VIH-00182914 IP26-00006817
Mrs RAMYA SRI
11-01-1993 33 Y 6 M 1 D (F)
Dr. KADIYALA RAMYA THEJA

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OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 12/7/26 Time of Arrival: 8AM Time Seen by Nurse: 8.10AM

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

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

- ☐ Severe Pain / Moderate Pain
- ☐ Bleeding PV: Slight / Heavy
- ☐ Decreased Fetal Movement
- ☐ No Fetal Movement
- ☐ Preterm rupture of Membranes / Leaking Water PV
- ☐ Preterm Labor/ Labor
- ☐ Spontaneous Rupture of Membrane / Leaking Water PV
- ☐ Other Reason: FL 28 CS

3) **Vital Signs:** Temperature: 98.F Pulse: 82 RR: 20 SpO_2: 99% BP: 116/71 Weight: .....

4) **Gestational Criteria:**

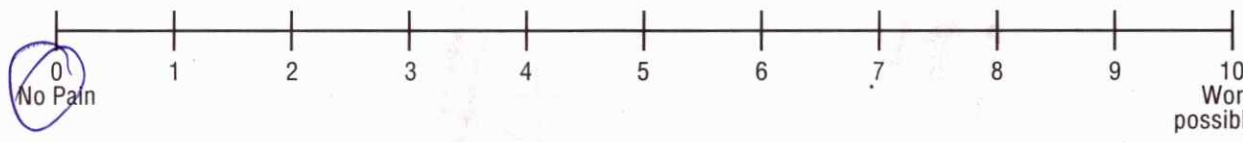
Gravida:	G	P	L	A

LMP: ..... EDD: ..... Gestational Age: .....

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:		

6

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



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

.....

6) **Past History:**

a) Surgeries: .....

b) Medical: NIL

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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: 8.15AM

Nurse Name : Mounika Nurse Signature: Mounika

Date: 12/7/26 Time: 8.10AM

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OBSTETRICS / GYNECOLOGY
NURSING INITIAL ASSESSMENT FORM

Date of Admission: 12/7/20

Baseline Information:

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

Primary Language: ☐ Telugu ☑ English ☐ Hindi ☐ Others, specify .....

Do you require an interpreter? ☐ Yes ☑ No if Yes specify .....

Source of Information: ☑ Patient ☑ Family ☐ Others, specify .....

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

If yes , identify .....

Chief Complaints: .....

..... FL LSCS .....

.....

Doctor Notified on Admission: ☐ Yes ☐ No

Name of the Doctor: .....

Time Notified: .....

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

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

Gynecology Assessment: ☐ Not Applicable

Menstrual History: .....

..... Regular .....

Onset of Menarche: .....

Menstrual Cycle: ☑ Regular ☐ Irregular

Last Menstrual Period: .....

Gynecology Surgical History:

Caesarean Section: ☐ No ☐ Yes

Cervical Cerclage: ☐ No ☐ Yes

Ectopic Pregnancy: ☐ No ☐ Yes

Myomectomy: ☐ No ☐ Yes

Others: _____

Gynecological History:

Contraceptives: ☐ No ☐ Yes

Vaginal Discharge: ☐ No ☐ Yes

Post-Coital Bleeding: ☐ No ☐ Yes

Infertility: ☐ No ☐ Yes

If Yes Type: ☐ Primary ☐ Secondary

Obstetric History: G ..... P ..... L ..... A .....

Previous LSCS: .....

Current Medication: ☑ None ☐ Yes, If Yes, Fill the reconciliation form

Family History: ☑ No Abnormalities Detected

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

☐ Liver disease ☐ Other .....

Vital Signs / Measurements: Temp: 98.1°F HR: 82 RR: 20

BP: 116/71 Weight: ..... Height: ..... BMI: .....

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

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Mrs RAMYA SRI
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Dr. KADIYALA RAMYA THEJA

PHYSICAL ASSESSMENT

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

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

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

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

☐ Mobility problem ☐ Walking Problem ☑ No Abnormality Detected

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☑ No Abnormality Detected

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

☐ Under Weight ☐ Diabetes Mellitus ☐ Hyperemesis Gravidarum

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

☐ Others .....

Inform consultant for positive criteria

SOCIAL SCREENING:

1. **Marital Status:** ☐ Single ☑ Married ☐ Divorced ☐ Widow
2. **Special Habits:** **Smoker:** ☐ Yes ☑ No **Alcohol Abuse:** ☐ Yes ☑ No **Drug Abuse:** ☐ Yes ☑ No

Social History: Lives With .....

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: .....

Orientation not given Reason: ..... N.A .....

Nurse Signature: ..... Mounika .....

Nurse Name: ..... Mounika .....

Date & Time: ..... 12/7/26 @ 8 Am .....

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CAESAREAN SECTION OPERATIVE NOTES

Surgeon's Name:	Dr Shalini Santosh	Date of Delivery:	12/7/2016
Assistant Surgeon:	Dr Mamtha	Time of Delivery:	12:47 pm
Anaesthetist's Name:	Dr Ameen	Gender of Baby:	Male
Type of Anaesthesia:	Spinal	Weight of Baby:	2-260 Kg
Neonatologist:	Dr Prashanti	AGPAR Score:	9, 10
Scrub Nurse:	Sayeetha	NICU Admission:	☐ Yes ☑ No

Pre-Operative Diagnosis:

☑ Elective ☐ Emergency Indication: Precious Pregnancy

Urgency

- ☐ Immediate Threat to life of woman or fetus
- ☐ Maternal or fetal compromise not immediately life threatening
- ☐ No maternal or fetal compromise but needs early delivery
- ☑ Delivery timed to suit woman and staff

Decision time: NA Knief to rectus: 2mm

CTG Description: Reactive

If there was a delay give the reasons: No Delay

Surgical Procedure: Elective Lower Segment C-Section

Post Operative Diagnosis: P1+0

Peri-Operative Complications: —

Amount of Blood Loss: ~150 cc Blood Transfused (in ML): —

Name and Number of Surgical Specimen sent for examination:

—

Examination Findings when Appropriate:

Presentation: ☑ Cephalic ☐ Breech ☐ Other .... Cervical Dilatation: ....open.... cm

5th Palpable: .... Fetal Position: ....

Station: ☑ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2 Moulding: ☐ None ☐ + ☐ ++ ☐ +++

Caput: ✗ ☐ + ☐ ++ ☐ +++ Meconium: ☐ None ☐ + ☐ ++ ☐ +++

Bladder Catheterized : ☑ Yes ☐ No Urine: ☑ Clear ☐ Blood Stained

Skin Incision: ☑ Pfannensteil ☐ Transverse ☐ Midline ☐ Other ....

Uterine Incision: ☑ Lower Segment ☐ Classical ☐ Inverted T ☐ J Incision

Previous Scar: ☐ Intact ☐ Thinnedout ☐ Ruptured ☑ No Scar

Incision Through Placenta: ☐ Yes ☑ No LUS not formed

Delivery of head: ☐ Manual ☑ Forceps one loop of cord around neck

Liquor: ☑ Clear ☐ Meconium: ☐ I ☐ II ☐ III ☐ Blood ☐ Offensive ☐ Not Offensive

Delivery of Placenta: ☑ Manual ☐ CCT .... ☑ Complete ☐ Incomplete ☐ Piecemeal

Cord Appearance: ....(N).... Cord around the neck ☑ Yes ☐ No 1 loop

Appearance of placenta: ....(N).... Cavity explored ☑ Yes ☐ No

Uterus, tubes and ovaries: ☑ Normal ☐ Not Normal Sterilization: ☐ Yes ☑ No

Uterine Closure: ☐ One Layer ☑ Two Layers ....Vicryl ~~2-0~~.... Suture

Peritoneal Closure: ☐ Pelvic ☑ Abdominal ☐ None ....Catgut no 1.... Suture

Sheath Closure: ....~~Vicryl no~~ 1.... Suture

Fat Closure: ☑ Yes ☐ No ....Catgut no: 1.... Suture

Skin Closure: ☑ Subcuticular ☐ Mattress .... Suture

Vagineal Evacuated ☑ Yes ☐ No

Drain: ☐ Yes ☑ No ☐ Remove in .... days ☐ Await instructions

Ctheter ☑ Yes ☐ No ☐ Remove in ....1.... days ☐ Await instructions

Swap & Instruments count correct? ☑ Yes ☐ No ☐ Post-op Antibiotics ☑ Yes ☐ No

Intra-Operative Antibiotics Cover: ☑ Yes ☐ No ☐ Thromboprophylaxis ☐ Yes ☐ No

Post-Operative Notes: ....

NBM x 4-6h

Drugs as charted → iv [illegible] + Metro x 24h P/o med

I/o monitory / w/k vitals 8am

Foley removed @ 6AM C/m

IVF/Analgesics/thromboprophylaxis as per Anaes

Drugs as charted

GRBS check daily today → POD-2 FBS/PPBS

Doctor Name: Dr Mamta Doctor Signature: Shalini [signature] For Dr Shalini

Date & Time: 12/7/2011 1:40pm

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Santhosha
Asst. Surgeon : Dr Manisha
Anaesthetist : Dr. Amrin
Scrub Nurse : Sr. Sangeetha

Patient Name : VIH-00182914 IP26-00006817 Mrs RAMYA SRI 11-01-1993 33 Y 6 M 1 D (F) Dr. KADIYALA RAMYA THEJA
UHID No. : .....
Date : 4/7/26 In-time : ..... Out-time : .....
..... Gender : .....
.....

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 12:30pm

Patient Has Confirmed
- Identity ☐Yes ☐No
- Site ☑Yes ☐No
- Procedure ☑Yes ☐No
- Consent ☑Yes ☐No

Site Marked ☑Yes ☐No ☐NA

Anaesthesia Safety Check Completed ☑Yes ☐No

Pulse Oximeter on Patient & Functioning ☑Yes ☐No

Does Patient have a:
- Known Allergy? ☐Yes ☑No

Difficult Airway / Aspiration Risk?
- Yes, & Equipment / Assistance Available ☑Yes ☐No

Risk of > 500ml Blood Loss (7ml/kg In Children)?
- Yes, and Adequate Intravenous Access and Fluids Planned ☑Yes ☐No ☐NA
- Blood Units Reserved ☑Yes ☐No ☐NA

Has Antibiotic Prophylaxis been given within the last 60 minutes? ☑Yes ☐No ☐NA

Signature : Anm
Name : Dr. Ameera

Before Skin Incision ➤➤

TIME OUT Time: 12:40pm

Confirm all team members have introduced themselves by Name and Role ☑Yes ☐No

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm
- Correct Patient (Check ID Band) ☑Yes ☐No
- Correct Site ☑Yes ☐No
- Correct Procedure ☑Yes ☐No

Anticipated Critical Events

Surgeon Reviews:
- What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? Adh 1hour 2000 ☐Yes ☐No ☐NA

Anaesthesia Team Reviews:
- Are There Any Patient-specific Concerns? ☐Yes ☑No ☐NA

Nursing Team Reviews:
- Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ✓ ☐Yes ☐No ☐NA
- **Is Essential Imaging Displayed?** ☐Yes ☐No ☐NA
- Power Supply, Earthing, Power Backup and functioning of equipment checked. ☐Yes ☐No

Signature : Y
Name : Ramya @ 12:40pm

Before Patient Leaves Operating Room

SIGN OUT Time: 1:30pm

Nurse Verbally Confirms with the Team:
- The Name of the Procedure Recorded ☑Yes ☐No
- That Instrument, Sponge and Needle Counts are Correct (or Not Applicable) ☑Yes ☐No ☐NA
- The Specimen is Labelled (including patient name) ☑Yes ☐No ☐NA
- Whether there are any Equipment Problems to be addressed ☑Yes ☐No ☐NA

To Surgeon, Anaesthetist and Nurse:
- What are the key concerns for recovery and management of this patient? ☑Yes ☐No

Signature : Shalini
Name : .....

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PATIENT TRANSFER FORM

VIH-00182914 IP26-00006817
Mrs RAMYA SRI
11-01-1993 33 Y 6 M 1 D (F)
Dr. KADIYALA RAMYA THEJA

	Date & Time of Admission: 12/1/26 @ 8:19 AM	Date & Time of Transfer Order: 12/1/26 @ 1:40pm
Treating Consultant Name: Dr. Ramya Theja	Transfer Ordered by: Dr. Amrit	Reason for Transfer: Observation
From Unit: GT	To Unit: Pre Post	Information to Attendant: Yes ☑ No ☐
Number of Sheets in Clinical File: –	Number of Imaging Films: –	Personal belongings including clinical documents. If any handed over to attendant: Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	RL	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
Ramya	Dr. Amrit

Patient & Clinical Records Received by :

Date & Time of Patient Received : 12/1/26 @ 1:40 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

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : MRS. RAMYA SRI Gender: ☐ Male ☐ Female Age : 33 YRS

UHID No : VIH - 00182914 Date : 12/07/2026

Instruction:
This consent form should be signed by Patient (If an adult 18 years or older) or by a parent / guardian, if the patient is a minor or lacks the ability to make an informed decision. The purpose of this form is to verify that you have received this information and have given your consent to the surgery or special procedure recommended to you.

I hereby authorize the performance of the following operation (s) or procedure (s) (use no abbreviation / Avoid technical terms)

ELECTIVE LOWER SEGMENT CAESERIAN SECTION

upon

MRS. RAMYA SRI (Name of the Patient)

I have been advised of the benefits and reason of the procedure(s) as indicated by the clinical observations and / or diagnostics performed. I recognized that the practice of medicine is as much an art as a science and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcomes. My questions regarding the condition, the proposed surgery and the outcome have been answered to my satisfaction prior to signing this form by the surgeon.

I have been explained the risks of this surgery /procedure and also about the reasonable alternative and the relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment.

I have been explained that the following complications though rare are possible and will not hold Surgeon, Anesthesiologist or the hospital staff responsible for any untoward event thereof.

Haemorrhage, PPH, Injury to adjacent organs - Ureta, Bladder, Intestines, Blood vessels, Need for Blood and Blood products transfusion,

My signature on this form indicates that

1. I have read and understood the information provided in this form
2. My doctor had adequately explained to me the operation or procedure along with the complications written above, along with the risks, benefits and other information.
3. I have had a chance to ask my surgeon questions.
4. I have received all the information I desire concerning the operation or procedure and
5. I authorize the consent to the performance of the operation or procedure.

Name of the Doctor who is performing the Surgery / Procedure: DR. SANTOSHI SHALINI.

Consentee :

Signature : Ramya sri

Name : Ramya sri

Date & Time : 12/7/26 10:10am.

Witness :

Signature :

Name :

Date & Time : 12/7/26 @ 10:10Am

Patient Attendant :

Signature : Praveen

Name : Praveen

Relationship with Patient: Husband

Date & Time : 12/7/26 10:10am

Doctor (who is taking the consent) :

Signature :

Name : Dr. Naveena

Date & Time : 12/7/2026 @ 10:15am

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : Mrs. RAMYA SREE Age : 32 yrs Gender : Male ☐ Female ☑

UHID NO: VIH-00182914 Surgeon Name: Dr. SHALINI

Anaesthesiologist : Dr. SAMIR

Operative procedure planned : Dr. LSCS

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

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

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

☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure

☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma / Renal Tubular Aacidosis

☐ Incapacitating Cronic Obstructive Pulmonary Disease

☐ Others : .....

Comments : .....

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

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient Mrs. RAMYA SREE the above mentioned operation / Diagnostic / Therapeutic procedures EL. LSCS

I authorize and give consent for anaesthesia (☐ Regional / ☐ General Anesthesia / ☐ Monitored Anesthesia Care as considered appropriate by the anaesthetic team.

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

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

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

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

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

- Pregnant : ☑ Yes ☐ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

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

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

Patient / Patient Attendant :

Signature : Ramya Sri

Name : P. Ramya Sai

Relationship with Patient: self

Date & Time : 11/7/26 5:10pm

Witness :

Signature : Praveen

Name : Praveen Punugula

Date & Time : 11/7/26 5:10PM

Doctor (who is taking the consent) :

Signature :

Name : Dr. SAIRAS.V

Date & Time : 11/07/2026 5:05pm

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: Mrs. RAMYA SREE Age: 32yr Sex: female UHID.No : VIH-00182914

Date: 11/07/2024 Time: 5:00 pm Proposed Operation: EL-LSCS

Diagnosis: PRIMI, 37wks ē IVF CONCEPTION.

B.P / CRT: 135/92 H.R: Weight: 81kgs ASA Physical Status: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

20/05 11.5 36.4 13090 3.77

Laboratory Data:

	11/07/24						
Hgb:	13.5	Glucose:		Protein:	5.7	HIV:	NR	X-Ray:
PCV:	41.7	Urea:	14	Alb:	3.0	HBS Ag:	NR	ECG:
WBC:	15470	Creat:	0.51	Total Bill:	0.11	HCV:		2D Echo:
Plate:	3.46	Na:		Dir. Bill:	0.06	Blood group:	O+ve	Stress/Anglo:
PT:		K:		LDH:		T3		Other:
PTT:		Ca++:		Alk phos:		T4		
INR:		Mg++:		Amylase:		TSH	1.36 → 1.98	HbA1C - 5.8
		Cl -:		SGOT/SGPT:	18/19			

Allergies: NKDA

Medical History: CVS : —

RESP : NAD

CNS : NAD

Renal : NAD

Hepatic / GE : NAD

Diabetes : Gest Diabetes : 6 Month on INSULIN. 8-8-7

Physical Activity:

Others : On TAB ECOSPIRIN 75mg OD TILL 6/7/24.

Past Anaesthetic History: NIL

Physical Exam: Mod Built & Nourished

Airway: MP 1 2 3 4 Mouth Opening: Mentohyoid Distance: Neck: Teeth: No loose teeth

Lungs : BLAEA, clear

Heart: S1S2+

CNS: NAD

Pregnant: ☐ Yes ☐ No ☐ NA Venous Access Site: Peripheral Spine Exam for regional : ok

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

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

Adv: 1. CBP, HbA1C

2. Viral Markers

3. To SKIP INSULIN on DAY of SURGERY.

Signature: Name: Dr. SAIRAM V.

Patient Sticker

ANAESTHESIA CHART

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Pre Induction Assessment:

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

H.R: 98/mt | B.P / CRT: 120/80 mm | SpO_2: 100% | R.R: 36/mt | Last Feed: >6h

Pre-OP Diagnosis: Baby 37 wks / SVD c/p | Operation: Elective LSCS | Date: [illegible]

Surgeon: Dr. Santhoshi | Anaesthesiologist: Dr. Anuroop | Technician: Anand

TIME	12:30	1:00	1:30	2:00
N_2O /AIR /O_2 LPM				
HALO /SO /SEVO				
Drugs:				
B. OXYTOCIN	3u	+3u		
FIO_2 / SaO_2	100	100	100	100
$ETCO_2$				
ECG	SR	SR	SR	SR
Temperature				
Urine Output				
Fluids: RL / RINGER LACTATE	100 →	→	→	→
Blood			100 →	

Antibiotic

Suppository P/R
c/p TRAMADOL 100mg
c/p DICLOFENAC

Blood Loss 100ml P/R

~350 ml

NOTES

Baby @ 12.47PM

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

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

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

LAB Values

ABG

GRBS @ 7PM →

Others

☑ Equipment Checked and Functional
☑ BP (D) UL
☐ Cuff Site: .....
☐ Art Site: .....
☑ EKG Lead – 3 Lead
☐ Temp Site
☐ FIO_2 Monitor
☐ Agent Monitor
☑ Pulse Oximeter
☐ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position: Supine
☑ Pressure Points Checked

Eye Care:
☐ Oint
☐ Tape
☐ Padding
☑ Awake

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

Times:
Anaes Start: 12:35PM
OP Start: ↓
OP End: ↓
Leave OR: 1:30PM

Anaesthesia:
☐ GA
☐ Monitored Anaesthesia Care
☑ Regional

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

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

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

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

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

Regional:
Extremity Specify: .....
☑ Spinal ☐ Epidural ☐ Caudal
Others: .....
Position: Sitting
Site: L3 L4 ☑ with introducer
Needle Size: 25G Depth: .....
Parasthesia ☐ Yes ☐ No
Catheter at skin ..... cm
Drug Name & Conc: 0.5% BUPIVACAINE
Bolus: (H) + Lignocaine
Infusion: FENTANYL
Block Level: .....
Comments: .....

Transportation to
☐ PACU ☐ ICU ☑ Other
Relaxant Reversed ☐ Yes ☐ No ☐ NA
Name of the Doctor: Dr Anuroop
Signature of the Doctor: [signature]

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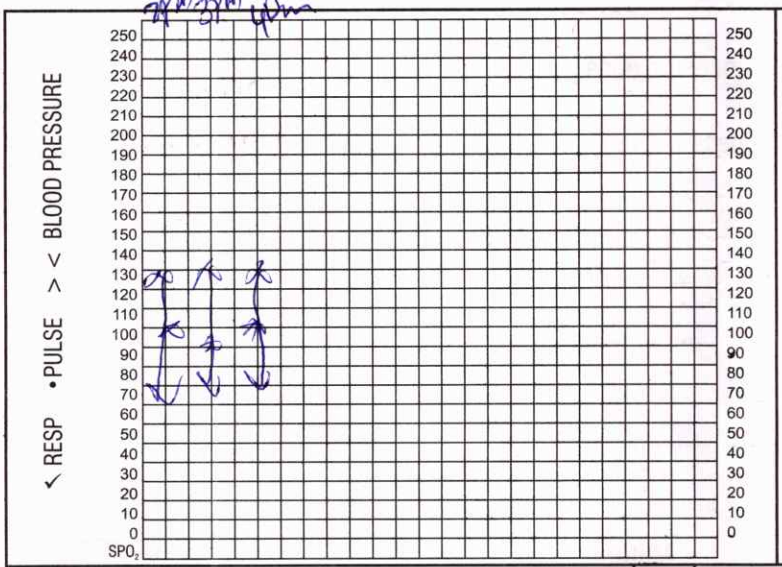
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Anusha .G 2PM 3PM 4PM Time Received : 1:40PM Time Discharged : .....



IV Cannula Site : left hand

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

Vomiting : ☐ Yes ☑ No Drug: .....
NG Tube : ☐ Yes ☑ No
Drain: ☐ Yes ☑ No
Urinary Catheter: ☑ Yes ☐ No
Chest Tube: ☐ Yes ☑ No
Nil Oral ☐ Yes ☑ No

IV Fluids: RL
Oral Feeds: NBM.

POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	MINUTES 30	60	90	OUT	SCORING INTERPRETATION
Able to move 4 extremities voluntary or on command Able to move 2 extremities voluntary or on command Able to move 0 extremities voluntary or on command	= 2 = 1 = 0	ACTIVITY	1	2	2	2	2	A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to deep breathe & cough freely Dyspnea or limited breathing Apneic	= 2 = 1 = 0	RESPIRATION	2	2	2	2	2	
BP ± 20 of Pre Anaesthetic leve BP ± 20-50 of Pre Anaesthetic leve BP ± 50 of Pre Anaesthetic leve	= 2 = 1 = 0	CIRCULATION	2	2	2	2	2	
Fully awake Arousable on calling Not responding	= 2 = 1 = 0	CONSCIOUSNESS	2	2	2	2	2	
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0	COLOR	2	2	2	2	2	
		TOTAL	9	10	10	10	10	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
12/7	2PM	0	Normal	Anusha
12/7	3PM	0	Normal	
12/7	4PM	0	Normal	

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

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

Anaesthesiologist Name : Dr. Ameen.
Anaesthesiologist Signature: Amm
Date & Time: 12/7/26

PACU Nurse Name : .....
PACU Nurse Signature: .....
Date & Time: 12/7/26

Transferred to Unit by (PACU): W/C
Date & Time: 12/7/2026 2:40pm

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: ..... Time: ..... Procedure done by .....

CSE /Spinal /Epidural Position : ..... Space :..... Technique (LOR/LOS) .....

Depth: ..... Catheter at Skin: ..... Attempts : .....

Parasthesia : Yes/No if yes details : .....

Solution Composition : .....

Any other issues :

a) .....

b) .....

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

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

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

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

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NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 13/7/26 Time: 12:12pm

Origin: Indian Height: — Weight: — BMI: ☐ ~ 26 kg/m² ☐ ~ 28 kg/m² ☐ ~ 30 kg/m²

Food Allergies: NO

Diagnosis: LSCS

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

Diet Advised:

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

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

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

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

Patient's / Attendant's

Signature: Ramya

Name: Ramya S

Date & Time: 13/7/26 ; 12:12pm

Dietician's

Signature: SS

Name: Sathvika.G

Date & Time: 13/7/26 ; 12:12pm

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CROSS CONSULTATION FORM

Doctor Name : Dr. Ramya Date : 13/7/26 Time : 1pm

Diagnosis : LSCS

Hospital : RCH - HMNR

Referred for : ☐ Opinion ☑ Co-Management ☐ Transfer of care

Type of Referral :
☐ Emergency
☐ Urgent
☐ Non Urgent

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature:

Findings and Recommendations :

Lactation care plan

- well formed Breast & Nipples
- colostrum seen
- primi
- Advice DBF every 2nd hourly on each side 15 - 20 mints & f/b Burping.
- Aim for deep latch as demonstrated in cradle hold (or) cross cradle.
- baby starting to suck with strong stimulation
- warm care
- monitor weight & output.

Consultant :

Name : Sathwika.G Signature : Date & Time : 13/7/26 ; 1pm

96-0000212987

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NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name: Mrs Ramya Sri		Age: 33Y	Gender: Female
UHID No: VHH-00182914	IP No: IP26-00006817	Date: 12/7/26	Time: 9:04AM
Diagnosis: LSCS		ward-07	

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	100mcg	1 Amp
2.	Morphine Sulphate Inj. 15mg/Ml		
3.	Remifentanil Hydrochloride Inj. 2MG		
4.	Remifentanil Hydrochloride inj. 1MG		

Doctor Name: Dr. SAIRAM.V

Doctor Registration No: APMC 75777

Signature: S-I

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

IP Registration No: IP26-00006817 ..... Date: 12/7/26

Aadhaar No. of the Patient (Optional): .....

1.	Name : Mrs Ramya Sri	Remarks
2.	Complete postal address (with contact number, if any)	MR NAGAR TECHNICAL Administrative Building Hyderabad
3.	Brief description of the illness	LSCS
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	NO
5.	Details of essential Narcotic drug dispensed	Fentanyl

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
12/7/26	Fentanyl	1Amp		

Dispensed by (Name & ID No.): Sarika 018443 Signature: .....

Received by (Name & ID No.): Saraswathi (021006) Signature: .....

Time: .....

Docu. No: RCH / FRM / CLINICAL / 133