 or 2
Obesity		1
Parity ≥ 3		1
Smoker		1
Gross varicose veins		1
Obstetric Risk Factors		
Pre-eclampsia in current pregnancy		1
ART/IVF (antenatal only)		1
Multiple pregnancy		2
Caesarean section in labour		1
Elective caesarean section		1
Mid-cavity or rotational operative delivery		1
Prolonged labour (24 hours)		1
PPH (1 litre or transfusion)		1
Preterm birth 37^{+0} weeks in current pregnancy		1
Stillbirth in current pregnancy		1
Transient Risk Factors		
Any surgical procedure in pregnancy or puerperium except immediate repair of the perineum, e.g. appendectomy, postpartum sterilization		3
Hyperemesis		3
OHSS (first trimester only)		4
Current systemic infection		1
Immobility, dehydration		1
Total		01
Signature of the Nurse		s/no paramedwai 016808
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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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	7am 4/8/26	M 4/8/26	
		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

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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02-08-2002 24 Y 0 M 2 D (F)
Dr. MATHANGI RAJAGOPALAN

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
4/8/26	6.30 AM	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NIL	[illegible] 016720[?]
4/8/26	9Am	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	No pain	[illegible] 04PF72[?]
4/8/26	11Am	2/10	Back pin	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☑ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	lomFstudll[?] pouch V	[illegible]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

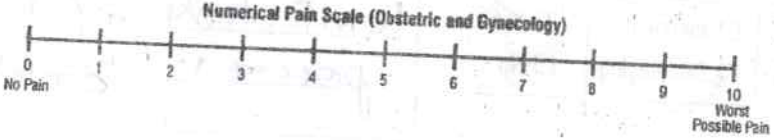
Re-assessment Frequency:

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

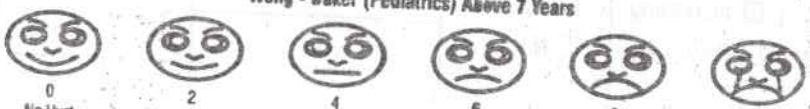
(P.T.O)

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years



FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs 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

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Patient II

BRADEN 'Q' SCALE

					Date : 4/8/26 4/8/26			
					Time : 8pm			
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4		
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4		
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4		
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4		
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4		
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	1	1		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4		
				TOTAL SCORE	25	25		
				Evaluator's Name		DSN 04/08/26		

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

Risk Score	Category	Action	Support Surfaces (**Please Note:** Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	⓫ Regular Turning Schedule ⓬ Enable as much activity as possible ⓭ Protect the heels ⓮ Use pressure redistribution surfaces ⓯ Manage moisture, friction and shear ⓰ 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	⓱ Use the Same Protocol as for **"At Risk"** Patients ⓲ 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	⓳ Follow the same protocol as for **"Moderate Risk"** Patients ⓴ In addition to regular turning schedule ㉑ 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	㉒ Use same protocol as for **"High Risk"** Patients ㉓ Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

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Patient's Name: IP18-00036750

MRD NO. GUC-00094461
Mrs SAHAR SHANAZ (F)
02-08-2002 24 Y 0 M 2 D
Dr. MATHANGI RAJAGOPALAN

Age : .... Sex: ☐ M ☐ F

Consultant ....

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 4/8/26 Time: 7 am

Location : Left cephalic

Size : 18G

Cannula inserted by : S/N paramesgran 0/6808

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
4/8/26	7.30am	☐Yes ☑No	☐Yes ☑No	Observed	[signature]
	9.30Am	☐Yes ☑No	☐Yes ☑No	Obs	[signature]
	11.30Am	☐Yes ☑No	☐Yes ☑No	Obs	[signature]
	1.30pm	☐Yes ☑No	☐Yes ☑No	Obs	[signature]
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐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

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

BirthRight™ BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
4/8/25	7am	yes	Educate & Inform about plan of treatment	patient	None	Oral	None	yes	good	

Part - III: CODES

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

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

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

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

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

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PAT[...]RM

GUC-00094461 IP18-00036750
Mrs SAHAR SHANAZ
02-08-2002 24 Y 0 M 2 D (F)
Dr. MATHANGI RAJAGOPALAN

	Date & Time of Admission	Date & Time of Transfer Order
	4/8/26 at 6:44AM	4/8/26 at 9.30 AM
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr. Mathangi	Dr. Vinitha.	Further Mgt
From Unit	**To Unit**	**Information to Attendant**
4 ADR	OT	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
IP file		Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

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

Patient & Clinical Records Received by : SANGEETHA

Date & Time of Patient Received : 4/8/26

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

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

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