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PATIENT DISCHARGE INTIMATION FROM NURSING STATION

CLEARANCE FOR DRUGS AND DISPOSABLES BILLING

GUC-00005290 IP18-00036335 Date: 7/7/26

Name of the Patient: Mrs SARANYA .S
25-01-1994 32 Y 5 M 12 D (F)
Dr. MATHANGI RAJAGOPALAN

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

Ward: 4th Floor Room No: 402

Certified that in respect of the above patient:

- ☐ a. There are no drugs for return
- ☐ b. Emergency cupboard issues have been replenished
- ☑ c. No pending indents are there against above patient
- ☑ d. Checked the bed side cupboard of the bed
- ☑ e. Checked by the patient's Mother / Father in the room

Patient Authorised Sign	Nurse Sign	Pharmacy Sign
Date:	Date: 7/7/26	Date: 7/07/26
Time:	Time: 6am	Time: 8.21am

Docu. No. : RCH /FRM / GENERAL / 117

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GUC-00005290 IP18-00036335
Mrs SARANYA .S
25-01-1994 32 Y 5 M 12 D (F)
Dr. MATHANGI RAJAGOPALAN

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing		6am					
Activity Sheet update by Pharmacy		8.21					

GUC-00005290
Mrs SARANYA .S
25-01-1994 32 Y 5 M 11 D (F)
Dr. MATHANGI RAJAGOPALAN
IP18-00036335

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ACTIVITY RECORD FOR BILLIN(

Name: MRS. SARANYA

UHID No: 5290 IP No: 36335 Consultant: DR. MATHANGI Dept: OBR

Date of Admission: 5/7/26 Time: 10.35pm Date of Discharge: ..... Time: .....

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

WARD TRANSFERS

	Date	Time	From	To	Signature of Nurse
	6/7/26	1PM	OBR	FMW	6/7/26

CROSS CONSULTATION VISIT

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
4/7/23	CBC	26021648	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
5/7/26	CBG - (1)			009021	
5/7/26	CBG - (2)			009021	
6/7/26	Infusion	9AM		1722344	
	CBG - (3)			009077	
	CBG - (4)			009077	
	CBG - (5)			009077	

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
5/7/26	IV placement	1	1722458	[illegible]

ANY OTHER INFORMATION:

6/7/26
Normal Vaginal delivery
11 AM to 12 PM
Dr. Mathangi
Dr. [illegible] lakshmi
Dr. Sree Devi | 981N [illegible]

Date: 7/7/26 Time: [illegible] Prepared By:

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

GUC-00005290 IP18-00036335
Mrs SARANYA .S
25-01-1994 32 Y 5 M 11 D (F)
Dr. MATHANGI RAJAGOPALAN

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DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement	7/4/26 at 10AM				
	INTIME	OUT TIME			
Arrangement of File by Nursing		7/4 at 10AM			
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

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BED SIDE CHECK LIST FOR NURSES

Date:	6/7	7/7							
Doctor's Orders	YES	YES							
Carried out or not	YES	YES							
Bed Side									
Structured Handover done	YES	YES							
IV Site	YES	YES							
Central Lines	NA	NA							
Arterial Lines	NA	NA							
Feeding Catheter	NA	NA							
Urinary Catheter	NA	NA							
Skin Care	YES	YES							
Eye Care	YES	YES							
Mouth Care	YES	YES							
Sterillum Bottle, Stethoscope	YES	YES							
Suction Bottle (Should be clean & empty)	NA	NA							
Intubation Tray	NA	NA							
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	NA	NA							
Ventilator Tubing,(Any Water, Blood)	NA	NA							
Humidification	NA	NA							
Check all Infusion (Labelling,Correct Preparation)	NA	NA							
Chest Physio & Neb	NA	NA							
Handed Over By Name :	Sul								
Signature :	Sul								
Date & Time:	06/7 8pm	7/7/26 2AM							
Hand Over Taken By Name :									
Signature :									
Date & Time:	7/7/26 8AM								

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 : IP18-00036335 **Admit Date** : 05-Jul-2026 **Admit Time** : 10:35 PM **UHID** : GUC-00005290

Patient Details :

Patient Name	: Mrs SARANYA .S	**Age**	: 32 Y 5 M 10 D
Guardian	: Mr P. PRAVEEN KUMAR	**DOB**	: 25-01-1994
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Married
Address (H)	: NO.1/2, BAKTHAVATCHALAM STREET,, TEACHERS COLONY, KODUNGAIYUR, CHENNAI - 600118 Kodungaiyur Chennai Tamil Nadu INDIA	**Phone No**	: 9445330020/ 9025242624
		E-mail	: p.praveenkumar2009@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : PRE OP 806 **Ward Name** : 8F-OT COMPLEX

Room No : PRE OP 806 **Admission Type** : First Visit

Contact Details :

Name : Mr P. PRAVEEN KUMAR **Relationship** : Husband

Contact Address : NO.1/2, BAKTHAVATCHALAM STREET,,TEACHERS COLONY, KODUNGAIYUR, CHENNAI - 600118 Kodungaiyur Chennai Tamil Nadu INDIA **Phone No** :

P. Praveen
Signature

Doctor Details :

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

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

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

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TEL NO :044-40122444
WEB : https://rainbowhospitals.in

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Mrs SARANYA .S**	**Age :**	**32 Y 5 M 10 D**
IP No:	**IP18-00036335**	**Sex:**	**Female**
Consultant:	**Dr. MATHANGI RAJAGOPALAN**	**Ward/Bed No:**	**8F-OT COMPLEX/PRE OP 806**

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 [illegible]rance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the [illegible]e 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 [illegible]earance. In case of failing the submission, I will pay 200/- Rs.
([illegible]ivers Signature:.....)
3 [illegible] Guide book has been given to me and I have been explained about the Hospitals rules and policies.
4 Financial and billing counseling has been done to me.

Signature of Patient/Relative:-> P. Pra

Name: -> P. Praveen Kumar

Relationship: -> Husband

Date: 05-07-2026 Time: 10:35

Witness Name: ASWIN

Witness Signature:

Patient Address:

NO.1/2, BAKTHAVATCHALAM STREET,,
TEACHERS COLONY, KODUNGAIYUR,
CHENNAI - 600118 Kodungaiyur
Chennai Tamil Nadu INDIA

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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 : > Sarayu. S	UHID Number : 05290
Self/Attendant Name : > Praveen Kumar P	Relation : > Husband
Self/ Attendant Signature : > P P Phone Number : > 9445330020	Name & Signature of Financial Counselor

GUC-00005290 IP18-00036335
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IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints PFM well.
No c/o pain, bleeding, leaking P/V
Induction of labor.

LMP: 8/10/25 EDD: 15/7/26.
Corrected EDD: 20/7/26. GA: 37w+6D.

Obstetric Formula:
G2P1L1

Menstrual History: Regular : ☑ Yes ☐ No

Obstetric Hostory:
PP - spontaneous conception.
P1L1 - 2021, FT, NVD, 9lbs, 2.3kgs, A&H.

Obstetric Examination

Fundal Height: Uterus @ term.

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

Ut. Activity: ☑ Relaxed ☐ Mild ☐ Mod ☐ Severe

Liquor: ☑ Adequate ☐ Oligo ☐ Poly

PP: ☐ Cephalic ☐ Breech Others _____

Head Fifths Palpable: 5/5th.

FHS: ☐ Normal ☐ Tachy ☐ Brady ☐ Absent

RISK FACTORS:

Per Speculum Examination not done.

Draining: ☐ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination

Cervix: 2 cms ☑ Long ☐ Partially effaced ☐ Effaced

Os: Closed _____ Dilated 2 fingers loose.

Membranes: ☑ Present ☐ Absent

Liquor: ☑ Clear ☐ Meconium ☐ Blood Stained

Presenting Part: ☑ Vertex ☐ Breech ☐ Others

Sutton: ☑ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Pelvis: ☑ Adequate ☐ Doubtful

Height: 161 cm
Weight: 66 kg
Allergies: NIL
Breast: ☑ Normal ☐ Abnormal
General Examination:
Consciousness: conscious Pallor: (-)
Icterus: (-) Edema: (-)
Temp: (N) PR: 86 bpm
BP: 110/70 mmHg DTR:
CVS: S1S2 (+). RS BAE (+) NVBS
Liver/Spleen: Urine Output:

DIAGNOSIS

32yrs/G2P1L1/Prev NVD/37w6D/LCB 5yrs/Induction of labor.

Patient Sticker

Family History:	Surgical History:
NIL.	NIL
Medical History:	**Medication History:**
NIL.	NIL.

Plan of Care: C/D/W Dr. Mathangi ma'am.

- monitor vitals.
- LTGs/ DFMC
- w/f pain abdomen/bleeding/ leaking P/V.
- prepare parts
- Secure IV line
- For PGE2 gel @ 4AM.

5/7/26. 9:45PM. P/A: uterus @ term
Relaxed
cephalic
FH⊕
clinically liquor↑

P/V: Cervix Soft
Posterior
2 cms long
2 fingers loose
membranes⊕
PPTx -3 Station.

Investigations:
CTG Reactive

Doctor Name: Dr. Akshita
Signature: 12/7/26
Date & Time: 5/7/26

Consultant Name: Dr. Mathangi. R
Signature: 12/7/26
Date & Time: 5.7.26

GUC-00005290
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RESULT SHEET

Date	19/6/26	7/7/26		Blood grouping & typing		
Time						
Hb	12.3	11.0		B +ve.		
PCV		32				
RBC		3.68		HIV		
WBC	9300	11,030		HBSAg	NR.	
N/L		74/		VDRL		
Platelets	2.76.	2.45		HCV		
CRP						
ESR				22/11/25		
PCT				TSH=1.870.		
RBS						
Na						
K				ECG		
Cl				2DECHO		
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L		18/7/26				

(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 : 22/6/26.

SIUL 36w

pla (P)

cephalic

FH (+)

AFI 13.9cms

EFW 3056gms

Radiology : USG : doppler (N)

X-Ray :

ECHO :

CT :

MRI

Others (ECG, Contrast Studies etc.,) :

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(1)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/26.	S/B Dr. [illegible]	
1:15AM	pt reviewed.	
	no sp c/o	
	PEM well	
	o/E afebrile	
	GC fair	
	P°/PE°	
	P/A uterus @ term	
	tightening	
	FH (+).	
CTG Reactive	cephalic	
	FH (+)	
	clinically liquor (N)	Plan
	P/V: Cervix soft	- post gel CTG 5:15AM
	posterior	- w/f progression
	2 cms long	of labor
	2 fingers loose	[signature]
	membranes (+)	
	PPh -3 station	128435
	↓ SAP, PGE2 gel kept intracervically	

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

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
06/07/2026	C/S/B Dr. Mathangi	
9:50 AM	Pt C/o Lower Abdominal Pain	
	P/A - Ut @ Term	Advice
T-(N)	(3C/20"/10/)	- All four's Position
PR - 82/min	Cephalic	- Continuous CTG
BP - 106/71 mm Hg	FHS - good	- Continue INJ. SYNTO acceleration
	P/V - Cx - 0.5cm long	- WIF Contractions / Progn
CTG - Reactive	OS - 3 cm dilated	
	Membranes (+)	
	Vertex @ - 3	
	↓ SAP, ARM done clear liquor drained.	
	82217	
6/7/26 10:30 AM	S/B Dr. Mathangi	
	Pt. received	
Syntocinon @ 2ml/hr CTG Reactive	C/o pushing sensation	
	P/V: Cx 0.5cm long OS 4cm dilated membranes absent Rx - 2 clear liquor Laky Pr	

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(2)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Advice	
	- All foms.	
	- Syntocinon acceleration.	
	- Continuous CTG.	
	- W/F progression.	
	16/7/26	
6/7/26	S/B Dr. Mathangi	
11.30 Am	c/o pushing sensation	
	p/v: Cx fully effaced.	
	OS fully dilated.	
	membranes (-)	
	Vx at +1	
		Advice
		- position for delivery
		- Inform NICU
		16/7/26

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/26 11:35 AM	NORMAL VAGINAL DELIVERY WITH RIGHT MEDIOLATERAL EPISIOTOMY WITH SHOULDER DYSTOCIA.	
	C/B - Dr. Madhangi A/B - Dr. Durgalakshmi / Dr. Shreeden	
Shoulder dystocia (+) Turtle sign (+) Woods corkscrew (+)	↓ ASP, pt ↓ lithotomy, perineum painted and draped. Pt. encouraged to bear down. Local anesthesia infiltration given. At crowning, RMLE given. Shoulder dystocia (+). McRoberts maneuver and suprapubic pressure given to deliver. Turtle neck sign (+) Woods corkscrew maneuver done. An Alive term GIRL baby delivered. Baby cried after birth. Cord clamped and cut and baby handed over to pediatrician. Episiotomy inserted and sutured in layers using rapid vicryl. Hemostasis secured.	
	P/A - Uterus firm & contracted well P/V - NO undue bleeding pr P/R - Rectal mucosa & Sphincter tone (N)	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	B | Alive term GIRL	
	A | 06.07.26 at 11:35 Am	
	B | 3.485 kg	
	Y | 8/10, 9/10.	
	Baby M/S	Advise - Normal diet - Oral fluids - monitor vitals - follow drug chart - W/F T bpv - DBF - CBC c/n 6am - Measure & inform 1st void. - Inform SOS. 16/4/26

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
07/7/2021	C/S/B Dr. Pavithra / Dr. Shreeden	
9:15Am		
PND-1	Pt reviewed, Nil c/o	Advice
	O/E Pt GG fair, Afebrile	- Normal diet
T-(N)	P° / PE°	- Plenty of oral fluids
PR-80/min	CVS /	- vitals Monitoring
BP- 120/60 mmHg	RS / NAD	- follow drug chart
Hb-11.0	P/A- Ut firm & well contracted	- W/F ↑ Bleeding PV
Voiding freely	soft	- Process discharge
Stools passed	L/E- BNNL, Epi wound healthy	
Baby-M/s		
B/L-Breast soft		
	C/S/B Dr Pavithra.	
21/7/21	Pt reviewed	
	Hb 11 g/dl.	

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

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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. Riyalakshmi S.R.

Date & Time : 5/7/26 10pm.

Nurse Name & Signature: S/N. Tamilselvi 01620

Date & Time : 5/7/26 at 10pm

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

GUC-00005290 IP18-00036335
Mrs SARANYA .S
25-01-1994 32 Y 5 M 11 D (F)
Dr. MATHANGI RAJAGOPALAN

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DRUG CHART

Date of Admission: ..... Drug Allergies: ..... ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

DRUG :				Date / Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

DRUG :				Date / Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

DRUG :				Date / Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

Signature .....

VERIFIED BY : Name .....

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REGULAR PRESCRIPTIONS

Weight 56kgs Ward. ADD

DRUG : Tab. AUGMENTIN

Dose	Route	Frequency	Start Date
625mg	PO	TDS	6/7

Name & Signature of the Doctor Starting the Drugs: 164285

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	6/7	7/7
	6AM	8am NS VA
	2pm SM AA	2PM (4 PM)
	10pm NS VA	10PM

DRUG : Tab. ALTON OR

Dose	Route	Frequency	Start Date
1gm	PO	TDS	6/7

Name & Signature of the Doctor Starting the Drugs: 164285

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	6/7	7/7
	6AM	8am NS V.A
	2pm SM AA	2pm (4pm)
	10pm NS V.A	10pm

DRUG : Cap. PAN-D

Dose	Route	Frequency	Start Date
40mg	PO	BD	6/7

Name & Signature of the Doctor Starting the Drugs: 164285

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	6/7	7/7
	7AM	NS AA
	7PM	SM AA

DRUG : JUSTIN SUPPOSITORY

Dose	Route	Frequency	Start Date
100mg	PR	BD	6/7

Name & Signature of the Doctor Starting the Drugs: 164285

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	6/7	7/7
	9AM	BS SM
	9PM	N.S V.A

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Weight. 36/5th Ward. LDR

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
6/7/26	4:15AM	DINOPROSTONE GEL	0.5MG	P/V	[illegible] 12/8/135	TJ / SP
6/7	9:35 AM	Inj. SUPACEF	0.1ml	ID	[illegible] 16428	SD / SD
6/7	10:30 AM	Inj. SUPACEF	1.5gm	IV	[illegible] 16428	SD / SD
6/7	10:30 AM	Inj. PETHIDINE	50mg	IM	[illegible] 16428	SD / SP
6/7	10:30 AM	Inj. PHENERGAN	25mg	IM	[illegible] 16428	SD / SP
6/7	11:30 AM	Inj. SYNTO	10 units	IM	[illegible] 16428	SD / SP
6/7	11:35 AM	Inj. TRAPIC	1gm	IV	[illegible] 16428	SD / SP
6/7	12:40 PM	Inj. CARBOPROST	250mcg	IM	[illegible] 16428	SD / SD
6/7	12PM	T. MISOPROSTOL	600mcg	PR	[illegible] 16428	SD / SP

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

GUC-00005290 IP18-00036335
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I.V. FLUIDS CHART

Weight. ..... 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
6/7	9AM	Inj. SYNTO 5 units in 500ml RL	IV	24 ml/hr	16428	SN / SP	6/7	16428	SN / SP
6/7	9:30AM	IVF 1 O RL	IV	free flow	16428	SN / SP	6/7	16428	SN / SP
6/7	11:30AM	Inj. SYNTO 20 units in 500ml RL	IV	125 ml/hr	16428	SN / SP	6/7	16428	SN / SP

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

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Early Warning Observation Score Chart - Obstetrics

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

5/7/26	Date																									
	Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20															20		12				18			20	
	0 - 10																									
Saturations	94 - 100 %															96%		94%				98%			98%	
	< 94 %																									
Administered O_2 (L/min.)																		RA				RA			RA	
Temp °C	40																									
	39																									
	38																									
	37															CBF		CBF				98°F			98°F	
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70															80		80				84			82bpm	
	60																									
	50																									
	40																									
Systolic Blood Pressure ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
	40																									
NEURO RESPONSE [✓]	Alert															✓		✓				✓			✓	
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30															✓		✓				✓			✓	
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal																									
	Heavy / Foul																									
Liquor	Clear / Pink															—		—				—			—	
	Green																									
TOTAL YELLOW SCORES																										
TOTAL ORANGE SCORES																										
Nurse Initial																										

On Nebulisation

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(9)

Early Warning Observation Score Chart - Obstetrics

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

6/7/20

		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20		20		18		18		18		22				22				22				22			
	0 - 10																									
Saturations	94 - 100 %		99%		99%		99%		100%		99%				99%				100%				100%			
	< 94 %																									
Administered O2 (L/min.)			RA		RA		RA		RA		RA				RA				RA				RA			
Temp°c	40																									
	39																									
	38																									
	37		98°F		98°F		98.6°F		98°F		98.6°F				98.6°F				98.6°F				98.6°F			
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90		80		82		80		84		88				84				84				80			
	80																									
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressure ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130		107		100		110		104		108				108				110				120			
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50										(84)				(52)				(65)				(52)			
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70		68		70		77		72		70				~70				80				~60			
	60																									
	50																									
	40																									
NEURO RESPONSE [✓]	Alert		✓		✓		✓		✓		✓				✓				✓				✓			
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30		✓		✓		✓		✓		✓				✓				✓				✓			
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal		-		-		-		-		-				-				-				-			
	Heavy / Foul																									
Liquor	Clear / Pink		✓		✓		✓		✓		✓				✓				✓				✓			
	Green																									
TOTAL YELLOW SCORES			0		0		0		0		0				0				0				0			
TOTAL ORANGE SCORES			0		0		0		0		0				0				0				0			
	Nurse Initial																									

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FLUID CHART

Sheet No. : 1

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

5/7/26		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											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm	←					on Admission			→		
	11:00 pm	H2O	100							150	0	Tw
	12:00 am										0	Tw
	01:00 am	H2O	100							200	0	Tw
Total Intake :		800ml				Total Output :				350		
	02:00 am	H2O	150								0	Tw
	03:00 am									200	0	Tw
	04:00 am	H2O	100								0	Tw
	05:00 am	H2O	150							250	0	Tw
	06:00 am									150	0	Tw
	07:00 am	H2O	100							100	0	Tw
Total Intake :		500				Total Output :				700		

Total 24 hrs. Intake	700ml	Total 24 hrs. Output	1050ml

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FLUID CHART

Sheet No. : 2

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

6/7/20

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
	08:00 am	HW	100ml								0	
	09:00 am	Juice	100ml	24	100					300	0	
	10:00 am			43	100						0	
	11:00 am	HW	100ml	72	100					200	0	
	12:00 pm			125	100						0	
	01:00 pm	HW	100ml	125	100						0	
Total Intake :		1129ml				Total Output :				500	0	
	02:00 pm										0	
	03:00 pm	H20	200								0	
	04:00 pm										0	
	05:00 pm	H20	200							350ml	0	
	06:00 pm										0	
	07:00 pm	H20	200							270	0	
Total Intake :		600ml				Total Output :				620 ml	0	
	08:00 pm	H20	100								0	
	09:00 pm										0	
	10:00 pm	H20	150							300	0	
	11:00 pm										0	
	12:00 am										0	
	01:00 am	H20	100							150	0	
Total Intake :		350				Total Output :				350 ml	0	
	02:00 am										0	
	03:00 am										0	
	04:00 am	H20	100							250	0	
	05:00 am										0	
	06:00 am										0	
	07:00 am	H20	100							300	0	
Total Intake :		200				Total Output :				550ml		

Total 24 hrs. Intake	2,444ml	Total 24 hrs. Output	2,020ml

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NURSING CARE RECORD

Date: 6/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night	10:30 pm	Achieve acceptable pain and discomfort	11pm	* Assess pain using pain scale * position patient comfortably	Reduced pain to some extend	Reassessment Done	[signature] 6/6-7/26

Docu. No: RCH /FRM / CLINICAL / 148

OUC-00005290 IP18-00036335
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NURSING CARE RECORD

Date: 6/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	7-30 Am	Ensure Safety	8 Am	Assess Patient Condition monitor vitals maintain I/o chart	Patient is Stable	Re-assessment Done	
Afternoon	1.30 Pm	Prevent Infection	2pm	Assess Pt condition monitor vitals maintain hair and nail hygiene	Preventing infection	Re-assessment Done	6/7/26
Night	8pm	prevent infection	9pm	attempt pt condition monitor vitals maintain hair/ nail hygiene	patient is Stable	Re-assessment was done	6/7/26

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NURSES NOTES

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
5/7/26	10.15 pm	ADMISSION NOTES: Patient Admission on 5/7/2026 patient came for Induction of labour. patient general condition fair. vitals are checked & recorded. patient Voided. CTG connected. FHR good fetal movements well. There is no allergic history. patient diagnosis G2P1L1 G1A 37wt6D/ prev NVD/ POL. There is no medical & surgical history. There is no allergic history Dr. Akshitha saw the patient checked PV Cx 2cm long, 2 finger loose advised to watch for spontaneous progression.	S/No paramedical 01b808
11 pm		CTG Informed to Dr. Akshitha Advised to continue CTG. FHR good.	S/No paramedical 01b808
11.50pm		CTG disconnected as per Doctor advice. parts preparation done. ↓SNP, IV line stat In Right metacarpal line.	S/No paramedical 01b863

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
6/7/26	12.30Am	patient general condition fair. vitals are checked & recorded. patient complaints of mild pain. provide comfortable position	S/o parameswaran 01/6808
	2.30Am	patient sleep. patient maintain selfvoiding. patient side no complaints of pain.	S/o parameswaran 016808
	3.30Am	Monitored vitals and Recorded. Maintained I/O. watching Contractions. pain assessment Done. No other complaints	[illegible] 016126
	4.15Am	Dr. Akshitha done PV Examination Cx soft, 2cm long, 2Finger loose Membrane present V-3Station 1/2 SAP PGE2 gel kept intracervically watching contractions	[illegible] 016120
	5.15Am	post gel CTG connected. FHR Monitored. Maintained I/O watching Contractions. pain assessment Done	[illegible] 016120
	6Am	Morning care given to patient. Maintained I/O. watching contractions. pain assessment Done. patient General condition fair	[illegible] 016120

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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NURSES NOTES

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☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
6/7/26	7.30 AM	patient care Handing over given to Morning duty Staff	[illegible] 6/7/2o
	7:30Am	Patient details handling over taken from morning Duty Staff - Patient is Conscious and oriented. Patient is on room air	
	8AM	⇒ Patient Vital signs stable. General condition fair ⇒ S/B Dr. Pavithra mam: Advice to contraction check. Patient having good contraction 10 mts 4 contraction 10-40 15 section. Inf to Dr. Pavithra mam. Advice to 9AM Syntocin started orders carry	[illegible] 011796.
	9AM	⇒ Inj Syntocin 5mu/ln started. Inf RL 125ml/hr on flow, CTG connected reached FHR good, Foetal movement good.	[illegible] 011796
	9Am	⇒ S/B Dr.Mathangi mam. Advice to AMR done Clear liquor. PV examination done - Pu. 0.5cm long. 3cm dilation membrane (+) Vertex (-3) station	[illegible] 011796

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
10cut 6/7/26	10AM	→ Syntocin 24 u/ml on flow, CTG good reaction, FHR good	→ [signature] 01/1740
	10:30AM	→ Inj Syntocin 48 ml/hr changed on flow, In ... pattern	→ [signature] 01/1740
	11AM	→ Patient in ... position. Patient vital stable. Patient having pushing sensation. Inf to Dr ... Patient shift to Labour room	→ [signature] 01/1740
	11:35AM	→ LABOUR NOTES: Patient having lithotomy position. Part's painting 4 draped. Inj lignocaine 2% infiltrated done. RML cut A single alive Normal vaginal delivery delivered. Girl baby. baby immediately cryed. baby hand over to Dr Imbrain Sir. Inj Syntocin 10unit Im given. Inj Syntocin 20unit 10 RL 0 at 12ml/hr on connected. uterus contracted well. Placenta spontaneous expel removed. Inj Diclopic 75mg IV & 100ml NS given	→ [signature] 10/1/26

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 5/7/26 Time of Arrival: 10pm Time Seen by Nurse: 10.10pm

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

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

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

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

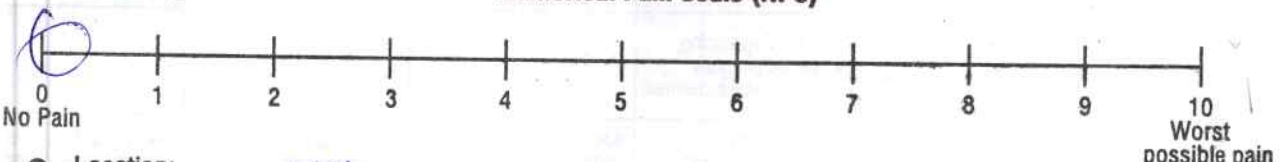
4) **Gestational Criteria:**

Gravida:	G 2	P 1	L 1	A

LMP: 8/10/25 EDD: 15/7/26 Gestational Age: 37+6days

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

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



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

6) **Past History:**

a) Surgeries: NIL

b) Medical: NIL

Patient Sticker

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

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

9) **Prenatal Medical History:**

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

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

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

Time seen by Doctor: 10.15pm

Nurse Name : S/N Tamilselvi 016720 Nurse Signature: [signature] 016720

Date: 5/7/26 Time: 10.10pm

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LABOUR AND DELIVERY NURSING ASSESSMENT

Date of Admission: 5/7/26

Baseline Information:

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

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

Do you require an interpreter? ☐ Yes ☑ No

Source of Information: ☑ Patient ☐ Family ☐ Others

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

handed over to Husband

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

If yes , identify

Chief Complaints: Patient admitted for DOL

Doctor Notified on Admission: ☑ Yes ☐ No

Name of the Doctor: Dr. Aishitha

Time Notified: 10.15PM

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

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

Blood Group: B+ve LMP: 3/10/25 EDD: 15/7/26 Gestational age during admission: 37+6 days

Contractions: NIL Vaginal Discharge: NIL

Obstetric History: G 2 P 1 L 1 A — Previous LSCS NIL

Height: Weight: BMI:

Temp: HR: RR: BP: SpO_2

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

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

Patient Sticker

Family History: ☐ No Abnormalities Detected

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

☐ Liver disease ☐ Other .....

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

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

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

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

☐ Mobility problem ☐ Walking Problem ☐ No Abnormality Detected

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

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

☐ Under Weight ☐ Diabetes Mellitus ☐ No Abnormality Detected

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

☐ Others .....

Inform consultant for positive criteria

SOCIAL SCREENING:

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

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

Social History: Lives With ..... Family .....

Orientation has been given regarding the following aspects:

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

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

Above information given to ..... Pertinent .....

Name of Person Orientation was given to: ..... Mrs. Saranya .....

Orientation not given Reason: .....

Nurse Signature: ..... S/N Tamil 01620 .....

Nurse Name: ..... S/N Tamilselvi 01620 .....

Date & Time: ..... 6/7/26 at 10.10pm .....

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RISK ASSESSMENT TOOL FOR DEEP VEIN THROMBOSIS

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

Date: 5/7/16

Pre - Existing Risk Factors	Tick	Score
Previous VTE (except a single event related to major surgery)		4
Previous VTE provoked by major surgery		3
Known high-risk thrombophilia		3
Medical comorbidities e.g. cancer, heart failure; active systemic lupus erythematosus, inflammatory polyarthropathy or inflammatory bowel disease; nephrotic syndrome; type I diabetes mellitus with nephropathy; sickle cell disease; current intravenous drug user		3
Family history of unprovoked or estrogen-related VTE in first-degree relative		1
Known low-risk thrombophilia (no VTE)		1
Age (≥35 years)		1
Obesity	✓	1 or 2
Parity ≥ 3		1
Smoker		1
Gross varicose veins		1
Obstetric Risk Factors		
Pre-eclampsia in current pregnancy		1
ART/IVF (antenatal only)		1
Multiple pregnancy		1
Caesarean section in labour		2
Elective caesarean section		1
Mid-cavity or rotational operative delivery		1
Prolonged labour (24 hours)		1
PPH (1 litre or transfusion)		1
Preterm birth 37^{+0} weeks in current pregnancy		1
Stillbirth in current pregnancy		1
Transient Risk Factors		
Any surgical procedure in pregnancy or puerperium except immediate repair of the perineum, e.g. appendectomy, postpartum sterilization		3
Hyperemesis		3
OHSS (first trimester only)		4
Current systemic infection		1
Immobility, dehydration		1
Total		0
Signature of the Nurse	SN Tamilselvi	
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	N 5/7/26	MAE 6/7/26	F 6/7
		Score	0	0	0
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0	0	0	0
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0	0	0	0
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0	0	0	0
IV / Heparin Lock or Saline	Yes	20			
	No	0	0	0	0
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0	0	0	0
Mental Status	Forgets limitations	15			
	Oriented to own ability	0	0	0	0
Total Morse Fall Scale Score:			0	0	0
		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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Morse Fall Risk Assessment Form

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Choose Highest Applicable Score from each Category		Date / Time	N 6/7	M 7/7	
		Score	0	0	
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			
	No	0	0	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:			0	0	
		Signature	6/7/22	7/7/22	

Fall Risk Grading		
Risk Level	**Morse Fall Score (MFS)**	**Action**
Low Risk	0 - 24	Standard Fall Precaution
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PAIN ASSESSMENT FORM

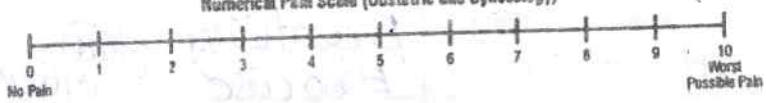
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
5/7/26	10pm	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NIL	0/6PM
6/7/26	2AM	01/10	Mild Abdomen	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Comfortable position	0/6PM
6/7/26	6AM	1/10	Lower abdomen	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Breathing Exercise	0/6PM
6/7/26	12PM	1/10	Abdom pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Comfortable position	
6/7/26	4PM	1/10	Abdomen pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Comfortable position	
6/7/26	8pm	1/10	Abdomen pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Comfortable position	
7/7/26	12AM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Comfortable position	
7/7/26	4AM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Comfortable position	
7/7/26	10AM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	8/2/26
				☐ 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.

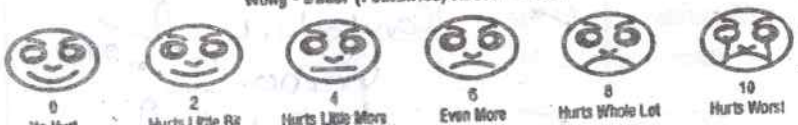
(P.T.O)

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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PAIN ASSESSMENT FORM

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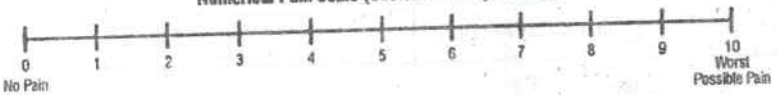

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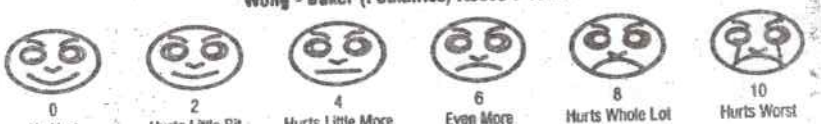

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Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs brawn up
Activity	Laying quietly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

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

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

GUC-00005290 IP18-00036335
Mrs SARANYA .S
25-01-1994 32 Y 5 M 11 D (F)
Dr. MATHANGI RAJAGOPALAN

BRADEN 'Q' SCALE

Rainbow® Children's Hospital — It takes a lot to treat the little
BirthRight BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

					Date : 5/7/26	5/7/26	6/7	6/7
					Time : N	N	E	N
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	3	3	3	3
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR **Friction** . Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
				TOTAL SCORE	27	27	27	27
				Evaluator's Name				

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

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

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

GUC-00005290 IP18-00036335
Mrs SARANYA .S
25-01-1994 32 Y 6 M 11 D (F)
Dr. MATHANGI RAJAGOPALAN

BRADEN 'Q' SCALE

(2)

Rainbow® Children's Hospital — It takes a lot to treat the little
BirthRight BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

				Date : 27/7			
				Time :			
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4		
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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.	3		
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Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4		
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				TOTAL SCORE	27		
				Evaluator's Name			

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

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

Risk Score	Category	Action	Support Surfaces (**Please Note:** Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
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Less than 9	Severe Risk	⓾ Use same protocol as for **"High Risk"** Patients ⓾ 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

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient's Name:..
MRD No: GUC-00005290 IP18-00036335 No.:....................
Mrs SARANYA .S
Age :.. 25-01-1994 32 Y 5 M 11 D (F) ..Sex: ☐ M ☐ F
Consu Dr. MATHANGI RAJAGOPALAN
....

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 5/7/26 Time: 11pm
Location : Right Metacarpal
Size : 18G
Cannula inserted by : S/N. Parameshwari

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
6/7/26	10AM	☐Yes ☑No	☐Yes ☑No	observ	[illegible]
	4AM	☐Yes ☑No	☐Yes ☑No	observ	[illegible]
	7:30AM	☐Yes ☑No	☐Yes ☑No	observ	[illegible]
	8AM	☐Yes ☑No	☐Yes ☑No	obsm	[illegible]
	10AM	☐Yes ☑No	☐Yes ☑No	obsm	[illegible]
	12pm	☐Yes ☑No	☐Yes ☑No	obsm	[illegible]
	2PM	☐Yes ☑No	☐Yes ☑No	observe	[illegible]
	4PM	☐Yes ☑No	☐Yes ☑No	observe	[illegible]
	6PM	☐Yes ☑No	☐Yes ☑No	observe	[illegible]
	8pm	☐Yes ☑No	☐Yes ☑No	observe	[illegible]
	10 pm	☐Yes ☑No	☐Yes ☑No	observe	[illegible]
7/7/26	12 am	☐Yes ☑No	☐Yes ☑No	observe	[illegible]
	2am	☐Yes ☑No	☐Yes ☑No	observe	[illegible]
	4am	☐Yes ☑No	☐Yes ☑No	observe	[illegible]
	6am	☐Yes ☑No	☐Yes ☑No	observe	[illegible]
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

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

CANNULA 2

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

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

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

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

PHLEBITIS ASSESSMENT AND MANAGEMENT RECORD

CANNULA 3

Date : Time:

Location :

Size :

Cannula inserted by :

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

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

CANNULA 4

Date : Time:

Location :

Size :

Cannula inserted by :

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

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

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

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

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

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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 G2P1L1 37+6 days 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		
5/7/26	10.30 pm	Informed consent	Educated to Patient about Understanding vaginal birth consent	Patient	NO	oral	None	verbal	Good	
6/7/26	8AM	Informed consent	Educated to patient about benefits of oral fluids	patient	NO	Oral	None	verbal	Good	
7/7/26	8AM	Informed consent	Educated to patient about benefits of Oral fluids	patient	NO	Oral	None	Verbal	Good	

Part - III: CODES

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

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

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

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

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

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BREAST FEEDING HANDOVER AND ASSESSMENT FORM

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

2. If No, Reason .....

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

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

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

Feeding Positions:
Cross Cradle

Feeding Positions:
Football / Clutch

6. Was the position explained:
   - [x] a. Yes
   - [ ] b. No

7. For Caesarian mothers:
   - [ ] a. Mother is required sit and feed from the 4th feed
   - b. Please explain football hold

   2(A)

8. NICU admission:
   - [ ] a. Mother needs to stimulate her breast for 2 min every 2 hours

   (UA)

9. Additional notes: ....

Continuity of Care: Date: ....

I: OR

A: 02

T: 02

C: 02

H: 01

4

Handover given by [illegible] 01 17 [illegible]

Signature [illegible] 01 17 [illegible]

Date & Time: 6/7/26.

Handover taken by ....

Signature ....

Date & Time: ....

PATIENT TRANSFER FORM

Rainbow® Children's Hospital — It takes a lot to treat the little.
BirthRight — BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

GUC-00005290 IP18-00036335
Mrs SARANYA .S (F)
25-01-1994 32 Y 5 M 11 D
Dr. MATHANGI RAJAGOPALAN

	Date & Time of Admission	Date & Time of Transfer Order
	5/7/26 at 10:35pm	6/7/26 at 1PM
Treating Consultant Name	Transfer Ordered by	Reason for Transfer
Dr. mathangi	Dr. Dinesh	Further treatment
From Unit	To Unit	Information to Attendant
LDR	7th floor	Yes ☐ No ☐
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?
Ip file	CTG (5)	

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	Tab. Augmentin 625mg	(10)
2.	Tab. Pan 40mg	(10)
3.	Tab. Pcm 1gm	(10)
4.		
5.		

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

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

Patient & Clinical Records Received by :

Date & Time of Patient Received :

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

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

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

Mrs. Saranya

PARTOGRAPH

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LABOUR

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

Indications for IOL-Accel: ☐ None ☑ Oxytocin

Memb. Repture Type: ☐ SROM ☐ PROM ☑ ARM

Presentation: ☑ Vertex ☐ Breech ☐ Others

INTRA PARTUM COMPLICATION

Maternal: ☑ None ☐ Pyrexia ☐ HTN ☐ Others

Liquor: ☐ Adequate ☐ Oligo ☐ Poly ☑ Clear

☐ Blood ☐ Meconium ☐ Cord: .....

Shoulder Dystocia: ☑ Yes ☐ No

DELIVERY DETAILS

Anesthesia: ☑ None ☐ Epidural

Non-epi: ☐ Local ☐ Spinal ☐ General

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

AVD: ☐ Outlet ☐ Low Forceps ☐ Ventouse ☐ Trails of Forceps

Indications: -

Application, Locking & Traction: -

Duration of Instrumentation: -

No. of Pulls: -

Catherised : ☐ Yes ☐ No

Type: ☐ Fileys ☐ Plain

Perineum : ☐ Intact ☑ Episiotomy ☐ Tear

Suture Material Used: Rapid vicryl 2-0 vicryl

STAGE III

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

PPH : ☐ Atomic ☐ Traumatic ☑ None

Lacerations: .....

Cervical: .....

Perineal: 2° tear

Others: .....

Prophylaxis: Synocinon Prostodin

Blood Loss: ~350ml

Blood Transfusion: -

Other Details (if any): -

Ractal Examination: N

DURATION OF LABOUR

1st Stage: 8 hours

2nd Stage: 10 mins

3rd Stage: 5 min

Duration of Active Pushing: .....

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

BABY DETAILS

Gender: GIRL

Weight: 3.485 kg

APGAR: 8/10, 9/10

Date and Time of Delivery: 6/7/20 @ 11:35 pm

LW Doctor: Dr. Dhanalakshmi

LW Sister: S/N Nivetha

PARTOGRAPH

Name: Mrs. Saranya

Obstetrics Formula: G2P1L1

Blood Group Type:

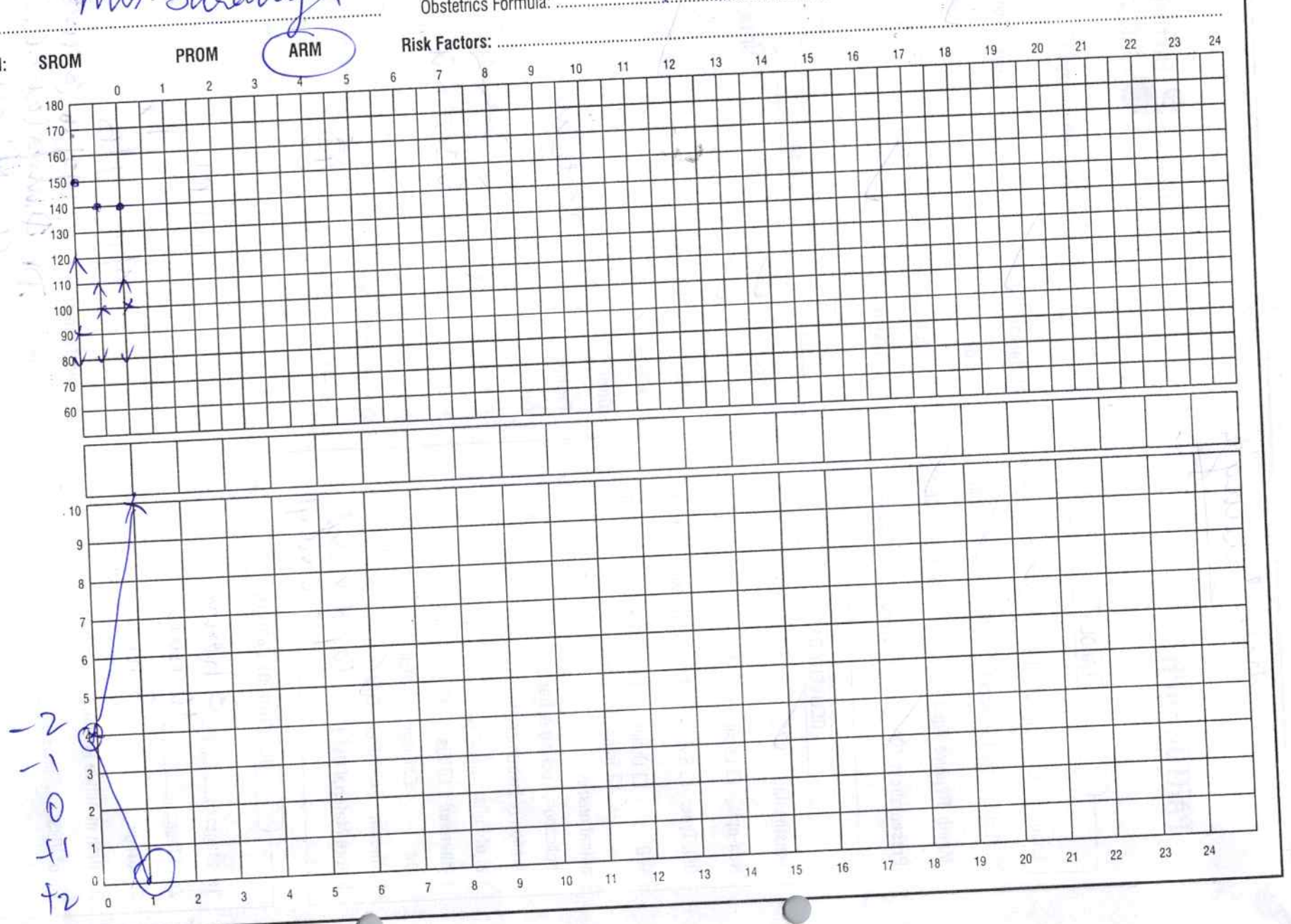
Risk Factors:

Memb. Ruptured: SROM PROM ARM

Fetal Heart ●

Maternal BP ↕

Maternal Pulse ×



Time	10:30 Am	11:30 Am																							
Signature	[illegible] 1642 S[illegible]																								
Fifths Palpable	2/5																								
Moulding / Caput	(+)																								
Amniotic Fluid	Clear																								
Position Cephalic / Breeth	C																								
Oxytocin	72 ml/h																								
	5U																								
Contractions in 10 mins 5 4 3 2 1																									
Drugs and IV Fluids	IVF RL 1Ø																								
Urinalysis Test																									
Urinalysis Amount																									

Record of Labor:

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

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

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

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

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

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

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

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

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

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

GUC-00005290 IP18-00036335
Mrs SARANYA .S
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INDUCTION OF LABOR CONSENT

GUC-00005290 IP18-00036335
Mrs SARANYA .S
25-01-1994 32 Y 5 M 11 D (F)
Dr. MATHANGI RAJAGOPALAN

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

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

You are scheduled for an induction of labor on 5/2/26 (date) at 37w6D (weeks of gestation).

The reason for your induction is Term gestation.

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

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

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

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

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

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

Patient
Signature: S. Saranya
Name: Mrs. Saranya S
Date & Time: 6/2/26

Patient Attendant:
Signature: P-PA
Name: Mr. Praveen Kumar
Relationship with Patient: Husband
Date & Time: 6/2/26

Doctor:
Signature:
128935
Name: Dr. Hrshita
Date & Time: 5/2/26

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

INFORMED CONSENT FOR VAGINAL BIRTH

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Your Right to a Safe Delivery

GUC-00005290 IP18-00036335
Mrs SARANYA .S
25-01-1994 32 Y 5 M 11 D (F)
Dr. MATHANGI RAJAGOPALAN

Patient Na ..... UHID No : .....

Gender: [Date : ..... Time : .....

I hereby authorized the performance of the following procedure:

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

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

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

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

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

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

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

Name of the Doctor performing the procedure: Dr. Mathangi. R

Consentee :

Signature : D. Saranya

Name : Mrs. Saranya S

Date & Time : 6/7/26

Witness :

Signature : .....

Name : .....

Date & Time : .....

Patient Attendant :

Signature : PP

Name : Mr. Praveen Kumar

Relationship with Patient: Husband

Date & Time : 6/7/26

Doctor (who is taking the consent) :

Signature : 12/7/26

Name : Dr. Mathangi

Date & Time : 5.7.26