

GUC-00086320
Mrs SUMATHI T
20-07-1995
Dr. LUCETTA AMELIA DIAS

IP18-00036308

30 Y 11 M 13 D (F)



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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

ACTIVITY RECORD FOR BILLING

Name: Mrs. SUMATHI T. UHID No: 86320 IP No: 36308 Consultant: Dr. Lueth Dept: LDR
Date of Admission: 3/7/26 Time: 5:21pm Date of Discharge: _____ Time: _____
Room / Bed No: _____ Ward: _____ Suggested Billable bed type: _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
3/3/26	7:40pm	LDR	5th floor	Shy Akah 01800
5/7/26	11:30AM	5th Floor	LDR	8/10 Q. Use rooms
5/7/26	2:30pm	2nd	5th floor	Alay/lu
5/7/26	10pm	5th	LDR	Baluy/02068r
6/7/2026	2:20pm	LDR	5th floor	DL 015177

CROSS CONSULTATION VISIT

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

INVESTIGATIONS

[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

[illegible]

ANY OTHER INFORMATION:

OTHER INFORMATION:
6/7/2026 Kluvi Affected Normal vaginal delivery.
Patient's Name:- 06/7/2026 at 11am to 12pm.
Business: 1 hour

Barkings : 1 hour

Dr. Lucette

DR. Pauthe

Date: 7/7/20 Time: 2:30 PM

Prepared By:

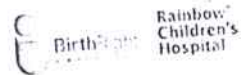
Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor

5th Floor



DISCHARGE TRACKING SHEET

UHID-

FLOOR-

NAME OF CONSULTANT-

GUC-00086320 IP18-00036308
Mrs SUMATHI T
20-07-1995 30 Y 11 M 16 D (F)
Dr. LUCETTA AMELIA DIAS



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

DISCHARGE TRACKING SHEET

UHID-

FLOOR-

NAME OF CONSULTA

GU:00086320

IP18-00036308

Mrs SUMATHI T

20-07-1995

30 Y 11 M 16 D (F)

Dr. LUCETTA AMELIA DIAS



ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement					
	INTIME	OUT TIME			
Arrangement of File by Nursing		7.30 pm	<i>[Signature]</i>		
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-00086320
Mrs SUMATHI T
20-07-1995
Dr. LIJETTA AMELIA DIAS



IP18-00036308

30 Y 11 M 15 D (F)

URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 6/7/26 at 6.30pm

Date of Removal:

Parameters	Date	Shift Time	6/7 P	6/7 N	7/7 M				
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			<i>Amelias</i>	<i>C. Prof</i>	<i>R. V. K.</i>				
Signature of the Nurse			<i>Amelias</i>	<i>S. Prof</i>	<i>R. V. K.</i>				

PARTOGRAPH

LABOUR

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

Indications for IOL-Accel: ☐ None ☐ Oxytocin

Memb. Repture Type: ☐ SRM ☐ PROM ☐ ARM

Presentation: ☐ Vertex ☐ Breech ☐ Others

INTRA PARTUM COMPLICATION

Maternal: ☐ Nome ☐ Pyrexia ☐ HTN ☐ Others

Liquor: ☐ Adequate ☐ Oligo ☐ Poly ☐ Clear

☐ Blood ☐ Meconium ☐ Cord:

Shoulder Dystocia: ☐ Yes ☐ No

DELIVERY DETAILS

Anesthesia: ☐ None ☐ Epidural

Non-epi: ☐ Local ☐ Spinal ☐ General

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

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

Indications:

Application, Locking & Traction:

Duration of Instrumentation:

No. of Pulls:

Catherised: ☐ Yes ☐ No

Type: ☐ Fileys ☐ Plain

Perineum: ☐ Intact ☐ Episiotomy ☐ Tear

Suture Material Used:

STAGE III

Placenta: ☐ Normal ☐ Abnormal ☐ RP Clots

☐ CCT ☐ Retained ☐ MRP

PPH: ☐ Atomic ☐ Traumatic ☐ None

Lacerations:

Cervical:

Perineal:

Others:

Prophylaxis: Synocinon Prostodin

Blood Loss:

Blood Transfusion:

Other Details (if any):

Ractal Examination:

DURATION OF LABOUR

1st Stage:

2nd Stage:

3rd Stage:

Duration of Active Pushing:

No. of VE'S:

BABY DETAILS

Gender:

Weight:

APGAR:

Date and Time of Delivery:

LW Doctor:

LW Sister:

PARTOGRAPH

Name:

Obstetrics Formula:

Blood Group Type:

Memb. Ruptured:

SR0M

PROM

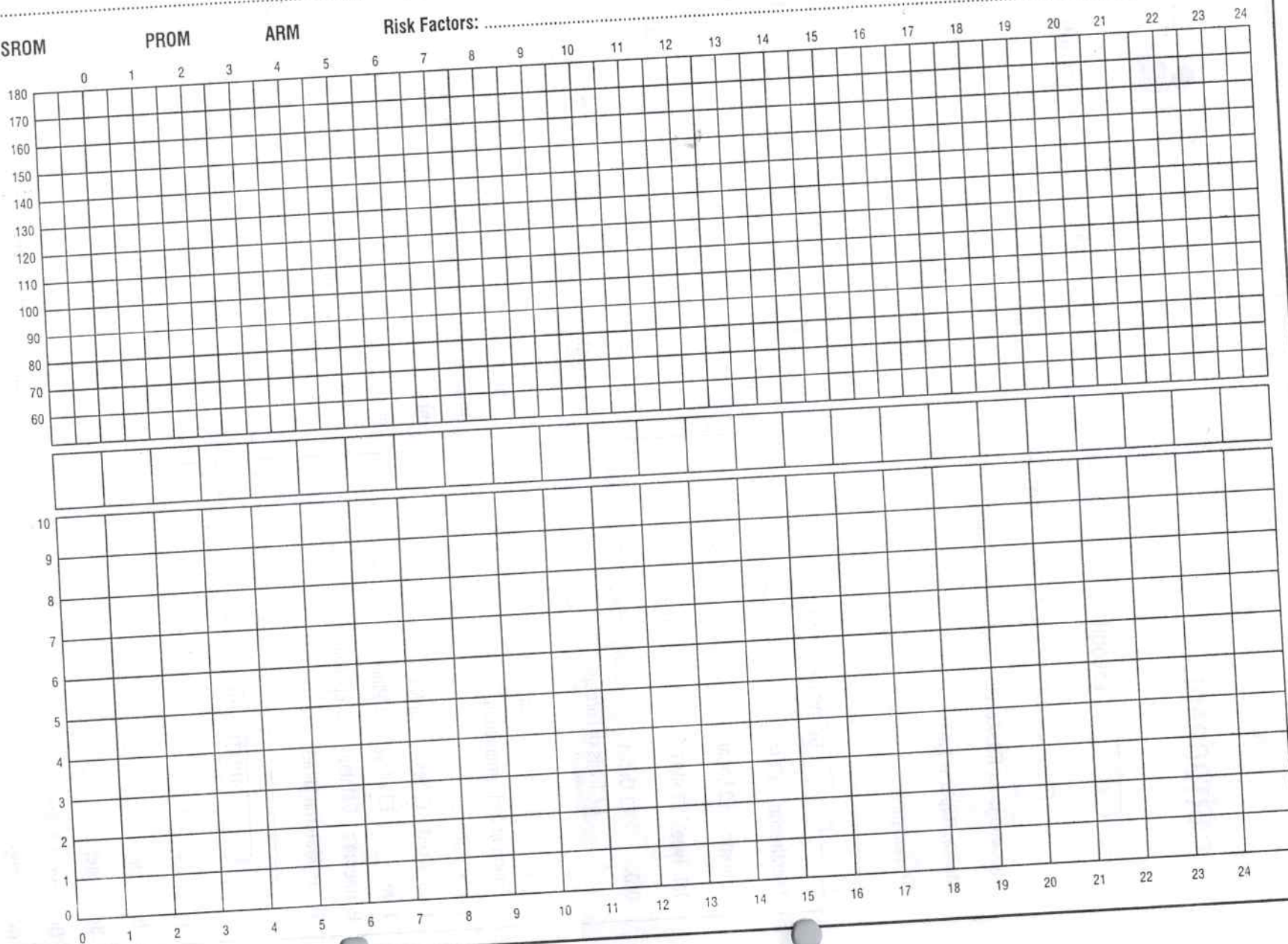
ARM

Risk Factors:

Fetal Heart ●

Maternal BP ↑↓

Maternal Pulse ×



Time

Signature

Fifths Palpable

Moulding / Caput

Amniotic Fluid

Position
Cephalic / Breeth

Oxytocin

Contractions
in 10 mins

Drugs and
IV Fluids

Urinalysis

Test

Amount

5
4
3
2
1

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:

PATIENT TRANSFER FORM

GUC-00086320 IP18-00036308
Mrs SUMATHI T
20-07-1995 30 Y 11 M 16 D (F)
Dr. LUCETTA AMELIA DIAS



Date & Time of Admission <i>3/7/2026 at 5.21 pm</i>		Date & Time of Transfer Order <i>6/7/2026 at 2.20 pm</i>
Treating Consultant Name <i>Dr. Lucetta</i>	Transfer Ordered by <i>Dr. Diyes</i>	Reason for Transfer <i>Partly mangel</i>
From Unit <i>NR</i>	To Unit <i>54m</i>	Information to Attendant Yes ☒ No ☐
Number of Sheets in Clinical File <i>5m</i>	Number of Imaging Films <i>on 16</i>	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☒ If yes, what ?
Medications / Consumables / Surgicals / Hand over		
Sl.No.	Item Name	Quantity
1.		
2.		
3.		
4.		
5.		
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐		
Name & Signature of Person who is Transferring <i>Dr. Lucetta</i>		Name of Person Ordered Transfer <i>Dr. Diyes</i>
Patient & Clinical Records Received by : <i>Dr. Diyes</i>		
Date & Time of Patient Received : <i>6/7/2026 at 2.20 pm</i>		

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

Patient Name: <i>Dr. J. K. Singh</i> Age: <i>45</i> Sex: <i>M</i>		Date: <i>12/12/2012</i> Time: <i>10:30 AM</i>	
Referring Doctor: <i>Dr. J. K. Singh</i> Referral No.: <i>12345</i>		Receiving Doctor: <i>Dr. A. B. Singh</i> Receiving No.: <i>67890</i>	
Reason for Transfer: <i>Transfer to another hospital for further treatment</i>		Remarks: <i>Transfer to another hospital for further treatment</i>	
Signature of Referring Doctor: <i>[Signature]</i> Date: <i>12/12/2012</i>		Signature of Receiving Doctor: <i>[Signature]</i> Date: <i>12/12/2012</i>	
Hospital Name: <i>Dr. J. K. Singh Hospital</i> Address: <i>123 Main Road, New Delhi</i>		Hospital Name: <i>Dr. A. B. Singh Hospital</i> Address: <i>456 Main Road, New Delhi</i>	
Transport Mode: <i>By Road</i> Vehicle No.: <i>DL-1234</i>		Transport Mode: <i>By Road</i> Vehicle No.: <i>DL-5678</i>	
Transporter Name: <i>Mr. X. Y. Z.</i> Contact No.: <i>9876543210</i>		Transporter Name: <i>Mr. P. Q. R.</i> Contact No.: <i>1098765432</i>	
Transporter Signature: <i>[Signature]</i> Date: <i>12/12/2012</i>		Transporter Signature: <i>[Signature]</i> Date: <i>12/12/2012</i>	

GUC-00086320 IP18-00036308
Mrs SUMATHI T
20-07-1995 30 Y 11 M 16 D (F)
Dr. LUCETTA AMELIA DIAS

PARTOGRAPH



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It takes a lot to treat the little.

BirthRight
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Your Right to a Safe Delivery

LABOUR

Labour: ☐ Spont ☐ IOL-PGE 1 ☐ E2 ☒ Others
Indications for IOL-Accel: ☐ None ☒ Oxytocin
Memb. Rapture Type: ☐ SROM ☐ PROM ☒ ARM
Presentation: ☒ Vertex ☐ Breech ☐ Others

INTRA PARTUM COMPLICATION

Maternal: ☒ None ☐ Pyrexia ☐ HTN ☐ Others
Liquor: ☒ Adequate ☐ Oligo ☐ Poly ☐ Clear
☐ Blood ☐ Meconium ☐ Cord:
Shoulder Dystocia: ☐ Yes ☒ No

DELIVERY DETAILS

Anesthesia: ☒ None ☐ Epidural
Non-epi: ☐ Local ☐ Spinal ☐ General
Del. Type: ☐ SVD ☐ Asst. Breech ☐ Twins
AVD: ☐ Outlet ☐ Low Forceps ☒ *KIRM* Ventouse
☐ Trails of Forceps
Indications: *poor maternal efforts*
Application, Locking & Traction:
Duration of Instrumentation:
No. of Pulls:
Catherised: ☐ Yes ☒ No
Type: ☐ Fileys ☐ Plain
Perineum: ☐ Intact ☒ Episiotomy ☐ Tear
Suture Material Used: *Rapid vices*

STAGE III

Placenta: ☒ Normal ☐ Abnormal ☐ RP Clots
☒ CCT ☐ Retained ☐ MRP
PPH: ☐ Atomic ☐ Traumatic ☒ None
Lacerations:
Cervical:
Perineal: *2° tear*
Others:
Prophylaxis: *Synocinon* Prostodin
Blood Loss: *~350 ml*
Blood Transfusion:
Other Details (if any):
Rectal Examination: *Normal*

DURATION OF LABOUR

1st Stage: *12 hours*
2nd Stage: *15 mins*
3rd Stage: *10 mins*
Duration of Active Pushing:
No. of VES:

BABY DETAILS

Gender: *B04*
Weight: *2.094 kg*
APGAR: *8/10, 9/10*
Date and Time of Delivery: *06.07.26 @ 11:20 AM*
LW Doctor: *Dr. Parithra*
LW Sister: *S/N: Annmya*

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:

INSTRUMENTAL DELIVERY PROFORMA

Patient Label

OBSTETRICIAN

ANAESTHETIST

ASSISTANT

DATE

TIME

PLACE

LABOUR
WARD

THEATRES

CONSENT

VERBAL / WRITTEN

EPISIOTOMY

YES / NO

BLADDER EMPTIED?

FOLEY IN/OUT NO

ANALGESIA
LOCAL / PUDENDAL
AMOUNT USED ____ 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
/ 5 PALPABLE

VAGINAL EXAMINATION

NUMBER OF CMs DILATED
STATION OF PRESENTING PART

-1 / 0 / +1 / +2 / +3

POSITION

DOA / LOA / ROA / ROP / LOP / DOP / LOT / ROT

CAPUT

0 + ++ +++

MOULDING

0 + ++ +++

INSTRUMENT USED

KIWI CUP / NEVILLE BARNES / WRIGLEYS / KIELLANDS / SIMPSONS

MANUAL ROTATION

YES / NO

TIME OF APPLICATION

No. OF TRACTIONS

ABANDONED

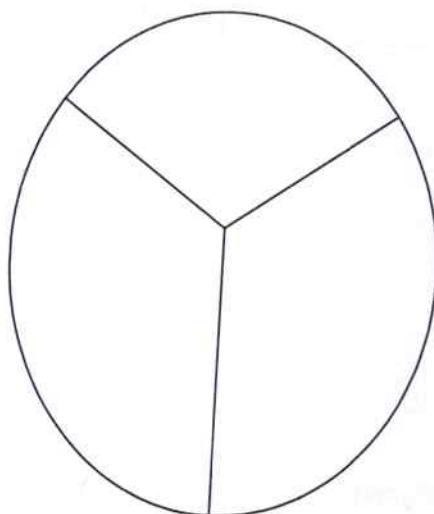
YES / NO

(FULL DETAILS IN NOTES)

TIME OF DELIVERY

LENGTH OF DELIVERY

Brief description of delivery and perineal repair.
(Please mark ventouse position on diagram)



EXTENT OF TEAR				
EPISIOTOMY / 1 ST degree / 2 ND degree / 3A / 3B / 3C / 4 TH degree (If 3 rd or 4 th , please complete proforma)				
SUTURE MATERIAL USED 2/0 VICRYL (number.....) 3/0 VICRYL (number.....) OTHER?	SUTURE TECHNIQUE CONTINUOUS/INTERRUPTED SKIN CLOSED? YES/NO		PR YES / NO	PV YES / NO
FOLEY CATHETER YES NO REMOVE (SHOULD REMAIN IN SITU FOR MIN OF 12HRS IF REGIONAL BLOCK USED)	SWAB COUNT PRE - REPAIR _____ POST - REPAIR _____		ANTIBIOTICS YES / NO (PRESCRIBE ON DRUG CHART)	ANALGESIA YES / NO (PRESCRIBE ON DRUG CHART)
	PARACETAMOL 1GM PR YES / NO	DICLOFENIC 100MGS PR YES / NO		

INDUCTION OF LABOR CONSENT

Name: GUC-00086320 IP18-00036308
 Mrs S. UMATHI T 20-07-1995 30 Y 11 M 14 D (F) Age: Gender: Male ☐ Female ☐
 UHID.No : Dr. LIJCETTA AMELIA DIAS Date:



You are scheduled for an induction of labor on (date) at (weeks of gestation).

The reason for your induction is

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: *[Signature]*

Name: MRS. S. Umathi

Date & Time: 5/7/26

Patient Attendant:

Signature: *[Signature]*

Name: TAMILARASAN R

Relationship with Patient: husband

Date & Time: 5/7/26

Doctor:

Signature: *[Signature]*

Name: Dr. Halima

Date & Time: 5/7/26

Witness

Signature:

Name:

Date & Time:

100

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INFORMED CONSENT FOR VAGINAL BIRTH

GUC-00086320 IP18-00036308
Patient Name Mrs S:UMATHI T 20-07-1995 30 Y 11 M 15 D (F) UHID No :
Dr. LUCETTA AMELIA DIAS
Gender: ☐ M  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. Lucetta

Consentee :

Signature : 
Name : Mrs. Sumathi
Date & Time : 5/7/26

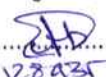
Witness :

Signature :
Name :
Date & Time :

Patient Attendant :

Signature : 
Name : TAMILARASAN R
Relationship with Patient: husband
Date & Time : 5/7/26

Doctor (who is taking the consent) :

Signature : 
Name : Dr. Lucetta
Date & Time : 5/7/26

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REPORT ON THE

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RBS CHART

(own stop)

Date	Time	RBS (mg/dl)	IVF %	Signature
3/7/26	6 pm	116 mg/dl	Dr. Divya Lakshmi	S. N. Aravind
3/7/26	7:15 pm	102 mg/dl	Dr. P. Cy.	S. J. Aravind
3/7/26	10:45 am	199 mg/dl	Dr. J. Aravind 4 unit	S. J. Aravind
3/7/26	3 am	154 mg/dl	—	S. J. Aravind
1/7/26	7:55 am	125 mg/dl	Dr. J. Aravind 6 unit	—
04/7/26	6:45 am	128 mg/dl	Inj. Fiasp 8 unit	S. J. Aravind
	9:15 am	264 mg/dl	—	—
	9:20 am	—	Inj. Fiasp 8 unit	S. J. Aravind
	9:30 am	—	Inj. Landus 10 unit	S. J. Aravind
04/7/26	10:30 am	141 mg/dl	—	S. J. Aravind
04/7/26	11:30 am	107 mg/dl	—	S. J. Aravind
04/07/26	12:30 pm	83 mg/dl	Dr. Akshita at 2:13 PM	S. J. Aravind
04/07/26	2:00 pm	89 mg/dl	Inj. Fiasp 6 unit at 2:13 pm	S. J. Aravind
4/7/26	5:55 pm	180 mg/dl	Inj. Fiasp 10 unit	S. J. Aravind
4/7	6 pm	130 mg/dl	—	S. J. Aravind
4/7	7 pm	105 mg	Inj. Fiasp 6 unit 7:35 PM	S. J. Aravind
4/7	8:55 pm	152 mg/dl	Inj. Fiasp 6 unit 8:56 PM	S. J. Aravind
4/7/26	10 pm	152 mg/dl	Inj. Landus 8 unit 10:10 PM	S. J. Aravind
5/7/26	7:30 am	93 mg/dl	Inj. Fiasp 8 unit 7:43 PM	S. J. Aravind
5/7/26	9:15 AM	182 mg/dl	Inj. Fiasp 10 unit 9:35 PM	S. J. Aravind
5/7/26	1:30 pm	71 mg	Inj. Landus 10 unit	S. J. Aravind
5/7	2:50 pm	189 mg/dl	3 pm - Inj. Fiasp 5 unit	S. J. Aravind
5/7	7:30 pm	112 mg/dl	7:53 pm - Inj. Fiasp 6 unit	S. J. Aravind
5/7	9:20 pm	159 mg/dl	Inj. Landus 6 unit - 9:25 PM Inj. Fiasp - 2 unit	S. J. Aravind
6/7/26	7 am	72 mg/dl	Dr. J. Aravind	S. J. Aravind
6/7/26	9 am	137 mg/dl	Dr. J. Aravind	S. J. Aravind
6/7/26	10 am	97 mg/dl	Dr. J. Aravind	S. J. Aravind
6/7/26	12 pm	95 mg/dl	Dr. J. Aravind	S. J. Aravind

3/10/1985 FHR

8pm - 150b/min

10pm - 144b/min

11pm - 140b/min

4/10/1985 3am - 130b/min

IP18-00036308

Mrs SUMATHI T

20-07-1995

30 Y 11 M 16 D (F)

Dr. LUCETTA AMELIA DIAS



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It takes a lot to treat the little.



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Your Right to a Safe Delivery

RBS CHART

[illegible]

ADMISSION SHEET

Registration Details :



Admission No : IP18-00036308

Admit Date : 03-Jul-2026

Admit Time : 05:21 PM UHID : GUC-00086320

Patient Details :

Patient Name : Mrs SUMATHI T

Age : 30 Y 11 M 13 D

Guardian : Mr TAMILARASAN R

DOB : 20-07-1995

Gender : Female

Religion :

Occupation :

Marital Status :

Address (H) : NO.52A, 21T EAST STREET, KAMARAJ NAGAR
Tiruvanmiyur Chennai Tamil Nadu INDIA
600041

Phone No : 9789833237/ 8610020622

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 TAMILARASAN R

Relationship : Husband

Contact Address : NO.52A, 21T EAST STREET, KAMARAJ
NAGAR Tiruvanmiyur Chennai Tamil Nadu INDIA
600041

Phone No : 8610020622


Signature

Doctor Details :

Doctor Name : Dr. LUCETTA AMELIA DIAS

Specialisation : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Dr. Lucetta Amelia Dias

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 7000.00

Payment Mode : Cash

Payor Name : SELFPAY

GENERAL CONSENT FOR TREATMENT

Patient Name: Mrs SUMATHI T

Age : 30 Y 11 M 13 D

IP No: IP18-00036308

Sex: Female

Consultant: Dr. LUCETTA AMELIA DIAS

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 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.

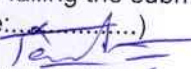
I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal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

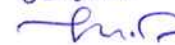
Name: Mr. Tamilarasan .P

Relationship: Husband

Date: 03/7/2026

Time: 5:21pm

Witness Name: Jothi

Witness Signature: 

Patient Address:

NO.52A, 21T EAST STREET, KAMARAJ
NAGAR Tiruvanmiyur Chennai Tamil
Nadu INDIA 600041

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 be applicable.
- ▶ 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 be 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 and 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 : <u>SUMATHI . T</u>	UHID Number : <u>Gene: 000 86320</u>
Self/Attendant Name : <u>TAMILARASAN . R .</u>	Relation : <u>Husband</u>
Self/ Attendant Signature : <u>Tamil</u> Phone Number : <u>9789833237</u>	Name & Signature of Financial Counselor <u>[Signature]</u>



இந்திய அரசாங்கம்
Government of India



Aadhaar no. issued: 14/12/2013



சுமதி ப
Sumathi P
பிறந்த நாள் / DOB : 20/07/1995
பெண் / Female

ஆதார் என்பது அடையாளத்திற்கான சான்றாகும். குடியறிமை, அல்லது பிறந்த தேதிக்கான சான்றல்ல. இது சரிபாற்பட்ட மட்டுமே பயன்படுத்தப்பட வேண்டும். ஆன்லைன் அங்கீகாரம் அல்லது QR குறியீட்டை ஸ்கேன் செய்தல் ஆஃப்லைன் 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).

3730 1049 0076

எனது ஆதார், எனது அடையாளம்

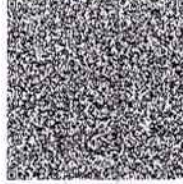


இந்திய தனித்துவ அடையாள ஆணையம்
Unique Identification Authority of India



முகவரி: C/O தமிழரசன் ராமகிருஷ்ணன், ஸ்ரீராம் கீர்த்தி பிளட்ஸ், நோ 52A, 21st East Street, Kamaraj Nagar, Near Saibaba Temple, Thiruvannamiyur, Tamil Nadu, 600041

Address: C/O Tamilarasan Ramakrishnan, Sriram Keerthi Flats, No 52A, 21st East Street, Kamaraj Nagar, Near Saibaba Temple, Thiruvannamiyur, Thiruvannamiyur, PO:Thiruvannamiyur, DIST:Chennai, Tamil Nadu, 600041



3730 1049 0076



1947



help@uidai.gov.in



www.uidai.gov.in



IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints: Able to PFM well.
Admitted for safe confinement in view of severe Fetal Growth Restriction

LMP: 26/09/2025 EDD: 30/07/2026 GA: 36w+1d

Obstetric Formula:

Menstrual History: Regular: ☒ Yes ☐ No

Primi

Obstetric Examination

M/S - 1 yr 4 months, Ncm

Obstetric History:

G₁ - PP, Spontaneous Conception

Fundal Height: uterus @ 32-34 weeks

Present Pregnancy Record:

ked and Immunised,
NT Scan - Normal; NB ⊕; NT - 1.4 mm
Anomaly Scan - Normal; B/L UTD A,
RISK FACTORS:
FTS - Low risk, ↑ risk of PE

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

Liquor: ☒ Adequate ☐ Oligo ☐ Poly

PP: ☐ Cephalic ☐ Breech Others _____

Head Fifts Palpable: 5/5th

FHS: ☒ Normal ☐ Tachy ☐ Brady ☐ Absent

GDM on OHA
Chronic Hypertension
FGR

Per Speculum Examination

Curdy white discharge ⊕

Draining: ☐ Present ☒ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination

Cervix: ☒ Long ☐ Partially effaced ☐ Effaced

Os: Closed Dilated one finger loose

Membranes: ☒ Present ☐ Absent

Liquor: ☒ Clear ☐ Meconium ☐ Blood Stained

Presenting Part: ☒ Vertex ☐ Breech ☐ Others

Sutton: ☒ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Pelvis: ☒ Adequate ☐ Doubtful

Height: 145 cm

Weight: 54.8 kg

Allergies: Nil

Breast: ☒ Normal ☐ Abnormal

General Examination:

Consciousness: Conscious Pallor: No

Icterus: No Edema: No

Temp: Normal PR: 95/min

BP: 100/54 mmHg DTR:

CVS: S₁S₂ ⊕ RS: B/L NVB ⊕

Liver/Spleen: Urine Output:

DIAGNOSIS

Primi LMP - 26/09/2025
M/S - 1 yr 4 months EDD - 30/07/2026
Ncm
Ove RMP

GA - 36 weeks + 1 day
Severe FGR
GDM on OHA
Chronic HTN

For Antepartum (A.P.T.O.)
safe confinement



36 wks

Consultant Name: Dr. Lucetta

Signature: For 8/18/22

Date & Time: 03/07/2021

Docu. No. : RCH / FRM / CLINICAL / 1407
IP18-00036308

Date: 30 Y 11 M 13 D (F)
GUC-00086320
Mrs SUMATHI T
20-07-1995
Dr. LUCETTA AMELIA DIAS

S.No



DOCTOR'S SHIFT CHANGE HANDOVER FORM

Department:

Shift:

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

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Your Right to a Safe Delivery

GUC-00086320 IP18-00036308
 Mrs SUMATHI T
 20-07-1995 30 Y 11 M 13 D (F)
 Dr. LUCETTA AMELIA DIAS



1

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7/26 10pm	8/R Dr Jaffer Lumbar / GA: 36+1 Serious FHR LHR on GA chronic amn.	
11/2/68	Nas/S OIE	UP / FHR
BP 86/44	Able to proceed	BP monitoring
PR 85/44	OIE	Shed FHR monitoring
SPR 95/44	P-LIFE	Shed 1 FHR
FHR - 104 bpm	CS / MRA	→ follow drop only
	P/A - at 32-34 wks	Can't / CL to stel
	Relaxed	Can't monitoring
	cephalic	
	high good	
	2/E - NAD	3/7/26

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/17/26 9:15 AM	S/B Dr. H. Salazar	
07:45	pt. reviewed	
	PFM well.	
	O/E: afebrile	
BP 100/70 mmHg	GC fair	Plan
PR 99 bpm	P ⁺ / PE ⁺	- 2nd Bathesol 6 pm today
SpO ₂ 99% @ RA	PIA waves @ 36 w	- CTG/DFMC
Temp @	Relaxed	- Follow drug orders
	FM ⊕	- CBG to volume
		- FM (phn) only
		- BP monitoring
	<u>Chad Dr. Loretta</u>	
	CBG - 264	
	↓	
	Lantus 10 U now	
	Fiasp 80 now	
	↓	
	check CBG after 1 hour	
		
		128A35

GUC-00086320

IP18-00036308

Mrs SUMATHI T

20-07-1995

30 Y 11 M 14 D

(F)

Dr. LUCETTA AMELIA DIAS



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/7/20	S/B Dr. Jayalakshmi	408/10/A
4:30 pm	pt. reviewed Able to PFM well	mgol
36 + 2 weeks	No s/s of hypoglycemia	Imminent eclampsia
PR 98/min	pt. Gc fair, afebrile	Advise
BP 110/60 mm	po / per	- Diabetic diet
Postmeal CBG - 180 mg/dl	nt ~ 36 weeks	- Hydration
	Relaxed	* Betnesol 2nd dose @ 6pm
	cephalic	* CBG 2nd hourly
	MHC good	* CTG @ 8pm
		* BP monitoring hourly FH
Voiding freely		- Next CBG @ 6pm
		- W/F hypoglycemia
		- Inform SOS

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/07/2026 10pm	C/S/B Dr. Pavithra Dr. Shreedevi Able to perceive fetal movements well INTJ. BETNESA 12mg 2 nd dose given @ 6pm No S/S of Imminent / Hypoglycemia Pt reviewed, Nil clo	Advice - Diabetic diet - Hydration - CBG (Pre & Post meal (2hr) monitoring)
GIA - 36w + 2 days		
T-N	Able to perceive fetal movements DIE Pt GIC fair, Afebrile P°/PE°	- Insulin according to Physician's - CTG TDS (Next @ 9am after Breakfast) - BP monitoring - W/F Hypoglycemia - Inform (S/S) - W/F Imminent S/S - follow drug chart.
PR - 90/min	WS RS / NAD	- 7
BP - 124/74mmHg	PA-ut @ 36 weeks Relaxed Cephalic FHS-good	
	8/22/17	
4/7/2026 10pm	C/D/W Dr. Krishna das 1.) 9pm CBG - 154mg/dl To give INTJ. FIASP 4U SC Repeat CBG @ 10pm ↓ CBG @ 10pm - 153mg/dl to given INTJ. LANTUS 80U SC ↓ To check Pre & Post breakfast CBG	

GUC-00086320
Mrs S.UMATHI T
20-07-1995 30 Y 11 M 14 D (F)
Dr. LUCETTA AMELIA DIAS

IP18-00036308

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/7/26: 9:40AM	S/B Dr. Lucetta	
0.4mc	pt reviewed	
36 wt 3D	PFM well	
	o/c afebrile	
BP 100/50mmHg	GI fair	Plan:
PR 90bpm	P°/PG°	- CTG TDS
SPG 99% @ RA	PIA uterus @ term	- diabetic diet
temp @	Relaxed	- CBG 6 value
	cephalic	- BP monitoring
	FH @	- w/ hypoglycemia
	clinically liquor	- follow drug orders
	(2)	
5/7/26: 12pm	S/B Dr. Lucetta	
	pt reviewed	
	PFM well	
	no sp. c/a	
	o/c afebrile	
	GI fair	
	P°/PG°	
	PIA uterus @ term	
	Relaxed	
	cephalic (7th)	
	FH @	
	clinically liquor (2)	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Plv: Cervix soft posterior 2 cms long 2 fingers loose membranes @ PPhx - 3 station	
	↓ SAP induced 2 foliis distended 2 so CI distilled water	
		Plan - CTG post foliis 1 hr (1 PM) - w/ foliis expel - DFM.
		120435
5/7/26 2 PM	S/B Dr. <u>Abubakar</u> pt reviewed PFM well o/b. afebrile pre lunch CRG 71 mg/dL ↓ informed Dr. <u>Krishnakumar</u> ↓ - no insulin - check post lunch 4 inform. CTG <u>Descriptive</u>	Prean: - chit to ward - FHS phasing - Post lunch CRG & inform - CTG @ 4 PM - Traction @ 4 PM - w/ foliis expel



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/26 1 AM	S/B Dr. Abulitei	
	pt reviewed	
	no sp c/o	
	o/e: afebrile	
BP 110/60 mmHg	GC fair	Plan:
PR 90 bpm	P° / P°	- Tab. Miso 20mg P/O
SpO ₂ 99% @ RA	P/A uterus @ term.	- post miso CTG @ 2 AM
Femur @	2/10" / 10"	
	cephalic	- w/lt progression of labor
Foley's inserted	FH @	
hydration given.	clinically liquor.	
6/7/26 5 AM	S/B Dr. Abulitei	127435
	pt reviewed	
	no sp c/o	
	PFM well	
	o/e afebrile	
	GC fair	C/D/w Dr. Lucetta
	P° / P°	Plan:
	P/A uterus @ term.	
	tightening	- Tab Miso 20mg P/O. new
Lt: Foley's removed	cephalic	- w/lt progress of labor
	FH @	
	clinically liquor @	
	P/V: Cervix soft	
	midposition	128435
	2 cms long.	
	2 cms dilated	
	membranes @	
	PPhx - 3 station	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/26 9:30 AM	S/B Dr. Lucilla	
	pt. reviewed	
	Able to PM well.	
	NO S/S of IE / Hypoglycemia	
	P/A: ut approx. 34 weeks	
	2c / 15 sec / 10 min	
	cephalic	
	FHS good	
	P/E: Cx 1cm long.	
	DS 3cm dilated.	
	membranes (+)	
	Vx - 3	
	ASP, ARM done - clear liquor	
	post ARM FHS good	
	Admice	
	- sitting -	
	- Synto medication	
	- Continuous CTG.	
	- Ij: EPIDOSIN 2cc slow IV	
	STAT + Ij: DROPER 1amp	
	IM STAT	
	- w/F contractions	
	- Droper watch	
	- inform SOS.	

Synto
CTG - reactive
@ 24 weeks



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/2/2026 10:45am	C/S/B Dr. Lucetta Pt reviewed o/e Pt ac fair afebrile P/PE CVS RS / NAD P/A - Ut firm mod active 40/30/10" cephalic / 2HS good P/V - cx well effaced os 8cm dilated memb ⊖ Vx @ +1 station	Advice - Squatting - 500 Synto @ 48ml/hour - Continuous CTG.
6/2/2026 11:15am	C/S/B Dr. Lucetta Pt reviewed o/e Pt ac fair afebrile P/PE CVS RS / NAD P/A - Ut firm mod active cephalic / 2HS good	Advice - Position for laboring - Continuous CTG. - w/f contraction.

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/2026 11:20 AM	Kivi Assisted Vaginal Delivery with Right mediolateral episiotomy. C/B Dr. Lucetta. A/B Dr. Pamithra. ↓ SAG, patient in dorsal lithotomy position, local parts painted and draped. With good uterine contraction, and full cervical dilatation, with good ^{poor} maternal efforts, another decision decision was made to apply kivi cup, mother delivered an alive boy baby who cried immediately after delivery (after birth). Fij Synto 10 U in 2 iv added to drip. Placenta & membranes delivered in toto. Episiotomy wound sutured in layers with Rapid vinyl. Ph - uterus firm & well contracted P/v - No undue bleeding pr P/R - Rectal Mucosa and Sphincter tone Normal	
		<u>Advice</u> - <u>(N) diet</u> - Plenty of orals. - Fij Supacy 1.5 g 2v 1-1-1. - Fij Paracetamol 1g 2v 1-1-1. - Fij Synto 20 units maintenance All 6 PM. - C Pantoprazole D 40mg 1-0-1 - INT. PANTOPRAZOLE 40mg 1-0-1
B	An alive boy baby.	
A	B.Wt - 2.094 KG.	
B	6/7/2026 @ 11:20 AM	
Y	Apgar - 8/10, 9/10.	

Date & Time	Progress Notes	Doctor's Order
6/7/26 9 PM	S/B Dr. Vinithe Pt reviewed; No 40 O/E: GC fair; Afebrile P/A: UT well contracted Soft L/E: BWNL; Epi wound intact CBD insitu	Adv: - To inform post dinner CAG - Normal diet - Plenty of fluids - Bladder drilling 4m 6am - Follow drug check
01/07/2021 10 AM	C/S/B Dr. Parvina Dr. Shudini Pt on bladder drilling Pt reviewed, Nil c/o O/E GC fair, Afebrile P/PE° P/A - ut well contracted Soft L/E - BWNL Epi wound Healthy	Advice - Normal diet - Plenty of oral fluids - Vitals Monitoring - Follow drug check - Inform (SOS)
T- ^(N) PR- 82/min BP- 121/72 mmHg Baby- Als BL- Breast soft Stools passed		

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker



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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker



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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker



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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

GUC-00085320 IP18-00036308
 Mrs SUMATHI T
 20-07-1995 30 Y 11 M 13 D (F)
 Dr. LUCETTA AMELIA DIAS



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RESULT SHEET

Date	26/6/26				
Time					
Hb	10.2				
PCV	31				D - POSITIVE
RBC	3.60				
WBC	10,450				
N/L	73/19				ICT - Negative
Platelets	4.02				
CRP					ECG } Normal
ESR					ECHO }
PCT					LVEF - 60%
RBS					
Na					TSH - 1.31
K					T4 - 15.01
Cl					T3 - 181
Ca/Mg					
Phosphate					HIV I & II } Non-Reactive
Urea					HBs Ag }
Creatinine					VDRL }
ALP					
SGPT					Rubella IgG - Positive.
SGOT					
T.Bill/Conj					HbA _{1c} - 4.8
T.Protein					
S.Albumin					Hb Electrophoresis - Normal
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells	15221				
N/L					

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	Tab. ECOSPIRIN	150mg	po	HS	—	☒ C ☐ DC
2	Tab. GLYCOMET SR	500-0 -800mg	po	1-01	—	☒ C ☐ DC
3	Tab. LABETALOL	50mg	po	OTD	—	☒ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Dnyaneshwari

Date & Time: 03/07/2026 at 5:20pm

Nurse Name & Signature: S. N. Kalyan

Date & Time: 03/07/2026 5:20pm

10/1/78

(1)

Page 1 of 1

Medication History

Medication History: This is a list of all the medications that the patient is taking at the time of the visit. It includes the name of the medication, the dose, the frequency, and the route of administration. (Example: 100mg of the drug 100mg)

129

Medication Name	Dose	Frequency	Route
1. 100mg	100mg	100mg	100mg
2. 100mg	100mg	100mg	100mg
3. 100mg	100mg	100mg	100mg
4. 100mg	100mg	100mg	100mg
5. 100mg	100mg	100mg	100mg
6. 100mg	100mg	100mg	100mg
7. 100mg	100mg	100mg	100mg
8. 100mg	100mg	100mg	100mg
9. 100mg	100mg	100mg	100mg
10. 100mg	100mg	100mg	100mg

Medication History: This is a list of all the medications that the patient is taking at the time of the visit. It includes the name of the medication, the dose, the frequency, and the route of administration. (Example: 100mg of the drug 100mg)

100mg of the drug 100mg

100mg of the drug 100mg

100mg of the drug 100mg

100mg of the drug 100mg



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: LDB

Shifted to: 5th 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	<u>Ly. BETNESOL</u>	<u>12mg</u>	<u>IM</u>	<u>STAT</u>	<u>3/7/26</u> <u>act bpm</u>	☒ C ☐ DC
2	<u>Tab. ELOSPirin</u>	<u>150mg</u>	<u>PO</u>	<u>STAT</u>	<u>-</u>	☒ C ☐ DC
3	<u>Tab. FERONOMIC PLUS</u>	<u>1 tab</u>	<u>PO</u>	<u>BD</u>	<u>-</u>	☒ C ☐ DC
4	<u>Tab. DICANIS</u>	<u>1 tab</u>	<u>PO</u>	<u>OD</u>	<u>-</u>	☒ C ☐ DC
5	<u>Tab. GLYCOMET SR</u>	<u>500-0</u> <u>-500mg</u>	<u>PO</u>	<u>1-0-1</u>	<u>-</u>	☒ C ☐ DC
6	<u>Tab. LABETALOL</u>	<u>50mg</u>	<u>PO</u>	<u>0-1-0</u>	<u>-</u>	☒ 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. Dnyalakshmi

Date & Time: 3/7/26

Nurse Name & Signature: Dr. N. Akshaya

Date & Time: 3/7/26 at 7pm

Page No.

Date

Topic

Name

Roll No.

Section

Lab No.

Experiment No.

Object of the experiment

1-2-3

Apparatus

Sl. No.	Observations	Calculation	Result
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Prepared by

Checked by

Signature

Date & Time

Place

Page No.

Date

GUC-00086320 IP18-00036308
Mrs SUMATHI T
20-07-1995 30 Y 11 M 16 D (F)
Dr. LUCETTA AMELIA DIAS



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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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: 5th 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						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature:

Date & Time:

Nurse Name & Signature: Deblina Deblina

Time & Date: 06/11/2016 at 2.20pm

Page 1 of 1



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form CMS-1016

Medication Reconciliation Form

Up Attn: [Name] [Address] [City] [State] [Zip]

Medication Reconciliation will be done at the time of admission, transfer, or discharge. It is the responsibility of the patient or family to provide a complete list of all medications, including over-the-counter drugs, herbal supplements, and vitamins.

(Example of the list to be provided to the provider)

Attn: [Name]

No.	Medication Name (Generic Name Capital Letters)	Dose	Frequency	Route	Start Date	Stop Date	Notes
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

Medication History Recorded by: [Name]

Location: [Name]

Date & Time: [Date] [Time]

Physician Name & Signature: [Signature]

Date & Time: [Date] [Time]

Form CMS-1016



DRUG CHART

Date of Admission: 31-10-2024 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-00086320
Mrs SUMATHI T
20-07-1995
Dr. LUCETTA AMELIA DIAS

IP18-00036308

30 Y 11 M 13 D (F)

REGULAR PRESCRIPTIONS

Weight. 54.8kg Ward. 12R



DRUG: <u>Cap. CANSOFT CI</u>				Date/Time: <u>3/7 11:55 AM</u>
Dose: <u>1 cap</u>	Route: <u>PO</u>	Frequency: <u>OD</u>	Start Date: <u>3/7</u>	
Name & Signature of the Doctor Starting the Drugs: <u>[Signature]</u> <u>164288</u>				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG: <u>Tab. LABETALOL</u>				Date/Time: <u>4/7 5:15 PM</u>
Dose: <u>50mg</u>	Route: <u>PO</u>	Frequency: <u>DD</u>	Start Date: <u>4/7</u>	
Name & Signature of the Doctor Starting the Drugs: <u>[Signature]</u> <u>164288</u>				
Additional Instructions: <u>Inform BP -</u>				
Daily Doctor's Endorsement by a Sign				

DRUG: <u>Tab. GLYCOMET SR</u>				Date/Time: <u>4/7 5:15 PM</u>
Dose: <u>500mg</u>	Route: <u>PO</u>	Frequency: <u>OD</u>	Start Date: <u>4/7</u>	
Name & Signature of the Doctor Starting the Drugs: <u>[Signature]</u> <u>164288</u>				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG: <u>Tab. GLYCOMET SR</u>				Date/Time: <u>3/7 4:15 PM</u>
Dose: <u>500mg</u>	Route: <u>PO</u>	Frequency: <u>OD</u>	Start Date: <u>3/7</u>	
Name & Signature of the Doctor Starting the Drugs: <u>[Signature]</u> <u>164288</u>				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

GUC-00086320
Mrs SUMATHI T
20-07-1995
Dr. LUCETTA AMELIA DIAS

IP18-00036308

30 Y 11 M 13 D (F)



Weight. 54.5kg Ward. LDR

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
3/7	6pm	INJ. BETNESOL	12mg	Im		SA
3/7	2pm	T. ECOSPIRIN	150mg	PO		SN
4/7	6pm	Inj. BETNESOL	12mg	Im		SA
4/7	8am	INS FIASP	6U	S/c		KS
4/7	9:20am	INS FIASP	8U	S/c		BA
4/7	9:30am	INS LANTUS	10U	S/c		KS
4/7	2:13pm	Ij. FIASP	6 units	S/c		KS
4/7	3:55p	Ij. FIASP	4 units	S/c		KS

VERIFIED BY : Name



I.V. FLUIDS CHART

Weight. 54.8 kg Ward. ... LDR

[illegible]



Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward LDR

DRUG: <u>Tab. FERONOMIC PLUS</u>				Date/Time	<u>5/7 4:15 PM</u>
Dose	Route	Frequency	Start Dt.		
<u>HRB</u>	<u>PO</u>	<u>1-0-1</u>	<u>2/7</u>	<u>8am</u>	<u>12 PM</u>
Name & Signature of the Doctor Starting the Drugs:				<u>[Signature] 16428</u>	
Additional Instructions:				<u>8am 12 PM 1 PM</u>	
Daily Doctor's Endorsement by a Sign					
DRUG: <u>Tab. DICALIS</u>				Date/Time	<u>4/7 5:15 PM</u>
Dose	Route	Frequency	Start Dt.		
<u>1 tab</u>	<u>PO</u>	<u>0-0-0</u>	<u>4/7</u>	<u>2pm</u>	<u>12 PM 1 PM</u>
Name & Signature of the Doctor Starting the Drugs:				<u>[Signature] 16428</u>	
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG: <u>IND SUPACEF</u>				Date/Time	<u>5/7 6:15 PM</u>
Dose	Route	Frequency	Start Dt.		
<u>1.5gm</u>	<u>IV</u>	<u>1-0-1</u>	<u>5/7/26</u>	<u>9:30 PM</u>	<u>12 PM 1 PM</u>
Name & Signature of the Doctor Starting the Drugs:				<u>[Signature] 16428</u>	
Additional Instructions:				<u>To continue post delivery</u>	
Daily Doctor's Endorsement by a Sign				<u>9:30 PM 12 PM 1 PM</u>	
DRUG: <u>Ij: PAN</u>				Date/Time	<u>6/7 4:15 PM</u>
Dose	Route	Frequency	Start Dt.		
<u>60mg</u>	<u>IV</u>	<u>1-0-1</u>	<u>6/7</u>	<u>9am</u>	<u>12 PM 1 PM</u>
Name & Signature of the Doctor Starting the Drugs:				<u>[Signature] 16428</u>	
Additional Instructions:				<u>7 PM 12 PM</u>	
Daily Doctor's Endorsement by a Sign					

VERIFIED BY : Name Signature

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

DRUG : <u>1. PARACETAMOL</u>				Date <u>6/7/14</u>
Dose <u>1gm</u>	Route <u>IV</u>	Frequency <u>1-1</u>	Start Dt. <u>6/7</u>	Time <u>8am</u>
Name & Signature of the Doctor Starting the Drugs: <u>[Signature]</u> <u>104288</u>				
Additional Instructions: <u>(12pm) IV</u> <u>SN</u>				
Daily Doctor's Endorsement by a Sign <u>[Signature]</u>				
DRUG : <u>T. UREMAX</u>				Date <u>6/7/14</u>
Dose <u>0.4m</u>	Route <u>PO</u>	Frequency <u>OD</u>	Start Dt. <u>6/7</u>	Time <u>10pm</u>
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : <u>T. GLYCOMET-SR</u>				Date <u>7/7/14</u>
Dose <u>500mg</u>	Route <u>PO</u>	Frequency <u>1-1</u>	Start Dt. <u>7/7</u>	Time <u>8am</u>
Name & Signature of the Doctor Starting the Drugs: <u>[Signature]</u> <u>124621</u>				
Additional Instructions: <u>8am</u>				
Daily Doctor's Endorsement by a Sign				
DRUG :				Date
Dose	Route	Frequency	Start Dt.	Time
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

Signature

VERIFIED BY : Name



STAT / ONCE ONLY DRUGS

Name:

Weight: 54.2 kgs

Sheet No: ①

DATE	TIME	MEDICATION	DOSAGE & OTHER INSTRUCTIONS	ROUTE	SIGNATURE		
					Doctor	Nurse-1	Nurse-2
4/7/26	1:25pm	Inj FIASP	6 units	SC	[Signature]	SA	
4/7/26	2:45pm	Inj FIASP	4 units	SC	[Signature]	SA	MM
4/7/26	10:10pm	Inj LANTUS	8 units	SC	[Signature]	SA	MM
5/6/26	9:35AM	INJ FIASP	4 units	SLC	[Signature]	RV	PL
5/6/26	9:35AM	INJ LANTUS	6 units	SK	[Signature]	RV	PL
5/6/26	12:20pm	INJ SUPACEF	0.1mg	ID	[Signature]	SN	SA
5/6/26	1:00pm	INJ SUPACEF	1.5gm	IV	[Signature]	SN	SA
6/7/26	1AM	TAB MISOPROSTOL	25mcg	P/O	[Signature]	TJ	SP
6/7/26	5:15AM	TAB MISOPROSTOL	25mcg	P/O	[Signature]	TJ	SP
6/7/26	6AM	ENEMA	100ml	PR	[Signature]	TJ	SP
6/7	9:40 AM	Inj: EPIDDSIN	2cc	SHW JV	[Signature]	DS	SN
6/7	9:40 AM	Inj: DROTIN	1amp	IM	[Signature]	DS	SN
6/7	10:25 AM	Inj: PETHIDINE	50mg	IM	[Signature]	DS	SN
6/7	10:25 AM	Inj: PRENERGAN	25mg	IM	[Signature]	DS	SN
6/7/26	11:20 AM	Inj: SYNTO	10 units	IM	[Signature]	DS	SN
6/7/26	11:25 AM	Inj: CARBO PROST	250mcg	IM	[Signature]	DS	SN
6/7/26	11:25 AM	Inj: TRAPIC	1gm	IV	[Signature]	DS	SN
6/7/26	11:40 AM	T-MISOPROSTOL	600mcg	PR	[Signature]	DS	SN
6/7/26	11:40 AM	UVSTIN SUPPOSITORY	100mg	PR	[Signature]	DS	SN



BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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

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																									
	0 - 10																									
Saturations	94 - 100 %																									
	< 94 %																									
Administered O ₂ (L/min.)																										
Temp °C	40																									
	39																									
	38																									
	37																									
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
40																										
Systolic Blood Pressure	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
60																										
50																										
Diastolic Blood Pressure	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
	40																									
	NEURO RESPONSE [✓]	Alert																								
		Voice																								
		Pain																								
Unresponsive																										
URINE mls / hour	> 30																									
	< 30																									
Proteinuria	Protein ++																									
	Protein > ++																									
Lochia	Normal																									
	Heavy / Foul																									
Liquor	Clear / Pink																									
	Green																									
TOTAL YELLOW SCORES																										
TOTAL ORANGE SCORES																										
Nurse Initial																										

3/7/26 FHR Chart

8pm - 150/mnt

10pm - 144/mnt

11pm - 140/mnt

4/7/26

3am - 130/mnt

7 to 8 - CTG

9.30 to 10.30am - CTG.

11.30am - 152 lwt in CTG Machine

11:40am - 154 lwt in Doppler

12.30am - 144 blm.

2pm - 134 - 140/mnt - Doppler

3pm - 150 bly

4pm - 158 bly

5pm - 145 to 150 blm

6pm - 140 to 145 bly

7pm - 150 bly

11pm - 150 to 160 blm.

12am - 132 - 142 blm

1am - 143 - 150 blm.

2am - 130 - 140 blm

3am - 150 - 160 blm

4am - 139 - 144 blm.

5am - 140 - 148 blm

6am - 130 - 144 blm

7am - 144 - 162 blm

5/7/26

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		8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	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																								
	0 - 10																								
Saturations	94 - 100 %																								
	< 94 %																								
Administered O ₂ (L/min.)																									
Temp °C	40																								
	39																								
	38																								
	37																								
	36																								
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
	40																								
	Systolic Blood Pressure	190																							
180																									
170																									
160																									
150																									
140																									
130																									
120																									
110																									
100																									
90																									
80																									
70																									
60																									
50																									
Diastolic Blood Pressure	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
	40																								
	NEURO RESPONSE [✓]	Alert																							
Voice																									
Pain																									
Unresponsive																									
URINE mls / hour	> 30																								
	< 30																								
Proteinuria	Protein ++																								
	Protein > ++																								
Lochia	Normal																								
	Heavy / Foul																								
Liquor	Clear / Pink																								
	Green																								
TOTAL YELLOW SCORES																									
TOTAL ORANGE SCORES																									
Nurse Initial																									

2/7/26

8am - 150 - 158 blm

9am - 148 - 152 blm

10AM - 149 blm

11AM - 150 blm

5/7/26 2pm - 148 to 152 blm

4pm - 140 blm

5pm - 135 blm to 138 blm

6pm - 148 blm

7pm - 155 blm

8pm - 152 blm

9pm - 140 - 160 blm

10pm - CTG

11pm - 148 blm

6/7/26 12AM - 148 blm

1AM - CTG

2AM - 148 blm

3AM - 144 blm

4AM - CTG

5AM - 144 blm

6AM - CTG

7AM - 150 blm

GUC-00086320
Mrs SUMATHI T
20-07-1995
Dr. LJCETTA AMELIA DIAS

IP18-00036308

30 Y 11 M 14 D (F)

arning Observation Score Chart - Obstetrics

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

05/08/26

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	90b/m				22		22		20b/m				20b/m							18		20		
	0 - 10																								
Saturations	94 - 100 %	99%				99%		99%		99%				99%							98%		99%		
	< 94 %																								
Administered O ₂ (L/min.)		RA				RA		RA		RA				RA							RA		RA		
Temp ^o C	40																								
	39																								
	38																								
	37	99.5				99%		99%		98%				98%							98%		98%		
	36																								
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100	90b/m				90%		90%		90%				90%							88%		84b/m		
	90																								
	80																								
	70																								
	60																								
	50																								
	40																								
Systolic Blood Pressure	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
Diastolic Blood Pressure	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
	40																								
NEURO RESPONSE [✓]	Alert	✓				✓		✓		✓				✓							✓		✓		
	Voice																								
	Pain																								
	Unresponsive																								
URINE mls / hour	> 30	✓				✓		✓		✓				✓							✓		✓		
	< 30																								
Proteinuria	Protein ++																								
	Protein > ++																								
Lochia	Normal	-				-		-		✓			-								-		-		
	Heavy / Foul																								
Liquor	Clear / Pink	-				-		-		✓			-								-		-		
	Green																								
TOTAL YELLOW SCORES		00				00		00		00			00					00			00		00		
TOTAL ORANGE SCORES		00				00		00		00			00					00			00		00		
Nurse Initial		2				4		4		4			4					4			4		4		

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

[illegible]



FLUID CHART

Sheet No. : 1

3/07/2026

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	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm	H ₂ O 100								100	NO IV line	SA
	07:00 pm											SA
Total Intake : 100ml						Total Output : 100ml						
	08:00 pm	Idly										
	09:00 pm	H ₂ O 100ml								✓	NO	M.M
	10:00 pm	Milk 250ml									IV	M.M
	11:00 pm	H ₂ O 200ml								✓	line	M.M
	12:00 am	H ₂ O 100ml										
	01:00 am											
Total Intake : 650ml						Total Output : 2 times						
	02:00 am									✓	NO	M.M
	03:00 am	H ₂ O 100ml										
	04:00 am	H ₂ O 100ml									IV	M.M
	05:00 am									✓		
	06:00 am	H ₂ O 200ml									line	M.M
	07:00 am											
Total Intake : 300ml						Total Output : 2 times						
Total 24 hrs. Intake		1050 ml										
Total 24 hrs. Output		2 times + 100ml										

10/10/2020



Roof	Slope
10/10/2020	10/10/2020
10/10/2020	10/10/2020
10/10/2020	10/10/2020
10/10/2020	10/10/2020

10/10/2020

10/10/2020

Roof	Slope
10/10/2020	10/10/2020
10/10/2020	10/10/2020
10/10/2020	10/10/2020
10/10/2020	10/10/2020

10/10/2020

Roof	Slope
10/10/2020	10/10/2020
10/10/2020	10/10/2020
10/10/2020	10/10/2020
10/10/2020	10/10/2020

10/10/2020

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10/10/2020

10/10/2020

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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
11/7/26	08:00 am	Billy											
	09:00 am	LIK 80ml									✓	No	dt
	10:00 am	H2O 100ml									✓	2v	dt
	11:00 am												dt
	12:00 pm	H2O 20ml									✓	1v	dt
	01:00 pm	1/2 apple									✓		
Total Intake :			200ml			Total Output :			4 times				
	02:00 pm	Chapati											dt
	03:00 pm	H2O 300ml									✓	No	dt
	04:00 pm											2v	dt
	05:00 pm	H2O 300ml									✓		dt
	06:00 pm											1v	dt
	07:00 pm	H2O 200ml									✓		
Total Intake :			800ml			Total Output :			3 times				
	08:00 pm	H2O 200ml										No	dt
	09:00 pm	H2O 100ml									✓	1v	dt
	10:00 pm	Mail 100ml											dt
	11:00 pm	H2O 100ml									✓	line	dt
	12:00 am												dt
	01:00 am										✓		dt
Total Intake :			500ml +			Total Output :			3 times				
	02:00 am											No	dt
	03:00 am												dt
	04:00 am											IV	dt
	05:00 am												dt
	06:00 am										✓	line	
	07:00 am	H2O 50ml											
Total Intake :			50ml			Total Output :			1 times				
Total 24 hrs. Intake			2.500ml			Total 24 hrs. Output			11 times				

FLIP



Page 1 of 1

Left Side		Right Side	
Item	Value	Item	Value
1. 1000	1000	1. 1000	1000
2. 2000	2000	2. 2000	2000
3. 3000	3000	3. 3000	3000
4. 4000	4000	4. 4000	4000
5. 5000	5000	5. 5000	5000
6. 6000	6000	6. 6000	6000
7. 7000	7000	7. 7000	7000
8. 8000	8000	8. 8000	8000
9. 9000	9000	9. 9000	9000
10. 10000	10000	10. 10000	10000
11. 11000	11000	11. 11000	11000
12. 12000	12000	12. 12000	12000
13. 13000	13000	13. 13000	13000
14. 14000	14000	14. 14000	14000
15. 15000	15000	15. 15000	15000
16. 16000	16000	16. 16000	16000
17. 17000	17000	17. 17000	17000
18. 18000	18000	18. 18000	18000
19. 19000	19000	19. 19000	19000
20. 20000	20000	20. 20000	20000
21. 21000	21000	21. 21000	21000
22. 22000	22000	22. 22000	22000
23. 23000	23000	23. 23000	23000
24. 24000	24000	24. 24000	24000
25. 25000	25000	25. 25000	25000
26. 26000	26000	26. 26000	26000
27. 27000	27000	27. 27000	27000
28. 28000	28000	28. 28000	28000
29. 29000	29000	29. 29000	29000
30. 30000	30000	30. 30000	30000
31. 31000	31000	31. 31000	31000
32. 32000	32000	32. 32000	32000
33. 33000	33000	33. 33000	33000
34. 34000	34000	34. 34000	34000
35. 35000	35000	35. 35000	35000
36. 36000	36000	36. 36000	36000
37. 37000	37000	37. 37000	37000
38. 38000	38000	38. 38000	38000
39. 39000	39000	39. 39000	39000
40. 40000	40000	40. 40000	40000
41. 41000	41000	41. 41000	41000
42. 42000	42000	42. 42000	42000
43. 43000	43000	43. 43000	43000
44. 44000	44000	44. 44000	44000
45. 45000	45000	45. 45000	45000
46. 46000	46000	46. 46000	46000
47. 47000	47000	47. 47000	47000
48. 48000	48000	48. 48000	48000
49. 49000	49000	49. 49000	49000
50. 50000	50000	50. 50000	50000

GUC-00086320 IP18-00036308
 Mrs S:UMATHI T
 20-07-1995 30 Y 11 M 14 D (F)
 Dr. LUCETTA AMELIA DIAS



FLUID CHART

Sheet No. : ③

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		Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
08/08/20	08:00 am	H2O	50ml							✓	NO	
	09:00 am											
	10:00 am	H2O	150ml							✓	IV	
	11:00 am										1 line	
	12:00 pm	H2O	100ml							200ml	0	✓
	01:00 pm											
Total Intake :			400 ml			Total Output :			200 ml			
	02:00 pm	H2O	100ml								0	✓
	03:00 pm	H2O	80ml							✓	0	✓
	04:00 pm	H2O	100ml								0	✓
	05:00 pm										0	✓
	06:00 pm	H2O	100ml							✓	0	✓
	07:00 pm										0	✓
Total Intake :			380 ml			Total Output :			240 ml			
	08:00 pm	H2O	100							200	0	Baliy
	09:00 pm	H2O	150								0	Baliy
	10:00 pm	H2O	100							250	0	Baliy
	11:00 pm										0	Baliy
	12:00 am	H2O	150							150	0	Baliy
	01:00 am										0	Baliy
Total Intake :			500 ml			Total Output :			600 ml			
	02:00 am	H2O	100							200	0	the
	03:00 am										0	the
	04:00 am	H2O	150							150ml	0	the
	05:00 am	H2O	100								0	the
	06:00 am									200	0	the
	07:00 am	H2O	100								0	the
Total Intake :			450 ml			Total Output :			550 ml			
Total 24 hrs. Intake		1730 ml										
Total 24 hrs. Output		1350 ml										

GUC-00086320 IP18-00036308
 Mrs SUMATHI T
 20-07-1995 30 Y 11 M 15 D (F)
 Dr. LUCETTA AMELIA DIAS



FLUID CHART

Sheet No. : (14)

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	IV	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am	H ₂ O	100	100	24ml					200	0	DS	
	09:00 am	H ₂ O	100	100	24ml					200	0	DS	
	10:00 am			100	24ml						0	DS	
	11:00 am	H ₂ O	100ml	100	24ml					200	0	DS	
	12:00 pm	H ₂ O	100	100	125						0	DS	
	01:00 pm	Jam	150	100	125						0	DS	
Total Intake : 1372 ml						Total Output : 600 ml							
	02:00 pm	H ₂ O	100ml								0	JH	
	03:00 pm	H ₂ O	100ml							450ml	0	JH	
	04:00 pm									500ml	0	JH	
	05:00 pm	H ₂ O	100ml	125ml			✓			✓	0	JH	
	06:00 pm						✓			✓	0	JH	
	07:00 pm	H ₂ O	200ml							160ml	0	JH	
Total Intake : 500ml + 250ml						Total Output : 610ml							
	08:00 pm	H ₂ O	100ml				✓			450ml	0	JH	
	09:00 pm	H ₂ O	100ml				✓			200ml	0	SA	
	10:00 pm	Jam	200ml				✓			200ml	0	SA	
	11:00 pm									200ml	0	SA	
	12:00 am									150ml	0	SA	
	01:00 am									250ml	0	SA	
Total Intake : 400ml						Total Output : 1050ml							
	02:00 am									200ml	0	SA	
	03:00 am									200ml	0	SA	
	04:00 am									200ml	0	SA	
	05:00 am									200ml	0	SA	
	06:00 am										0	SA	
	07:00 am	Milk	100ml							200ml	0	SA	
Total Intake : 150ml						Total Output : 850ml + 200ml							
Total 24 hrs. Intake			2,672ml			Total 24 hrs. Output			3,110ml				

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NURSING SHIFT HAND OVER FORM

SITUATION		Diagnosis: <i>primi 36+1 day</i>						Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:						
BACKGROUND		Surgery / Procedure: <i>—</i>						Post OP Day:						
BACKGROUND	Date	<i>3/7/26</i>		<i>3/7/26</i>		<i>4/7/26</i>		<i>4/7/26</i>		<i>5/7/26</i>		<i>5/7/26</i>		
	Shift	<i>E</i>		<i>N</i>		<i>M</i>		<i>E</i>		<i>N</i>		<i>M</i>		
	Medical Condition (Any special condition to be noted):	<i>HTN</i>		<i>HTN</i>		<i>HTN</i>		<i>HTN</i>		<i>HTN</i>		<i>HTN</i>		
ASSESSMENT	Diet:	<i>Normal</i>		<i>Normal</i>		<i>Normal</i>		<i>Normal</i>		<i>Normal</i>		<i>Normal</i>		
	Allergy:	☐ Yes ☒ No		☐ Yes ☒ No		☐ Yes ☒ No		☐ Yes ☒ No		☐ Yes ☒ No		☐ Yes ☒ No		
	Ventilation (RA, NP, NIV, VENTI):	<i>—</i>		<i>—</i>		<i>—</i>		<i>—</i>		<i>—</i>		<i>—</i>		
	Tubes/Drains/Catheter:	☐ Yes ☒ No		☐ Yes ☒ No		☐ Yes ☒ No		☐ Yes ☒ No		☐ Yes ☒ No		☐ Yes ☒ No		
	Vital Signs:	Temp:	<i>98.0</i>		<i>98.2</i>		<i>98.8</i>		<i>98.8</i>		<i>98.1</i>		<i>98.1</i>	
		Res:	<i>20b/m</i>		<i>20b/m</i>		<i>20b/m</i>		<i>20b/m</i>		<i>20b/m</i>		<i>20b/m</i>	
		SpO ₂ :	<i>100%</i>		<i>98%</i>		<i>100%</i>		<i>99%</i>		<i>99%</i>		<i>99%</i>	
		Pulse:	<i>89b/m</i>		<i>90b/m</i>		<i>112b/m</i>		<i>98b/m</i>		<i>92b/m</i>		<i>90b/m</i>	
		BP:	<i>100/60</i>		<i>110/76</i>		<i>106/71</i>		<i>109/65</i>		<i>110/78</i>		<i>102/52 (89)</i>	
		LOC:	<i>conscious</i>		<i>conscious</i>		<i>conscious</i>		<i>conscious</i>		<i>conscious</i>		<i>conscious</i>	
Fall Risk Score:		<i>25</i>		<i>25</i>		<i>25</i>		<i>25</i>		<i>25</i>		<i>25</i>		
Pain Score:	<i>0/10</i>		<i>0/10</i>		<i>0/10</i>		<i>0/10</i>		<i>0/10</i>		<i>0/10</i>			
Skin Integrity	<i>Normal</i>		<i>Normal</i>		<i>Normal</i>		<i>Normal</i>		<i>Normal</i>		<i>Normal</i>			
Recommendations	Safety Needs:	☐ Yes ☒ No		☐ Yes ☒ No		☐ Yes ☒ No		☐ Yes ☒ No		☐ Yes ☒ No		☐ Yes ☒ No		
	Physiotherapy:	<i>N/A</i>		<i>N/A</i>		<i>N/A</i>		<i>N/A</i>		<i>N/A</i>		<i>N/A</i>		
	Others Specify:	☐ Yes ☒ No		☐ Yes ☒ No		☐ Yes ☒ No		☐ Yes ☒ No		☐ Yes ☒ No		☐ Yes ☒ No		
	Special Diet:	<i>Normal</i>		<i>Normal</i>		<i>Normal</i>		<i>Normal</i>		<i>Normal</i>		<i>Normal</i>		
	Critical Lab Test / Values:	<i>—</i>		<i>—</i>		<i>—</i>		<i>—</i>		<i>—</i>		<i>—</i>		
	Other Special Orders / Medications:	☐ Yes ☒ No		☐ Yes ☒ No		☐ Yes ☒ No		☐ Yes ☒ No		☐ Yes ☒ No		☐ Yes ☒ No		
	PU Prophylaxis:	☐ Yes ☒ No		☐ Yes ☒ No		☐ Yes ☒ No		☐ Yes ☒ No		☐ Yes ☒ No		☐ Yes ☒ No		
	DVT Prophylaxis:	☐ Yes ☒ No		☐ Yes ☒ No		☐ Yes ☒ No		☐ Yes ☒ No		☐ Yes ☒ No		☐ Yes ☒ No		
	ADL (Dependent / Non Dependent):	<i>Non Dependent</i>		<i>Non Dependent</i>		<i>Non Dependent</i>		<i>Non Dependent</i>		<i>Non Dependent</i>		<i>Non Dependent</i>		
	Post Operative Procedure Special Orders:	<i>N/A</i>		<i>—</i>		<i>—</i>		<i>—</i>		<i>—</i>		<i>—</i>		
Handed Over By Name :		<i>S. N. Akaly</i>		<i>S. N. Akaly</i>		<i>S. N. Akaly</i>		<i>S. N. Akaly</i>		<i>S. N. Akaly</i>		<i>S. N. Akaly</i>		
Signature / ID :		<i>SA 018005</i>		<i>SA 018005</i>		<i>SA 018005</i>		<i>SA 018005</i>		<i>SA 018005</i>		<i>SA 018005</i>		
Date:		<i>3/7/2026</i>		<i>4/7/26</i>		<i>4/7/26</i>		<i>4/7/26</i>		<i>5/7/26</i>		<i>5/7/26</i>		
Time:		<i>8pm</i>		<i>8am</i>		<i>8am</i>		<i>2pm</i>		<i>7:30am</i>		<i>11:30am</i>		
Taken Over By Name :		<i>S. N. Akaly</i>		<i>S. N. Akaly</i>		<i>S. N. Akaly</i>		<i>S. N. Akaly</i>		<i>S. N. Akaly</i>		<i>S. N. Akaly</i>		
Signature / ID :		<i>SA 018005</i>		<i>SA 018005</i>		<i>SA 018005</i>		<i>SA 018005</i>		<i>SA 018005</i>		<i>SA 018005</i>		
Date:		<i>3/7/26</i>		<i>4/7/26</i>		<i>4/7/26</i>		<i>4/7/26</i>		<i>5/7/26</i>		<i>5/7/26</i>		
Time:		<i>8pm</i>		<i>8am</i>		<i>2pm</i>		<i>2pm</i>		<i>8am</i>		<i>2pm</i>		

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:				
	Surgery / Procedure:		Post OP Day:				
BACKGROUND	Date	Shift					
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp:					
		Res:					
		SpO ₂ :					
		Pulse:					
		BP:					
		LOC:					
		Fall Risk Score:					
Pain Score:							
Skin Integrity							
Recommendations	Safety Needs:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:						
	Others Specify:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
ADL (Dependent / Non Dependent):							
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							

ADDITIONAL INFORMATION

DATE: 10/10/2017

REFERENCE NUMBER

100

101

102

103

104

105

DATE: 10/10/2017

TIME: 10:10

LOCATION: 101

DESCRIPTION: 102

REMARKS: 103

STATUS: 104

REMARKS: 105

REMARKS: 106

REMARKS: 107

REMARKS: 108

REMARKS: 109

REMARKS: 110

REMARKS: 111

REMARKS: 112

REMARKS: 113

REMARKS: 114

REMARKS: 115

REMARKS: 116

REMARKS: 117

REMARKS: 118

REMARKS: 119

REMARKS: 120

GUC-00086320

IP18-00036308

Mrs SUMATHI T

20-07-1995

30 Y 11 M 13 D (F)

Dr. LUCETTA AMELIA DIAS



NURSING CARE RECORD

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

BirthRight
BY RAINBOW HOSPITAL'S
Your Right to a Safe Delivery

Date: 3/7/2006

Goals

- ☐ Maintain Airway and Oxygenation
☐ Maintain Personal Hygiene
☐ Identify Potential Complications

- ☐ Relieve Pain & Discomfort
☒ Prevent Infection
☐ Any Others. Specify.....

- ☐ Maintain Fluid Balance
☐ Meet Elimination Needs

- ☐ Improve Activity Tolerance
☐ Ensure Safety

- ☐ Maintain Good Nutritional Status
☐ Early Ambulation Reduce Anxiety

- ☐ Maintain Skin Integrity
☐ Patient & Family Education

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon	6pm	Reduce Risk of Hospital Acquired & wound Infection	6:30 pm	Maintain strict hand hygiene use Aseptic techniques during procedure & dressing change	patient was stable	Reassessment was done	S/Analy 018080
Night	8 pm	Maintain Good Nutritional Status	10 PM	→ Assess the nutritional status of patient → Encourage to take balanced diet.	Nutritional Status was good.	Reassessment Done	Thilini Gattin

GUC-00086320

IP18-00036308

Mrs SUMATHI T

20-7-1995

30 Y 11 M 14 D (F)

Dr. LUCETTA AMELIA DIAS



NURSING CARE RECORD

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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: 5/7/20

Goals

- ☐ Maintain Airway and Oxygenation
☒ Maintain Personal Hygiene
☐ Identify Potential Complications

- ☐ Relieve Pain & Discomfort
☒ Prevent Infection
☐ Any Others. Specify.....

- ☐ Maintain Fluid Balance
☐ Meet Elimination Needs

- ☐ Improve Activity Tolerance
☐ Ensure Safety

- ☒ Maintain Good Nutritional Status
☐ Early Ambulation Reduce Anxiety

- ☐ Maintain Skin Integrity
☐ Patient & Family Education

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am	Maintain Personal hygiene		⇒ Maintain the oral hygiene ⇒ Strictly hand washing.	Maintain the oral hygiene	Maintained the personal hygiene	N. S. S.
Afternoon	1.30 pm	Ensure prevent Infection		⇒ Maintain the strict hand washing ⇒ Maintain Personal hygiene	⇒ Maintain the strict hand washing	Maintained the strict hand washing	N. S. S.
Night	8pm	⇒ To Maintain Nutritional Status.		⇒ To Maintain encourage high rich diet	⇒ To Improve Nutritional	⇒ The client's vital sign stable	S. S.



NURSING CARE RECORD

Date: 06/11/2026

Goals

- ☐ Maintain Airway and Oxygenation
☐ Maintain Personal Hygiene
☐ Identify Potential Complications

- ☐ Relieve Pain & Discomfort
☒ Prevent Infection
☐ Any Others. Specify.....

- ☐ Maintain Fluid Balance
☐ Meet Elimination Needs

- ☐ Improve Activity Tolerance
☐ Ensure Safety

- ☐ Maintain Good Nutritional Status
☐ Early Ambulation Reduce Anxiety

- ☐ Maintain Skin Integrity
☐ Patient & Family Education

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am	Administer acetaminophen pain control and comfortable	8:20 AM	→ Assess pain using pain scale → patient in comfortable position	patient vitals are stable	Reassessment done	
Afternoon	2pm	Prevent infection		→ Assess the mother condition → provide strict hand washing	Patient: prevented infection	Re assessment done	
Night	8pm	→ To Maintain Nutritional Status		→ To encourage high rich diet.	→ The Patient improve Nutritional Status	The patient vital signs stable	

GUC-00086320

IP18-00036308

Mrs S:UMATHI T

20-07-1995 30 Y 11 M 14 D (F)

Dr. LIJCETTA AMELIA DIAS



2 NURSING CARE RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: 05/07/26

Goals

- ☒ Maintain Airway and Oxygenation
☒ Maintain Personal Hygiene
☐ Identify Potential Complications

- ☐ Relieve Pain & Discomfort
☐ Prevent Infection
☐ Any Others. Specify.....

- ☐ Maintain Fluid Balance
☐ Meet Elimination Needs

- ☐ Improve Activity Tolerance
☐ Ensure Safety

- ☐ Maintain Good Nutritional Status
☐ Early Ambulation Reduce Anxiety

- ☐ Maintain Skin Integrity
☐ Patient & Family Education

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am	to promote Health Hygiene		→ Assessed patient's condition → Encourage oral & Hand Hygiene → Daily changed dress bed sheet	Maintained personal Hygiene	Reassessment done	deep 2009/07
Afternoon	2pm	Achieve acceptable Pain Control and comfort	2pm	→ Assess the Pain using Pain Scale → Administered analgesia as prescribed.	Patient vital sign	Reassess done	deep
Night	8pm	Maintain/Ensure Safety		→ Assess the pain using pain scale → Bed in low lying position	prevent fall injury	Reassessment done	deep

NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Admission Notes	
3 Feb 20	5:30 PM	⇒ Mrs. Sumathi came for safe confinement view of severe FUR growth restriction. Under Dr. Lucetta she is primigravida 36+1 days know case of severe FUR. GDM on OHA GTTIN. checked for vital signs recorded patient vital are stable conscious oriented perineal preparation was done. Dr. Lucetta to take High vaginal swab. collected & sent to lab. patient general condition fair CTU was connected FHR is good ⊕	
	6pm	⇒ checked for CBV 116 mld. Informed Dr. Divya lakshmi. Advised to inj Betnesol 1mg Im given to patient Stopped CTU as per protocol order	Dr. Divya lakshmi 01805
	7pm	⇒ Dr. Divya lakshmi Advised to PT shifted towards patient care hand over given to 3rd floor staff nurse	Dr. Divya lakshmi 01805

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

NURSES NOTES

- ☒ No Known Drug Allergies
☐ Drug Allergies ... none

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
3/7	4:10 PM	← Received notes → → Patient Received from LOR to 5th floor → Patient details Handled over taken by LOR S/N to 5th floor S/N	J. Li 018346
	7:15 PM	→ RBS checked lo2 inserted to LOR Cuy	
	7:30 PM	→ Heavily Seized & Epilepsy → Patient detail Handled over given to Night duty S/N	J. Li 018346 S. Li 018346
3/7/26	7:30 PM	Night Duty → The Patient hand over from evening duty staff patient is conscious & oriented.	S. Ang 018346
	8:00 PM	→ The Patient vital signs clearly recorded. The Patient FHR 140 clearly recorded.	
	9:00 PM	→ Due Medication is given as per drug chart maintained by nurse.	S. Ang 018346

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

- ☒ No Known Drug Allergies
☐ Drug Allergies ... Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
3/8/26	10:00am	→ The patient is FHR 144bpm. clearly recorded.	
	10:45pm	→ The patient is PR 199mg/dl clearly recorded. Inform to Dr. Jennifer mam advise human Actrapid 4 unit told mam.	S. / Prof 2/8/26
	11:pm	→ The patient FHR clearly recorded. 144bpm. → SpO2 human Actrapid 4 unit is given as per drug chart monitoring document.	
4/7	12:00am	The patient vital signs clearly recorded.	S. / Prof 2/8/26
	2:00am	→ The patient is sleeping is well. Patient is no any other complications.	S. / Prof 2/8/26
	3:00am	→ The patient PR 154mg/dl. Inform to Dr. Jennifer mam advise to Jan CTD.	
	4:00am	→ The patient vital signs clearly recorded.	S. / Prof 2/8/26
	6:00pm	→ The child PR 128mg/dl Inform to Dr. Jennifer mam advise to Flarep bumper & Gold mam.	S. / Prof 2/8/26

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

NURSES NOTES

- ☒ No Known Drug Allergies
☐ Drug Allergies All

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
8/7/26	7:00am	The patient is CTU is connected. CTU not CTU Normal. good intake after CTU start.	
	8:00am	=> Inj: Fasp 6 one is given man. after 1 hour recen. CBCs.	J/O/26
		=> The patient hand over from morning duty staff	
		Undergoing duty	
8/7	7:30 am	-> Patient detected. Handling over taken by Night duty staff - patient was Conscious and Alert patient was active & alert	J/O/26 019346
	8pm	-> vitals all checked and recorded vitals are stable patient had Breast fast, Due day 3 on	J/O/26 019346
	9:15 am	-> CBC checked 26mg/dl informed to Dr. Alshaker	
		-> Doctor's advice to Inj: fasp 6 and Jantus 10mg and check CBCs After 1hr	J/O/26 019346
	9:30 am	CBCs are low fasp 6 and Jantus 10mg are given. CTG connected	
	9:30 am	Jantus 10mg are given.	J/O/26 019346
	10:15 am	-> CTG Done	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
4/7		- Dr. Akshita mam advice to do hourly CBG Monitor	
		- Dr. Lucetta mam saw the patient and gave advice to hourly fill with Doppler machine.	
		and Bed Side Scan done	July 019346
	10:30 am	- CBG Checked and Rechecked 14mg/dl fHR checked	
	11:30 am	- CBG Checked 107mg/dl informed to Dr. Akshita, fHR checked.	
	12:30 pm	- CBG Checked 83mg/dl informed to Dr. Akshita. Doctor advice to give 1/2 Apple, fHR checked	
		- Vitals are checked and Rechecked Vitals are Good & Stable	July 019346
	1pm	- Patient ate apple, drug given	
	2pm	- CBG Checked 89mg/dl and informed to Dr. Akshita Doctor advice to give theogel	
	2:11pm	Phone Call about Jay's fHR sent	
	2:13pm	- Jay's fHR sent, done	July 019346
		- Patient had ^{sterile} Lunch @ 2:15pm	
	3:30 pm	- Post lunch CBG Checked and informed to Dr. Dinya	
		- Dinya mam advice to give Grape Units	July 019346

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
4/7	3:55 pm	2ml Fiap units as given vitals all checked and Rechecked vitals are stable	Su 019346
	5pm	→ CTG Connected, Dr Divya advice to connect CTG → HR checked & Rechecked	Su 019346
	6pm	CBE checked 130mg/dl Informed to Dr Divya → 2ml Betasol as given as per day chart order	Su 019346
	7pm	→ CBE checked 105mg/dl and informed to Dr. Divya Doctor's advice to give 2ml Fiap units	Su 019346
	7:35 pm	→ 2ml Fiap units given → Maintaining feeds & reports → Child detail handling and given to night duty staff	Su 019346
4/7	7:30pm	Night duty → The Patient hand over from evening duty staff. Patient consciously oriented. Patient is under roomair.	Su 019346
	8:00pm	The Patient vital signs cheeky recorded.	Su 019346

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00086320

IP18-00036308

Mrs S:UMATHI T

20-07-1995

30 Y 11 M 14 D (F)

Dr. LIJETTA AMELIA DIAS



(4)

NURSES NOTES

Rainbow Children's Hospital
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☒ No Known Drug Allergies

☐ Drug Allergies ... Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
4/8	8:50pm	The patient CBC-154 mg/Lu clearly recorded. Inform to Dr. Parthia mam advice to inj: Flap 11 unit given by Alex CRC 10pm.	S. Amos 01/08/05
	8:56pm	8:56pm	
	9:00pm	→ inj: Flap 11 unit is given as per drug chart maintain by parent.	S. Amos 01/08/05
	9:00pm	→ All medication is given as per drug chart maintain by parent.	
	10:00pm	→ The patient is CBC-154 mg/Lu Inform to Dr. Parthia mam advice to inj: Latex 8 unit given to 2 mg.	S. Amos 01/08/05
	10:10pm	→ inj: Latex 8 unit is given as per drug chart maintain by parent.	
		→ The patient has Dr. Parthia mam seen the advice to To clear pre-post breakfast CRC, CTM TDS - TMA 9am	S. Amos 01/08/05
	11pm	→ The patient RHR clearly recorded	S. Amos 01/08/05
4/8	12:00am	The patient clear signs clearly recorded RHR clearly recorded	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

NURSES NOTES

☒ No Known Drug Allergies

☐ Drug Allergies Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
15/7/16	2:00am	→ The patient is sleeping is well. Patient is no any other complaint. FHR clearly recorded.	
	4:00am	→ The patient vital signs clearly recorded.	SP/AN
	6:00am	→ The patient FHR clearly recorded.	
	7:30am	→ The patient PRS 93 mg given album to Dr. Pankaj man advice ins. fasp 8 am is given → The patient to admit morning duty → The child hand over from morning duty staff. Morning duty on (05/126)	SP/AN
	7:30am	The patient Handing over taken from night duty staff the patient was conscious & oriented	
	2AM	Vital signs are checked & Recorded vital signs are stable	SP/AN
	8:10AM	Due to medication given as per drug chart order.	
	9:15AM	Post op was checked 182ml	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00086320

Mrs S. UMATHI T

20-07-1995

Dr. LUCETTA AMELIA DIAS

IP18-00036308

30 Y 11 M 14 D (F)



NURSES NOTES

Rainbow Children's Hospital
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☒ No Known Drug Allergies

☐ Drug Allergies ... nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		continue	
		informed DR. Ashitta man.	
		man told. inj. Fiasep 40	
		and inj. Lantus 60	
	9:30am	inj. Fiasep 40 and inj. Lantus 60 was given	
		as per doctor order →	<u>nil.</u>
	9:40am	DR. Ashitta man seen the patient advice to continue same	<u>02/11/13</u>
	11 AM	The patient was comfortable position. no any fresh complaints	<u>Sush</u> <u>02/11/13</u>
	11:30am	The patient shifted 5th to LDR the patient Handing over given to LDR staff →	<u>Sush</u> <u>02/11/13</u>
5/11/13	11:30am	Receiving the patient from 5th floor in surgery case. While receiving the patient complains of weight a fever, having difficulty in breathing well. Voiced hoars.	<u>nil.</u> <u>02/11/13</u>
	12pm	→ \$13 Dr. Lucetta man Advice to follow up at 7:45 PM. Patient co-operated well	
		→ 10/11/13	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

NURSES NOTES

☒ No Known Drug Allergies

☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
<u>Local</u> 5/7/20	10pm	→ CBG: 11mg/dl. Lit to Dr. Akshita near Advice to No Insulin work → 01/01/20	
		→ Post Foley CG (urinated) reaction FHR good, Fetal movement good.	01/01/20
	2pm	→ Patient shift to 4th floor. hand over to 5th floor shift → 01/01/20	
		← Received note →	
	2:30 pm	- patient Received from LDR to 5th floor - patient detail - Handing over - taken by LDR staff to 5th floor LDR	01/01/20
		→ patient was conscious and oriented patient was active & alert for line patterns, Daps given	01/01/20
	2:50pm	CBE checked and 18mg/dl informed to Dr. Akshita.	
	2:55pm	→ Dr. Akshita advice through phone Call Jay- fasp units	
	3pm	Jay- fasp units given FHR checked and Rechecked	01/01/20
	4pm	vitals are checked and Rechecked vitals are stable	01/01/20

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



6 NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies

N11

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
	Side PM	→ Dr. Akshita mom give tea patient and push flush 20cc distilled water traction low	Sing 019346
	6pm	→ CBC Counsel finished at 2pm and reactive	
		→ Dr. Akshita mom advice to keep message patient well shift CDR at 10pm	
	7:26 PM	→ CBC post-dinner CBC 112mg/l labored to LDR Cuy	Sing 019346
		→ Maintaining records of inputs	
	7:52 PM	→ CBC labored to Dr. Krishnadas Sr. Doctor advice to give 6 units of fiasp with dinner	
	7:53 PM	→ fiasp 6 units given	
		→ patient detail handling and given to Night Duty Staff	Sing 019346
		Night duty Notes.	
5/7	7:50pm	The patient details handing over taken from evening duty Staff - patient is conscious.	
		IV line present and patency →	Balraj/020685
	8pm	Vital signs checked & Recorded	
		Vitals are stable. →	Balraj/020685
	9pm	Due to medications are given as per drug chart →	Balraj/020685

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies

Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		→ Continue Notes ←	
6/17	9.20pm	CB4 Checked & Recorded. CB4: 159mg/dl. Informed to Dr. Krishnadas sir. Advised to give Tinj. Fiasp - 2 units given	Balwaj/020685
	9.30pm	Dr. Krishnadas sir via phone call advised to give Tinj. Lantus 6 unit - given →	Balwaj 020685
		⇒ the patient shifted to Mico cell.	J/01202
	10pm	Receiving notes Patient Received From 5th Floor to LDR Patient Care Handing over taken from 5th Floor Staff. Monitored vitals and Recorded. ECG connected. FHR Monitored. Pain assessment Done - No any other complaints	Shree 016120
	11pm	Monitored vitals and Recorded. Maintained DLO. Patient General condition Fair. Pain assessment Done. Patient Conscious and oriented.	Shree 016120
6/17/26	12am	Monitored vitals and Recorded. Maintained DLO. Pain assessment Done. FHR Monitored	Shree 016120

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

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☒ No Known Drug Allergies

☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
6/7/20	12.30 AM	CTG Connected. FHR Monitored. Maintained Flo. Pain assessment Done. No any other complaints. watching contractions	Shree 01/6/20
	1 AM	T-NISO 25mg p/o given as per doctor order. Maintained Flo. Monitored vitals Recorded. Foley's Insite.	Shree 01/6/20
	2 AM	Post T-NISO CTG Connected, FHR Monitored. Pain assessment Done. No any other complaints. watching contractions. Patient General Condition Fair	Shree 01/6/20
	3 AM	Maintained Flo. Monitored Flo. Pain assessment Done, watching contractions. Patient General Condition Fair. FHR Monitored	Shree 01/6/20
	4 AM	Maintained Flo. FHR Monitored. Pain assessment Done. No any other complaints. Patient General Condition Fair	Shree 01/6/20
	5 AM	Dr. Alishitha done p/v Examination & Soft, med position, 2cm long 2cm dilated, Membrane present vx - 3 station. advised to give T-NISO 25mg p/o given	Shree 01/6/20

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NURSES NOTES

☒ No Known Drug Allergies

☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		as per doctor order	<i>[Signature]</i> 01520
	6Am	post-T. NISO CTG on connect. FHR Monitoring. Enemagiven. Pain assessment done. watching contractions. Morning care given to patient. No any other complaints	<i>[Signature]</i> 01520
	7Am	FHR monitored. CTG disconnected. No any other complaints. Patient General Condition Fair.	<i>[Signature]</i> 01520
	7:30pm	patient care Handling over given to Morning duty Staff	<i>[Signature]</i> 01520
		Morning duty (06/07/2026)	
	7:30 AM	patient handing over taken by morning duty. Staff Nishi patient conscious and oriented General condition Fair	<i>[Signature]</i> 01520
	8Am	patient checked when given water one stable patient Change post born CB 9Am. patient 7:30 Am 7:2mg ldl 8/B DR. paritosh nam advise to 9 Am Trj : Synton	<i>[Signature]</i> 01520

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

NURSES NOTES

☒ No Known Drug Allergies

☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
06/7/20	9am	patient checked CBs 13.7mg/dl Inform to DR. parvitha mam patient Tij: Synton 500 RI 500ml Start 24ml patient Comocney FIR ⊕ 140b/min patient conscious and oriented in CBs patient hospitalized Conducts Fein	Off 01/7/20
	9.30 AM	patient due medication given good suckling S/B DR. Lucetta mam ply examination 1cm long 3cm defatus 100g ARM done clear Apix patient OK Continue Tij: Synton continue	Off 01/7/20
	10am	patient checked inter signs inter are stable OK going on FIR ⊕ 140b/min patient Tij: Synton continue CBs 9.7mg/dl Inform to DR. parvitha mam	Off 01/7/20
	10.45 AM	S/B DR. Lucetta mam ply examination seen defatus patient Shifts 100g ⊕ patient General condition FIR	Off 01/7/20

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

NURSES NOTES

☒ No Known Drug Allergies

☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
06/11/25	11:15 AM	patient on 1pnnedney FHR 140 bpm patient conscious and oriented s/p DR. Mott's exam. plus external full dilatation	
6/11/25	11:20 AM	Kini Affered Normal vaginal delivery with Episiotomy ↓ cap patient in dorsal lithotomy position local pants painted and draped. with good uterine contractions and full cervical dilation with poor maternal efforts. was made to apply Kini cup. Mother delivery an alive boy. Bee who could immediately after delivery father huts cry Baby Trj: Synto 100mg and Trj: Synto 20 mg 125u. patient Trj: cabent 250mg 100 given Trj: Typle 1g 14 given. patient before Trj: cabent given the center of 10mm. delivery in 40s episiotomy was suts.	

6
Type
ISO 11140

STEAM

Man.: 2025 - 06
Exp.: 2030 - 06
Ref.: 106.303.0500
Lot.: 14176

Green = Sterilized

SV: 121°C - 15 min.
134°C - 3.5 min.

Steritech

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

- ☒ No Known Drug Allergies
☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
6/7/26	contn	subcut in layers with Rapid way. uterus firm well contracted. plac bleeding minimal patient T. miso coming plr put. Lubin's Supper plr put patient Normal position given B - 06/07/2026 A - 2.094 kg B - Boy Y - 810.910	
	12pm	patient checked vital one stable patient chn. CBU. 95mg/dl Inform to DR. patient's mom B - Breast both way soft U - uterus was well contracted - B - Bowel movement present B - patient still new Not urin passed L - Lochis present No odourous foul smelling E - Epistomy wound healthy only.	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

☒ No Known Drug Allergies

☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
6/7/20	10:00am	H - Home's signs Negative E - Emotions Status	
	1:00pm	Good patient Checked can 20mg/dl Inform to DR. patient's mom admin give to Food patient Food given	YDP 01/07/20
	2:15pm	patient Checked 160mg/dl inform to DR. Lucetta mom	YDP 01/07/20
	2:30pm	patient handing over given 5th floor staff Nurse patient conscious and oriented hem condition fine	YDP 01/07/20
		Receiving Note.	
	2:40pm	patient details handover taken from the LDR Staff. patient was conscious & oriented. Dr line patient.	YDP 01/07/20
	3:40pm	patient was passed over to 4th floor. Inform to Doctor. mom Advise/ follow No chart.	YDP 01/07/20

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

☒ No Known Drug Allergies

☒ Drug Allergies nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
6/7	4pm	Dr. Divya mam See the patient - check the Scatue. patient was unio 500ml. Inform to the Dr. Lucetta mam.	John Oso
		Check The vital sign. vital are the stable [cp PP CRT] [H H Lrr]	
	5:20pm	Dr. Lucetta mam see the patient mam Advic Disite the catheter. monitor urine output	John Oso
	6:30pm	Cathutisation done. Inform to the Dr. Lucetta mam. output. 160 ml.	John Oso
	7pm	See indication as given for the drug chart Order.	John Oso
	7:30pm	monitor the chart patient details handover given to the Night duty staff	John Oso
6/7	7:30pm	Night duty The patient hand over from evening duty staff. The patient conscious & oriente	Sfor

6
Type
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STEAM
Green =
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Man.: 2025 - 06
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Ref.: 106.303.0500
Lot.: 14176
SV: 121°C - 15 min.
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Steritech

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NURSES NOTES

☒ No Known Drug Allergies

☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
8/6		AV line is present. C.R.D is present.	
	8:00pm	→ The cephalic vital sign clearly recorded.	
		→ Due Medication is given as per drug chart maintenance document.	S. Arora 01/25/25
	10:00pm	→ The patient has 203mg Inform to Dr. Vinita man. & will inform pt. loss stool complaint told man man advice to 7. Biflax told.	S. Arora 01/25/25
		→ Due Medication is given as per drug chart maintenance document.	
	11:00pm	7. Biflax is given as per drug chart maintenance document.	S. Arora 01/25/25
8/6	12:00am	→ The cephalic vital sign clearly recorded	
	1:00am	→ The cephalic is sleep is well. pt is no any other complaint	
	4:00am	→ The patient vital sign clearly recorded → Due Medication is given as per drug chart maintenance document	S. Arora 01/25/25

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC:00086320

Mrs SUMATHI T

20-07-1995

Dr. LUCETTA AMEILIA DIAS

IP18-00036308

30 Y 11 M 16 D (F)



NURSES NOTES

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

BirthRight
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Your Right to a Safe Delivery

☒ No Known Drug Allergies

☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		R- Breast engorged	
		U- uterine contractions	
		B- BBD is present.	
		B- Bladder meome	
		L- Lochia rubra present	
		R- Rada is not applicable	S. Hod
		H- Homen sign present	08/8/16
		E- emotional status good.	
7/16	7:30pm	→ TW patiente Dr. Lucetta mam phone call order to CBD cheery.	
		PRB. 87mg/lac cheery	
		Inform to Dr. Lucetta mam	
		advice to algomet se every	S. Hod
		BD 60/2 mam	08/8/16
		→ The CBD is clamped	
		Due MIDline 1st 2nd 3rd as	
		per drug dent mally y	
		Cement	S. Hod
		→ The Patient 1st 2nd 3rd	
		mally cement.	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

- ☐
- No Known Drug Allergies

- ☐
- Drug Allergies

[illegible]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient's Name:.....

GUC-00086320

IP18-00036308

MRD NO:.....

Mrs SUMATHI T

20-07-1995

30 Y 11 M 13 D (F)

Age :.....

Dr. LUCETTA AMELIA DIAS



J M O F

Consultant :

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 5/7/20

Time: 1pm

Location : Outpatient

Size : 18G

Cannula inserted by : Nurse 1011740

CANNULA 2

Date :

Time:

Location :

Size :

Cannula inserted by :

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
5/7	12pm	☐ Yes ☒ No	☐ Yes ☒ No	Obs	red
	2:30pm	☐ Yes ☒ No	☐ Yes ☒ No	Obs	red
	4pm	☐ Yes ☒ No	☐ Yes ☒ No	Obs	red
	6pm	☐ Yes ☒ No	☐ Yes ☒ No	Obs	red
	8pm	☐ Yes ☒ No	☐ Yes ☒ No	Obs	red
	10pm	☐ Yes ☒ No	☐ Yes ☒ No	Obs	red
6/7	12am	☐ Yes ☒ No	☐ Yes ☒ No	Obs	red
	2am	☐ Yes ☒ No	☐ Yes ☒ No	Obs	red
	4am	☐ Yes ☒ No	☐ Yes ☒ No	Obs	red
	6am	☐ Yes ☒ No	☐ Yes ☒ No	Obs	red
	8am	☐ Yes ☒ No	☐ Yes ☒ No	Obs	red
	10am	☐ Yes ☒ No	☐ Yes ☒ No	Obs	red
	12pm	☐ Yes ☒ No	☐ Yes ☒ No	Obs	red
	2pm	☐ Yes ☒ No	☐ Yes ☒ No	Obs	red
	4pm	☐ Yes ☒ No	☐ Yes ☒ No	Obs	red
	6pm	☐ Yes ☒ No	☐ Yes ☒ No	Obs	red
7/7	8pm	☐ Yes ☒ No	☐ Yes ☒ No	Obs	red
	10pm	☐ Yes ☒ No	☐ Yes ☒ No	Obs	red
	12am	☐ Yes ☒ No	☐ Yes ☒ No	Obs	red
	2am	☐ Yes ☒ No	☐ Yes ☒ No	Obs	red
	4am	☐ Yes ☒ No	☐ Yes ☒ No	Obs	red
	6am	☐ Yes ☒ No	☐ Yes ☒ No	Obs	red
		☐ Yes ☒ No	☐ Yes ☒ No		
		☐ Yes ☒ No	☐ Yes ☒ No		
		☐ Yes ☒ No	☐ Yes ☒ No		
		☐ Yes ☒ No	☐ Yes ☒ No		
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		☐ Yes ☒ No	☐ Yes ☒ No		
		☐ Yes ☒ No	☐ Yes ☒ No		

PHLEBITIS ASSESSMENT AND MANAGEMENT RECORD

CANNULA 3

Time:

Location :

Size :

Cannula inserted by :

CANNULA 4

Time:

Location :

Size :

Cannula inserted by :

[illegible]

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

[illegible]

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 TREATMENT RESITE / REMOVE CANNULA

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Mrs SUMATHI T

20-07-1995

30 Y 11 M 13 D (F)

Dr. LUCETTA AMELIA DIAS



Morse Fall Risk Assessment Form

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

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Your Right to a Safe Delivery

Choose Highest Applicable Score from each Category		Date / Time	E	N	M	Fall Risk Grading		
		Score				Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25						
	No	0	0	0	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15	15	15	15			
	No	0						
Ambulatory Aid	Furniture	30				Low Risk	0 - 24	Standard Fall Precaution
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0	0	0			
IV / Heparin Lock or Saline	Yes	20						
	No	0	0	0	0			
GAIT / Transferring	Impaired	20				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	Weak (uses touch for balance)	10	10	10	10			
	Normal /On Bed Rest /Immobile	0						
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0	0	0	0			
Total Morse Fall Scale Score:			25	25	25			
		Signature	Abalys	myk	my			

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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27

Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	E	N	M	Fall Risk Grading		
		Score						
History of Falling (immediately or w/in 3 months)	Yes	25				Risk Level	Morse Fall Score (MFS)	Action
	No	0	0	0	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15	15	15	15	Low Risk	0 - 24	Standard Fall Precaution
	No	0						
Ambulatory Aid	Furniture	30				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0	0	0			
IV / Heparin Lock or Saline	Yes	20				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	No	0	0	0	0			
GAIT / Transferring	Impaired	20						
	Weak (uses touch for balance)	10	10	10	10			
	Normal /On Bed Rest /Immobile	0						
Mental Status	Forgets limitations	15						
	Oriented to own ability	0	0	0	0			
Total Morse Fall Scale Score:			25	25	25			
Signature			<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>			

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

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

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

1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

2. The second part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

3. The third part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

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Mrs SUMATHI T

20-07-1995

30 Y 11 M 13 D (F)

Dr. LUCETTA AMELIA DIAS



PAIN ASSESSMENT FORM

Rainbow Children's Hospital
It takes a lot to trust the kids.

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
3/7/26	7pm	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	no pain	Abdomen 01808
3/7/26	1am	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	nil	upper abdomen
4/7/26	8am	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Nil	S. N. N. N. N. 607241
4/7	2pm	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Nil	Shy 01808
4/7	2pm	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	nil	shy 01808
5/7	2am	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Nil	shy 01808
5/7	8am	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	nil	D. C. S. L. 01808
5/7	12pm	1/10	Lower Abdomen	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Comfortable position	shy 01808
5/7	8pm	1/10	Lower Abdomen	☐ Continuous ☒ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	comfortable position	Amber 607241
6/7/26	12am	1/10	Lower Abdomen	☐ Continuous ☒ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	comfortable position	shy 01808

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 relieving intervention.

d) Within 30 - 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdrawn, 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, rigid, or jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort



Wong - Baker (Pediatrics) Above 7 Years



Neonatal Pain, Agitation and Sedation Scale (up to 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1		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 RR, BP, SpO ₂	No variability with stimuli Hyperventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SpO ₂ 75-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SpO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
6/7/26	4AM	1/10	mid lower abdomen	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Comfortable position	Shirley 9/6/26
6/7/26	8AM	1/10	mid lower abdomen	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	comfortable position	Shirley 9/6/26
6/7/26	10AM	2/10	lower abdomen	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	comfortable position	Shirley 9/6/26
6/7/26	12p	2/10	Epigastrium	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	comfortable position	Shirley 9/6/26
6/7/26	2pm	1/10	epigastrium	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	comfortable position	Shirley 9/6/26
6/7/26	8pm	1/10	epigastrium	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☒ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	in para. then nil	Shirley 9/6/26
6/7/26	10pm	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	nil	Shirley 9/6/26
7/7	8am	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	nil	Shirley 9/6/26
7/7	8pm	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	nil	Shirley 9/6/26
				☐ 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
c) Prior to pain relieving intervention.

b) Then every 4 hours.

d) Within 30 - 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdrawn, 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, rigid, or jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Comforted, relaxed	Reassured by occasional touching, hugging, or being talked to, disarable	Difficult to console or comfort



Wong - Baker (Pediatrics) Above 7 Years



Neonatal Pain, Agitation and Sedation Scale (up to 1 Month)

Assessment Criteria	Sedation		Neutral	Pain / Agitation	
	-2	-1		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
Behavioral 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 constant
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	Constant clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO ₂	No variability with stimuli Hyperventilation 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-00086320
M^{rs} SUMATHI T

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20-07-1995

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Dr. LUCETTA AMELIA DIAS



BRADEN 'Q' SCALE

Rainbow
Children's
Hospital
Makes a lot to treat the little

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date:	Time:
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	3/7/2006	3/7/2006
"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.	7pm	8pm
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.	4/1/2006	4/1/2006
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.	2pm	2pm
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.		
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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.		
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.		
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	
Docu. No. : RCH /FRM / CLINICAL / 119					Evaluator's Name	

27 27 27 27
Abba 4/1/2006 6:00 pm

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	⑩ Regular Turning Schedule ⑩ Enable as much activity as possible ⑩ Protect the heels ⑩ Use pressure redistribution surfaces ⑩ Manage moisture, friction and shear ⑩ 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	⑩ Use the Same Protocol as for "At Risk" Patients ⑩ 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	⑩ Follow the same protocol as for "Moderate Risk" Patients ⑩ In addition to regular turning schedule ⑩ 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	⑩ Use same protocol as for "High Risk" Patients ⑩ 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-00086320

IP18-00036308

Mrs SUMATHI T

20-07-1995

30 Y 11 M 14 D (F)

Dr. LUCETTA AMELIA DIAS



BRADEN 'Q' SCALE

Rainbow
Children's
Hospital

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date:	4/7	5/7	5/7	5/7
					Time:	8PM	8AM	E	N
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		4	4	4	4
'Activity The degree of physical activity'	1. Bedfast: Confined to bed	2. Chairfast: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		3	3	3	3
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4	4	4	4
FRICION-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 of 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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	4	4
TOTAL SCORE						27	27	27	27
Evaluator's Name						Sopan	Wah	my	Dr. The

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

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

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
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Less than 9	Severe Risk	⑩ Use same protocol as for "High Risk" Patients ⑩ 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



OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 3/9/26 Time of Arrival: 5:30pm Time Seen by Nurse: 5:30pm

1) Level of Consciousness: ☒ Conscious ☐ Semi-Conscious ☐ Unconscious

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

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

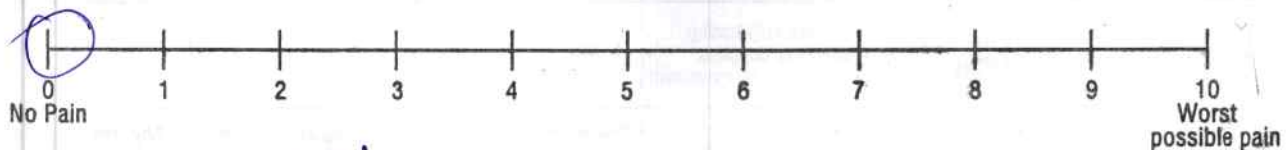
3) Vital Signs: Temperature: 98.8 Pulse: 89b/min RR: 20b/min SpO₂: 100% BP: 100/60mmHg Weight: 54.8kg

4) Gestational Criteria:

Gravida:	G <u>1</u>	P <u>—</u>	L <u>—</u>	A <u>—</u>
LMP:	<u>26/9/25</u>	EDD:	<u>30/11/2026</u>	Gestational Age: <u>36+1 days</u>
Uterine Contraction	☐ Yes ☒ No ☐ NA	Onset	<u>—</u>	Time <u>—</u> Frequency: <u>—</u>
Membrane Rupture	☐ Yes ☒ No ☐ NA	Onset	<u>—</u>	Time <u>—</u> Fluid Color: <u>—</u>
Vaginal bleeding	☐ Yes ☒ No ☐ NA	Onset	<u>—</u>	Time <u>—</u> Amount: <u>—</u>
Pre Eclampsia Symptoms	☐ Yes ☒ No ☐ NA	If Yes specify: Headache / Visual Symptoms / Pain Abdomen / Vomiting <u>—</u>		
Good fetal Movement	☒ Yes ☐ No ☐ NA	If No specify: <u>—</u>		

5) Pain Screening:

Numerical Pain Scale (NPS)



- ⑩ Location: NIL
 ⑩ Duration: NIL Days / Weeks/ Months (Strike out which is not applicable)
 ⑩ Character: NIL
 ⑩ Frequency: NIL
 ⑩ Interventions: NIL

6) Past History:

- a) Surgeries: NIL
 b) Medical: BDM on OHA / HTN



7) Allergy: ☐ Yes ☒ No, If Yes :

8) Current Medications: ☐ Prenatal Vitamin ☐ None ☐ Others: Tab: Vylocomet 500mg

9) Prenatal Medical History:

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

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: 5:30pm

Nurse Name: S. N. Aravind 01808

Nurse Signature: SA

Date: 3/7/24 Time: 6pm

01808



LABOUR AND DELIVERY NURSING ASSESSMENT

Date of Admission: 3/7/2016

Baseline Information:

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

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

Do you require an interpreter? ☐ Yes ☒ No

Source of Information: ☒ Patient ☐ Family ☐ Others

Personal belonging if any: ☒ Jewelry ☐ Nose Ring ☐ Bangles ☐ Anklets ☐ Finger Ring ☐ Bracelets
handed over to Attended

Allergies: ☐ Yes ☒ No ☒ Medications ☐ Blood Transfusion ☐ Food ☐ Other: _____
If yes, identify _____

Chief Complaints: Patient came for safe confinement. (FHR) Doctor Notified on Admission: ☒ Yes ☐ No
Name of the Doctor: Dr. S. M. Lakshmi
Time Notified: _____

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

Past Medical History

Past Surgical History

Previous Hospital Admission

UDM on OHA
WHTN.

NIL

Blood Group: O+ve LMP: 26/9/25 EDD: 30/7/26 Gestational age during admission: 36+1 day

Contractions: NO Vaginal Discharge: NO

Obstetric History: G 1 P 1 L 1 A 1 Previous LSCS NO

Height: 124.5 Weight: 54.8 BMI: 24.2
Temp: 98.5 HR: 89b/m RR: 20b/m BP: 100/60mmHg SpO2: 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) UDM
☐ Diabetes	☐ Bad Obstetric History	
☐ Anemia	☐ Obesity (BMI)	
	☐ Twins / Multiple Pregnancy	

Family History: ☐ No Abnormalities Detected

- ☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Stroke ☐ Seizures ☐ Kidney disease
☐ Liver disease ☐ Other Father T2Dm, HTN / mother T2Dm

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

Fall Assessment: ☒ Yes ☐ No Score 25 (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. Sumathi

Orientation not given Reason:

Nurse Signature:

Nurse Name:

Date & Time:



RISK ASSESSMENT TOOL FOR DEEP VEIN THROMBOSIS

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

Date:.....

21/7/26

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 or 2
Parity ≥ 3	7		1
Smoker			1
Gross varicose veins			1
Obstetric Risk Factors			
Pre-eclampsia in current pregnancy			1
ART/IVF (antenatal only)			1
Multiple pregnancy			1
Caesarean section in labour			2
Elective caesarean section			1
Mid-cavity or rotational operative delivery			1
Prolonged labour (24 hours)			1
PPH (1 litre or transfusion)			1
Preterm birth 37 ⁺ weeks in current pregnancy			1
Stillbirth in current pregnancy	7		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			2
Signature of the Nurse			
S/N Aboals 01800			
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.

GUC-00086320

IP18-00036308

Mrs SUMATHI T

20-07-1995

30 Y 11 M 13 D (F)

Dr. LUCETTA AMELIA DIAS



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It takes a lot to treat the little.

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BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

BREAST FEEDING HANDOVER AND ASSESSMENT FORM

1. Breastfeeding initiated?
☒ a. Yes ☐ b. No
2. If No, Reason
3. Nipple condition:
☒ a. Nipple well formed
☐ b. Flat nipple
☐ c. Inverted nipple
☐ d. Short nipple
4. Milk flow:
☒ a. Good
☐ b. Drops of colostrums
☐ c. Dry
5. Steps for Positioning and attachment:
☒ a. Baby goes to the breast
☒ b. Mother always sits with a back support
☐ c. Ear-shoulder-hip should be in a straight line
☐ d. The baby takes a latch on the areola and not on the nipple



Feeding Positions:
Cross Cradle



Feeding Positions:
Football / Clutch

6. Was the position explained:

- ☒ a. Yes
☐ b. No

7. For Caesarian mothers: NA

- ☐ a. Mother is required sit and feed from the 4th feed
☐ b. Please explain football hold

8. NICU admission: NA

- ☐ a. Mother needs to stimulate her breast for 2 min every 2 hours

9. Additional notes:

Date: 6/1/2026

Continuity of Care:

L-2
A-2
T-2
C-2
H-1
9

Handover given by

D. Sobelmann

Handover taken by

Signature

D. Sobelmann
at 12pm

Signature

Date & Time:

06/1/2026 at 12pm

Date & Time:

PATIENT TRANSFER FORM

1

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

GUC-00086320 IP18-00036308

Mrs SUMATHI T

20-07-1995

30 Y 11 M 13 D (F)

Dr. LUCETTA AMELIA DIAS



No.

Date & Time of Admission

3/7/20at 5:21 pm

Date & Time of Transfer Order

3/7/20at 4pm

Treating Consultant Name

Dr. Lucetta

Transfer Ordered by

Dr. Dimalabam

Reason for Transfer

Observation

From Unit

LDR

To Unit

5th floor

Information to Attendant

Yes ☒

No ☐

Number of Sheets in Clinical File

Whole IP files

Number of Imaging Films

cm.

Personal belongings including clinical documents. If any handed over to attendant

Yes ☐

No ☐

If yes, what? ☒

Medications / Consumables / Surgicals / Hand over

Sl.No.

Item Name

Quantity

1.

2.

3.

4.

5.

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

Dr shifted to ward

Name & Signature of Person who is Transferring

Dr. Dimalabam
01800

Name of Person Ordered Transfer

Dr. Dimalabam

Patient & Clinical Records Received by :

Dr. Dimalabam
01800

Date & Time of Patient Received :

3/7/20 at 5:21 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

PATIENT TRANSFER FORM

GUC-00086320 IP18-00036308

Mrs SUMATHI T
20-07-1995 30 Y 11 M 14 D (F)
Dr. LIJCETTA AMELIA DIAS



Date & Time of Admission <i>31/7/2026 at 5:21pm</i>		Date & Time of Transfer Order <i>5/7/26 at 2:30pm</i>
Treating Consultant Name <i>Dr. Lucette</i>	Transfer Ordered by <i>Dr. Lucette</i>	Reason for Transfer <i>Fetus Orbits</i>
From Unit <i>2002</i>	To Unit <i>5th Floor</i>	Information to Attendant Yes ☒ No ☐
Number of Sheets in Clinical File <i>1p free</i>	Number of Imaging Films <i>-</i>	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring <i>Dr. Lucette</i>	Name of Person Ordered Transfer <i>Dr. Lucette</i>
--	---

Patient & Clinical Records Received by :

[Signature]
01/9/26

Date & Time of Patient Received :

[Signature]
01/9/26 5/7/26 at 2:30pm

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

[] Unavailable Box

If the transfer order form is completed, attach it to the back of this form.

Date & Time of Patient Transfer

Patient's Clinical Record Number

Name & Signature of Patient

Strong Summary Notes Within 24 Hours

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

Number of Sheets in Clinical File

From Unit

Testing Operator's Name

Patient Name & Unit No.

PATIENT TRANSFER FORM

CLINICAL RECORDS
CLINICAL RECORDS
CLINICAL RECORDS

PATIENT TRANSFER FORM

GUC-00086320 IP18-00036308

Mrs SUMATHI T
20-07-1995 30 Y 11 M 14 D (F)
Dr. LIJCETTA AMELIA DIAS



Date & Time of Admission <i>3/7/2020 5.20 PM</i>		Date & Time of Transfer Order <i>5/7/2020 11.30 AM</i>
Treating Consultant Name <i>Dr. Mutha.</i>	Transfer Ordered by <i>Dr. Sridhar</i>	Reason for Transfer <i>Further management</i>
From Unit <i>5/7</i>	To Unit <i>202</i>	Information to Attendant Yes ☒ No ☐
Number of Sheets in Clinical File <i>30</i>	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant. Yes ☐ No ☐ If yes, what ?
Medications / Consumables / Surgicals / Hand over		
Sl.No.	Item Name	Quantity
1.	<i>under pad.</i>	<i>(1)</i>
2.	<i>8 gloves</i>	<i>(1)</i>
3.	<i>20 ml Syringe</i>	<i>(1)</i>
4.	<i>10 ml Syringe</i>	<i>(1)</i>
5.	<i>Supacel</i>	<i>(1)</i>
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐		
Name & Signature of Person who is Transferring <i>Dr. Mutha. 5/7/20 @ 11.30 AM</i>		Name of Person Ordered Transfer
Patient & Clinical Records Received by : <i>5/7/2020</i>		
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

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

GUC-00086320

IP18-00036308

Mrs SUMATHI T

20-07-1995

30 Y 11 M 13 D (F)

Dr. LUCETTA AMELIA DIAS



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. Plan | 6. Discharge Medication | 10. Fall Risk Education |
| Diagnosis <u>room 3671 day</u> | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices |
| 2. Treatment and Care | 8. Diagnostic Test / Procedures | Safety |
| 3. Pain Management | 9. Nutrition / Diet | 12. Patient's / Family Rights |
| 4. Informed Consent | | 13. Risk / Safety |
| 5. Medication / Therapy (safety, effects/ side effect, interactions) | | |

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		
9/7/26	7pm	YES	Educated about the RISK safety	patient	no Learning Barriers	oral	NONE	YES	good	Shabeer
9/7/26	8am	yes	Educated about the breast care	patient	no Learning Barriers	oral	NONE	YES	good	Shabeer
8/7/26	8am	yes	patient Educated to discuss contraindications breastfeeding	patient	no Learning Barriers	oral	NONE	YES	good	Shabeer

Part - III: CODES

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

Learning Barriers:

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

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

Mechanism/s to overcome barrier/s:

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

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

100% Satisfaction	24/7 Support	100% Quality	100% Security
100%	24/7	100%	100%

100% Satisfaction	24/7 Support	100% Quality	100% Security
100%	24/7	100%	100%

100% Satisfaction	24/7 Support	100% Quality	100% Security
100%	24/7	100%	100%

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100%	24/7	100%	100%

100% Satisfaction	24/7 Support	100% Quality	100% Security
100%	24/7	100%	100%

100% Satisfaction	24/7 Support	100% Quality	100% Security
100%	24/7	100%	100%



NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 07/07/2026 Time: 12:50 PM

Origin: _____ Height: 145 CM Weight: 54.8 Kg BMI: ☒ ~ 26 kg/m²
☐ ~ 28 kg/m²
☐ ~ 30 kg/m²

Food Allergies: _____

Diagnosis: KINI ASSISTED VAGINAL DELIVERY T RMLP

Type of Diet: ☐ Liquid ☐ Soft ☐ Normal ☒ Diabetic GDM, GHTN.
☐ 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: S.T.L.

Name: Sumathi.T

Date & Time: 07/07/2026 @ 12:50 PM

Dietician's

Signature: A.M. (018336)

Name: A. Sadiga Feebeen

Date & Time: 07/07/2026 @ 12:50 PM

DIETARY NOTES

Date	Time	Notes	Sign
06/07/26	11 AM.	KIWI ASSISTED VAGINAL DELIVERY & PMLF done. - Patient is on Normal Diet - Patient is stable - Oral intake is better. - Advised to take well-balanced diet. - Consumer small frequent meals <u>RPA values</u>- Energy - 1600 kcal Protein - 47-49 g/d	A.P. (018356)
07/07/26	9 AM.	- Patient is on Normal Diet - Patient is stable - Oral is Adequate. - Advised to take probiotics & foods for milk secretion such as garlic, fenugreek & Oats	A.P. (018356)