GUC-00084304
Mrs JEFFY JONE IP18-00036700
20-06-1996 30 Y 1 M 12 D (F)
Dr. PRIYADHARSHINI S M

Rainbow Children's Hospital

UHID- FLOOR-

DISCHARGE TRACKING SHEET

NAME OF CONSULTANT-

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

GUC-00084304 IP18-00036700
Mrs JEFFY JONE
20-06-1996 30 Y 1 M 11 D (F)
Dr. PRIYADHARSHINI S M

ACTIVITY RECORD FOR BILLING

Name: Infant Jeffy Jone J.

UHID No: 84304 IP No: 36700 Consultant: Dr. Priyadharshini Dept: LDR

Date of Admission: 31/7/26 Time: ..... Date of Discharge: ..... Time: .....

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
31/7/26	6pm	LDR	7th floor	
1/8/26	2:15 Am	7th floor	LDR	
01/8/26	11 Am	LDR	701	

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
2/8/26	CBC	26024276	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
3/7	CTU ①	4pm		010329	Akalya 018088
	CTU ②			010328	Akalya 018088
	CTG ③	8 pm		010337	
	CTG ④	9:30pm		010338	
11/3/26	Infusion pumps	3.20Am	9Am	143770	018720
	CTU - 5			01034	Deno
	CTU - 6			01034	Deno
	CTU - 7			01034	Deno
	CTU - 8			01034	Deno

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
1/8/26	IV placement	1	1738761	bani
1/8/26	catheterisation	1	1738761	bani / 01760
1/8/26	Diet Counselling	(1)	1736029	A. Jagdish (08336)

ANY OTHER INFORMATION:

Vacuum Asst Normal vaginal delivery done at 5.46 pm on 2/8/26 at 5.30 pm to 6.30 pm

Dr Priyadharshini.

Dr Karthika.

Dr 01760

Date: 2/8/26 Time: 6AM Prepared By: S/N madhumitha

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Simedha 607383	7th FLOOR		

Rainbow Children's Hospital | BirthRight

DISCHARGE TRACKING SHEET

7th floor.

UHID- FLOOR- NAME OF CONSULTANT-

GUC-00084304 IP18-00036700
Mrs JEFFY JONE
20-06-1996 30 Y 1 M 12 D (F)
Dr. PRIYADHARSHINI S M

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement	2/8/26 @ 12.5PM.		021295		
	INTIME	OUT TIME			
Arrangement of File by Nursing	2/8/26	12.5PM	021295		
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

GUC-00084304 IP18-00036700
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20-06-1996 30 Y 1 M 11 D (F)
Dr. PRIYADHARSHINI S M

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Your Right to a Safe Delivery

BED SIDE CHECK LIST FOR NURSES

Date:	31/7	1/8	2/8						
Doctor's Orders	yes	yes	YES						
Carried out or not	yes	yes	YES						
Bed Side									
Structured Handover done	Yes	Yes	YES						
IV Site	NA	Yes	YES						
Central Lines	NA	NA	NA						
Arterial Lines	NA	NA	NA						
Feeding Catheter	NA	NA	NA						
Urinary Catheter	NA	NA	NA						
Skin Care	yes	yes	YES						
Eye Care	yes	yes	YES						
Mouth Care	yes	yes	YES						
Sterillum Bottle, Stethoscope	yes	yes	YES						
Suction Bottle (Should be clean & empty)	NA	NA	NA						
Intubation Tray	NA	NA	NA						
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	NA	NA	NA						
Ventilator Tubing,(Any Water, Blood)	NA	NA	NA						
Humidification	NA	NA	NA						
Check all Infusion (Labelling,Correct Preparation)	NA	NA	NA						
Chest Physio & Neb	NA	NA	NA						
Handed Over By Name :	V. Abhi	V. Abhi	[signature]						
Signature :	[signature]	[signature]	[signature] 02/8/26						
Date & Time:	31/7/26 @ 8pm	1/8/26 @ 7.30am	2/8/26 @ 8AM						
Hand Over Taken By Name :	V. Abhi	[signature]							
Signature :	[signature]	[signature]							
Date & Time:	31/7/26 8pm	1/8 8pm							

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 : IP18-00036700 **Admit Date** : 31-Jul-2026 **Admit Time** : 04:47 PM **UHID** : GUC-00084304

Patient Details :

Patient Name : Mrs JEFFY JONE
Guardian : Mr ABISHEK J
Gender : Female
Occupation :
Address (H) : 13, 112, RAMS APARTMENT, RAMA STREET, Nungambakkam Bazaar Chennai Tamil Nadu INDIA 600034

Age : 30 Y 1 M 11 D
DOB : 20-06-1996
Religion :
Martial Status :
Phone No : 9600513755/ 9094167632
E-mail : no@gmail.com

Admission Details :

Bed Type : PRIVATE ROOM **Bed No** : PVT 701 **Ward Name** : 7F-PVT/SUITE
Room No : PVT 701 **Admission Type** : First Visit

Contact Details :

Name : Mr ABISHEK J
Contact Address : 13, 112, RAMS APARTMENT, RAMA STREET, Nungambakkam Bazaar Chennai Tamil Nadu INDIA 600034

Relationship : Husband
Phone No :

Signature

Doctor Details :

Doctor Name : Dr. PRIYADHARSHINI S M
Referral Doctor : Self
Co-Consultant :

Specialisation : OBSTETRICS AND GYNECOLOGY
Phone No :

Payment Details :

Payment Mode : DC/CC Card

Deposit Amount : 20000.00
Payor Name : MEDI ASSIST INSURANCE TPA PVT LTD

Rainbow Children's Hospital
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TEL NO :044-40122444
WEB : https://rainbowhospitals.in

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Mrs JEFFY JONE**		
IP No:	**IP18-00036700**	**Age :**	**30 Y 1 M 11 D**
Consultant:	**Dr. PRIYADHARSHINI S M**	**Sex:**	**Female**
		Ward/Bed No:	**7F-PVT/SUITE/PVT 701**

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 c[illegible] of the patient.

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

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

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

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

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

Signature of Patient/Relative:

Name:

Relationship:

Date: Time:

Wittness Name:

Wittness Signature:

Patient Address:
13, 112, RAMS APARTMENT, RAMA STREET, Nungambakkam Bazaar
Chennai Tamil Nadu INDIA 600034

Rainbow Children's Hospital

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Rainbow Children's Hospital - Guindy

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

ADMISSION SHEET

Registration Details :

Admission No : IP18-00036700 **Admit Date** : 31-Jul-2026 **Admit Time** : 04:47 PM **UHID** : GUC-00084304

Patient Details :

Patient Name	: Mrs INFANT JEFFY JONE J	**Age**	: 30 Y 1 M 11 D
Guardian	: Mr ABISHEK J	**DOB**	: 20-06-1996
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 13, 112, RAMS APARTMENT, RAMA STREET, Nungambakkam Bazaar Chennai Tamil Nadu INDIA 600034	**Phone No**	: 9600513755/ 9094167632
		E-mail	: no@gmail.com

Admission Details :

Bed Type : MICU **Bed No** : MICU 802 **Ward Name** : 8F-OT COMPLEX

Room No : MICU 802 **Admission Type** : First Visit

Contact Details :

Name : Mr ABISHEK J **Relationship** : Husband

Contact Address : 13, 112, RAMS APARTMENT, RAMA STREET, Nungambakkam Bazaar Chennai Tamil Nadu INDIA 600034 **Phone No** :

J. Abishek

Signature

Doctor Details :

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

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

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

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Mrs INFANT JEFFY JONE J**	**Age :**	**30 Y 1 M 11 D**
IP No:	**IP18-00036700**	**Sex:**	**Female**
Consultant:	**Dr. PRIYADHARSHINI S M**	**Ward/Bed No:**	**8F-OT COMPLEX/MICU 802**

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 c[illegible] 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.
(R[illegible]ivers Signature:.....J. Abishek.....)

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: J. Abishek

Name: ABISHEK. J

Relationship: J. Abishek HUSBAND

Date: 31-7-26 Time: 4:47 Pm

Witness Name: Naveen

Witness Signature:

Patient Address:
13, 112, RAMS APARTMENT, RAMA STREET, Nungambakkam Bazaar
Chennai Tamil Nadu INDIA 600034

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 : Mrs. Priyanka Jaffy Jones.J	UHID Number : GUC-0008430Y
Self/Attendant Name : J. ABISHEK	Relation : HUSBAND
Self/ Attendant Signature : J. Abishek Phone Number : 9094167632	Name & Signature of Financial Counselor

भारतीय विशिष्ट पहचान प्राधिकरण

Unique Identification Authority of India

AADHAAR

முகவரி: கேர் ஆப்: அபிஷேக் ஜெ, 112 பிளாட் 13 2வது தளம் ராம்ஸ் அபார்ட்மெண்ட்ஸ், ராமா தெரு, நுங்கம்பாக்கம், சென்னை, தமிழ் நாடு, 600034

Address: C/O: Abishek J, 112 Flat 13 2nd Floor Rams Apartments, Rama Street, Nungambakkam, PO:Nungambakkam, DIST:Chennai, Tamil Nadu, 600034

Details as on 07/04/2024

2910 9684 2161

1947

help@uidai.gov.in

www.uidai.gov.in

भारत सरकार

Government of India

आधार

இன்பன்ட் ஜெபி ஜோன்

Infant Jeffy Jone

பிறந்த நாள் / DOB : 20/06/1996

பெண் / Female

2910 9684 2161

ஆதார் என்பது அடையாளத்திற்கான சான்றாகும், குடியுரிமை, அல்லது பிறந்த தேதிக்கான சான்றல்ல. இது சரிபார்ப்புடன் மட்டுமே பயன்படுத்தப்பட வேண்டும் (ஆன்லைன் அங்கீகாரம் அல்லது QR குறியீட்டை ஸ்கேன் செய்தல்/ஆ.ப்லைன் XML)

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).

2910 9684 2161

मेरा आधार, मेरी पहचान

GUC-00084304
Mrs JEFFY JONE
20-06-1996 30 Y 1 M 11 D (F)
Dr. PRIYADHARSHINI S M
IP18-00036700

Rainbow Children's Hospital — It takes a lot to treat the little.
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IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints
Able to pass Well.
Pt came for IOL.

Obstetric Formula:
Primigravida.

Obstetric History:
B & 2, Spont. conception.
Had Regular AN visits @ Rainbow.
NT Scan - (N), 7TS Screen-Neg.

Present Pregnancy Record:
Anomaly Scan - (N)
Growth Scans - (N)

RISK FACTORS:
→ K/c/o Hypothyroid on T. Thyronorm 25mg 1 od since conception
→ Pt was taking T. Ecosprin 150mg at bedtime till 36 weeks

Height: 159 cm
Weight: 64.2 kg
Allergies: Nil
Breast: ☐ Normal ☐ Abnormal
General Examination:
Consciousness:
Icterus:
Temp: (N)
BP:
CVS: S1S2 (+)
Liver/Spleen:
Pallor: No
Edema: No
PR:
DTR:
RS NVBS (+)
Urine Output:

LMP: 30/10/2025 EDD: 6/8/2026
Corrected EDD:
GA: 39 wks + 1 day
Menstrual History: Regular: ☑ Yes ☐ No 3/30

Obstetric Examination
Fundal Height:
Ut. Activity: ☑ Relaxed ☐ Mild ☐ Mod ☐ Severe
Liquor: ☑ Adequate ☐ Oligo ☐ Poly
PP: ☑ Cephalic ☐ Breech Others _____
Head Fifths Palpable: 4/5th.
FHS: ☑ Normal ☐ Tachy ☐ Brady ☐ Absent

Per Speculum Examination
Draining: ☐ Present ☐ Absent ☐ Bleeding
Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination
Cervix: 1cm ☑ Long ☐ Partially effaced ☐ Effaced — Soft, posterior.
Os: Closed _____ Dilated 2 finger tight.
Membranes: ☑ Present ☐ Absent
Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained
Presenting Part: ☑ Vertex ☐ Breech ☐ Others
Sutton: ☑ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2
Pelvis: ☑ Adequate ☐ Doubtful
Gynaecoid.

DIAGNOSIS
30 years Primigravida. 0+0 M/S - 24/24 hrs Nens. Spont Concp. | LMP - 30/10/2025. EDD - 6/8/2026 (RMP) | GA - 39 wks + 1 day.

Hypothyroid / Fetus - (R) Adnexal cyst

Docu. No. : RCH /FRM / CLINICAL / 087

(P.T.O)

GUC-00084304 IP18-00036700
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20-06-1996 30 Y 1 M 11 D (F)
Dr. PRIYADHARSHINI S M

Family History:

Mother - Hypothyroid, DM.

Father - DM

Surgical History:

? cyst removal ↓ Local anaes. near to (R) Ear

Medical History:

→ ~~Anaemia~~ Rx'd c FCM 500mg for Hb-8.6

→ K/c/o Hypothyroid x 7. Thyronorm 25mcg 1od since conception.

→ ~~Dengue NS1 positive at 28 weeks~~ IgG (+) IgM equivocal (Symptomatic mgt / Plt - 3.85)

Medication History:

T. Ecospirin 150mg at bedtime till 36 weeks

Plan of Care:

→ Admission CTG.

→ T. Misoprostol 50mcg PO given at 4:30pm

→ Next Misoprostol 50mcg PO at 8:30pm.

→ Next CTG at 8pm

→ Wf contractions

→ T. Misoprostol 50mcg PO given at 8:30pm

Shift to ward

Investigations:

Doctor Name: Dr. Ramitha

Signature: [signature] MY682

Date & Time: 31/07/2026

Consultant Name: Dr. Priyadharshini

Signature: [signature] MY682

Date & Time: 31/07/2026

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RESULT SHEET

Date	18/6/26	10/7	21/8/26.			
Time						
Hb	8.0	9.8	8.4			
PCV	25.	31.2	26			
RBC		3.81				
WBC		8100	13230			
N/L		70/20/6.	~~3.95~~			
Platelets		3.46.	3.95			
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
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						

Bld G/T | O+ve.

HIV
HBsAg | NR.
VDRL

11/5 TSH - 4.71

FBS - 89
PP BS - 132.

18/6 TSH - 2.11.

8/1 Hb Electrophoresis - (N)

Echo -

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

124682.

(P.T.O)

GUC-00084304 IP18-00036700
Mrs JEFFY JONE
20-06-1996 30 Y 1 M 12 D (F)
Dr. PRIYADHARSHINI S M

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S/B Dr. Panithra	
1/8/2024 5:20PM	↓ BBP, Epidural analgesia done by anaesthetist Catheterisation done.	
	O/E	C/T/T Dr. Priyadharshini
CRL-Reactive	P/V - Cx well effaced OS 3-4cm dilated Membrane (+) Vx @ -2 station.	Advice - To start Inj Syntocinon 5 units in 1000ml NS @ 24ml/hour.
	Mydr	
01/08/24 4:15PM	C/S/B Dr. Priyadharshini	
	Pt reviewed	
	O/E c/o spont rupture of membrane. P/V - Cx well effaced OS fully dilated Membrane (-) Vx @ 0 station.	Advice - Inj Syntocinon @ 24ml/hour - Squatting. - W/F contractions. - Inj Taxim IS IV Stat (after test dose)
	Mydr	

eloped mild itching, redness over arms, Breast
Taxim test dose. Full dose not given.

GUC-00084304 IP18-00036700
Mrs JEFFY JONE
20-06-1996 30 Y 1 M 11 D (F)
Dr. PRIYADHARSHINI S M

(9)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
01/08/2026 5.40 AM	C/S/B Dr. Priyadharshini / C/S/B Dr. Pavithra.	
	Pt reviewed.	
	o/e	Advice
	P/v- Cx well effaced	- Active pushing.
	os fully dilated	- Wtf contractions
G1P1 Occasional Fourth Degree ®	membs ⊖	- Inj Cupacef 1.5g IV stat (A?D)
	Vx @ +1 station	
01/08/2026 5.46 AM.	Vacuum Assisted Vaginal Delivery with Right Mediolateral Episiotomy.	Ind- Narrow Subpubic arch.
	C/B- Dr. Priyadharshini.	
	A/B- Dr. Pavithra	
	↓ SPR, patient in dorsal lithotomy position, local parts painted and draped. With good uterine contraction, full cervical dilatation and good maternal efforts, due to narrow pubic space decision made to apply vacuum cup. 2% lignocaine infiltrated into perineum. ® mediolateral episiotomy was given. Vacuum cup applied at vertex and baby head delivered by extension. followed by body. Cord clamped and cut. Baby handed over to paediatrician. Inj Carbetocin 100mcg in 100ml NS IV given. Episiotomy wound sutured in layers with Rapid vicryl.	
	P/A - Uterus firm & cont well.	
	P/V - NO undue bleeding P/V.	
	P/R - Rectal mucosa free & intact.	

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

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Dr. PRIYADHARSHINI S M

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		Advice
		- (N) DAC
		- Plenty of oral fluids.
		- Inj Supacef 1.5g IV Stat (ATD) (One dose)
		- F/B T. TAXIM O 200mg (1-0-1)
		- T. PANTOPRAZOLE 40 mg (1-0-1)
		- T. ZERODOL SP (1-0-1)
		- Ice Packing for L/A.
		- CBC c/m 6Am.
		- Measure 1st void urine.
		- T. CEFTUM 500mg 1-0-1
B	An alive girl baby	
A	B.wt - 3.018 kg.	
B	Apgar - 7/10, 8/10.	
4	01/08/2026 @ 5:46Am	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/8/26.	C/S/B Dr. Akshitha / Dr. Shreedevi	
8:30 Am		
PND-0	D/E Pt GC fair, Afebrile	Advice
	P° / PE°	- Normal diet
T-(N)	CVS /	- Plenty of oral fluids
PR- 88/min	RS / NAD	- Vitals Monitoring
BP- 110/70mmHg.	P/A - uterus firm & well contracted	- Follow drug chart
	Soft	- W/F ↑ Bleeding PV
Baby - m/s	L/E - BWNL, labial Swelling ↓ed.	- Measure & inform 1st void
B/L - Breast soft	Epi wound Intact	- CBC c/m 6Am
Not voided Yet		- Ice pack for L/A
	Dr. 182217	
02/08/2026	C/S/B Dr. Akshitha / Dr. Shreedevi	
10 AM		
	Pt reviewed, Nil c/o	Advice
PND-0	Pt voided - 300ml, PVRU - 20ml	- Normal diet
	D/E Pt GC fair, Afebrile	- Plenty of oral fluids
T-(N)	P° / PE°	- Vitals Monitoring
PR- 88/min	CVS /	- Follow drug chart
BP- 110/70mmHg.	RS / NAD	- W/F ↑ Bleeding PV
	P/A - ut well Contracted	- CBC c/m 6Am
Baby - m/s	Soft	- Inform (Sos)
B/L - Breast soft	L/E - BWNL, labial Swelling ↓ed	
	Epi wound Intact	
	Dr. 182217	Shift to ward.

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/8/26	C/S/B Dr. Vinitha / Dr. Shreeden	
3:30pm		
	Pt reviewed, N/V c/o	Advice
PND-0	O/E Pt GC-fair, Afebrile	- Normal diet
	P° / PE°	- Plenty of oral fluids
T-(N)	CVS /	- Vitals Monitoring
PR- 78/min	RS / NAD	- Follow drug chart
BP- 108/62mmHg	P/A - Ut well contracted	- W/F ↑ Bleeding PV
	Soft	- CBC c/m 6 Am
Baby - M/s	L/E - BWNL	- Inform (SOS)
B/L - Breast soft	Epi wound Intact	
widing freely		
Passed stools	18221	
1/8/26	P1 L2 / Kenii assisted delivery / PND#0	
8pm	Pt reviewed	Pt
Normal	N/V complaints	Normal diet
PR 110/min	T/E -	Plenty of oral fluids
RR 18/min	Pt ayclenic	Vitals Monitoring
P/A - NLS	P/PE -	SOS follows drug orders
BSL monitor	CVS /	
Baby - M/S	RS / NAD	
Passed stools	P/A - Ut firm - contracted	
	L/E - BWNL	

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

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Mrs JEFFY JONE
20-08-1996 30 Y 1 M 12 D (F)
Dr. PRIYADHARSHINI S M

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/8/26. 8:50AM	S/B Dr. Sheela	
O.Type		
PNDAY1.	pt reviewed.	voiding freely, passed stools.
	2/8/26.	
	Hb = 8.4 O/E: afebrile	
	PCV = 26. GC fair	
	TC = 13230. P° / PE°.	Plan:
	P/t = 3.85 P/A: Uterus wod soft	normal diet
	BS ⊕	hydrate
BP = 100/70mmHg		ambulate
PR 84bpm.	L/E: BW NL.	w/t ↑ bleeding P/V
B/L breast soft		
secretions ⊕		2/8/26
Baby m/s		
DBF		

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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Dr. PRIYADHARSHINI S M

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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

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

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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BirthRight BY RAINBOW HOSPITALS
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Date: ..... Department: ..... Shift: .....

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

GUC-00084304 IP18-00036700
Mrs JEFFY JONE
20-06-1996 30 Y 1 M 11 D (F)
Dr. PRIYADHARSHINI S M

(1)

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MEDICATION RECONCILIATION FORM

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

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

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

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T. Thyronorm	25mcg	PO	1-0-0	31/7	☑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 : 124682 Dr. Pavithra.

Date & Time : 31/07/2026, 4PM

Nurse Name & Signature: S/H Akalya 18080

Date & Time : 31/7/26

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

GUC-00084304
Mrs JEFFY JONE
20-06-1996 30 Y 1 M 12 D (F)
Dr. PRIYADHARSHINI S M
IP18-00036700

(2)

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MEDICATION RECONCILIATION FORM

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

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

Shifting From: LDR Shifted to: 7th floor

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T. THYRONORM	25mcg	PO	OD	1/8/26 6AM	☒C ☐DC
2	T. CEFTUM	500mg	PO	BD	-	☒C ☐DC
3	T. PANTOPRAZOLE	40mg	PO	BD	1/8/26 7AM.	☒C ☐DC
4	T. ZERODOL SP	1Tab	PO	BD	—	☒C ☐DC
5						☐C ☐DC
6						☐C ☐DC
7						☐C ☐DC
8						☐C ☐DC
9						☐C ☐DC
10						☐C ☐DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Shreedevi $182217

Date & Time : 1/8/2026

Nurse Name & Signature: SN Akshaya 018050

Date & Time : 1/8/2026

GUC-00084304 IP18-00036700
Mrs JEFFY JONE
20-06-1996 30 Y 1 M 11 D (F)
Dr. PRIYADHARSHINI S M

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DRUG CHART

Date of Admission: 3/7/26 Drug Allergies: ..... ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

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

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

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

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

GUC-00084304 IP18-00036700
Mrs JEFFY JONE
20-06-1996 30 Y 1 M 11 D (F)
Dr. PRIYADHARSHINI S M

REGULAR PRESCRIPTIONS

Weight. 64.2kg Ward. 2 DR

DRUG : T. THYRONORM

Dose	Route	Frequency	Start Date
25mcg	PO	1-0-0	1/8

Name & Signature of the Doctor Starting the Drugs: [signature] 124682

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	1/8	2/8
6AM	SS	SM / VA

DRUG : T. TAXIM - O

Dose	Route	Frequency	Start Date
200mg	PO	1-0-1	1/8

Name & Signature of the Doctor Starting the Drugs: [signature] 124682

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	1/8
8AM	\
8PM	—

Stop

DRUG : T. PANTOPRAZOLE

Dose	Route	Frequency	Start Date
40mg	PO	1-0-1	1/8

Name & Signature of the Doctor Starting the Drugs: [signature] 124682

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	1/8	2/8
7AM	SA / SP	SM / VA
7PM	AA / SS	

DRUG : T. ZERODOL-SP

Dose	Route	Frequency	Start Date
1 TAB	PO	1-0-1	1/8

Name & Signature of the Doctor Starting the Drugs: [signature] 124682

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	1/8	2/8
8AM	/	AA / SS
9PM	7:58 PM AA / SS	

GUC-00084304 IP18-00036700
Mrs JEFFY JONE
20-06-1996 30 Y 1 M 11 D (F)
Dr. PRIYADHARSHINI S M

Weight. 64.9kg Ward. 2 DR

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
31/7/26	4:30PM	T. MISOPROSTOL	50mcg	PO	124682	SA SN
31/7/26	8:30 PM	T. MISOPROSTOL	50mcg	PO	124682	P.E V.A
1/8/2026	12:30AM	T. PARACETAMOL	1g	PO	124682	P.E V.A
1/8/26	4AM	Inj EPIDOSIN	2cc	Slow IV	124682	TJ MD
1/8	4:30AM	Inj TAXIM	0.1ml	IV		TJ MD
1/8	5.45 AM	Inj SUPACEF	0.1ml	Id		TJ MD
1/8/26	5.59AM	Inj CARBETOCIN	100mcg in 100ml NS	IV		TJ MD
1/8/26	6.30 AM	T. Misoprostol	600mcg	PR		TJ MD
1/8/26	6.30 AM	Justin Suppository	100mcg	PR		TJ MD

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Mrs JEFFY JONE
20-06-1996 30 Y 1 M 11 D (F)
Dr. PRIYADHARSHINI S M

I.V. FLUIDS CHART

Weight. 54.2 Kg Ward. IDA

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
1/8	3:20 AM	Inj Syntocinon 5 units in 100 RL	IV	24 ml/hr		TJ MD	1/8/26		TJ MD
1/8	3 AM	IVF 3 @ RL	IV	100 ml/hr		TJ MD	1/8/26		TJ MD

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

GUC-00084304 IP18-00
Mrs JEFFY JONE (F)
20-06-1996 30 Y 1 M 11 D
Dr. PRIYADHARSHINI S M

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight 64.9 kg Ward LDR

DRUG : T. CEFTUM

Dose	Route	Frequency	Start Dt.
500mg	PO	1-0-1	1/8/26

Name & Signature of the Doctor Starting the Drugs: 182217

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time	1/8	2/8
8AM	/	RRS 35
8pm	SM VA	
	DI	Dr

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time

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

Patient Sticker

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REGULAR PRESCRIPTIONS

Weight .... Ward ....

Sheet No: ....

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

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date
Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date
Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date
Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date
Time

GUC-00084304 IP18-00036700
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20-06-1996 30 Y 1 M 13 D (F)
Dr. PRIYADHARSHINI S M

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STAT / ONCE ONLY DRUGS

Name: .....

Weight: ..... kgs

Sheet No: .....

DATE	TIME	MEDICATION	DOSAGE & OTHER INSTRUCTIONS	ROUTE	SIGNATURE		
					Doctor	Nurse-1	Nurse-2
2/8/26	11.45 AM	INJ FCM	500mg	IV	[signature] 22436	AA	SS.

Docu. No. : RCH /FRM / CLINICAL / 136

GUC-00084304 IP18-00036700
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Dr. PRIYADHARSHINI S M

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Early Warning Observation Score Chart - Obstetrics

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

		Date	31/7																						
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20										20				22				22		20		20			
	0 - 10																									
Saturations	94 - 100 %										100				100				99%		99%		99%			
	< 94 %																									
Administered O_2 (L/min.)											RA				RA				RA		RA		RA			
Temp °C	40																									
	39																									
	38																									
	37																									
	36										98F				98.6F				98.6F		98F		98F			
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100										80				[illegible]				[illegible]		90		84		80	
	90																									
	80																									
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressure ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
	40																									
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											0				0				0		0		0			
TOTAL ORANGE SCORES											0				0				0		0		0			
Nurse Initial											[illegible]				[illegible]				[illegible]		[illegible]		[illegible]			

On admission 140/80 112/71 110/80 116/80 110/70 110/70

GUC-00084304
Mrs JEFFY JONE
20-08-1996 30 Y 1 M 11 D (F)
Dr. PRIYADHARSHINI S M
IP18-00036700

(2)

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Warning Observation Score Chart - Obstetrics

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

1/8/26	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				22			
	0 - 10																								
Saturations	94 - 100 %	100		100		99%				99%				98%				99%				100%			
	< 94 %																								
Administered O_2 (L/min.)		RA		RA		RA				RA				RA				RA				RA			
Temp°C	40																								
	39																								
	38																								
	37	98.0		98.6		97.8F				97.8F				98.6F				98.6F				98.6F			
	36																								
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90	80		88		78bpm				80bpm				86bpm				84bpm				82bpm			
	80																								
	70																								
	60																								
	50																								
	40																								
Systolic Blood Pressue ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120	118		110		108				97				125				120				110			
	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
	50					(70)				(62)				(83)				(80)				(64)			
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70	80		60		62				54				73				80				80			
	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			
TOTAL ORANGE SCORES		0		0		0				0				0				0				0			
Nurse Initial																									

GUC-00084304 IP18-00036700
Mrs JEFFY JONE
20-06-1996 30 Y 1 M 11 D (F)
Dr. PRIYADHARSHINI S M

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FLUID CHART

Sheet No. : 1

31/7/25

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

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	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		→		On Admission							
	04:00 pm										NO IV line	SS
	05:00 pm	H20	100									
	06:00 pm	H20	100							200		
	07:00 pm	H20	50									
Total Intake :		450ml				**Total Output :**				200ml		
	08:00 pm	H20	200ml								NO	S
	09:00 pm											
	10:00 pm	H20	100ml									
	11:00 pm									200ml	+V	S
	12:00 am	H20	200ml									
	01:00 am										Ui	S
Total Intake :		500ml				**Total Output :**				200ml		
	02:00 am	H20	100	RL 500						200	0	Tab
	03:00 am	H20	150	500	Syrup 2.5					(CBD) 100	0	Tab
	04:00 am	H20	100		1.2						0	Tab
	05:00 am	H20	150		2.5					100	0	Tab
	06:00 am	H20	100								0	Tab
	07:00 am	H20	150								0	Tab
Total Intake :		1,810ml				**Total Output :**				400		

Total 24 hrs. Intake	2,560ml	Total 24 hrs. Output	800ml

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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.

1/8/26

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	H2o	100								0	SA
	09:00 am	H2o	100				✓				0	SA
	10:00 am	H2O	100							300	0	SA
	11:00 am										0	
	12:00 pm	H2o	150ml								0	
	01:00 pm										-	
Total Intake :		450ml				**Total Output :**	300ml					
	02:00 pm	H2o	200ml									
	03:00 pm	H2O	200ml									
	04:00 pm	H2o	150ml							250ml	0	
	05:00 pm	H2o	200ml									
	06:00 pm	H2o	200ml							200ml	0	
	07:00 pm	H2O	150ml									
Total Intake :		H2O-850ml				**Total Output :**	700ml			250ml	0	
	08:00 pm	H2o	200ml								0	
	09:00 pm	milk	200ml							200ml	0	
	10:00 pm	H2O	200ml								0	
	11:00 pm										0	
	12:00 am	H2o	200ml							150ml	0	
	01:00 am										0	
Total Intake :		800ml				**Total Output :**	350ml					
	02:00 am	H2o	200ml								0	
	03:00 am										0	
	04:00 am	H2o	200ml								0	
	05:00 am										0	
	06:00 am	H2o	200ml								0	
	07:00 am	H2o	200ml								0	
Total Intake :		600ml + 200 = 800ml				**Total Output :**	Nil					

Total 24 hrs. Intake	2,900 ml

Total 24 hrs. Output	1,350 ml motion - 1

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NURSING CARE RECORD

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Date: 3/7/2026

Goals

- ☐ Maintain Airway and Oxygenation
- ☐ Maintain Personal Hygiene
- ☐ Identify Potential Complications
- ☑ 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				I			
Afternoon	4pm	Achieve pain control Acceptable comfortable	4:30 pm	Assess pain using pain scale regularly position promptly Offer / reveal position	patient was stable	Reassessment was Done	Ready 01808
Night	8pm	Achieves Acceptable pain Control Comfortable	9pm	Assess pain using pain scale regularly position at Comfortably	patient was Stable	Reassessment was done	6077

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NURSING CARE RECORD

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Date: 1/8/26

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	8pm	Achieve Acceptable pain control & comfort	8:30 Am	Assess pain using pain scale regularly. position patient comfortably. ~~Administer Analgesics.~~	patient was stable	Reassessment was done	Akalya 01/8/26
Afternoon	2pm	maintain good nutritional status.	2:30 pm	maintained good nutritional status.	Encourage oral intake.	Reassessment done.	Soniya
Night	8pm	Maintain good Nutritional Status.	9pm	maintained Good Nutritional Status	encourage oral intake	Reassessment was done	6.0221

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NURSES NOTES

☑ ~~No Known~~ Drug Allergies
☐ Drug Allergies ..... INJ. TAXM Allergy .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Admission Notes	
21/12/26	4pm	patient come for admission Induction of Labour under Dr. priyadharshini She W/ Pom 39+1day known case of Hypothyroid. Surgical history of Cyst removal head (R). Checked for vital sign recorded Pt vital are stable pastis preparation was done CTG was connected FHR is good (+) patient general condition fair →	Ataka 0180
	4:30 pm	Dr. pavithra advised to Tab' mifee 50mg orally given to patient continue for CTG monitor FHR is good (+) →	Ataka 0180
		⇒ Dr. pavithra advised to stoped CTG pt shifted to ward FHR is good (+) →	Ataka 0180
	6pm	⇒ patient care handovers given to 4th floor staff Nurse →	Ataka 0180
	6pm.	Receiving notes on 21/12/26 patient received from LDR to 4th floor. patient details handy over taken from the ataka patient conscious and oriented. No/views patient is on Normal diet →	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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NURSES NOTES

☐ No Known Drug Allergies
☐ Drug Allergies Inj. Taxim Allergy

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
31/7/21	6pm.	Patient CTG @ 8pm Explain. Maintain Intake and output charts	Ph
	7:30pm.	Patient details handing over to night duty staff —	Ph
		NIGHT DUTY	
31/7/21	7:30pm	patient details handing over taken from evening duty staff pt was stable and conscious. CTG was connected on 8:00pm informed by mam no other complaints normal diet pt on hypothyroidism — Inj 600 mg	
	8:00pm	CTG was started and trace was sended to Dr. yasmin mam to see	
	8:30pm	Contraction CTG and mam say stopped Syntocinon & misoprostol — Inj 600 mg	
	9:30pm	CTG was started and Dr. yasmin mam came to see the patient and the abdomen Continue CTG — Inj 600 mg	
	10:00pm	CTG was going mam advice to give warm water Continue CTG	
	10:30pm	Mam say stop CTG and CTG on 8:00am patient walk freely	

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NURSES NOTES

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☑ No Known Drug Allergies
☐ Drug Allergies ..... Inj. Tarion Allergy .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
1/8/26	12:00pm	Vitals were checked and recorded maintain F/o Chart. no other Complaints	
	12:30pm	pt was sleep well & pt Complaints pain. Dr. pavithra mam advice to give Tab para 1gm. contraction Fair contraction 15 to 20 sec.	
		Shifting note	
	2:00pm	pt Complaints pain. Dr. pavithra mam Can be Receive pt pr was 5cm dilation 3cm. Dr pavithra mam ordered to shifted the LDR	
	2:15pm	pt details handing over given by LDR staff. pt shifted to 2nd floor to LDR	
		Receiving Notes	
	2.30pm	patient Received from 4th Floor to LDR. patient care Handing over taken from 4th Floor staff. Monitored vitals and Recorded. maintained IVo. CTG connected. FHR monitoring. patient complaints of pain. Informed to Dr. priyadharshini advised for Epidural. doctors order carried out. Epidural consent	

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NURSES NOTES

☐ ~~No~~ Known Drug Allergies
☐ Drug Allergies ..... Inj. Tazim Allergy .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
1/3/20		taken from patient and attender. IV cannulation done by SN. Devi 18G Venflon. IV Cannula observed	
	3AM	Catheterization done by Dr Pawithra 16 FR Foleys. No leaking, No onset of fever. Epidural done by Dr. Chetti. No any other complaints. pain assessment done	
	3.30pm	Dr. Pawithra advised for Inj. Synto in Connecta. Inj. Syntocinon 5 units in RL 500ml 21 ml/hr started CTG on Connect. FHR Monitoring No any other complaints	
	4AM	CTG on Connect. FHR Monitoring Maintained. No. pain assessment done. Contractions - Inj. Syntocinon 5ml/hr on connect. No other complaints.	
	4.15AM	Dr. Priyadharshini Mam done PV Examination. Cx well effaced os fully dilated, Membrane absent. Inj. Tazim o. Inj. Diclofenac Ix at @ station. CTG on Connect. Inj. Syntocinon 5ml/hr on connected as per doctor order	

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GUC-00084304 IP18-00036700
Mrs JEFFY JONE
20-06-1996 30 Y 1 M 12 D (F)
Dr. PRIYADHARSHINI S M

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NURSES NOTES

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☑ No Known Drug Allergies
☐ Drug Allergies ..... Inj. Taxim Allergy .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
1/8/20	4.48 AM	Patient developed mild itching redness over arms Breast after Inj. Taxim test dose. Full dose not given. CTG ON connect. FHR monitoring	01/8/20
	5.40 AM	Dr. Priyadharshini & well informed os fully dilated, membrane absent, Vx at +1 station. Inj. Ceftriaxone 0.1mg IM given as per doctor order	01/8/20
	5.46 AM	**Delivery Details** Vacuum assisted vaginal Delivery with Right mediolateral episiotomy under SAB, patient in dorsal lithotomy position, local parts painted and draped with gauze chlorine contraction full cervical dilation and good maternal efforts due to narrow pubic space decision made to apply vacuum cup 2% Lignocaine infiltrated into perineum. (R) mediolateral episiotomy cuts given. Vacuum cup applied at vertex and baby head delivered by extension. followed by Baby cord clamped and cut. Baby handed over to pediatrician.	

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NURSES NOTES

☐ No Known Drug Allergies
☑ Drug Allergies ..... INJ. TAXIM ALLERGY .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
1/8/26		Inj. carbetocin 100mg in 100ml NS IV given. episiotomy wound sutured in layer with Rapid Vicryl.	
		Baby details	
		B - Alive Girl Baby	
		A - 1/8/26 at 5.46AM	
		B - 3.018 kg	
		y - 7/10, 8/10	Jaw 01620
	6.30AM	patient General condition Fair. PV Bleeding Minimal. Patient conscious and oriented. No any other complaints.	
		B - Breast is Soft, No enlargement	
		U - Uterus contracted	
		B - Bladder Not yet voided	
		B - Bowel movement Present	
		L - Lochia Rubra No Foul smelling	
		E - REEDA Assessment Done	
		H - Human sign Negative	
		E - Emotional Status good	Jaw 01620
	7.30AM	patient Care Handing over given to Morning duty staff	Jaw 01620

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NURSES NOTES

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☐ No Known Drug Allergies
☑ Drug Allergies ..... INJ. TAXIM ALLERGY

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
01/8/26	7:30 Am	Morning duty patient care hand over taken from Night duty staff Nurse patient was stable conscious & oriented IV line posent & patent. Pt vital are stable patient general condition fair More fall risk assessment was done score is 0. pain Assessment was done Score is 1/10 →	Atalya 01808
	8Am	checked for vital signs recorded Pt vital are stable Bleeding minimal patient is wall care was done Tab' Thyronorm 25mcg orally given to patient have a food →	Atalya 01808
	9Am	B- Breast is soft No Enlargment U - Utrus was Contracted B - Bowel movement posent B - Pt is self voiding L - Lochia Rubra posent E - REEDA Assessment was done H - Homan signs negative E - Pt Emotional good	Atalya 01808

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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NURSES NOTES

☐ No Known Drug Allergies
☐ Drug Allergies ..... Inj TAXIM ALLERGY .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
11/8/26	10:30 Am	patient has voided 300ml Informed Dr. Akshitha Epidural catheter was removed patient was stable	
	11Am	⇒ Dr: Sreedevi post voiding scan was done advised to pt shifted to ward pt care hand over given to the floor staff Nurse	Akshaya 01800 Akshaya 0700
	11 PM	Receiving Notes On 11/8/26 patient received from LOR to the floor patient details handy Oxy taken from Shrinyalaya. patient conscious and oriented IV line patent clave present patient is on (A) diet	
	12pm	Vital Signs checked and Recorded Maintain Intake and Output Chart	
	1.30pm	patient details handy On Epaxy dici start	

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NURSES NOTES

☐ No Known Drug Allergies
☑ Drug Allergies ..... Inj. Taxim allergy.

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Evening Duty Notes:	
1/8/26.	1.30pm	Handover received from morning duty staff. child is active and oriented. IV line present. Normal diet. Tomorrow CBC to be done.	Jeffy Orsk
	2pm	patient taken diet. No other vomiting complaints.	
		Checked vital sign and Recorded.	Jeffy
		Administered due medication as per chart and Recorded.	01955.
	3.30pm	ptn side Dr. Vinitha mam come and see the ptn	
		Dr. vinitha advice ptn intake of water, ambulate the ptn. plenty of water tomorrow morning 6 am CBC sample testing and vitals monitor, watch for PV bleeding is normal, ptn is stable.	Yha
	5.pm	ptn vitals are monitoring and stable. ptn continues monitoring Plt chart and PV bleeding is normal.	Yha
	6.30pm	ptn feeding is low amount of secretion and advice the ptn intake of adequate	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

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NURSES NOTES

☑ No Known Drug Allergies
☐ Drug Allergies ..... Inj Ibuprofen Allergy .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
01/8/26	6.30am.	water. continues monitoring Obstet. pt is stable. dose medication given as per drug chart order. No any other complaints	TBA
	7.30 pm.	patient details handing over to Night duty staff.	
		NIGHT DUTY	
01/8/26	7.30pm	patient details handing over taken from morning duty staff. pt was stable. Complaints pain in episiotomy site. tomorrow CBC was taken at 6am. tomorrow plan for discharge	
	8.00pm	Vitals was checked and recorded maintain no chart no other complaints IV line is patter medication was given as per drug order	
	10.00pm	B - Breast is Normal U - Uterus is Contracted B - Bowel movement is normal B - Bladder urine was voided L - Lochia Rubra is present E - Legs is applicable H - Homan sign is negative	

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GUC-00084304 IP18-00036700
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PAIN ASSESSMENT FORM

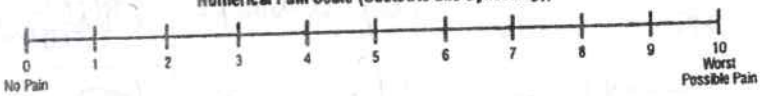
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
31/7	4pm	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NO pain	Akalya 01/8/26
31/7	10AM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	No pain	[illegible] 6.07.26
1/8/26	2.30 pm	2/10	Back & Abdomen	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Epidural	[illegible] 01/8/26
1/8/26	5AM	1/10	Episiotomy site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Pharmacology therapy	[illegible] 01/8/26
1/8/26	8AM	4/10	Episiotomy site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	comfortable position	Akalya 01/8/26
1/8/26	2pm	1/10	episiotomy site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Comfortable position.	[illegible] 01/8/26
1/8/26	8pm	1/10	episiotomy site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	comfortable position	[illegible] 6.07.26
2/8/26	12pm	1/10	episiotomy site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	comfortable position	[illegible] 6.07.26
2/8/26	8PM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	[illegible] 02/8/26
				☐ 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

GUC-00084304 IP18-00036700
Mrs JEFFY JONE
20-06-1996 30 Y 1 M 11 D (F)
Dr. PRIYADHARSHINI S M

BRADEN 'Q' SCALE

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

BirthRight
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Your Right to a Safe Delivery

					Date : 31/7 31/2 3/8/26 1/8/26
					Time : 4pm 8pm 8am 2pm
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4 4 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. Linan 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 physiologicaily 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	Akal 60777 01888 Dhj

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

GUC-00084304 IP18-00036700
Mrs JEFFY JONE
20-06-1996 30 Y 1 M 12 D (F)
Dr. PRIYADHARSHINI S M

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 : 1/8/26	2/8/26		
					Time : 8pm	8AM		
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.	2	4		
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	3	3		
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4		
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4		
FRICTION-SHEAR **Friction** . Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4		
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	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		
				TOTAL SCORE	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
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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-00084304 IP18-00036700
Mrs JEFFY JONE
20-06-1996 30 Y 1 M 11 D (F)
Dr. PRIYADHARSHINI S M

(D)

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

BirthRight™ BY RAINBOW HOSPITALS
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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	E 31/7/26	N 31/7/26	M 1/8/26
		Score	10	10	20
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
	No	0			
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10	10	10	
	Normal /On Bed Rest /Immobile	0			
Mental Status	Forgets limitations	15			
	Oriented to own ability	0	0	0	0
Total Morse Fall Scale Score:			10	10	20
		Signature	01808	607778	01808

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

GUC-00084304 IP18-00036700
Mrs JEFFY JONE
20-08-1996 30 Y 1 M 11 D (F)
Dr. PRIYADHARSHINI S M

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BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	01/8/26	N 1/8/26	N 2/8/26
		Score	30	30	30
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	10	10	10
	Normal /On Bed Rest /Immobile	0			
Mental Status	Forgets limitations	15			
	Oriented to own ability	0	0	0	0
Total Morse Fall Scale Score:			30	30	30
		Signature	[signature]	[signature]	[signature] 02 Jaar

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 NO:
Age :
GUC-00084304 IP18-00036700
Mrs JEFFY JONE (F)
20-06-1996 30 Y 1 M 11 D
Dr. PRIYADHARSHINI S M
M ☐ F
Consultant :

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 1/8/26 Time: 2.30AM
Location : Left - metacarpal
Size : 18G
Cannula inserted by : S/N - Devi

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
1/8/26	3AM	☐Yes ☒No	☐Yes ☒No	observed	
	5AM	☐Yes ☒No	☐Yes ☒No	observed	
	7AM	☐Yes ☒No	☐Yes ☒No	observed	
	9Am	☐Yes ☒No	☐Yes ☒No	Obser	
1/8	1pm	☐Yes ☒No	☐Yes ☒No	obsm	
	5pm	☐Yes ☒No	☐Yes ☒No	observe	
	7pm	☐Yes ☒No	☐Yes ☒No	obser	
	9Am	☐Yes ☒No	☐Yes ☒No	obsme	
	11pm	☐Yes ☒No	☐Yes ☒No	obsme	
2/8/26	1Am	☐Yes ☒No	☐Yes ☒No	obsme	
	3Am	☐Yes ☒No	☐Yes ☒No	obsme	
	5Am	☐Yes ☒No	☐Yes ☒No	obsme	
	Am	☐Yes ☒No	☐Yes ☒No	obse	
	11AM	☐Yes ☐No	☐Yes ☐No	patten	
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐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

GUC-00084304 IP18-00036700
Mrs JEFFY JONE
20-06-1996 30 Y 1 M 11 D (F)
Dr. PRIYADHARSHINI S M

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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
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		
3/7	4pm	Yes	Explained about the pain management	pt	Eduction level	Orally	Non	Yes	good	Staffnurse
01/8/25	8am	yes	Explained about the Fall risk.	pt	Eduction level	orally	Non	Yes	good	01805 Staffnurse 01805
2/8/25	8AM	yes	Explained about the pain management.	Patient	Eduction Level	Oral	Non	yes	good	02nurse

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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LABOUR AND DELIVERY NURSING ASSESSMENT

Date of Admission: 31/7/2026

Baseline Information:

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

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 Attenders

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

If yes , identify .....

Chief Complaints: Pt came for tor

Doctor Notified on Admission: ☐ Yes ☐ No

Name of the Doctor: Dr. Pavithra

Time Notified: 4:40 Pm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Anemia treated fem 500mg. Hypothyroid. Dengue NS1 positive. at 28weeks	2cyst removal. LSCS under local anesthesia head to (R) Eal.	—

Blood Group: Otve LMP: 30/10/25 EDD: 6/8/26 Gestational age during admission: 39+1 days

Contractions: No Vaginal Discharge: No

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

Height: 159 Weight: 64.2kg BMI: 24

Temp: 98°F HR: 88 bpm RR: 20 b/m BP: 110/70 mmHg SpO$_2$ 100%

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

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

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Family History: ☐ No Abnormalities Detected

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

☐ Liver disease ☐ Other ..... Mother - Hypothyroid / Father DM .....

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

Fall Assessment: ☐ Yes ☑ No Score ..... 15 ..... (complete the Morse Fall Risk Assessment Sheet)

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

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

☐ Mobility problem ☐ Walking Problem ☑ No Abnormality Detected

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

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

☐ Under Weight ☐ Diabetes Mellitus ☑ No Abnormality Detected

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

☐ Others .....

Inform consultant for positive criteria

SOCIAL SCREENING:

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

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

Social History: Lives With ..... Husband .....

Orientation has been given regarding the following aspects:

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

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

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

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

Orientation not given Reason: .....

Nurse Signature: .....

Nurse Name: ..... 01809 .....

Date & Time: ..... 31/7/24 at 4:40pm .....

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OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 31/7/2026 Time of Arrival: 4pm Time Seen by Nurse: 4pm

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: FOL

3) **Vital Signs:** Temperature: 98F Pulse: 81bpm RR: 20bpm SpO_2: 100 BP: 110/70mmHg Weight: 64.2kg

4) **Gestational Criteria:**

Gravida:	G 1	P —	L —	A —

LMP: 20/10/25 EDD: 6/8/2026 Gestational Age: 39+1 day

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)

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

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

6) **Past History:**

a) Surgeries: Cyst removal & Local Anesthesia Incision to Right Fem.

b) Medical: Hypothyroid (Anemia) Treated FEM100mg

(P.T.O.)

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: 4:40pm

Nurse Name: S.N.A Kaur 018050 Nurse Signature: SA 018050

Date: 31/10/21 Time: 4:30pm

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RISK ASSESSMENT TOOL FOR DEEP VEIN THROMBOSIS

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

Date: 31/7/26

Pre - Existing Risk Factors	Tick	Score
Previous VTE (except a single event related to major surgery)		4
Previous VTE provoked by major surgery		3
Known high-risk thrombophilia		3
Medical comorbidities e.g. cancer, heart failure; active systemic lupus erythematosus, inflammatory polyarthropathy or inflammatory bowel disease; nephrotic syndrome; type I diabetes mellitus with nephropathy; sickle cell disease; current intravenous drug user		3
Family history of unprovoked or estrogen-related VTE in first-degree relative		1
Known low-risk thrombophilia (no VTE)		1
Age (≥35 years)		1
Obesity		1
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		1
Signature of the Nurse	S/M Mccarley 0150	
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.

Patient Sticker

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URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 1/2/26 at 3:30AM Date of Removal: 1/2/26 at 5-30AM

Parameters	Date / Shift Time	1/2/26 3AM						
Need for the Catheter		☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hand Hygiene		☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Usage of Sterile Equipment		☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the Collection bag below the level of bladder		☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Check the Tube for Obstruction (Free of Kinking)		☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Catheter dated as policy		☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Collecting bag is been emptied regularly?		☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Maintenance of closed system for the catheter		☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing clean and dry?		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the line removed as Policy?		☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Performance of Perineal Care		☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Onset of New Fever		☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Asses for the leakage at the site of insertion		☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Nurse		SN Tanuja Sahu						
Signature of the Nurse								

CBD removed

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

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INSTRUMENTAL DELIVERY PROFORMA

Patient Label

GUC-00084304 IP18-00036700
Mrs JEFFY JONE
20-06-1996 30 Y 1 M 12 D F)
Dr. PRIYADHARSHINI S M

OBSTETRICIAN	Dr. Priyadharshini	
ANAESTHETIST		
ASSISTANT	Dr. Pavithra	
DATE	1/08/2026	
TIME	5:46 Am	
PLACE	LABOUR WARD	THEATRES

CONSENT	EPISIOTOMY	BLADDER EMPTIED?
VERBAL / WRITTEN	YES / NO	FOLEY IN/OUT NO
ANALGESIA LOCAL / PUDENDAL AMOUNT USED 10ml MLS OF _____ EPIDURAL / SPINAL GA	**CTG** NORMAL / SUSPICIOUS / PATHOLOGICAL (WRITE FULL DETAILS IN MAIN NOTES IF NOT NORMAL CTG)	**LIQUOR** CLEAR / BLOOD STAINED / MECONIUM **ABDOMINAL FINDINGS** 0 /5 PALPABLE

VAGINAL EXAMINATION

NUMBER OF CMs DILATED 10cm
STATION OF PRESENTING PART -1 / 0 / +1 / +2 / +3

POSITION	DOA / LOA / ROA / ROP / LOP / DOP / LOT / ROT
CAPUT	0 + ++ +++
MOULDING	0 + ++ +++

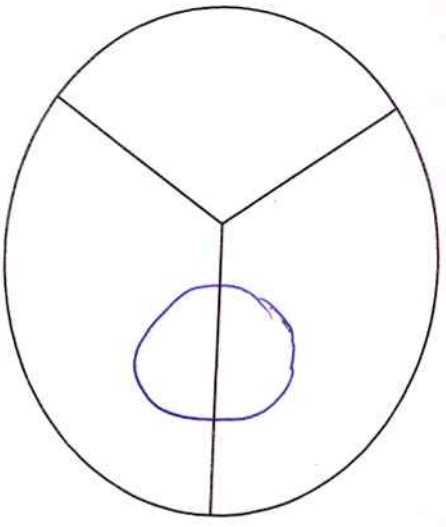
INSTRUMENT USED

Vacuum cup
KIWI CUP / NEVILLE BARNES / WRIGLEYS / KIELLANDS / SIMPSONS

MANUAL ROTATION	TIME OF APPLICATION	No. OF TRACTIONS
YES / NO	5:45Am	-
ABANDONED YES / NO (FULL DETAILS IN NOTES)	**TIME OF DELIVERY** 5:46 Am	**LENGTH OF DELIVERY** -

Brief description of delivery and perineal repair.

(Please mark ventouse position on diagram)



EXTENT OF TEAR

EPISIOTOMY / 1ST degree / 2ND degree / 3A / 3B / 3C / 4TH degree (If 3rd or 4th, please complete proforma)

SUTURE MATERIAL USED	**SUTURE TECHNIQUE**	**PR**	**PV**
2/0 VICRYL (number.....) 3/0 VICRYL (number.....) OTHER? Rapid vicryl.	CONTINUOUS/INTERUPTED SKIN CLOSED? YES/NO	YES / NO	YES / NO

FOLEY CATHETER	**SWAB COUNT**		**ANTIBIOTICS**	**ANALGESIA**
YES NO REMOVE .... (SHOULD REMAIN IN SITU FOR MIN OF 12HRS IF REGIONAL BLOCK USED)	PRE – REPAIR Correct POST – REPAIR Correct		YES / NO (PRESCRIBE ON DRUG CHART)	YES / NO (PRESCRIBE ON DRUG CHART)
	PARACETAMOL 1GM PR YES / NO	**DICLOFENIC 100MGS PR** YES / NO		

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Mrs JEFFY JONE
20-06-1996 30 Y 1 M 12 D (F)
Dr. PRIYADHARSHINI S M

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: ☐ Nome ☐ Pyrexia ☐ HTN ☑ Others Hypothyroid

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 Vacuum
☐ Trails of Forceps

Indications: Narrow Subpubic arch

Application, Locking & Traction: .....

Duration of Instrumentation: .....

No. of Pulls: .....

Catherised : ☑ Yes ☐ No

Type: ☑ Fileys ☐ Plain

Perineum : ☐ Intact ☑ Episiotomy ☐ Tear

Suture Material Used: Rapid vicryl

STAGE III

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

PPH : ☐ Atomic ☐ Traumatic ☑ None

Lacerations: .....

Cervical: .....

Perineal: Episiotomy

Others: .....

Prophylaxis: (Synocinon) Prostodin

Blood Loss: 350 ml

Blood Transfusion: .....

Other Details (if any): .....

Ractal Examination: Normal

DURATION OF LABOUR

1st Stage: 4 hours

2nd Stage: 10 mins

3rd Stage: 5 mins

Duration of Active Pushing: .....

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

BABY DETAILS

Gender: Girl

Weight: 3.018 kg

APGAR: 7/10, 8/10

Date and Time of Delivery: 11/8/26 ; @ 5:46 am

LW Doctor: Dr. Priyadharshini

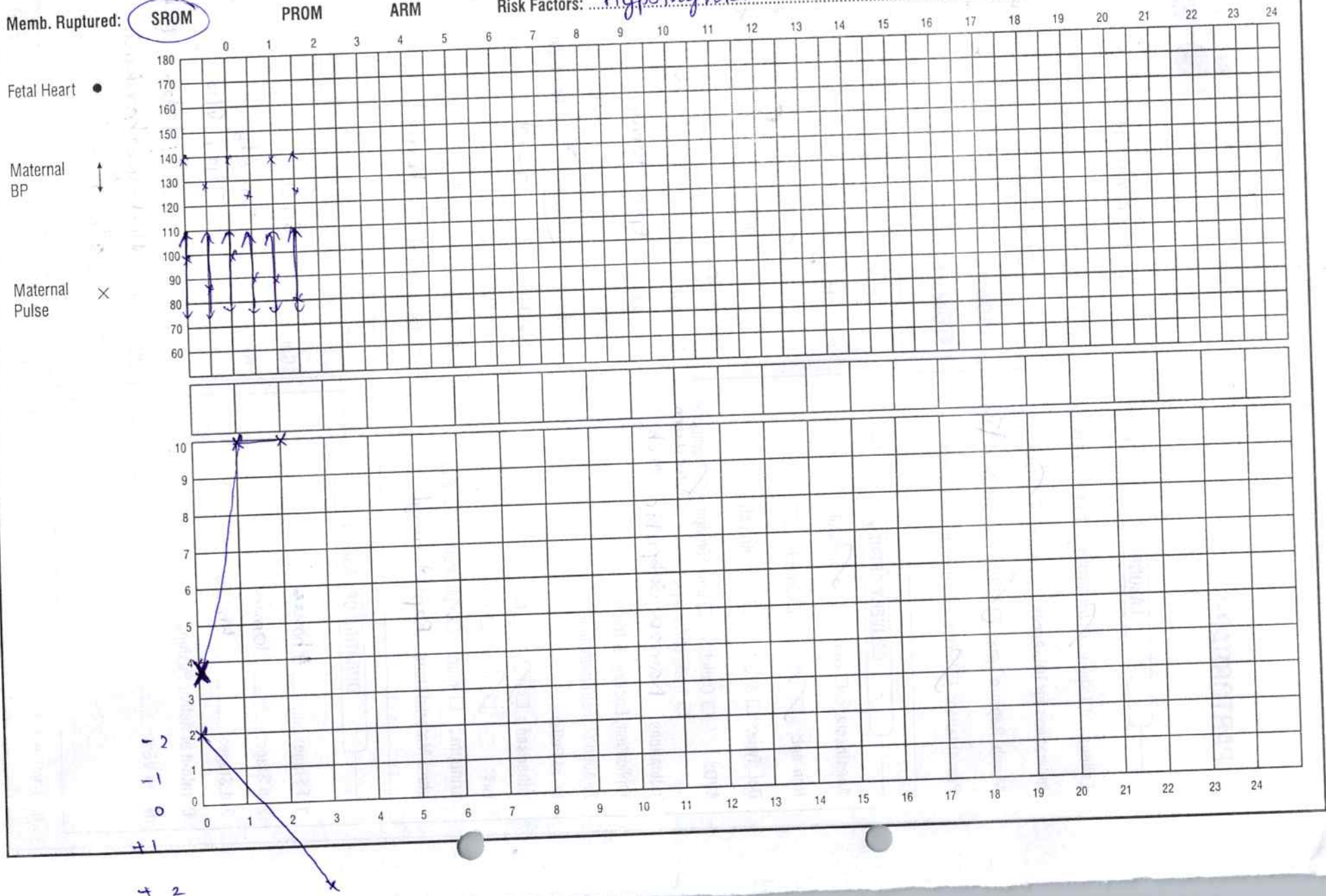
LW Sister: S. N. Devi

(P.T.O.)

PARTOGRAPH

Name: Mrs. Jeffy Jane Obstetrics Formula: Primi Blood Group Type: O +ve

Memb. Ruptured: SROM PROM ARM Risk Factors: Hypothyroid



Time	3:20 Am	4:20 Am	5:20 Am	6:20 Am
Signature	182217	182217	182217	182217
Fifths Palpable	3/5	0/5	0/5	0/5
Moulding / Caput	N / N	N / N	N / N	N / N
Amniotic Fluid	C	C	C	C
Position Cephalic / Breeth	C	C	C	C
Oxytocin	24 ml/hr	72 ml/hr	120 ml/hr	120 ml/hr
Contractions in 10 mins (5, 4, 3, 2, 1)				
Drugs and IV Fluids	10 RL	10 RL	10 RL	10 RL
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: .....

INFORMED CONSENT FOR VAGINAL BIRTH

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BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

GUC-00084304 IP18-00036700
Mrs JEFFY JONE
20-06-1996 30 Y 1 M 12 D (F)
Dr. PRIYADHARSHINI S M

UHID No : .....

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. Priyadharshini

Consentee :

Signature : J. Jeffy

Name : Mrs. JEFFY JONE

Date & Time : 31/7/26

Patient Attendant :

Signature : .....

Name : Mr. ABISHEK.J

Relationship with Patient: .....

Date & Time : 31/7/2026

Witness :

Signature : .....

Name : .....

Date & Time : .....

Doctor (who is taking the consent) :

Signature : 82217

Name : Dr. Shreedevi

Date & Time : 31/07/2026

Patient Sticker

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Your Right to a Safe Delivery

INDUCTION OF LABOR CONSENT

GUC-00084304
IP18-00036700
Mrs JEFFY JONE
20-06-1996 30 Y 1 M 12 D (F)
Dr. PRIYADHARSHINI S M

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

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

You are scheduled for an induction of labor on 31/07/2026 (date) at 39 weeks + 1 day (weeks of gestation).

The reason for your induction is Term

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: J. Jeffy
Name: MRS. JEFFY JONE
Date & Time: 31/7/26

Patient Attendant:
Signature: .....
Name: MR. ABISHEK. J
Relationship with Patient: .....
Date & Time: 31/7/26

Doctor:
Signature: 182217
Name: Dr. Shreedevi
Date & Time: 31/07/2026

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

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CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MAC

GUC - 00084304.

Patient Name : Mrs. JEFFY JONE Age : 30yrs

Gender : M ☐ F ☑ - IP No : IP18 : 00036700 Consultant : Dr. PRIYADARSHINI S.M.

Ward / Bed No. : Anaesthesiologist : Dr. Chitti Subban

Operative procedure planned : labour Epidural Analgesia.

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

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

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

☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure

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

☐ Incapacitating COPD ☑ Others : Hypertension

Comments : .....

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

DECLARATION BY PATIENT / GUARDIAN / PROXY

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

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

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

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

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

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

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

Pregnant: ☑ Yes ☐ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

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

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

Patient / Patient Attendant :

Signature : J. Jeffy

Name : JEFFY JONE

Relationship with Patient: SELF

Date & Time : 1/8/26 at 2.30 AM

Witness :

Signature : .....

Name : Mr. ABISHEK.T

Date & Time : 1/8/26

Doctor (who is taking the consent) :

Signature : 89365

Name : Dr. Clitt Subhan

Date & Time : 1/8/2026 2.50 pm

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Ip no: 18-00036700

Name: MRS. JEFFY JONE Age: 30 Sex: F UHID.No : GWC-00084304

Date: 11/8/2026 Time: 2.50 pm Proposed ~~Operation~~ Procedure: Labour Epidural analgesia

Diagnosis: PRIMIGRAVIDA / 39w+2D / Hypothyroidism on ?

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

Laboratory Data:

Hgb: 9.8	Glucose: FBS 89 / PPBS 132	Protein:	HIV:	X-Ray:
PCV: 31.2	Urea:	Alb:	HBS Ag: N/R	ECG:
WBC: 8,100	Creat:	Total Bill:	HCV:	2D Echo:
Plate: 3.46 L	Na:	Dir. Bill:	Blood group: O" POSITIVE	Stress/Anglo:
PT:	K:	LDH:	T3	Other:
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH 2.11	
BT/CT = 1'38" / 5'15"	Cl-:	SGOT/SGPT:		

Allergies: NKDA

Medical History: CVS : -

RESP : - Diabetes : -

CNS : - H/o Dengue (+) => 7th month of Pregnancy.

Renal : -

Hepatic / GE : - Physical Activity: METS > 4.

Others : K/C/O Hypothyroidism on ? T. Thyronorm 25 mg OD.

Past Anaesthetic History: -

Physical Exam: PA. Conscious, oriented, afebrile

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

Lungs : B/L AE (+)

Heart: S1S2 (+).

CNS: NFND

Pregnant: ☑Yes ☐No ☐NA | Venous Access Site : (+) Spine Exam for regional : (N)

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

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

Signature: ..... Name: Dr. Chitti Subban

89365

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

Patient Sticker

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☐ No		Fasting Status:	
Physical Status:	Patient Identified	☐ Consent Present	☐ Chart Reviewed

H.R:	B.P / CRT:	SpO_2:	R.R:	Last Feed:

Pre-OP Diagnosis: ..... Operation: ..... Date : .....

Surgeon: ..... Anaesthesiologist: ..... Technician: .....

TIME

N_2O /AIR /O_2 LPM

HALO /SO /SEVO

Drugs:

FIO_2 / SaO_2

$ETCO_2$

ECG

Temperature

Urine Output

Fluids

Blood

Antibiotic

Suppository

Blood Loss

NOTES

B.P
V Systolic
Λ Diastolic
X Mean
• Heart Rate

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

240 220 200 180 160 140 120 100 80 60 40 20 10 0

LAB Values

ABG

GRBS

Others

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

Position: .....
☐ Pressure Points Checked

Eye Care:
☐ Oint
☐ Tape
☐ Padding
☐ Awake

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

Times:
Anaes Start: .....
OP Start: .....
OP End: .....
Leave OR: .....

Anaesthesia:
☐ GA
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP: .....
☐ ART: .....
☐ IV: .....
☐ IV: .....
☐ IV: .....

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

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

☐ Awake ☐ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# ..... Attempts: .....
Difficulty Why? .....

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

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

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

Name of the Doctor : .....
Signature of the Doctor : .....

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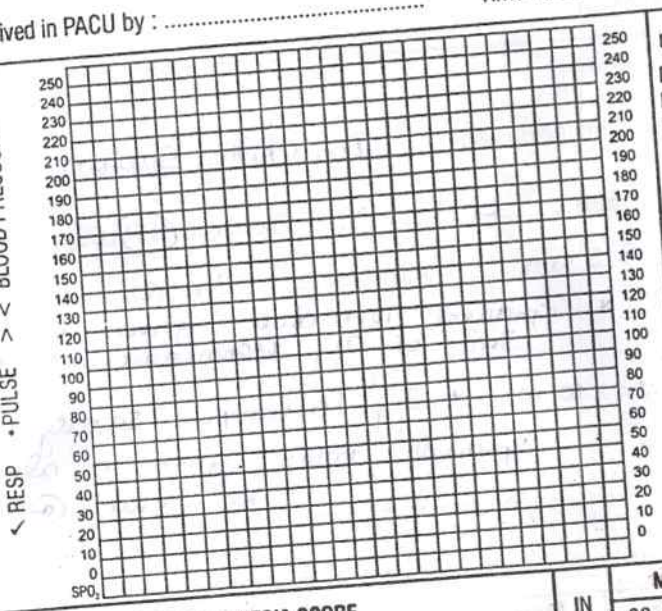
Patient Sticker

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : ..... Time Received : ..... Time Discharged : .....



IV Cannula Site : .....

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

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

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

SCORING INTERPRETATION

A Minimum Total Score of 8 is Required for Discharge

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature

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

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

Anaesthesiologist Name : .....
Anaesthesiologist Signature: .....
Date & Time: .....

PACU Nurse Name : .....
PACU Nurse Signature: .....
Date & Time: .....

Transferred to Unit by (PACU): .....
Date & Time: .....

Mrs. JEFFY JONE 30/F.

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: 1/8/2026 Time: 2.50 am. Procedure done by Dr. Chitti Subhan

CSE /Spinal /(Epidural) Position : Sitting Space : L1-L2 Technique (LOR)/LOS)

Depth: 3.5 cms Catheter at Skin: 8.5 cms Attempts : Single

Parasthesia (Yes)/No if yes details : Inj. * Epidural Test dose given : 3ml of Inj. Lignocaine 1.5% + Adrenaline 5 mcg/ml

Solution Composition : Inj. Ropin 0.2% 10 ml + Inj. Fentanyl 50 mcg

Any other issues :

a) Epidural Bolus given in aliquots of 5ml @ 3am

b)

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

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

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

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: 89365

Doctor Name: Dr. Chitti Subhan

Date and Time : 1/8/2026 3.10 am

RAINBOW CHILDREN'S MEDICARE LIMITED
157 - 160, Anna Salai, Guindy, Chennai - 600 015.

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Sl.No. 2560

NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name :		Age:	Gender:
UHID No:	IP No:	Date:	Date:
Diagnosis:			Time:

PRESCRIPTION DETAILS (Tick only one of the following)

S.No.	Drug Name	Dosage / No. Vials / Ampoule	Remarks
1.	Inj Fentanyl Citrate (100 mcg/2ml)		
2.	Fentanyl Citrate 25 mcg patch		
3.	Morphine Inj 10 MG / ML		
4.	Pethidine 50 MG / 1ML		

Doctor Name:

Signature:

Doctors Medical Council Registration No.

NARCOTIC DISPENSING FORM
APPENDIX 4 - FORM NO. 3E
(Details of the Patient to whom Essential Narcotic Drugs Dispensed

IP Registration No: .....

Date: .....

Aadhaar No. of the patient(optional):.....

1.	**Name**			**Remarks**	
2.	Complete postal address (with contact number, if any)				
3.	Brief description of the illness				
4.	Whether registered with any other registered medical practioner / recognized medical institution (if yes, details to be recorded)				
5.	Details of essential narcotic drugs dispensed				
Date		**Name of the Essential Narcotic Drugs**	**Quantity**	**Signature / Thumb Impression of the patient**	**Remarks, if any**

Dispensed by (Name & ID No.):

Signature:

Received by (Name & ID No.):

Signature:

Time:

Docu. No: RCHBH /FRM / CLINICAL / 133

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Birthright

Sl.No. 2560

PATIENT TRANSFER FORM

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GUC-00084304 IP18-00036700
Mrs JEFFY JONE
20-06-1996 30 Y 1 M 11 D (F)
Dr. PRIYADHARSHINI S M

Date & Time of Admission	Date & Time of Transfer Order
31/7/26 @ 4.47 pm	01/8/26 @ 2:15 pm

Treating Consultant Name	Transfer Ordered by	Reason for Transfer
Dr. priyadharshini	Dr. pavithra	For further procedure

From Unit	To Unit	Information to Attendant
7th floor	LDR	Yes ☒ No ☐

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

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	under pad	1
2.	eAsma	1
3.	Polyflurb	3
4.	Monflon	1
5.	Bacclo Scrub	

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
V. Abirami	Dr. Pavithra

Patient & Clinical Records Received by : M. Dani 01/8/26

Date & Time of Patient Received : 1/8/26 at 2.15 pm

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

Unavailable Bed Nurse not Available Available Bed not ready

(1)

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PATIENT TRANSFER FORM

GUC-00084304 IP18-00036700
Mrs JEFFY JONE
20-08-1996 30 Y 1 M 11 D (F)
Dr. PRIYADHARSHINI S M

	Date & Time of Admission	Date & Time of Transfer Order
	3/7/2026 at 4:47pm	3/7/2026 at 6pm
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr. priyadharshini	Dr. pavithra	Observation
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**
whole IP files	CD 4	Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐
Pt shifted to ward

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sathkala	Dr: pavithra,

Patient & Clinical Records Received by : Hari 6/7/26 6:10pm

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

(3)

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PATIENT TRANSFER FORM

GUC-00084304 IP18-00036700
Mrs JEFFY JONE
20-06-1996 30 Y 1 M 12 D (F)
Dr. PRIYADHARSHINI S M

No.	Date & Time of Admission	Date & Time of Transfer Order
	31/7/26 at 4:22 Apm	1/8/26 at 11 Am

Treating Consultant Name	Transfer Ordered by	Reason for Transfer
Dr. priyadharshini	Dr Akshitha	Observation

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
Whole Tp files	—	Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	Tab: pantoprazole	(9)
2.	Tab: Zerodol sp	(10)
3.	Tab. Reftum	(10)
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
S/Nakaya 01800	Dr: Akshitha

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

GUC-00084304 IP18-00036700
Mrs JEFFY JONE
20-06-1996 30 Y 1 M 12 D (F)
Dr. PRIYADHARSHINI S M

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NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 01/08/2026 Time: 01:20PM

Origin: — Height: 159cm Weight: 64.2 kg BMI: ☑ ~26 kg/m² ☐ ~28 kg/m² ☐ ~30 kg/m²

Food Allergies: NIL

Diagnosis: Vacuum Assisted Vaginal Delivery T RMLE.
· Anemia
· Hypothyroid

Type of Diet: ☐ Liquid ☐ Soft ☑ Normal ☐ Diabetic
☐ Vegetarian ☐ Non-Vegetarian ☐ Vegan

Diet Advised:

Liquid Diet – ORS/ Coconut Water / Butter Milk / Barley Water / Soups

Normal Diet – Rice, Rotis, Dal and Soft Cooked Vegetables and Curd

Soft Diet – Soft Rice, Dal and Vegetable Curries Soft Cooked, Curd

Diabetic Diet – Brown Rice / Oats/ Dahlia/ Rotis, Dal and Vegetables and Curd (Avoid Roots / Tubers)

Patient's / Attendant's Signature: Husband J.A

Name: ABISHEK. J

Date & Time: 1-8-26 / 1:20PM

Dietician's Signature: A.S (01833G)

Name: A. Sadiqa Farheen

Date & Time: 1-8-26 @ 1:20PM

DIETARY NOTES

Date	Time	Notes	Sign
01/08/26.	8:30 AM.	Vacuum Assisted Vaginal Delivery ~~I~~ RMLE. • Normal Diet. • Patient is stable. Oral intake is Better. - Advised to take easy - digest foods. - Consume small - frequent meals. - Include galactogogues food for milk secretion - garlic, fennel and Oats (etc) - ~~POA - Values~~ Energy — 1600 kcal. Protein - 17 - 19 g/d.	A.M (Col 8336)