Birthright Rainbow Children's Hospital

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

GUC-00094294 IP18-00036615
Mrs RASHMICA RAJENDHRAN
29-07-1992 33 Y 11 M 27 D (F)
Dr. Nithya Ramachandran

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing		6.00am	P. [signature] 060724				
Activity Sheet update by Pharmacy			[signature]				

ACTIVITY RECORD FOR BILLING

Rainbow® Children's Hospital
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Name: Mrs. Rashmica 33y/f

UHID No: 94294 IP No: ..... Consultant: Dr. Nithya Dept: .....

Date of Admission: ..... Time: ..... Date of Discharge: ..... Time: .....

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
25/7/26	4.45pm	ADR	7th floor	

CROSS CONSULTATION VISIT

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
25/7	CTG - (1)			010066	[illegible]
25/7	CTG (2)			010066.	[illegible]
25/7	CTG - (3)			010072	[illegible] 607261

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
25/7/26	IV placement	(1)	1732982.	

ANY OTHER INFORMATION:

.....

.....

.....

.....

.....

.....

Date: 26/7/26 Time: 6:06 AM Prepared By: .....

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
P.V 607261			

Children's Hospital | BirthRight

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

GUC-00094294 IP18-00036615
Mrs RASHMICA RAJENDHRAN
29-07-1992 33 Y 11 M 26 D (F)
Dr. Nithya Ramachandran

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement	26/7/26 at 9AM				
	INTIME	OUT TIME			
Arrangement of File by Nursing		26/7/26 at 9AM			
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-00094294 IP18-00036615
Mrs RASHMICA RAJENDHRAN
29-07-1992 33 Y 11 M 26 D (F)
Dr. Nithya Ramachandran

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BED SIDE CHECK LIST FOR NURSES

Date:	26/7/16								
Doctor's Orders	YES								
Carried out or not	YES								
Bed Side									
Structured Handover done	YES								
IV Site	YES								
Central Lines	NA								
Arterial Lines	NA								
Feeding Catheter	NA								
Urinary Catheter	NA								
Skin Care	YES								
Eye Care	YES								
Mouth Care	YES								
Sterillum Bottle, Stethoscope	YES								
Suction Bottle (Should be clean & empty)	YES								
Intubation Tray	NA								
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	NA								
Ventilator Tubing,(Any Water, Blood)	NA								
Humidification	NA								
Check all Infusion (Labelling,Correct Preparation)	NA								
Chest Physio & Neb	NA								
Handed Over By Name :									
Signature :									
Date & Time:	26/7/16 02:10PM								
Hand Over Taken By Name :									
Signature :									
Date & Time:									

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Guindy

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

ADMISSION SHEET

Registration Details :

Admission No : IP18-00036615 **Admit Date** : 25-Jul-2026 **Admit Time** : 03:23 PM **UHID** : GUC-00094294

Patient Details :

Patient Name	: Mrs RASHMICA RAJENDHRAN	**Age**	: 33 Y 11 M 26 D
Guardian	: Mr HARISH RAJAGOPALAN	**DOB**	: 29-07-1992
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: BF2, PALLAVA HEIGHTS, 54, 5TH ST, MYLAPORE Mylopore Chennai Tamil Nadu INDIA 600004	**Phone No**	: 9962629068/ 8056171442
		E-mail	: rashmicarajendran@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 HARISH RAJAGOPALAN **Relationship** : Husband

Contact Address : BF2, PALLAVA HEIGHTS, 54, 5TH ST, MYLAPORE Mylopore Chennai Tamil Nadu INDIA 600004 **Phone No** : / 9962629068

Signature

Doctor Details :

Doctor Name : Dr. Nithya Ramachandran **Specialisation** : OBSTETRICS AND GYNECOLOGY

Referral Doctor : SELF **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

Rainbow Children's Hospital
BirthRight by Rainbow

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GENERAL CONSENT FOR TREATMENT

Patient Name:	**Mrs RASHMICA RAJENDHRAN**	**Age :**	**33 Y 11 M 26 D**
IP No:	**IP18-00036615**	**Sex:**	**Female**
Consultant:	**Dr. Nithya Ramachandran**	**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 care of the patient.

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

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

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

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

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

Signature of Patient/Relative: T. L. Harish

Name: Mr. Harish Raja Gopalan
Relationship: Husband
Date: 25/07/2026 Time: 03:23 Pm
Witness Name: A. Sivasankari
Witness Signature: A.

Patient Address:
BF2, PALLAVA HEIGHTS, 54, 5TH ST, MYLAPORE Mylopore Chennai Tamil Nadu INDIA 600004

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BILLING POLICY

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

DECLARATION

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

Patient Name : Mrs. Rashmica	UHID Number : GUC-00094292
Self/Attendant Name : HARISH.R	Relation : HUSBAND
Self/ Attendant Signature : Phone Number :	Name & Signature of Financial Counselor

RCH/GDY/FRM/CLINICAL/426

இந்திய அரசாங்கம்
Unique Identification Authority of India
Government of India

பதிவு அடையாளம் / Enrollment No. : 2193/00276/04059

01/01/2017

To
Rashmica R
ராஷ்மிக்கா ர
D/O. Rajendhiran
NO 5/7 2B RAMI NIVAS
BALAJI NAGAR 3RD STREET
ROYAPETTAH
Royapettah
Royapettah,Chennai,Chennai,
Tamil Nadu - 600014
9962629068

KA039276284FH

03927628

உங்கள் ஆதார் எண் / Your Aadhaar No. :

5920 4132 8559

எனது ஆதார், எனது அடையாளம்

இந்திய அரசாங்கம்
Government of India

ராஷ்மிக்கா ர
Rashmica R

பிறந்த நாள் / DOB: 29/07/1992

பெண்பால் / Female

5920 4132 8559

எனது ஆதார், எனது அடையாளம்

GUC-00094294 IP18-00036615
Mrs RASHMICA RAJENDHRAN
29-07-1992 33 Y 11 M 26 D (F)
Dr. Nithya Ramachandran

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IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

C/o pain abdomen since 7:30am on 25/7/26

Obstetric Formula:

$G_2P_1L_1$

Obstetric Hostory:

G_1 : 2022 ; EM. LSCS (Ind G_2NSL)
Girl ; 2.89 kg ; A & H.

G_2 : PP ; Spontaneous conception

Present Pregnancy Record:

31/1/26 NT : 1-8 MM ; FTS - Screen Neg

2[illegible]/26 : Anomalies R/o

RISK FACTORS:

Nil

Height: 157 cm
Weight: 81 kg
Allergies: Nil
Breast: ☑ Normal ☐ Abnormal
General Examination:
Consciousness: Conscious Pallor: No
Icterus: No Edema: No
Temp: Afebrile PR: 82/min
BP: 110/70 DTR:
CVS: $S_1 S_2$ ⊕ RS NVBS
Liver/Spleen: Urine Output:

LMP: 2/11/25 EDD: 9/8/26
Corrected EDD: GA: 37w 6d

Menstrual History: Regular : ☑ Yes ☐ No

Obstetric Examination

Fundal Height: TCHM

No pain since admission to hospital (≃ 11am)

Ut. Activity: ☑ Relaxed ☐ Mild ☐ Mod ☐ Severe
Liquor: ☑ Adequate ☐ Oligo ☐ Poly
PP: ☑ Cephalic ☐ Breech Others _____
Head Fifths Palpable: _____
FHS: ☑ Normal ☐ Tachy ☐ Brady ☐ Absent

Per Speculum Examination

Draining: ☐ Present ☑ Absent ☐ Bleeding
Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination 1.5 cm long

Cervix: ☐ Long ☐ Partially effaced ☐ Effaced
Os: Closed _____ Dilated 1 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

DIAGNOSIS

$G_2P_1L_1$ | 37w 6d | Previous LSCS |
Admitted for observation

Patient Sticker

Family History:

Father - DM

Mother - DM

Surgical History:

Previous LSCS (Emergency) 2022

Medical History:

Nil

Medication History:

- T. Tricum Active 0-1-0
- T. Fol 123 1-0-0
- T. Speedral 0-0-1

Plan of Care: CD/W Dr. Nithya S/B Dr. Lucetta

- Admission
- W/F contractions; draining P/V; Bleeding P/V; decreased fetal movements
- Follow drug chart
- CTG Q6H
- FHR Q2H
- Inform SOS
- Shift to ward

Investigations:

CTG.

Doctor Name: Dr. Vimitha

Signature: 121113

Date & Time: 25/7/26

Consultant Name: Dr. Nithya

Signature: FOR)

Date & Time: 25/7/26

GUC-00094294 IP18-00036615
Mrs RASHMICA RAJENDHRAN
29-07-1992 33 Y 11 M 26 D (F)
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RESULT SHEET

Date	20/7					
Time						
Hb	12.2					
PCV						
RBC						
WBC	13750					
N/L						
Platelets	3,06,000					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

B1 grp : O positive

FBS : 86

14/12/25 : HbsAg, HIV, RPR] NR

TSH : 0.98

Hb A1C : 5.5

ECG, ECHO] Not done in this Pregnancy

(P.T.O)

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

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : 20/7/26 37w 1d

X-Ray : Cephalic ; PI - Anterior Grade II calcification

ECHO : AFI : 10 ;

CT : EFW : 2932 g (Interval growth Maintained)

MRI Doppler Normal

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

GUC-00094294 IP18-00036615
Mrs RASHMICA RAJENDHRAN (F)
29-07-1992 33 Y 11 M 26 D
Dr. Nithya Ramachandran

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/4/26 6:40 pm 37+6 weeks	S/B Dr. Vinodhini / Dr. Divyalakshmi pt reviewed	
	O/E: pt GC fair, afebrile P° / PE°	Advice
T = N	P/A = Ut. term relaxed cephalic FHS good	- (N) diet. - oral fluids. - monitor vitals - follow drug chart
PR = 72/min BP = 110/70 mmHg		- CTG Q6H - Next at 2AM, 8 AM
CTG - Reactive	SPT scan (+), healthy	- FHR Q2H till 10 pm)
	YE: NAD	- D/S tmrw if comfort - w/f contractions - inform SOS.
	[signature] 16428	
26/04/2026 8:30 am 38 weeks	C/S/B Dr. Pavithra. Pt reviewed	Advice
T (N) BP 110/60 PR 80/min	O/E Pt GC fair afebrile P / PE CVS / RS NAD	- (N) Diet. - Plenty of orals. - Vitals monitoring. - Follow drug chart - Plan Discharge today.
CTG-Reactive	P/A - Ut term relaxed cephalic, FHS good. SPT scan (+) healthy.	[signature] 14968.

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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MEDICATION RECONCILIATION FORM

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

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

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

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T. SPEEDRAL	1tab	P/O	OD 0-0-1		☑C ☐DC
2	T. FOL 123	1tab	P/O	1-0-0		☑C ☐DC
3	T. TRICUM ACTIV	1tab	P/O	0-1-0		☑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 Vinitha
12/11/3

Date & Time : 25/7/26

Nurse Name & Signature: ..... Sipooja

Date & Time : 25th 5pm

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DRUG CHART

Date of Admission: 25/7/26 Drug Allergies: ..... ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

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

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

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

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

GUC-00094294 IP18-00036615
Mrs RASHMICA RAJENDHRAN
29-07-1992 33 Y 11 M 26 D (F)
Dr. Nithya Ramachandran

REGULAR PRESCRIPTIONS Weight. 81 Ward. LSR

DRUG : T. FOL 123	Dose	Route	Frequency	Start Date
	1 tab	PO	1-0-0	26/7

Name & Signature of the Doctor Starting the Drugs: 12113

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	26/7
	8am

DRUG : T. TRICUM ACTIV	Dose	Route	Frequency	Start Date
	1 tab	PO	0-1-0	26/7

Name & Signature of the Doctor Starting the Drugs: 12113

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	26/7
	1pm

DRUG : T. SPEEDRAL	Dose	Route	Frequency	Start Date
	1 tab	PO	0-0-1	25/7

Name & Signature of the Doctor Starting the Drugs: 12113

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	26/7
	8pm

DRUG :	Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	

GUC-00094294 IP18-00036615
Mrs RASHMICA RAJENDHRAN
29-07-1992 33 Y 11 M 26 D (F)
Dr. Nithya Ramachandran

Weight. 81 Ward. 6BR

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

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

Patient Sticker

I.V. FLUIDS CHART

Weight. 81 Ward. UDR

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign

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

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33 Y 11 M 26 D
29-07-1992
Dr. Nithya Ramachandran

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Sheet No. ....

REGULAR PRESCRIPTIONS

Weight 81........ Ward LDR.........

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

DRUG :

Date / Time

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Date / Time

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Date / Time

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Date / Time

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Patient Sticker

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

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

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

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Early Warning Observation Score Chart - Obstetrics

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

25/7/26

		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20								18		20				20				20				20			
	0 - 10																									
Saturations	94 - 100 %								100		97%				95%				98%				98%			
	< 94 %																									
Administered O_2 (L/min.)									RA		RA				RA				RA				RA			
Temp °c	40																									
	39																									
	38														98.1°F				98.5°F				98.2°F			
	37								98°F		98.6°F															
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80								80		76				85				80				80			
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressure ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120								120		110				100				112				110			
	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									0		0				0				0				0			
TOTAL ORANGE SCORES									0		0				0				0				0			
Nurse Initial									PD		PD				PD				PD				PD			

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

FHR Monitoring

4pm - 150 b/m.

6pm - 148-152 bmi

8PM - 150 b/m - 160 b/min

10PM - 148 - 152 b/m

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FLUID CHART

Sheet No. : 10

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

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :								**Total Output :**				
25/7/20	02:00 pm				on admission						0	
	03:00 pm	H2O	200ml							200	0	
	04:00 pm										0	
	05:00 pm	H2O	150ml								0	AA
	06:00 pm	H2O	100ml				✓			200ml	0	AA
	07:00 pm										0	AA
Total Intake :		450ml						**Total Output :**		400ml - U		
	08:00 pm										0	P.U
	09:00 pm	H2O	200								0	P.U
	10:00 pm										0	P.U
	11:00 pm	H2O	200								0	P.U
	12:00 am									500	8	P.U
	01:00 am	H2O	100								8	P.U
Total Intake :		500ml						**Total Output :**		500ml		
	02:00 am										0	P.U
	03:00 am	H2O	100				✓			300	0	P.U
	04:00 am										0	P.U
	05:00 am										0	P.U
	06:00 am	H2O	200							200	0	P.U
	07:00 am										0	P.U
Total Intake :		300ml						**Total Output :**		500ml		

Total 24 hrs. Intake	1250 ml	Total 24 hrs. Output	1400 ml + 2 times Bowel operi

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NURSES NOTES

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☑ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		On admission notes	
25/7/26	1.30pm	pt mrs. Rashmica 33y/F. she is G2P1L1 / prev LSCS / 37wt6d / observation. pt came c/o lower abdomen pain. pt was get admitted under Dr. Nithya. vital signs checked & recorded BP-110/70 PR-78b/m RR-18b/m Temp-97°F. CTG connected FHR⊕ Informed to Dr. Vinitha soon Also pt history collected. Advice to give T. Para 1gm T. para 1gm IV given as per doctor order.	Snlpog.
	2pm	CTG is connected as per doctor order. Encourage to take adequate oral fluid.	Snlpog.
	4pm	pt vital signs gradually recorded. Dr. Vinitha advice to shift ward. CTG to be held. FHR monitoring 2nd hrly order carried out	Pogh
	4.45pm	pt shifted to ward as per doctor order. pt care hand over given to 4th floor staff	Pogh

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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☑ No Known Drug Allergies

☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
25/7/26	4.30pm.	Reciving Notes	
		Patient Reciving from LDR to 7th floor. Bed side Assessment done. Patient Conscious & Oriented. IV line @ Pattom. Voice Self voided. Patient details handing Over taken from LDR Staffs. — &	
		Patient taken Normal diet. Patient FHR monitored. @ hourly CTG @ 8pm todo. No any pain. Provided Comfortable position. — &	
	5pm.	Patient vitals Sign Checked & Recorded. vitals are Stable. NO Chart monitored. No any other Complaints. patient Continue oral medication W/F Contractions: draining P/V, Bleeding P/V, decreased fetal movements. Follow drug chart, CTG @6H, FHR @2H, todo the follow. — &	
	6.30pm.	Patient vitals are Stable. NO Chart monitored. No any other Complaints.	
	7.30pm.	Patient details handing over to night duty Staff — &	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 25/7/26 Time of Arrival: 1:30pm Time Seen by Nurse: 2pm

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

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

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

3) **Vital Signs:** Temperature: 98f Pulse: 80 RR: 18 SpO_2: 100 BP: 110/70 Weight: 81

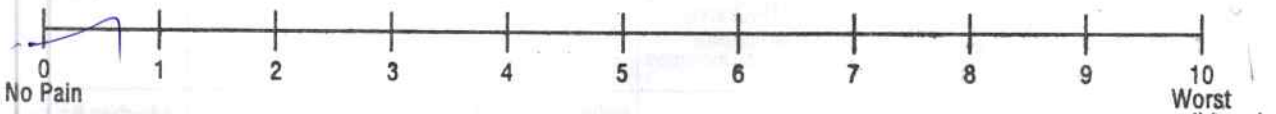
4) **Gestational Criteria:**

Gravida:	G 2	P 1	L 1	A

LMP: 2/11/25 EDD: 9/8/26 Gestational Age: 37+0+6d.

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

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



- Location: ..... nil / lower abdomen .....
- Duration: ..... nil / 10 secs ..... Days / Weeks/ Months (Strike out which is not applicable)
- Character: .....
- Frequency: ..... 1 in 5 mints .....
- Interventions: ..... comfortable bed position .....

6) **Past History:**

a) Surgeries: ..... prev LSCS .....

b) Medical: ..... nil .....

Patient Sticker

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

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

9) **Prenatal Medical History:**

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

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

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

Time seen by Doctor: 2pm

Nurse Name : S. Poolen Nurse Signature:

Date: 25 Feb Time: 2pm

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RISK ASSESSMENT TOOL FOR DEEP VEIN THROMBOSIS

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

Date: 25/7/18

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

RISK ASSESSMENT FOR VENOUS THROMBOEMBOLISM (VTE)

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

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

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BRADEN 'Q' SCALE

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				Date : 25/7 / Time : 2pm	25/7 8pm	26/7 8am
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	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 waking hours.	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
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
FRICTION-SHEAR **Friction** . Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4
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
				TOTAL SCORE	23	27	27
				Evaluator's Name	[illegible]	Plas	[illegible]

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

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

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	25/7/26	25/7/26	26/7/26
		Score	2pm	8PM	8AM
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0	0	0	0
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0	0	0	0
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0	0	0	0
IV / Heparin Lock or Saline	Yes	20			
	No	0			
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	10	6	0
Total Morse Fall Scale Score:			10	10	10
		Signature	[signature]	[signature]	[signature]

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

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient's Name: GUC-00094294 Mrs RASHMICA RAJENDHRAN IP18-00036615
MRD NO:.... 29-07-1992 33 Y 11 M 26 D (F)
Dr. Nithya Ramachandran
Age :........ : ☐ M ☐ F
Consultant :..

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 25/7/26 Time: 1.30pm
Location : Ⓡ metacarpal.
Size : 18
Cannula inserted by : S/N Parameswari

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
	2pm	☐Yes ☑No	☐Yes ☑No	observ	[illegible]
	4pm	☐Yes ☑No	☐Yes ☑No	obs	[illegible]
	8pm	☐Yes ☑No	☐Yes ☑No	Obser	P.G
26/7	12AM	☐Yes ☑No	☐Yes ☑No	Obser	P.G
	4AM	☐Yes ☑No	☐Yes ☑No	Obser	P.G
	6AM	☐Yes ☑No	☐Yes ☐No	patch	[illegible]
26/7/26	10AM	☐Yes ☑No	☐Yes ☑No	patten	AA
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

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

CANNULA 2

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

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

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

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

PHLEBITIS ASSESSMENT AND MANAGEMENT RECORD

CANNULA 3

Date : Time:

Location :

Size :

Cannula inserted by :

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

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

CANNULA 4

Date : Time:

Location :

Size :

Cannula inserted by :

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

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

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

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

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

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

GUC-00094294 IP18-00036615
Mrs RASHMICA RAJENDHRAN
29-07-1992 33 Y 11 M 26 D (F)
Dr. Nithya Ramachandran

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

Identified Education Needs:

1. Diagnosis G2P1L1 / Prev / 37wk6d / Plan
2. Treatment and Care
3. Pain Management
4. Informed Consent
5. Medication / Therapy (safety, effects/ side effect, interactions)
6. Discharge Medication
7. Infection Control Measures
8. Diagnostic Test / Procedures
9. Nutrition / Diet
10. Fall Risk Education
11. Safe use of Medical Equipment / Implantable Devices Safety
12. Patient's / Family Rights
13. Risk / Safety

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III: Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding	Comments	Designation / Signature
25/7/26	2pm	yes	patient educated to Baby movement monitoring	patient	No learning Barrier	Oral	None	well	Good	[signature]
26/7/26	8pm	yes	Patient Educated to Baby movement monitoring	patient	No Learning Barrier	Oral	None	Oral	good.	[signature] 02nar

Part - III: CODES

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

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

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

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

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

Doc No. : RCH / FRM / CLINICAL / 187

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BREAST FEEDING HANDOVER AND ASSESSMENT FORM

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

2. If No, Reason .....

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

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

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

Feeding Positions:
Cross Cradle

Feeding Positions:
Football / Clutch

6. Was the position explained:
   - ☐ a. Yes
   - ☐ b. No

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

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

9. Additional notes: .....

Date: .....

Continuity of Care:

Handover given by .....

Signature .....

Date & Time: .....

Handover taken by .....

Signature .....

Date & Time: .....

PATIENT TRANSFER FORM

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GUC-00094294 IP18-00036615
Mrs RASHMICA RAJENDHRAN
29-07-1992 33 Y 11 M 26 D (F)
Dr. Nithya Ramachandran

Treating Consultant Name	Date & Time of Admission	Date & Time of Transfer Order
DR - Nithya	27/07/2026 at 3-23pm	25/7/2026 at 4.45pm
	Transfer Ordered by	**Reason for Transfer**
	DR - Venithes	Fetal [illegible]
From Unit	**To Unit**	**Information to Attendant**
CDR	7th floor	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
five	OT (2)	Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
S N Soheteron OTTC	DR. Venithes

Patient & Clinical Records Received by : [signature] 021295

Date & Time of Patient Received : 25/7/26 @ 4.50pm

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

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

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