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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PATIENT DISCHARGE INTIMATION FROM NURSING STATION

CLEARANCE FOR DRUGS AND DISPOSABLES BILLING

GUC-00093901 IP16-00036514
Ms R INBASHREE
17-05-2007 19 Y 2 M 2 D (F)
Dr. MATHANGI RAJAGOPALAN

Name of the Patient: .....

UHID No: .....

Ward: .....

Date: .....

.....

Gender: .....

Room No: .....

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

Date: .....

Time: .....

Nurse Sign

Date: 19/7/26

Time: 8.30 am

Pharmacy Sign

Date: 19/7/26

Time: .....

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

GUC-00093901 IP18-00036514
Ms R INBASHREE
17-05-2007 19 Y 2 M 2 D (F)
Dr. MATHANGI RAJAGOPALAN

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	INTIMATE	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing		19/1/26 @ 8.30am	ABM 01/5/26				
Activity Sheet update by Pharmacy							

GUC-00093901 IP18-00036514
Ms R INBASHREE
17-05-2007 19 Y 2 M 1 D (F)
Dr. MATHANGI RAJAGOPALAN

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ACTIVITY RECORD FOR BILLING

Name: ms. Inbashree

UHID No: 93901 IP No: 36514 Consultant: Dr. Mathangi Dept: UDR

Date of Admission: 18/7/26 Time: Date of Discharge: Time:

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
18/7/26	9.45pm	UDR	HIP.	

CROSS CONSULTATION VISIT

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
~~18/7/26~~			

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
18/7/16	Infusion pump	11:20Am	8.40pm	21729321	S/N AROYE 018050

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
18/7/26	IV placement	1	1729319	
18/7/26	Packed red cell (Issue)	1	26023095	
18/7/26	Blood transfusion	1	1729319	
18/7/26	PRBC (Issue)	(1)	26023132	

ANY OTHER INFORMATION:

.....

.....

.....

.....

.....

.....

Date: 19/7/26 Time: 8.30 Prepared By: .....

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
0890			

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GUC-00093901 IP18-00036514
Ms R INBASHREE
17-05-2007 19 Y 2 M 2 D (F)
Dr. MATHANGI RAJAGOPALAN

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement					
	INTIME	OUT TIME			
Arrangement of File by Nursing	9/7/26 at 11.45 AM		DS-Ops 5/7/26		
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

ANNAI TERESA BLOOD BANK & APHERESIS CENTRE

(Run by Little Roses Trust)

LICENCE No.: 506/28C

No.946, 1st Floor, Bazzar Road, Ram Nagar (South) Madipakkam, Chennai - 91. Ph.: 044-22580803, 48616108
Mobile : 9840143108, 9840333108 E.mail : annaiteresabloodbank@gmail.com web : www.annaiteresabloodbank.com

COMPATIBILITY REPORT

Patient's Name: Mrs. R. Inbasree Age: 19 yrs Sex: F

Patient's Blood Group & Rh Typing: B positive IP No: - Ward: -

Hospital Name: Rainbow children's Hospital (Guc)

Bag Blood Group & Rh Typing: B positive DATE: 15.07.26 TIME: 9:50 pm

S.No.	BAG NUMBER	COMPONENTS	DATE OF COLLECTION	DATE OF EXPIRY	SEG.No.
1.	2865	PRBC	03.07.26	14.08.26	ET925A26
2.	8903	PRBC	06.07.26	17.08.26	6B2 02559

Major X Matching : Saline / Alb / AHG / Column (Gel)

Minor X Matching : Saline / Alb / AHG / Column (Gel)

COMPATIBLE

Cross Matched by: Jayaraj Checked by:

Dr. C.FLORENCE, MBBS
(Reg. No. 127546)
Medical Officer

ANNAI TERESA BLOOD BANK & APHERESIS CENTRE

(Run by Little Roses Trust)

LICENCE No.: 506/28C

No.946, 1st Floor, Bazzar Road, Ram Nagar (South) Madipakkam, Chennai - 91. Ph.: 044-22580803, 48616108
Mobile : 9840143108, 9840333108 E.mail : annaiteresabloodbank@gmail.com web : www.annaiteresabloodbank.com

COMPATIBILITY REPORT

Patient's Name: Mrs. R Intasree Age : 19 yrs Sex : F

Patient's Blood Group & Rh Typing : B positive IP No : — Ward : —

Hospital Name : Rainbow Childrens Hospital (Guest)

Bag Blood Group & Rh Typing : B positive DATE : 15.07.26 TIME : 9:50 PM

S.No.	BAG NUMBER	COMPONENTS	DATE OF COLLECTION	DATE OF EXPIRY	SEG.No.
1.	2865	PRBC	03.07.26	14.08.26	ET925A26
2.	2903	PRBC	06.07.26	17.08.26	6B2 02559

Major X Matching : Saline / Alb / AHG / Column (Gel)

Minor X Matching : Saline / Alb / AHG / Column (Gel)

COMPATIBLE

Cross Matched by : Lavanya Checked by :

Dr. C.FLORENCE, MBBS
(Reg. No. 127546)
Medical Officer

Rainbow Children's Hospital

Birthright 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 : IP18-00036514 **Admit Date** : 18-Jul-2026 **Admit Time** : 08:45 AM **UHID** : GUC-00093901

Patient Details :

Patient Name	: Ms R INBASHREE	**Age**	: 19 Y 2 M 1 D
Guardian	: Mr N RAJ KUMAR	**DOB**	: 17-05-2007
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 19/18, ELANGO STREET, TVK NAGAR Hasthinapuram Kanchipuram Tamil Nadu INDIA 600064	**Phone No**	: 9499951925/ 9841050806
		E-mail	: NO@GMAIL.COM

Admission Details :

Bed Type : MICU **Bed No** : MICU 805 **Ward Name** : 8F-OT COMPLEX

Room No : MICU 805 **Admission Type** : First Visit

Contact Details :

Name : Mr N RAJ KUMAR **Relationship** : Father

Contact Address : 19/18, ELANGO STREET, TVK NAGAR Hasthinapuram Kanchipuram Tamil Nadu INDIA 600064 **Phone No** : 9499951925

Signature

Doctor Details :

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

Referral Doctor : Friends **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

Rainbow Children's Hospital

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

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Ms R INBASHREE**	**Age :**	**19 Y 2 M 1 D**
IP No:	**IP18-00036514**	**Sex:**	**Female**
Consultant:	**Dr. MATHANGI RAJAGOPALAN**	**Ward/Bed No:**	**8F-OT COMPLEX/MICU 805**

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:..... N.Rajkumar

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

Signature of Patient/Relative: N.Rajkumar

Name: RAJ KUMAR
Relationship: FATHER
Date: 18-7-26 Time: 8:45am
Witness Name: Pavithra.P
Witness Signature:

Patient Address:
19/18, ELANGO STREET, TVK NAGAR
Hasthinapuram Kanchipuram Tamil
Nadu INDIA 600064

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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 : Ms. INDHASHREE	UHID Number : Roc-0009 3901
Self Attendant Name : N. Rajkumar	Relation : Father
Self/ Attendant Signature : N. Rajkumar Phone Number :	Name & Signature of Financial Counselor

भारत सरकार

आधार

இந்திய அரசாங்கம்
Government of India

இந்திய தனிப்பட்ட அடையாள ஆணைய அமைப்பு
Unique Identification Authority of India

பதிவேட்டு எண்/ Enrolment No.: 2986/61339/34136

To
இன்பாஸ்ரீ ரா
Inbashree R
D/O Rajkumar,
57 95,
MAVADUKURICHI ROAD,
PERAVURANI,
VTC: Peravurani,
PO: Peravurni,
District: Thanjavur,
State: Tamil Nadu,
PIN Code: 614804,
Mobile: 9444023177

உங்கள் ஆதார் எண் / Your Aadhaar No. :
2156 5380 6255
VID : 9122 9990 2636 7500

எனது ஆதார், எனது அடையாளம்

இந்திய அரசாங்கம்
Government of India

Aadhaar no. issued: 26/12/2012

இன்பாஸ்ரீ ரா
Inbashree R
பிறந்த நாள்/DOB: 17/05/2007
பெண்/ FEMALE

ஆதார் எனது அடையாளத்திற்கான சான்றாகும் குடியுரிமை அல்லது பிறந்த தேதிக்கான சான்றல்ல. இது சரிபார்த்தல் மட்டுமே பயன்படுத்தல் வேண்டும். ஆன்லைன் அங்கீகரிப்பு அல்லது ஒ குறியீட்டை ஸ்கேன் செய்தல் ஆ பயன்படுத்தவும்.
Aadhaar is proof of identity, not of citizenship or date of birth. It should be used with verification (online authentication, or scanning of QR code / offline XML)

2156 5380 6255

எனது ஆதார், எனது அடையாளம்

Ref. No. : F/GYNIC/18

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

I.P. ADMISSION SHEET FOR GYNECOLOGY

GUC-00093901 IP18-00036514
Ms R INBASHREE
17-05-2007 19 Y 2 M 1 D (F)
Dr. MATHANGI RAJAGOPALAN

Date of Admission : _____

Time of Admission : _____

PERSONAL DETAILS

Name : Miss. R. INBASHREE Age 19 Years Date of Birth _____

UHID No.: GUC-0009390 | IP No.: 18-000

Department : OG Consultant : _____

PRESENTING COMPLAINTS

19 years old | Menorrhagia | LMP- 20/06/2026 | Admitted for Blood transfusion.

- C/o heavy menstrual bleeding (Heavy for 5 days
- Irregular cycles / 30-90
- No H/o bleeding PR
- Hb - 5.5 / Plt - 5.29
- MCV - Low
- Attained menarche @ 11 year (2018)
- Exertion dyspnea (+)

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : Not married	Parity : -
Previous Periods : Irregular	Mode of Delivery -
LMP : 20/06/2026	Last Child Birth : -
Contraception : ___	

MEDICAL HISTORY	SURGICAL HISTORY
Febrile Seizures	Nil
FAMILY HISTORY	**NOTES / ALLERGIES**
Father - HT / DM	Nil

INITIAL ASSESSMENT :

Date 18/07/2026

Ht. 148 cm Wt. 61.5 kg

BMI 28.08 kg/m²

B.P 90/60

Pallor ⊕ ⊕

CVS S1 S2 ⊕

Respiratory System B/L NVBS ⊕

Thyroid

PR - 100/min

SpO_2 - 100 % ↓ RA

Breasts

B/L Normal

Abdominal Examination

P/A - Soft

Local / Speculum Examination

Not done

Bimanual Pelvic Examination

Not done

PROVISIONAL DIAGNOSIS : 19yrs / Menorrhagia / For Blood transfusion / PCOS

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT	PRESCRIPTION
	- Blood transfusion - 2 ⊙ PRBC	

Name of the Doctor : Dr. Mathangi

Date : 18/07/2026 Time : 9:30 AM

182217

Signature of Doctor

GUC-00093901 IP18-00036514
Ms R INBASHREE
17-05-2007 19 Y 2 M 1 D (F)
Dr. MATHANGI RAJAGOPALAN

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RESULT SHEET

Date	17/7/26	14/7/26				
Time						
Hb	5.1	5.5			B - POSITIVE	
PCV	18.1					
RBC	2.45					
WBC						
N/L						
Platelets		5.27				
CRP						
ESR						
PCT						
RBS						
Na						
K					Hb Electrophoresis - Normal	
Cl						
Ca/Mg						
Phosphate					TSH - 2.91	
Urea					TT4 - 7.50	
Creatinine					TT3 - 101.63	
ALP						
SGPT						
SGOT					BT - 2 min 40 sec	
T.Bill/Conj					CT - 5min 50 sec	
T.Protein						
S.Albumin						
S.Globulin					Vit D - 28	
A/G Ratio						
Uric Acid					Folic Acid > 20	
S.Amylase						
Sr.Lipase					LDH - 278	
Blood Lactate						
S.Cholesterol					Iron - 102	
PT/INR	12.2/1.0				TIBC - 567	
APTT	24.8				Ferritin - 73.70	
CSF Protein / Sugar					Transferrin 454	
Cells					Transferrin % - 17.98	
N/L					UIBC - 465	

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

(P.T.O)

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : .....

.....

.....

.....

15/07/2021

Radiology : USG : Uterus 7.0 X 3.6 X 4.4 cm PCOS

X-Ray : ET- 10.8 mm

ECHO : Endometrical cavity - Normal

CT : (R) Ovary - 3.2 X 3.3 X 2.2 cm (volume - 12.08 cc)

MRI : (L) Ovary - 4.0 X 1.9 X 3.0 cm (volume - 11.86 cc)

Others (ECG, Contrast Studies etc.,) : Both the ovaries shows multiple small follicles which are peripherally arranged, suggestive of PCOS

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/07/2026 10:30 Am	Bag No : 2865	
Pre-Transfusion vitals	B-Positive	Post-Transfusion vitals
T-(N)	10 PRBC	T-(N)
PR-104/min	Started @ 10:20 Am	PR-100 bpm
BP-100/52 mmHg	Ended @ 2:15 pm	BP-104/60 mmHg
	NO adverse reactions	
	Date of collection : 03.07.2026	
	Date of Expiry : 14.08.2026	
18/7/26 2:30 pm	S/B Dr. Divyalakshmi	
	pt. reviewed, comfortable.	
	10 PRBC transfused.	
	NO adverse reactions	
T-(N)	C/D/W Dr. Mathangi	
PR-100/min	Advice:	
BP-104/62 mm	- To transfuse 2nd unit PRBC	
SpO2-100% @ RA	- monitor vitals.	
Validity free	- Inform SOS.	

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

16/7/26

GUC-00093901 IP18-000365
Ms RINBASHREE
17-05-2007 19 Y 2 M 1 D
Dr. MATHANGI RAJAGOPALAN

Rainbow® Children's Hospital
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/07/2026	Bag NO : 2903	
Pre-Transfusion T-(N) PR- 100 bpm BP- 100/60 mmHg	B-Positive 1@ PRBC Starting time 4:15pm Ending time 8:40pm No transfusion Reaction.	Post Transfusion Vitals T-(N) PR- 86/min. BP- 100/60
	Date of collection : 06.07.2026 Date of Expiry : 17.08.2026	
18/07/2026 8:45pm	C/S/B Dr. Panimalar Pt reviewed	
T-(N) BP- 100/60 PR- 86/min	O/E Pt c/c fair afebrile Pallor (+) No PE CVS / RS / NAD P/A - Soft.	Advice - Vitals monitoring - Follow drug chart.
	Shift to Ward	

GUC-00093901 IP18-0003651
Ms R INBASHREE
17-05-2007 19 Y 2 M 1 D
Dr. MATHANGI RAJAGOPALAN

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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

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Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Doc

GUC-00093901 IP18-00036514
Ms R INBASHREE
17-05-2007 19 Y 2 M 1 D (F)
Dr. MATHANGI RAJAGOPALAN

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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

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

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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

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-00093901 IP18-00036514
Ms R INBASHREE
17-05-2007 19 Y 2 M 1 D (F)
Dr. MATHANGI RAJAGOPALAN

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MEDICATION RECONCILIATION FORM

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

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

Shifting From: ..... 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 : .....

Date & Time : 18/7/26 @ 8am

Nurse Name & Signature: S/N Paramasivam

Date & Time : 18/7/26 @ 8. am

GUC-00093901 IP18-00036514
Ms R INBASHREE
17-05-2007 19 Y 2 M 1 D (F)
Dr. MATHANGI RAJAGOPALAN

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DRUG CHART

Date of Admission: 18/7/26 Drug Allergies: .... ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

DOCTOR
- Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line / 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 ....

GUC-00093901 IP18-00036514
Ms R INBASHREE
17-05-2007 19 Y 2 M 1 D (F)
Dr. MATHANGI RAJAGOPALAN

REGULAR PRESCRIPTIONS

Weight 61.5kg Ward FDR

DRUG : T. TRAPIC

Dose	Route	Frequency	Start Date
1g	P/O	1-0-1	19/7

Name & Signature of the Doctor Starting the Drugs:
12113

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ / Time ▾	19/7
8am	
8pm	

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time ▾

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time ▾

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time ▾

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Weight. 61.5 kg Ward. ICU

	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

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

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17-05-2007 19 Y 2 M 1 D (F)
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I.V. FLUIDS CHART

Weight. 61.5kg Ward. ADR

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
18/x	10.20AM 2.15pm	1 ⊖ PRBC	IV	50ml/hr		SP J.T	18/4/26		SP J.T
18/x	4.15pm to 8.40pm	1 ⊖ PRBC	IV	50ml/hr.		M.D J.T	18/4/26		SP 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

18/7/26	Date																							
	Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																								
	21 - 30																								
	11 - 20	20				20				20	22	22	22	18				18				18			
	0 - 10																								
Saturations	94 - 100 %	99				100				99	99	99	99	100				99				98%			
	< 94 %																								
Administered O_2 (L/min.)		RA				RA				RA	RA		RA	RA				RA				RA			
Temp°c	40																								
	39																								
	38	98F				98F				98F								98.6F				97.6F			
	37										98.6			98.6F											
	36																								
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110	100				100				88								96bt				96bt			
	100										90	90	90												
	90																								
	80																								
	70																								
	60																								
	50																								
	40																								
Systolic Blood Pressue ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100	90				100				102	110	100	100	100				105				109			
	90																								
	80																								
	70																								
	60																								
	50																								
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
	50	60				62				62	70	60	70	60				66				60			
	40																								
NEURO RESPONSE [✓]	Alert	✓				✓				✓				✓				✓				✓			
	Voice																								
	Pain																								
	Unresponsive																								
URINE mls / hour	> 30	✓				✓				✓				✓				✓				✓			
	< 30																								
Proteinuria	Protein + +																								
	Protein > + +																								
Lochia	Normal	–				–				–	–	–	–	–				–				–			
	Heavy / Foul																								
Liquor	Clear / Pink	–				–				–	–	–	–	–				–				–			
	Green																								
TOTAL YELLOW SCORES		0				0				0	0	0	0	0				0				0			
TOTAL ORANGE SCORES		0				0				0	0	0	0	0				0				0			
Nurse Initial		R				R				W	M	M	L	St				M				R			

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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.

18/7/26

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	H20	100ml									
	09:00 am	H20	150ml							150ml	0	
	10:00 am	H20	100ml		Blood 250ml					100ml	0	
	11:00 am	Juice	150ml							150ml	0	
	12:00 pm	H20	100ml								0	
	01:00 pm									350ml	0	
											0	
Total Intake : 850ml										Total Output : 750ml		
	02:00 pm	Juice	150							250	0	Tulu
	03:00 pm	H20	100							200	0	Tulu
	04:00 pm	Juice	150								0	Tulu
	05:00 pm										0	Tulu
	06:00 pm	H20	150								0	Tulu
	07:00 pm	H20	100							350	0	Tulu
Total Intake : 650ml										Total Output : 800ml	0	Tulu
	08:00 pm	H2o	200ml							300ml	0	Tulu
	09:00 pm									✓	0	Mgl
	10:00 pm	Milk	100ml								0	Mgl
	11:00 pm										0	Mgl
	12:00 am										0	Mgl
	01:00 am	Light	100ml								0	Mgl
Total Intake : 400ml										Total Output : 300ml + 1 time wet.	0	Mgl
	02:00 am										0	Mgl
	03:00 am										0	Mgl
	04:00 am	Light	200ml							✓	0	Mgl
	05:00 am										0	Mgl
	06:00 am										0	Mgl
	07:00 am	Milk	100ml								0	Mgl
Total Intake : 400ml										✓	0	Mgl
										Total Output : 2 times wet.		

Total 24 hrs. Intake	2300ml	Total 24 hrs. Output	1850ml + 8 times wet.

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Ms R INBASHREE
17-05-2007 19 Y 2 M 1 D (F)
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(1)

NURSES NOTES

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
18/7/26	8am	ADMISSION NOTES: Patient admission on 18/7/26. patient came for Blood transfusion. patient conscious & oriented. vitals are checked & recorded. patient diagnosis menorrhagia for blood transfusion. Hb - 5.5 mg/dl. patient medical history of febrile seizure. There is no surgical history There is no allergic history Dr. Vinitha saw the patient advised to do blood transfusion Dr. priyadharshini (Anesthetist) saw the patient to start blood transfusion.	S/N paramedical 01b808
	9am	↓ SOP, IV line start in Right cephalic vein. IV line patten Blood consent, Explain patient & patient attender blood consent uptained.	S/N paramedical 01b808
	9.30AM	Blood received. Dr. Vinitha S/N paramedicare check blood, cross check done. Blood warmth. pre vitals checked.	S/N paramedical 01b808

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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Dr. MATHANGI RAJAGOPALAN

NURSES NOTES

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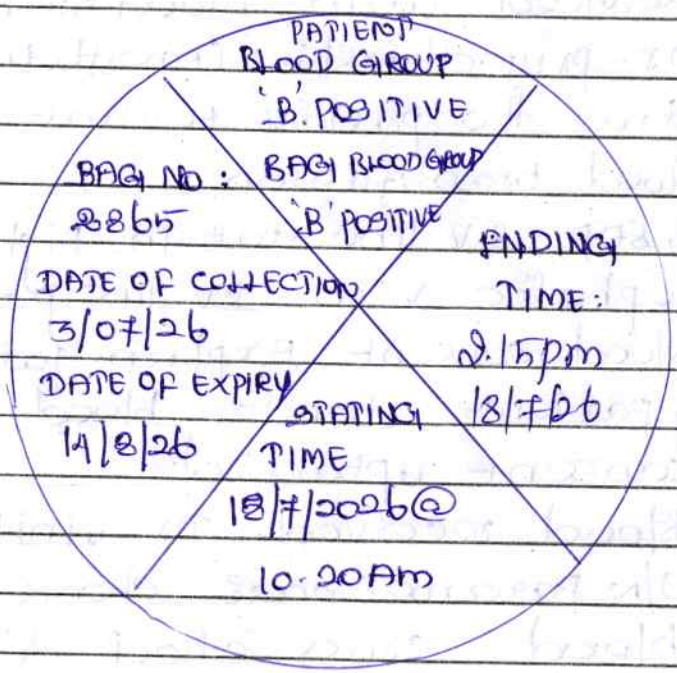
☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
18/7/26	10.20 am	Blood transfusion Notes: Blood warmth done. Patients general condition fair. Vitals are checked & recorded. IV line pattern. Blood transfusion started. Informed to Dr. Vinitha/Dr. Shradevi	
	10.35 am	There is no allergic reaction Patient side no complaints. Vitals are stable.	s/p parasuram 01b808
	11.00 am	patient maintain selfvoiding. Blood drops increase. patient side no complaints.	s/p parasuram 01b808
			s/p parasuram 01b808



NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00093901 IP18-000365
Ms RINBASHREE (F)
17-05-2007 19 Y 2 M 1 D
Dr. MATHANGI RAJAGOPALAN

(2)

NURSES NOTES

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☑ No Known Drug Allergies

☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
18/7/26	12pm	Patient general condition fair. Vitals are checked & recorded. Blood 100ml/hr onflow to the patient. patient maintain self voiding.	S/No paramedical 0168 08
	1pm	patient side no complaints vitals are stable. There is no allergic reaction.	S/No paramedical 0168 08
	2pm	Monitored Vitals and Recorded. Maintained I/o. Patient General condition fair.	0168 20
	2.15pm	Ist unit PRBC Blood Transfusion End. patient dosent have any allergic Reaction after Transfusion	0168 20

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

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

BAG NO.	COLLECTION DATE	EXPIRY DATE	VOLUME
2865	03.07.26	14.08.26	250 ml

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

BLOOD GROUP: B
Rh₀ (D): Pos

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

PREPARED FROM A VOLUNTARY BLOOD DONOR

Patient Sticker

NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
18/7/26	3pm	Maintained IVo. Monitored vitals and Recorded. patient General condition Fair. patient conscious and oriented	18/7/26
	4.15pm	Monitored vitals and Recorded. Maintained IVo. 2 unit PRBC Started as per doctor Order. IV cannula observed. No other complaints.	
	5pm	Monitored vitals and Recorded. Maintained IVo. patient dosent have any allergic Reaction during Transfusion	18/7/26
	6pm	Monitored vitals and Recorded. Maintained IVo. patient General Condition Fair. patient conscious	

PATIENT BG "B-POSITIVE"

BAG1 BLOOD GROUP "B" POSITIVE

START TIME 4:15pm

END TIME 08.00 pm

BAG1 NO 2903

DOC: 6/7/26

DOEX: 17/8/26

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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Ms R INBASHREE
17-05-2007 19 Y 2 M 1 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
12/7/26		and oriented. No any other complaints →	01/07/26
	7pm	Maintained I/o. Blood Transfusion on connect. No any other complaints - patient doing self voide. Patient Conious and oriented →	01/07/26
	7.30 pm	Patient Care Handing over given to night duty staff → Night duty	01/07/26
	7.30pm	pt came had over taken from evening duty staff. pt consious & oriented. IV line ⊕ & patten. Blood transfusion going on infusion. 100ml/h. Provide comfortable bed position.	SN pog
	8pm	pt had normal diet, Encourage to take adequate oral fluid.	SN pog
	8.40pm	Blood transfusion ended. Informed to Dr. Punitha, Advice to shift ward. plan discharge tomorrow. Orders carried out.	pog
	9.30pm	pt voided 300ml urine. Provide comfortable bed position.	SN pog

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NURSES NOTES

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☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
18/7/26		BP - 100/60 mmHg. PR - 118 bpm RR - 26 bpm Temp - 98.2°F.	

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

BAG NO.	COLLECTION DATE	EXPIRY DATE	VOLUME
2903	06.07.26	17.08.26	334 ml

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

BLOOD GROUP: B
Rh₀ (D): Pos

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

PREPARED FROM A VOLUNTARY BLOOD DONOR

18/7/26	9.45pm	pt shifted to ward as per doctor order. pt care hand over given to the ward staff. ← Receiving Notes →	SN Pooja
	9.50pm	The patient details handing over taken from IDR staff to 4th floor staff. the patient is conscious and oriented. IV line present. no pain, no swelling. IV line patent.	Nurse

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OBSTETRICS / GYNECOLOGY
NURSING INITIAL ASSESSMENT FORM

Date of Admission: 18/7/26

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 Blood transfusion

Doctor Notified on Admission: ☑ Yes ☐ No

Name of the Doctor: Dr. Vinitha

Time Notified: 8am

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

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

Gynecology Assessment: ☐ Not Applicable

Menstrual History: 12 yrs

Onset of Menarche: Irregular

Menstrual Cycle: ☐ Regular ☑ Irregular

Last Menstrual Period: 20/6/26

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 Father – HT/DM

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

BP: 90/60mmHg Weight: 61.5kg Height: 148cm BMI:

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

Patient Sticker

PHYSICAL ASSESSMENT

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

Fall Assessment: ☑ Yes ☐ No Score ..20.. (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore: ☑ Yes ☐ No Score ..28.. (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 ..Mother & father..

Orientation has been given regarding the following aspects:

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

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

Above information given to ..patient..

Name of Person Orientation was given to: ..Mr. Inbashree..

Orientation not given Reason: .....

Nurse Signature: ..S/N Akalya D1809..

Nurse Name: ..S/N D1809..

Date & Time: ..18/7/26..

GUC-00093901 IP18-00036514
Ms R INBASHREE
17-05-2007 19 Y 2 M 1 D (F)
Dr. MATHANGI RAJAGOPALAN

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RISK ASSESSMENT TOOL FOR DEEP VEIN THROMBOSIS

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

Date: 18/9/26

Pre - Existing Risk Factors	Tick	Score
Previous VTE (except a single event related to major surgery)		4
Previous VTE provoked by major surgery		3
Known high-risk thrombophilia		3
Medical comorbidities e.g. cancer, heart failure; active systemic lupus erythematosus, inflammatory polyarthropathy or inflammatory bowel disease; nephrotic syndrome; type I diabetes mellitus with nephropathy; sickle cell disease; current intravenous drug user		3
Family history of unprovoked or estrogen-related VTE in first-degree relative		1
Known low-risk thrombophilia (no VTE)		1
Age (≥35 years)		1
Obesity		1
Parity ≥ 3		1 or 2
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	S/Nakalya 18/9/26	
Action Plan		

RISK ASSESSMENT FOR VENOUS THROMBOEMBOLISM (VTE)

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

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

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	M 18/9/26	E 18/7/26	N 18/7/26
		Score		20	8pm
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0	0	0	0
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0	0	0	0
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0	0	0	0
IV / Heparin Lock or Saline	Yes	20	20	20	20
	No	0			
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0	0	0	0
Mental Status	Forgets limitations	15		0	0
	Oriented to own ability	0	0		
Total Morse Fall Scale Score:			20	20	20
		Signature	Akshya 18/9/26	Full 18/7/26	[illegible]

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

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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Patient's Name:....   ....

MRD N   ).:......................

Age :.....   ex: ☐ M ☐ F

Consulta... ....

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Ms R INBASHREE
(F)
17-05-2007
19 Y 2 M 1 D
Dr. MATHANGI RAJAGOPALAN

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 18/7/26 Time: 9AM

Location : Right cephalic vein

Size : 184

Cannula inserted by : S/N parameshwari

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
18/7/26	9:30	☐Yes ☒No	☐Yes ☒No	obser	SA
	12pm	☐Yes ☒No	☐Yes ☒No	obse	SA
	2pm	☐Yes ☒No	☐Yes ☒No	observ	tia
	4pm	☐Yes ☒No	☐Yes ☒No	observ	fia
	6pm	☐Yes ☒No	☐Yes ☒No	observ	fui
	8pm	☐Yes ☒No	☐Yes ☒No	observ	Skf
	10PM	☐Yes ☒No	☐Yes ☒No	Observed	misa
19/7	12AM	☐Yes ☒No	☐Yes ☒No	Observed	NSR
	4AM	☐Yes ☒No	☐Yes ☒No	obsed	PPR
	6AM	☐Yes ☒No	☐Yes ☒No	obsed	PR
	6AM	☐Yes ☒No	☐Yes ☒No	obsed	PRR
	8am	☐Yes ☒No	☐Yes ☒No	obsed	PRR
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

Cannula removed : ☐Yes ☐No, if yes date and time :

RX any initiated : ☐Yes ☐No ☐NA If Yes specify-

Phlebitis score:

CANNULA 2

Date : Time:

Location :

Size :

Cannula inserted by :

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

Cannula removed : ☐Yes ☐No, if yes date and time :

RX any initiated : ☐Yes ☐No ☐NA If Yes specify-

Phlebitis score:

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

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

PHLEBITIS ASSESSMENT AND MANAGEMENT RECORD

CANNULA 3

Date : Time:

Location :

Size :

Cannula inserted by :

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

Cannula removed : ☐Yes ☐No, if yes date and time :

RX any initiated : ☐Yes ☐No ☐NA If Yes specify-

Phlebitis score:

CANNULA 4

Date : Time:

Location :

Size :

Cannula inserted by :

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

Cannula removed : ☐Yes ☐No, if yes date and time :

RX any initiated : ☐Yes ☐No ☐NA If Yes specify-

Phlebitis score:

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

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

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

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INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
18/12/18	9Am	YES	Educated about the Informed consent	Pt	Education Gone	Orally	None	Yes	good	S/N Abeda 18/12/18
19/12/18	9AM	Nutrition & Diet	Encouraged the oral intake. Avoid outside food	Pt & Mother	No Learning Barrier	Oral	None	Verbalizing understanding	good	[illegible]

Part - III: CODES

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

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

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

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

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

PATIENT TRANSFER FORM

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Dr. MATHANGI RAJAGOPALAN

Treating Consultant Name: Dr. mathangi	Date & Time of Admission: 18/07/2026	Date & Time of Transfer Order: 18/07/2026 @ 9.45pm
	Transfer Ordered by: Dr. pavithra	Reason for Transfer: pt care.
From Unit: ICU	To Unit: 412	Information to Attendant: Yes ☑ No ☐
Number of Sheets in Clinical File: pt dr file	Number of Imaging Films: —	Personal belongings including clinical documents. If any handed over to attendant: Yes ☐ No ☐ If yes, what? —

Medications / Consumables / Surgicals / Hand over

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

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐
Dr. pavithra

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
S. Priya	Dr. pavithra

Patient & Clinical Records Received by : SIN. Angel 01898 18/7/26 @ 9.45pm

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

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(a) (2)

BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 18/07/2026 Time: 10.20am

Blood Group of the Patient: 'B' POSITIVE Blood Group on the Blood Bag: 'B' POSITIVE

Blood Bank Issue No: 2865 Date of Collection: 3/7/26 Date of Expiry: 14/8/26

Date & Time of Starting Transfusion: 18/7/26 @ 10.20am Planned duration of Transfusion: 4 hrs

Check for Correct Unit: ✓ Correct Patient: ✓

Blood products cross checked by: Nurse 1: S/N. Parameswari Nurse 2: S/N Akalya

Before starting transfusion vitals: Temp: 98°F HR 104bpm RR: 20bpm BP: 100/60 mmHg SpO_2 99%.

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO_2	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
18/7/26 10.20am	15 Min	104bpm	98°F	100/60	99%	NIL	NIL	NIL	NIL
10.35am	15 Min	104bpm	98°F	95/56	100%	NIL	NIL	NIL	NIL
11 am	30 Min	100bpm	98°F	103/62	100%	NIL	NIL	NIL	NIL
11.30am	30 Min	97bpm	98°F	88/57	97%	NIL	NIL	NIL	NIL
12 pm	30 Min	100bpm	98°F	102/62	98%	NIL	NIL	NIL	NIL
1 pm	1 Hr	94bpm	98°F	99/61	99%	NIL	NIL	NIL	NIL
1.30 pm	1 Hr	100bpm	98°F	103/60	99%	NIL	NIL	NIL	NIL
2pm		92bpm	98°F	102/62	98%	NIL	NIL	NIL	NIL

Comments: Monitored vitals and Recorded. patient dosent have any allergic Reaction

Name of the Incharge-Nurse: S/N. N. Devi

Signature of the Incharge-Nurse: 18/7/26

Date & Time: 18/7/26 at 2pm.

Name of the Nurse: S/N. Tamilselvi 018720

Signature of the Nurse: 18/7/26

Date & Time: 18/7/26 at 2pm

(2)

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BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 18/7/26 Time: 4.15pm

Blood Group of the Patient: B-POSITIVE Blood Group on the Blood Bag: B-POSITIVE

Blood Bank Issue No: 26023132 Date of Collection: 6/7/26 Date of Expiry: 17/8/26

Date & Time of Starting Transfusion: 18/7/26 at 4.15pm Planned duration of Transfusion: 4 HOURS

Check for Correct Unit: ✓ Correct Patient: ✓

Blood products cross checked by: Nurse 1: S/N: DEVI Nurse 2: S/N: TAMIZSELVI

Before starting transfusion vitals: Temp: 98°F HR 82bt/m RR: 20brm BP: 102/62 SpO_2 99%

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO_2	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
18/7/26	4.15pm 15 Min	82bt/m	98°F	102/62	99%.	+	—	—	—
18/7/26	4.30pm 15 Min	92bt/m	98°F	102/62	99%.	—	—	—	—
18/7/26	5pm 30 Min	90bt/m	98°F	100/66	99%.	—	—	—	—
18/7/26	5.30pm 30 Min	86bt/m	98°F	90/50	99%.	—	—	—	—
18/7/26	6pm 30 Min	82bt/m	98°F.	102/66	98%.	—	—	—	—
18/7/26	7pm 1 Hr	90bt/m	98°F	100/62	100%.	—	—	—	—
~~18/7/26~~	8pm 1 Hr	86	98.2°F	100/60	100%.	—	—	—	—

Comments: .....

.....

Name of the Incharge-Nurse: S/N: Devi

Signature of the Incharge-Nurse: .....

Date & Time: 18/7/26 at 4.15pm.

Name of the Nurse: SOORIA S

Signature of the Nurse: .....

Date & Time: 18/7/26 at 8.40pm

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CONSENT FOR BLOOD TRANSFUSION

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Dr. MATHANGI RAJAGOPALAN

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

UHID No.:..... IP NO.. .....Ward/Bed No. .....

Type of Blood Product : 1© PRBC .....

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

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

Name of Patient / Attendant R. Inbashree / N. RAJKUMAR

Signature of Patient / Attendant R. Inbashree / N. Rajkumar

Date 18/07/2026

Time : 10 AM

Relationship with Patient: Father.