

ADMISSION SHEET



Registration Details :

Admission No : IP5-00176166 Admit Date : 09-Jul-2026 Admit Time : 06:03 PM UHID : BAH-00661087

Patient Details :

Patient Name : Mrs KASTURI BABY NAGA ANUSURYA Age : 49 Y 6 M 8 D
Guardian : Mr KASTURI NAGESWARA RAO DOB : 01-01-1977
Gender : Female Religion :
Occupation : Martial Status : Married
Address (H) : H NO 18-54-9, AMMAVARI THOTA Nuzvid Phone No : 8500911728/ 9440983739
Krishna Andhra Pradesh INDIA 521201 E-mail : SESHANK.K@GMAIL.COM

Admission Details :

Bed Type : MICU Bed No : MICU 426 Ward Name : 4F-BIRTHING CENTRE
Room No : MICU 426 Admission Type : First Visit

Contact Details :

Name : Mr KASTURI NAGESWARA RAO Relationship : Husband
Contact Address : H NO 18-54-9, AMMAVARI THOTA Nuzvid Phone No : 8500911728
Krishna Andhra Pradesh INDIA 521201

[Signature]
Signature

Doctor Details :

Doctor Name : Dr. SASIKALA KOLA Specialisation : OBSTETRICS AND GYNECOLOGY
Referral Doctor : Self Phone No :
Co-Consultant :

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00
Payor Name : STAR HEALTH AND ALLIED INSURANCE CO LTD

INVESTIGATIONS

Date	Investigations	Order No.	Signature
9/7/26	ECG	26068741	Tunn Tunn
	X-ray.	034163	
	2D Echo	034257	
9/7/26	Blood grouping, creatinine	26068741	Tunn
9/7/26	TSH, PT/APTT, CUE, uric acid	26068743	Tunn
9/7/26	HIV, HbsAg, HEV	26068775	Tunn
9/7/26	CRP		
9/7/26	8-10 PM pre dinner 189 mg/dL	26069158	Sucande
9/7/26	10 PM post dinner 223 mg/dL		Sucande
10/7/26	pre breakfast 5:00 AM 144 mg/dL	26069166	Sucande
10/7/26	CRP	26068906	Pull.
Cross checked done			

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
9/7/26	IV placement	1	9696218	Tunny
9/7/26	PAC	1	9696218	Tunny
9/7/26	blood transfusion	O2 (PRBS)	9696219	Smeand

cross checked for

ANY OTHER INFORMATION

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Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 9/7/2026

Time of Admission :

Allergies: NKA

☒ Not know any drug allergies

PRESENTING COMPLAINTS :

P2L2A1 E Anemia. (Hb: 4.3)

c/o: Bleeding P/V : April till date.
Used 1-2 pads/day - on/off.

L LMP: March 2026

LLMP: feb 2026

9/7/26: UT-AV, 94 x 62 x 59mm, Adenomyosis, ET: 11.7mm.
anterior myometrium-15mm, posterior myometrium-25mm.
fibroid polyp- 46 x 45 x 42mm, posterior adenomyoma

MENSTRUAL HISTORY

OBSTETRIC HISTORY

Year of Marriage: ML-33 yrs INCM

Parity: P2L2A1

Previous Periods: regular

Mode of Delivery: 2 MVD's, 1997-SP

LMP: April 2026

Last Child Birth: LCB-1995

Contraception: Tubectomised
: 1999

♂, AGH.

PAST MEDICAL HISTORY

PAST SURGICAL HISTORY

hypo thyroid. : 4 months

HTN : 5 yrs

Anemia : 2022 -
no Blood transfusion done
- no allergic reaction.

DGC - done - 2022
Hb: heavy menstrual cycle
HPE - Chronic papillary
endocervicitis simple
hyperplasia.



FAMILY HISTORY:

Mother - HTN

Father - DM, Cardiac arrest.

MEDICATION HISTORY:

1) T. temp norm - 35 deg

INITIAL ASSESSMENT:

Date <u>9/6/26</u>	Breasts	Local/Speculum Examination <u>Pl - ex large cervical Fibroid polyp.</u> <u>mucopurulent discharge present</u>
Ht. _____ Wt. _____		
BMI _____		
B.P. <u>110/70 mmHg</u>		
Pallor <u>(+)</u> PR <u>104/min</u>	Abdominal Examination	Bimanual Pelvic Examination <u>Pl. uterus, Rv, Nj, mobile</u> <u>Tender, Free large cervical Fibroid present.</u>
CVR <u>S1S2 (+)</u>		
Respiratory System <u>BAT (+)</u>		
Thyroid <u>(N)</u>		

PROVISIONAL DIAGNOSIS:

Severe
P2L2A1 Severe Anemia. ± AUB - L/A for Management
for

INVESTIGATIONS ORDERED

Hb → 4.3 (6/7/26)

Plt → 5.13 lac.

WBC : 6,600

CVF: PC → 1-2
E-C → few

RBS - 190

TSH → 6.6

PLAN OF MANAGEMENT

cto/w Dr. Maithri

- 1) admission, Physician review
- 2) send BGT, CBC, RBS, Creatinine
S-TM, HBA, HIV 1/2, HCV.
- 3) APTT, PT-INR, CUE, Urine CBS
- 4) ECG, 2D Echo, X-ray PAX
- 20 PRBC issue & give today
- 20 PRBC reserve for tomorrow
- plan surgery (cervical Fibroid & polypoid LDC, + Hysterectomy)

Name of the Doctor:

Dr. Brahm

Signature of Doctor

On

Date & Time:

9/8/2016 10 AM

DR. MAITHRI MALLEMA
Registration No: 60

Maithri MALLEMA



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/1/22 8:30pm	P2 L2 A1 - Anemia + AUB - Cervical Prolapsed G/C Fair Afebrile PR - 100/min BP - 118/70 mmHg SpO2 - 98% (A/R) R - BNSC P/A - soft. No RMA (M) LV Systolic Function. Diastolic Dysfunction Grade I. No MR / NO AR / mild PAM/TRT. No PE / No clot or vegetation Tul - colopathy abnormaly	ad (1) 20 PRBC - issue today (2) gen inj lax 20mg (10) before 2nd PRBC (3) 20 PRBC reserve for tomorrow (4) do pre & post meal sugars & inform Dr. Niveditha (5) Trace, 8-7 SK, urals, CuE, urine Cu (6) Informed consent. (7) NBM From 12 AM.
	Pt - K JNR - 1 APTT 31. Creatinine - 1.1 BUN - 0.4 mg/dL	
	RRS - 179 - @ 7:30pm PACU	
		Dr. Arshya
		NB Sivard



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/21 2pm	P2, A1 - Arterio + AUB futa A/Ble PR - 100/min BP - 120/80 mm SpO2 - 96% @ Rn P/A - n/l PB before breakfast 144. Tm - 3.25	ad - ① Consent ✓ ② Pac ✓ ③ NBM ④ 20 PRBs reserved. ⑤ do sugar Monitor after surgery ⑥ Inform com ✓ ⑦ Trace Repat ⑧ CBL - 9AM (urgent)
10/7/21 6AM	P2, A1 - Arterio + AUB + Cervical Fibroid polyp futa A/Ble PR - 100/min BP - 120/80 mm SpO2 - 98% @ Rn P/A - n/l PB before breakfast - 144	ad - ① CBL ② NBM ③ 20 PRBs reserved. ④ do sugar Monitor after surgery ⑤ Inform com ✓ ⑥ Trace the Repat ⑦ CBL - 9AM do &

Dr. Anshu Kumar

NB Swaid

Dr. Anshu Kumar

NB Swaid (P.T.O)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/2026 9:00 AM	Pt. A / Anemia / AUB for cervical fibroid polypectomy + Dec 2 OPRBC transfused	
	OLE	Adv
Uprah-NR	Ceftriaxone	1) NBM
Trace-CBP	BP-101/55/66 mmHg	2) post preparation
PACV	PR-85 BPM	3) Informed consent
	SpO2-98% + PA	4) Receive 2 OPRBC
	PA-Soft	5) Shift to OT on call
		6) Inform SUs
FBs-144 mg/dL		
10/7/26	Hb-7.1	Dr. Dinesh
	WBC-6.85	
	PLT-4.68 L	
	Trace WFE report	
	2 OPRBC - Received	
	CuF - Leucocytes (+)	
	PC-8-10	
	RBCs-50-60	
	non hemolyzed blood (+)	



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Mrs KASTURI BABY NAGA
01-01-1977 49 Y 6 M 9 D (F)
Dr. SASIKALA KOLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/19/26 5:00pm	POD-01 fibroid polypectomy pt comfortable. off Ge-faxen	Adv ① NBM for 24 hrs ② IUF @ 50ml/hr ③ I/O charting (strict) ④ Monitor vitals every 30 min ⑤ Drugs as charted ⑥ Inform NRS. ⑦ w/o active bleeding ⑧ Encourage voiding. Dr. Divya
10/20/26 6pm	POD-01 fibroid polypectomy K/C/O HTN/hypothyroid/anemia BP- 112/76 (R4) HR- 72bpm SpO ₂ - 100% on RA P/A- Soft, non-tender BS @ w/o active bleeding	Adv ① Clear liquids now ② If tolerating soft diet @ 10pm ③ Encourage to pee ④ Drugs as charted ⑤ Ambulate ⑥ Urts 4th day ⑦ Can be shifted to ward

Srisha

Noted by [Signature] (P.T.O)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/26 1:30 PM	POD-1 / fibrinid polypuroney. H+N / Hypothyroid anemia pt comfortable ambulating	
	o/e	
	Bp-107/65mmHg	Adv
	PR-76 bpm	① Soft diet
	SpO ₂ -98% RA	② Hydration
S/E DUE	plA - soft	③ Ambulation
	UE - nap.	④ Vitals + h hees
	Continue previous medication	⑤ Drugs as charted
	plan <u>discharge</u>	⑥ Inform sus
		Dr. Divya
		Noted by Latha
		10/8 AM

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



CROSS CONSULTATION FORM

Doctor Name : Date : 9/7/26 Time :

Diagnosis :

Hospital :

Type of Referral :

☐ Emergency

☐ Urgent

☐ Non Urgent

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

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

Signature:

Findings and Recommendations :

49 yr old female
Pls for TTH
known HTN / Hypothyroid on
sev. Anaemia
of DOE chf - 3-4 months
No other
SS
In DM
Tested
no test done
Anti HTN - T. OLMX H
day 60
Q Continue with Mild Cardiac Dist
Q Can be taken up with Mild Cardiac Dist
after Correction of Anaemia
Q Avoid volume overload with prior lasix

Consultant :

Name : Dr. K. Lakshmi Ravi Signature : Date & Time : 9/7/26

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OPERATION THEATER NOTES

Patient's Name : Mrs. Kasturi Baby Naga Age : 49y Gender : ☐ Male ☒ Female
UHID No. : BAH-00661087 Weight : Height :

Surgeon : Dr. Sasikala Kola Asst. Surgeon :

Anesthetist : Dr. Shilpa OT Nurse : Poobharathi B. OT Technician : Anish

Pre-Operative Diagnosis :

Surgical Procedure : Cervical fibroid polypectomy

Indications for Surgery : AUB - P (large cervical polyp) & severe anemia

Date : 10/7/26. Start Time : 1:45 PM End Time :

Pre Operative Preparations : all pre op medications given

Post Operative Diagnosis : 100% post fibroid polypectomy

Peri-Operative Complications : Nil

Operation Notes : 1) large 6x6cm cervical fibroid polyp seen in the vagina coming out of the cervix
2) vaginal walls retracted & speculum, both lips of cervix held with vulsellum.
3) small incision made over the fibroid polyp and edges held for grip
4) pedicle of the polyp identified arising from the posterior lip of cervix
5) pedicle clamped cut and ligated.
6) polypectomy done and sent for HPE

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RESULT SHEET

Date	6/7/26	19/9/26	10/7/26		
Time					
Hb	4.3	4.5	7.1		
PCV		16.0	23.2		
RBC		2.56	3.51		
WBC	6.600	7.18	6.85		
N/L					
Platelets	5.13	4.73	4.68		
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine		1.1			
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	14/1.0	14/1.0			
APTT	31	31			
CSF Protein / Sugar					
Cells					
N/L					

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 :

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Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :

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Patient




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MEDICATION RECONCILIATION FORM

Drug Allergies: < NKA

☒ 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	Thyronorm	25mcg	PO	OD	9/7/26	☐ C ☒ DC
2	J. Olmo 40H	40mg	PO	OD	9/2/26	☐ 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: Dr. D. V. S.

Date & Time: 9/7/26 ; 4:50 pm

Nurse Name & Signature: Swapna

Date & Time: 9/7/26 6 pm

Weight Ward

DRUG: T. PANTOPRAZOLE

Date	10/7	10/7
Time		

Dose	Route	Frequency	Start Dt.
------	-------	-----------	-----------

40mg	P/O	O.D	10/7
------	-----	-----	------

Name & Signature of the Doctor
Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG: T. PARACETamol

Date	10/2	11/7
Time		

Dose	Route	Frequency	Start Dt.
------	-------	-----------	-----------

SDimg	PO	710	6/7/2
-------	----	-----	-------

Name & Signature of the Doctor Starting the Drugs: _____

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG: Diclofenac

Date
Time

Dose	Route	Frequency	Start Dt.
------	-------	-----------	-----------

smg	PO	BD	10/7/
-----	----	----	-------

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

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

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																				

VERIFIED BY : Name Signature



DRUG CHART

Date of Admission: 9/2/2016 Drug Allergies: None ☒ 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:																			

Weight. Ward. ORC

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 01-01-1977 49 Y 6 M 8 D (F)
 Dr. SASIKALA KOLA

Weight. Ward. BC



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
10/7/26	1:30 AM	Inj LASIX	2mg	IV	[Signature]	Sharda Tanya
10/7	12:40 PM	Inj. PARACETAMOL	1gm	IV	[Signature]	W/H Ravi
10/7	1:50 PM	Inj morphine	6mg	IV	[Signature]	Bobi Raneh
10/7	12:50 PM	Inj. TRANSDEXMIC-ACID	1gm	IV	[Signature]	Bobi Raneh

Signature

VERIFIED BY : Name

Weight. Ward. B/L

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TELEPHONE / VERBAL ORDER AND CRITICAL RESULT REPORTING FORM

☐ Telephone Order

☒ Verbal Order

☐ Critical Result Reporting

Name of Reporter: Bro. Chandhu

A. Order as per Medication Chart	☐ N/A	Route	Dose	Direction If Any

B. ☒ Critical Result Reporting (Lab/Radiology/others/ If Any)	☐ N/A	☐ Intervention for Critical Results?
HB: 4.5 mg/dl		20 PRBC Given.

Order Recipient Response: Please Tick	☒ Yes	☐ No
Write Down by the receiver		
Read Back by the recipient		
Confirmed by the reporter		

Receiving by:	Ordering Doctor Signature
Name: <u>Sis. Sunandya</u>	Name:
Receiving Time: <u>10pm</u> Date: <u>9 / 7 / 26</u>	Signature Time: Date: / /
Signature: <u>Sunandya</u>	

Notes for Telephone / Verbal order:

1. Verbal Order is for Emergency Situation only.
2. Doctor should sign the order ASAP but not later than 24 hours.
3. This form shall be placed in the Doctor Orders Part.

BAH-00661087 IP5-00176166
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 Dr. SASIKALA KOLA



MULTI-DISCIPLINARY PLAN OF CARE FORM

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Diagnosis: P2 L2 A1 / AUB-L / Severe Anemia

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
9/7/26 6pm	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☒ Per-Op ☐ Post Op	→ AUB-L → Severe anemia	→ to correct anemia	→ Blood transfusion	<i>[Signature]</i>	☐ Nursing ☐ Others:
9/7 6pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	→ fear and anxiety	→ to reduce fear and anxiety	→ Provided Psychological Support	<i>[Signature]</i>	☐ Medical ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

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INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

Identified Education Needs:

- | | | | |
|----------------------------|--|--|---|
| 1. Diagnosis | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet | 13. Risk / Safety |
| 2. Treatment and Care Plan | 6. Discharge Medication | 10. Fall Risk Education | 14. Activity / Exercise |
| 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices Safety | 15. Social & Rehabilitation Needs |
| 4. Informed Consent | 8. Diagnostic Test / Procedures | 12. Patient's / Family Rights | 16. Special Discharge / Follow-up Education / Coping Skills |
| | | | 17. Others |

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		
9/07/26	4:47pm	1, 2, 1	Diagnosis, treatment	PT / S	1	0	1	1		<i>Dr. S.</i>
9/8	6pm	1	Infection control measures	PT's	1	0	1	1	0	<i>S.</i>

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 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							

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Mrs KASTURI BABY NAGA
01-01-1977 49 Y 6 M 8 D (F)
Dr. SASIKALA KOLA



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OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 01/12/2026

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: came for Doctor Notified on Admission: ☒ Yes ☐ No
Name of the Doctor: Dr. Sowanthi
Time Notified: 5:30 pm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
hypothyroid	D&C done 2024.	

Gynecology Assessment: ☐ Not Applicable Menstrual History: Onset of Menarche: Regular 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 2 L 2 A 1

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: 98.2 F HR: 105 RR: 20
BP: 117/70 Weight: Height: BMI:

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



PHYSICAL ASSESSMENT

General Appearance: ☒ Healthy ☐ ill looking ☐ Anxious ☐ Agitated ☐ Others:

Fall Assessment: ☐ Yes ☐ No Score 35 (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore: ☐ Yes ☐ No Score 28 (complete the Braden Q Sheet)

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

- ☐ Mobility problem ☐ Walking Problem ☒ No Abnormality Detected
☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☒ No Abnormality Detected

- ☐ Overweight ☐ Poor Appetite > 3 Days ☐ Needs Therapeutic Diet.
☐ Under Weight ☐ Diabetes Mellitus ☐ Hyperemesis Gravidarum

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

- ☒ Calm & Cooperative ☐ Restless ☐ Depressed ☐ Agitated ☐ Confused
☐ Others

Inform consultant for positive criteria

Cultural & Spiritual Needs: ☐ Yes ☒ No if Yes specify 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: Baby

Orientation not given Reason:

Nurse Signature: Sy

Nurse Name: Swapul

Date & Time: 9/1/26 @ 6pm

r. SASIKALA KOLA

(F)

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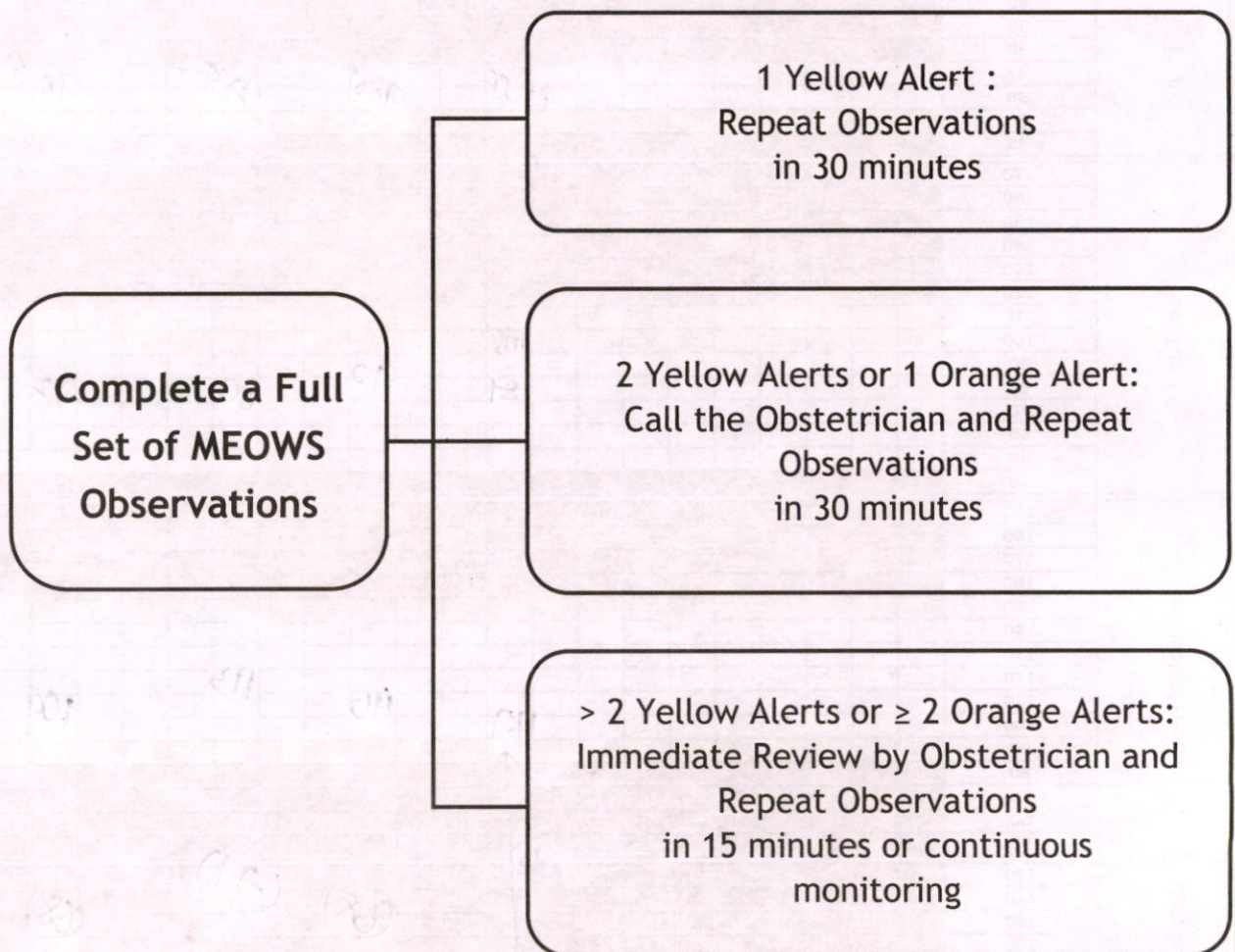
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~~10/9/26~~

CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT

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																										

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

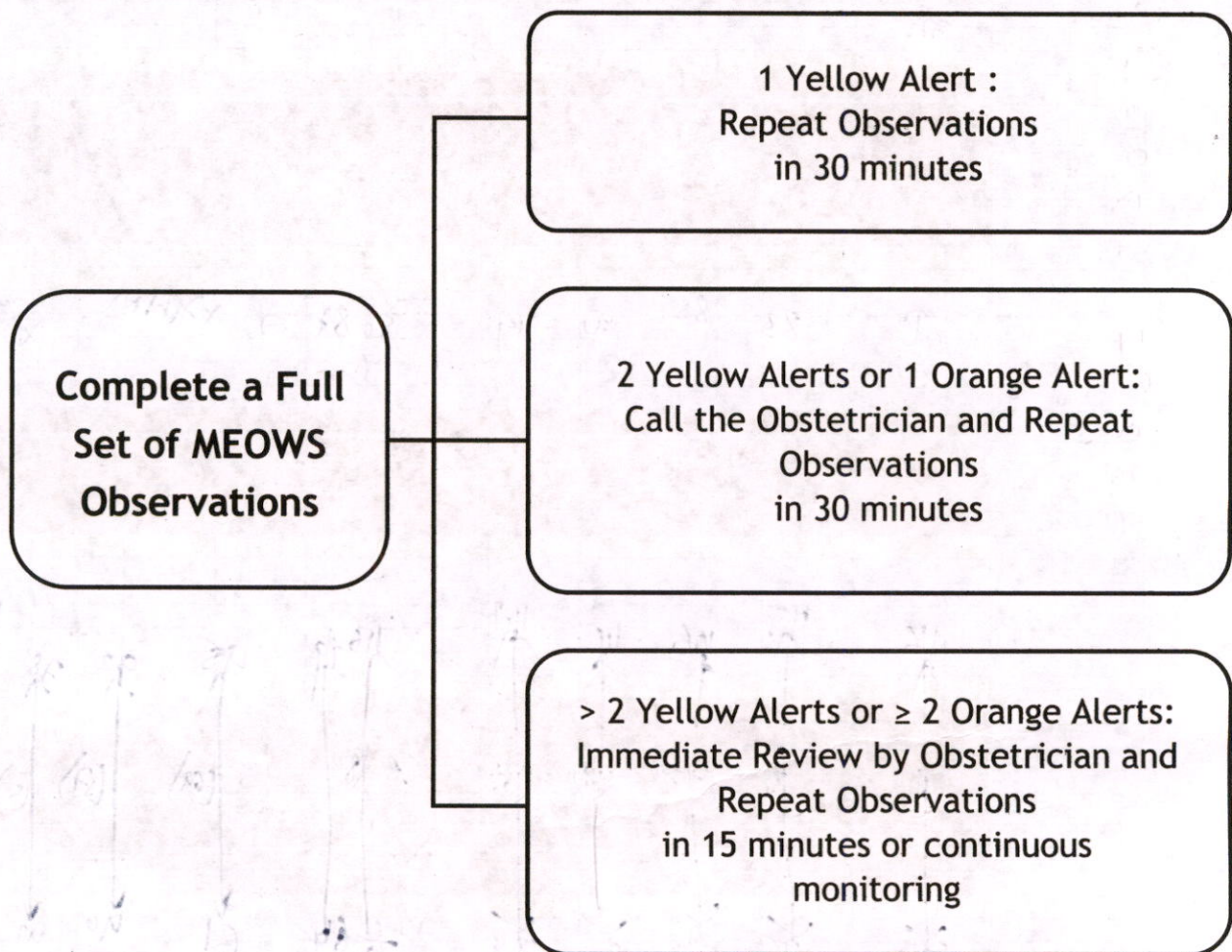


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CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

[illegible]

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

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01-01-1977 49 Y 6 M 8 D (F)
Dr. SASIKALA KOLA



FLUID CHART

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Sheet No. : ①

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
3. 24 hrs. total to be entered in the kardex in RED.

		Intake				Output						IV Site Thrombo- phlebitis Score	Sign. Nurse		
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine					
			Mouth	I.V	N.G										
	08:00 am														
	09:00 am														
	10:00 am														
	11:00 am														
	12:00 pm														
	01:00 pm														
Total Intake :						Total Output :									
	02:00 pm														
	03:00 pm														
	04:00 pm														
	05:00 pm														
	06:00 pm	tho													
	07:00 pm	tho													
Total Intake : Taken						Total Output : Passed									
	08:00 pm	H2O													
	09:00 pm														
	10:00 pm														
	11:00 pm	H2O													
	12:00 am														
	01:00 am	H2O													
Total Intake : taken.						Total Output :									
	02:00 am	H2O													
	03:00 am														
	04:00 am	PL H2O 100ml													
	05:00 am	PL NBM 100ml													
	06:00 am	PL NBM 100ml													
	07:00 am	PL NBM 100ml													
Total Intake : NBM						Total Output :									
Total 24 hrs. Intake		400 ml - PL				Total 24 hrs. Output									

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FLUID CHART

Sheet No. : 1

10/7/20

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			NG	Diarrhoea	Output				IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G			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												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output : U-1 M-0							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output : U-1 M-0							
Total 24 hrs. Intake			Taken										
Total 24 hrs. Output			U-4 M-0										

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NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 9/7/2026

Assessment: patient complaint fear and Anxiety

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
5 PM	→ assess the Patient condition	5 PM	→ assessed the Patient condition	→ Patient stable
6:00 PM	→ monitor vitals	6:40 PM	→ monitored vitals	
5 PM	→ cannulation	7:30 PM	→ cannulation done	
8 M	→ Safety		→ Provided side rails	
	→ Ambulation		→ Ambulation done	
8 PM	→ I/O chart monitoring	8:30 PM	→ I/O chart monitored	

Re-Assessment:

Re-Assessment 6th hour

Special Notes:

vitals monitoring

Nurse Signature:

SL

Nurse Name:

Swapna

Date & Time:

9/6/26 2pm

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 9/2/26

Assessment: patient c/o fear & anxiety

Goals

- | | | | | | |
|---|--|---|---|---|--|
| ☐ Maintain Airway and Oxygenation | ☐ Relieve Pain & Discomfort | ☐ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☐ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☐ Maintain Personal Hygiene | ☐ Prevent Infection | ☐ Meet Elimination Needs | ☒ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☒ Patient & Family Education |
| ☐ Identify Potential Complications | ☐ Any Others. Specify..... | | | | |

Time	Plan of Care	Time	Implementation	Evaluation
8PM	Assess to pt condition	9PM	Assessed to pt condition	pt is comfortable
10PM	IO/Hard	11PM	IO/Hard maintaining	
12AM	Medications	2AM	INS: Metrogyl 100mg IV provided	
3AM	Blood transfusion	5AM	2 PRBS IV provided	
6AM	soft diet	8:30 AM	soft diet given	
9AM	NBM	8AM	NBM till doctor's orders	

Re-Assessment: re-assessment 2nd hourly vitals done

Special Notes: NBM till doctor's orders

Nurse Signature: [Signature]

Nurse Name: Suranda (606299)

Date & Time: 10/2/26 8AM

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Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 10/7/26

Assessment:

patient complains fear & needy

Goals

- ☐ Maintain Airway and Oxygenation
- ☐ Relieve Pain & Discomfort
- ☒ Maintain Fluid Balance
- ☐ Improve Activity Tolerance
- ☒ Maintain Good Nutritional Status
- ☐ Maintain Skin Integrity
- ☐ Maintain Personal Hygiene
- ☒ Prevent Infection
- ☐ Meet Elimination Needs
- ☐ Ensure Safety
- ☐ Early Ambulation Reduce Anxiety
- ☐ Patient & Family Education
- ☐ Identify Potential Complications
- ☐ Any Others. Specify.....

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess the Pt condition	8:15 am	Assessed the Pt condition.	
10am	monitoring vital	11am	vitals checked & recorded.	
12pm	2/0 chest medication	1pm	2/0 chest medication given.	
2pm	IV Fluids	6pm	stated IV Fluids.	* Patient is stable
4pm	* provide NBM		* provided NBM	
7pm	* ensure patient safety	8pm	* provided Pt safety	

Re-Assessment:

Re-Assessment 6th hour.

Special Notes:

NBM by further order

Nurse Signature:

[Signature]

Nurse Name:

Lanna (Nurse)

Date & Time:

10/7/26 8pm

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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 10-6-26

Assessment:

Patient is having light pain in Surgery Site

Goals

- | | | | | | |
|---|---|--|---|---|---|
| ☐ Maintain Airway and Oxygenation | ☒ Relieve Pain & Discomfort | ☒ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☐ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☐ Maintain Personal Hygiene | ☐ Prevent Infection | ☐ Meet Elimination Needs | ☐ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☐ Patient & Family Education |
| ☐ Identify Potential Complications | ☐ Any Others. Specify..... | | | | |

Time	Plan of Care	Time	Implementation	Evaluation
8PM	u Assess the patient general condition	9pm	u Assessed the patient general condition	Patient is stable now.
10PM	u Monitor vitals and Record	11PM	u Monitoring vitals and Recorded	
12AM	- To Monitor I/O Chart	12AM	- Monitored I/O Chart	
3AM	- To Administer Medication as Advice.	3:10 AM	- Medication Administered as Advised.	
6AM	- To Ensure Safety.	6AM	- Ensured Safety & Signs	
8AM	- To Ensure Ooals & voiding	8AM	- Ensured Ooals & voiding	

Re-Assessment:

Pain Subside Now.

Special Notes:

NA

Nurse Signature:

Supina

Nurse Name:

Supina

Date & Time:

10/6/26 @ 8AM.

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Sheethi Department: ORL Date of Admission: 9/7/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:				
BACKGROUND	Area	Shift Time	ORL 2pm-8pm	ORL 8pm-8pm	ORL 8pm-8pm	Med 8pm-8pm	3rd Shift 11A-8A
	Medical Condition (Any special condition to be noted):		NA	NA	NA	NA	PODRO
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	98.1F	98.6F	98.1F	98.1F	98.2F
		Res:	20	20	20	20	20
		SpO ₂ :	99%	100%	99%	99%	100%
		Pulse:	105b/min	90	105b/min	105b/min	95b/min
		BP:	119/70	118/69	116/70	110/70	110/70
		Fall Risk Score:		20	20	20	20
Pain Score:	0	0	0	0	0/10		
Recommendations	Safety Needs:	Cide Sail	Cide Sail	Cide Sail	NA	Side Sail	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	NA	NA	NA	NA	NA	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	Blood transfus	NA	NA	NA	NA	
Post Operative Procedure Special Orders:		NA	NA	NA	NA	NA	
Handed Over By Name :		Swagat	Swagat	Swagat	Swagat	Swagat	
Signature :		Swagat	Swagat	Swagat	Swagat	Swagat	
Date:		9/7/26	10/7/26	10/7/26	10/7/26	11/7/26	
Time:		2pm	8pm	8pm	10:30A	8pm	
Taken Over By Name :		Swagat	Swagat	Swagat	Swagat	Swagat	
Signature :		Swagat	Swagat	Swagat	Swagat	Swagat	
Date:		9/7/26	10/7/26	10/7/26	10/7/26	11/7/26	
Time:		8pm	8pm	8pm	8pm	8pm	

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area / Shift Time:						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp: Res: SpO ₂ : Pulse: BP: Fall Risk Score: Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
	Post Operative Procedure Special Orders:						
	Handed Over By Name :						
	Signature :						
	Date:						
	Time:						
	Taken Over By Name :						
	Signature :						
	Date:						
	Time:						



CHECKLIST FOR THROMBOPHLEBITIS

ah26 10/2/26.

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0	0	0				
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			-	-	-	-				
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			-	-	-	-				
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			-	-	-	-				
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			-	-	-	-				
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			-	-	-	-				
Signature of the Nurse													

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : Kasturi Name : Kasturi

Signature of Ward In Charge :

Signature : Veeva Name : Veeva

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Morse Fall Risk Assessment Form

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Choose Highest Applicable Score from each Category		Date / Time	9/17/26	9/17/26	10/7/26	Fall Risk Grading		
		Score	2pm 8pm	8pm 8pm	8am 8pm	Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25				Low Risk	0 - 24	Standard Fall Precaution
	No	0	0	0				
Secondary Diagnosis (more than one diagnosis)	Yes	15	15	15	15	Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
Ambulatory Aid	Furniture	30				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0						
IV / Heparin Lock or Saline	Yes	20	20	20	20	Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0	0	0				
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0	0	0				
Total Morse Fall Scale Score:			30	30	30			
		Signature	Swapne	Swapne	Aditya			

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.

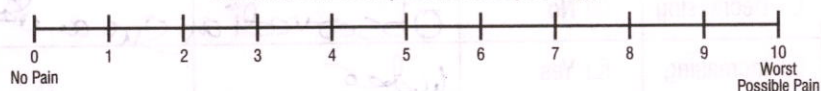
- ☐ Initiate constant observation by healthcare provider as appropriate to patient's needs

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, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

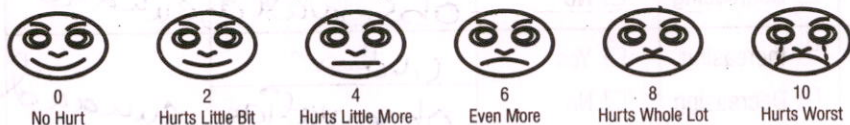
Numerical Pain Scale (Obstetric and Gynecology)



Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
10/7	7pm	0/10	NO Pn	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Stanne
10/7	10pm	1	Surgey sub	☒ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☒ Sharp ☐ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☐ Yes ☐ No	Tab 6ml	Pun
10/7	6Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Pt under observation	hos
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

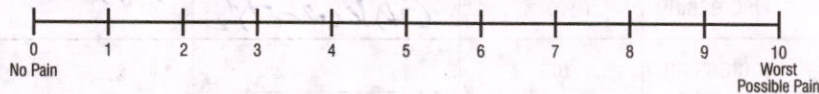
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

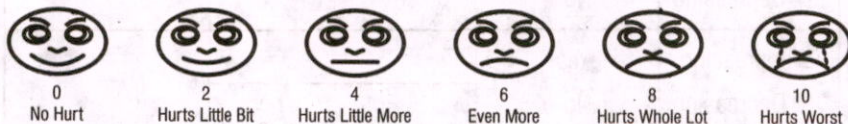
Numerical Pain Scale (Obstetric and Gynecology)



Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
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Wong - Baker (Pediatrics) Above 7 Years





CONSENT FOR BLOOD TRANSFUSION

Name: Mrs. KASTURI BABY NAGA Anusurya Age: 49 Gender: Male ☐ Female ☒
UHID.No: BAM-00661087 Date: 9/7/2026

Type of Blood Product: ☐ Fresh Frozen Plasma ☒ Packed Red Blood Cells ☐ Random Donor Platelets
☐ Cryoprecipitate ☐ Single Donor Platelet ☐ Whole Blood
☐ Albumin ☒ Red Blood Cell ☐ Others

I Kasturi Baby Naga Anusurya hereby give my consent for whole blood transfusion or the blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for Human Immunodeficiency Virus antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections occur even with screened blood, especially if it is in. The "window period" and also due to various other infections which have not been screened for. I also understand that any blood components transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

The doctor have explained to me about the alternative for this procedure that IV IRON injections
and oral tablets.

All the above-mentioned risk, benefits and alternatives have been explained to me by the doctor treating me / my patient in the language that I fully understand and I accept the same and give my consent for all transfusions (the whole blood / or blood components Packed Red Blood Cells, Red Blood Cell, Platelets, Fresh Frozen Plasma, Cryoprecipitate etc.) to me / my Patient during he present hospital stay and treatment.

Patient (Or Patient Relative / Guardian):

Doctor (Who is talking the consent)

Signature: K. Baby Naga Anusurya Signature: Dr. Divya

Name: Kasturi baby naga Anusurya Name: Dr. Divya

Date & Time: 9/7/2026; 5:00pm Date & Time: 9/7/26 5:00pm

Witness

Signature: [Signature]

Name: Suanda

Date & Time: 9/7/26 9PM



Ammonia
pH

Ammonia 10.00

10.00

10.00



Ammonia 10.00

Ammonia 10.00

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BAH-00661087 IP5-00176166
Mrs KASTURI BABY NAGA
01-01-1977 49 Y 6 M 8 D (F)
Dr. SASIKALA KOLA



2

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 10-7-26 Time: 2 AM

Blood Group of the Patient: O+ve Blood Group on the Blood Bag:

Blood Bank Issue No: 10-7-26 Date of Collection: 16-6-26 Date of Expiry: 28-7-26

Date & Time of Starting Transfusion: 10-7-26 @ 2 AM Planned duration of Transfusion: 1 hr

Check for Correct Unit: ☐ Correct Patient: ☒

Blood products cross checked by: Nurse 1: Sumanda Nurse 2: Tuma

Before starting transfusion vitals: Temp: 98.6 F HR: 84 RR: 12 BP: 100/70 SpO₂: 100%

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
10-7-26	15 Min	84	98.6 F	100/70	100%	-	-	-	-
10-7-26	15 Min	85	98.6 F	101/70	100%	-	-	-	-
10-7-26	30 Min	82	98.6 F	101/72	100%	-	-	-	-
10-7-26	30 Min	85	98.6 F	100/70	100%	-	-	-	-
10-7-26	30 Min	84	98.6 F	100/72	100%	-	-	-	-
10-7-26	1 Hr	85	98.6 F	100/70	100%	-	-	-	-
10-7-26	1 Hr	82	98.5 F	100/68	100	-	-	-	-

Comments: After Transfusion

no adverse reaction

Name of the Incharge-Nurse: Krenthi

Name of the Nurse: Sumanda

Signature of the Incharge-Nurse: [Signature]

Signature of the Nurse: [Signature]

Date & Time: 10-7-26 @ 2 AM

Date & Time: 10-7-26 @ 2 AM

Rainbow Hospital Blood Centre, Rainbow Childrens Hospital
D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road No.2,
Banjara Hills, Hyderabad, Telangana State
Lic.No. 46/HD/TS/2018/BB/G

LEUCO REDUCED BLOOD CELLS I.P

Qty. 260 ml. Prepared from Whole human blood collected in 63 ml. of C.P.D.A.
Solution.



Rh Positive

HIV I & II/ HBsAG/ HCV - Non
reactive
VDRL - Non reactive
MP - Negative
NAT(HIV I & II/ HBsAG/ HCV)- Non
reactive

Unit No.: BAH26-01430
Blood Group: O Rh Positive
Collection Date: 16/Jun/2026
Expiry Date: 28/Jul/2026

1) Administer Without Warming. 2) Shake Gently Before Use. 3) Do Not
Add Any Medication. 4) Check Blood Group on Label & Recipient's
Group and Name Before Administration. 5) Use Sterile Transfusion Set
With Filter. 6) Do Not Use if there is any leakage. 7) Do Not Use if
There is any discoloration. 8) Store Between 2° C to 6° C. 9) Do Not Use if
Antibiotic is present.

Issue Label / CrossMatching Report

Patient : Mrs KASTURI BABY NAGA ANUSURYA
Patient's Blood Group : O Rh Positive
Hosp/Dr : Rainbow Childrens Hospital, dr sasikala kola
UHID No.: BAH-00661087 Wd-Bed No.:

Product : LR-PRBC
Blood Group : O Rh Positive

Unit No.: BAH26-01430

XMMatching Report:Compatible

X-matched by: R.RAMESH

Rainbow Hospital Blood Centre, Rainbow Childrens
Hospital

D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road
No.2, Banjara Hills, Hyderabad, Telangana State

Lic No. 46/HD/TS/2018/BB/G

Issue Dt : 10/Jul/2026
Colln. Dt : 16/Jun/2026
Exp. Dt : 28/Jul/2026
Issued By : MONOJ



BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 9-7-26 Time: 10pm

Blood Group of the Patient: O⁺ Blood Group on the Blood Bag: O⁺

Blood Bank Issue No: 9-6-26 Date of Collection: 21-6-26 Date of Expiry: 02-8-26

Date & Time of Starting Transfusion: 9-7-26 @ 10pm Planned duration of Transfusion: 1hr

Check for Correct Unit: ☐ Correct Patient: ☒

Blood products cross checked by: Nurse 1: Sumendra Nurse 2: Terna

Before starting transfusion vitals: Temp: 98.6 F HR: 84 RR: 12 BP: 110/70 SpO₂: 100%

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
9-7-26	15 Min	84	98.6 F	110/70	100%	-	-	-	-
9-7-26	15 Min	82	98.1 F	111/70	100%	-	-	-	-
9-7-26	30 Min	80	98.6 F	111/70	100%	-	-	-	-
9-7-26	30 Min	85	98.6 F	111/74	100%	-	-	-	-
9-7-26	30 Min	80	98.1 F	111/75	100%	-	-	-	-
9-7-26	1 Hr	84	98.6 F	100/70	100%	-	-	-	-
9-7-26	1 Hr	90	98.3 F	113/72	100	-	-	-	-

Comments:

Name of the Incharge-Nurse: Kranthi

Name of the Nurse: Sumendra

Signature of the Incharge-Nurse: [Signature]

Signature of the Nurse: [Signature]

Date & Time: 9-6-26 @ 10pm

Date & Time: 9-6-26 @ 10pm

Rainbow Hospital Blood Centre, Rainbow Childrens Hospital
D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road No.2,
Banjara Hills, Hyderabad, Telangana State
Lic.No. 46/HD/TS/2018/BB/G

LEUCO REDUCED BLOOD CELLS I.P

Qty. 265 ml. Prepared from Whole human blood collected in 63 ml. of C.P.D.A.
Solution.



Rh Positive

HIV I & II/ HBsAG/ HCV - Non
reactive

VDRL - Non reactive

MP - Negative

NAT(HIV I & II/ HBsAG/ HCV)- Non
reactive

Unit No.: BAH26-01471

Blood Group: O Rh Positive

Collection Date: 21/Jun/2026

Expiry Date: 02/Aug/2026

1) Administer Without Warming. 2) Shake Gently Before Use. 3) Do Not
Add Any Medication. 4) Check Blood Group on Label & Recipient's
Group and Name Before Administration. 5) Use Sterile Transfusion Set

Wi Th Ap Ar 9) al

Issue Label / CrossMatching Report

Patient : Mrs KASTURI BABY NAGA ANUSURYA

Patient's Blood Group : O Rh Positive

Hosp/Dr : Rainbow Childrens Hospital, dr sasikala kola

UHID No.: BAH-00661087 Wd-Bed No.:

Product : LR-PRBC

Blood Group : O Rh Positive

Unit No.: BAH26-01471

XMatching Report: Compatible

X-matched by: R.RAMESH

Issue Dt : 09/Jul/2026

Colln. Dt : 21/Jun/2026

Exp. Dt : 02/Aug/2026

Issued By : R.RAMESH

**Rainbow Hospital Blood Centre, Rainbow Childrens
Hospital**

D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road
No.2, Banjara Hills, Hyderabad, Telangana State
Lic.No. 46/HD/TS/2018/BB/G

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00661087 IP5-00176166 Mrs KASTURI BABY NAGA 01-01-1977 49 Y 6 M 9 D (F) Dr. SASIKALA KOLA 		Date & Time of Admission 9/2/2020 9pm	Date & Time of Transfer Order 10/2/2020 10:30pm
		Transfer Ordered by Dr. Shanthi	Reason for Transfer polyptomy
From Unit Mew	To Unit 3rd floor	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 30.	Number of Imaging Films Ech - 2-ray 20 ceph	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 Sr - Prema.		Name of Person Ordered Transfer Dr - Shanthi	
Patient & Clinical Records Received by :		Impigga @ 10:50pm	
Date & Time of Patient Received :			
If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :			
☐ Available Bed	☐ Nurse not Available	☐ Available Bed not ready	

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

BAH-00661087 IP5-00176166
Mrs KASTURI BABY NAGA
01-01-1977 49 Y 6 M 9 D (F)
Dr. SASIKALA KOLA



It takes a lot to treat the little.

Right
JW HOSPITALS
to a Safe Delivery

Patient Name : Mrs. BABY NAGA ANASURYA Gender: ☐ Male ☒ Female Age : 50 years
UHID No : BAM-00661087 Date : 10/07/2026

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)

CERVICAL FIBROID POLYPECTOMY + DILATATION AND WRETAGGE
+ HYSTERECTOMY upon

(Name of the Patient)

Mrs. Baby Naga Anasurya

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.

Bleeding, infection, Injury to adjacent structures, Need for blood 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. Sasikala

Consentee :

Signature : Mrs. Baby Naga Anasurya

Name : Mrs. Baby Naga Anasurya

Date & Time : 10/7/2026 ; 11:30pm

Witness :

Signature : _____

Name : _____

Date & Time : _____

Docu. No. : RCHBH / FRM / CLINICAL / 027

Patient Attendant :

Signature : K. Shashank

Name : K. Shashank

Relationship with Patient : Son

Date & Time : 10-7-26 @ 11:30pm

Doctor (who is taking the consent) :

Signature : Dr. Dhanu

Name : Dr. Dhanu

Date & Time : 10/07/2026 ; 11:30pm

BAH-00661087 IP5-00176166
Mrs KASTURI BABY NAGA
01-01-1977 49 Y 6 M 8 D (F)
Dr. SASIKALA KOLA



CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☒ Patient Attendant

Operative Procedure: Kasturi Baby Naga Anurupa → Hysteroscopy with Biopsy
Anaesthesiologist: Dr. Subramanyam Surgeon: Dr. Sasikala Kola

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 can be achieved by infusing weak solutions of local anaesthetics and 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 ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders
☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease
☐ Others Bleeding, delayed emergence

Declaration by Patient Attendant

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team
☐ Regional Anaesthesia ☐ General Anaesthesia ☐ Monitored Anaesthesia Care
- 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, allergic reactions, headaches, variations in blood pressure, nausea and vomiting.
- I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Access, arterial line, use of suppositories and or nerve blocks for pain relief, changing from regional to general anaesthesia etc) which are considered necessary by them during the course of surgery.
- I also 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 if need arises.
- I acknowledge that the anaesthesiologist have informed me about the anaesthetic procedure, risk, benefits and alternative treatments.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: K. Shashank
Name: K. Shashank
Relationship with patient: Son
Date & Time: 9/7/26 - 9:45 PM

Witness:

Signature: [Signature]
Name: Guard
Date & Time: 9/7/26 10 PM

Doctor (who is taking consent):

Signature: [Signature] Name: Dr. Sri Surya Date: 9/7/26 Time: 9:45 PM

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స:

అనస్థీషియా వైద్యుడు: శస్త్రచికిత్స నిపుణుడు:

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

సాధారణ అనస్థీషియా అనేది శస్త్రచికిత్స ముందు రోగిని పూర్తిగా అవస్థాపక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్రావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు.

రిజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్కోటిక్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై రిస్క్:

క్రింద పేర్కొన్న వైద్య సమస్యల కారణంగా ఉండే అధిక ప్రమాదాల గురించి వైద్యులు నాకు వివరంగా చెప్పారు. నాకు ఉన్న సందేహాలను నేను అడిగాను మరియు అవి నివృత్తి చేయబడ్డాయి.

☐ హృదయ వ్యాధి ☐ రక్తపోటు ☐ మధుమేహం ☐ మూత్రపిండాల వైఫల్యం ☐ బహుళ అవయవ వైఫల్యం

☐ కాలేయ సమస్యలు ☐ షాక్ ☐ ఊబకాయం ☐ దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)

☐ ఇతరవి:

రోగి / రోగి అటెండెంట్

- అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
☐ రిజనల్ అనస్థీషియా ☐ జనరల్ అనస్థీషియా ☐ మానిటర్డ్ అనస్థీషియా కేర్
- అనస్థీషియా ఉపయోగంలో అప్పుడప్పుడూ జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. వీటిలో ఇంజెక్షన్ ఇచ్చిన చోట నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అలెర్జిక్ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెనస్ యాక్సెస్, ఆర్థిరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాక్కులు, రిజనల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందానికి నేను అనుమతి ఇస్తున్నాను.
- శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న వైద్యుల బృందానికి కూడా నేను అనుమతి ఇస్తున్నాను.
- అనస్థీషియా విధానం, ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయ చికిత్సల గురించి అనస్థీషియా వైద్యులు నాకు వివరించినట్లు నేను అంగీకరిస్తున్నాను.
- పై సమాచారం అంతా నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో వాటికి సమాధానాలు ఇచ్చారు. ఈ అనుమతి నేను పూర్తిగా స్వచ్ఛమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

Department of Anaesthesiology PRE-ANAESTHETIC EVALUATION

BAH-00661087 IP5-00176166
Mrs KASTURI BABY NAGA
01-01-1977 49 Y 6 M 8 D (F)
Dr. SASIKALA KOLA

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BirthRight
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Name: Kasturi Baby Naga Anukura Age: 49y Sex: F UHID No: BAH-00661087
Date: 9/7/26 Time: 9:15pm Proposed Operation: Hysteroscopy with Biopsy
Diagnosis: P2 L2 A1 c Severe Anemia c AUB- L.A.B
B.P / CRT: 117/62 H.R: 98bpm Weight: ASA Physical Status: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

G/H 26 L.3
Hgb: 6.3
PCV: 6.600
WBC: 5.13 lab.
Plate:
PT:
PTT:
INR:

RBE -190
Glucose: Protein:
Urea: Alb:
Creat: Total Bill:
Na: Dir. Bill:
K: LDH:
Ca++: Alk phos:
Mg++: Amylase:
Cl-: SGOT/SGPT:

HIV:
HBS Ag:
HCV:
Blood group:
T3:
T4:
TSH: 6.6

X-Ray:
ECG: BP-62/
2D Echo: Mild tachycardia ⊕
Stress/Angio: mild cone LVI
Other: No Palma
Normal LV systolic
diastolic dysfunction
Mild PAH
Sev collapsing
No PE

Medical History: CVS: Hypertension : 5 years. Olmesartan 40mg
Hydrochlorothiazide 12.5mg
Diabetes: Nil
RESP: Anemia : 2022.
CNS: No H/O Blood transfusion
Renal: Pallor ⊕
Hepatic / GE: Physical Activity: Active
Others: Hypothyroid : 4 months. Tab. Thyronorm - 25mg
Past Anaesthetic History: H/O tubectomy 2000 ↓ Sedation ? (uneventful)
Hysteroscopy 2022 ↓ Sedation (uneventful)
Physical Exam: No Allergic reactions
Airway: MP 1 2 3 4 Mouth Opening: 73fb. Mento-hyoid Distance: (N) Neck: (N) Teeth: All teeth
Lungs: RAE ⊕, clear
Heart: S1 S2 ⊕
CNS: Grossly Intact. Venous Access Site: 18G Spine Exam for regional: (N)
Pregnant: ☐ Yes ☒ No ☐ NA (L) hand
Anaesthetic Plan: ☐ MAC ☐ REGIONAL ☐ GA-ETT ☒ LMA

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

CURRENT MEDICATIONS	DOSAGE
Tab. OLMESARTAN	40mg
Hydrochlorothiazide	12.5mg
Tab. THYRONORM	25mg

Pre-Operative Instructions:
1. DVT Prophylaxis: Water / ORS 2 Hours
2. NIL ORAL: Others 6 Hours
3. Informed Consent: ☐ Standard ☒ High Risk
4. Post Operative Pain Management: ☒ Discussed with Patient
5. Other Instructions: Rare 20PRBC

Signature: Dr. K. S. Sanyal Name: Dr. K. S. Sanyal

BAH-00661087 IP5-00176166
Mrs KASTURI BABY NAGA
01-01-1977 49 Y 6 M 9 D (F)
Dr. SASIKALA KOLA



ANAESTHESIA CHART

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Children's
Hospital
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Pre Induction Assessment:

Change in Patient Condition:

☐ Yes ☒ No

Physical Status:

☒ Patient Identified

Fasting Status:

76hrs

☒ Consent Present

☒ Chart Reviewed

H.R: 102

B.P / CRT: 137/80

SpO₂: 99% RA

R.R: 12/min

Last Feed: 9/7

Pre-OP Diagnosis:

Surgeon: Dr. Sankar

Operation: O/gc, polypectomy

Date: 10/7

Anaesthesiologist: Dr. M. J. D. S.

Technician: Ramya B.

TIME

N₂O (AIR/O₂) LPM

HALO/SO₂ (SEVO) LPM

Drugs:

MIDAZOLAM 2mg IV

FENTANYL 100mcg IV

PROPOFOL 150mg IV

Antibiotic

Suppository

Blood Loss

NOTES

B.P

V Systolic

A Diastolic

X Mean

• Heart Rate

Tourniquet on Time

Tourniquet off Time

Throat Pack In

Throat Pack Out

LAB Values

ABG

GRBS

Others

Temp:

☒ HME

☐ Cling Film

☒ Hugger's

☐ Other

Times:

Anaes Start: 1:15pm

OP Start: 2:15pm

OP End: 2:15pm

Leave OR: 2:15pm

Anaesthesia:

☒ GA

☐ Monitored Anaesthesia Care

☐ Regional

Line (Size & Location)

☒ CVP

☐ ART

☒ IV

☐ IV

☐ IV

☐ IV

☐ IV

☐ IV

☐ IV

☐ IV

☐ IV

☐ IV

☐ IV

☐ IV

☐ IV

☐ IV

☐ IV

☐ IV

Induction

☒ IV

☐ Pre O₂

☐ Others

☒ Mask

☒ Airway

☐ Oral

☐ Tracheostomy

☐ Drug:

☐ Awake

☐ Video Laryngoscopy

☐ Fiberoptic

Blade#

Attempts:

Difficulty Why?

☐ Bilat = BS

☐ Semi-Closed Circle

☒ Closed Circle

☐ Other

Regional:

Extremity

☐ Spinal

Others:

Position:

Site:

Needle Size:

Parasthesia ☐ Yes ☐ No

Catheter at skin

Drug Name & Conc:

Bolus:

Infusion:

Block Level:

Comments:

Transportation to

☐ PACU

☐ ICU

Relaxant Reversed ☐ Yes ☐ No

Name of the Doctor: Dr. Sankar

Signature of the Doctor: Dr. Sankar

BAH-00661087 IP5-00176166
Mrs KASTURI BABY NAGA
01-01-1977 49 Y 6 M 9 D (F)
Dr. SASIKALA KOLA



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POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Sr. Kanng Time Received : 3 pm Time Discharged :

RESPIRATORY < PULSE > BLOOD PRESSURE 250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 SPO₂	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0				IV Cannula Site : <u>48</u> ☐ O₂ Mask ☐ Nasal Prongs ☐ Tracheostomy ☐ T-Piece ☐ Oral Airway ☐ Nasal Airway Vomiting : ☐ Yes ☒ No NG Tube : ☐ Yes ☒ No Drain : ☐ Yes ☒ No Urinary Catheter : ☐ Yes ☒ No Chest Tube : ☐ Yes ☒ No Nil Oral : ☐ Yes ☒ No IV Fluids : <u>u</u> Oral Feeds :																																																
	POST ANAESTHESIA SCORE (Modified Aldrete Score) <table border="1"> <thead> <tr> <th></th> <th>IN</th> <th colspan="3">MINUTES</th> <th>OUT</th> </tr> <tr> <th></th> <th></th> <th>30</th> <th>60</th> <th>90</th> <th></th> </tr> </thead> <tbody> <tr> <td>Able to move 4 extremities voluntary or on command = 2 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 0</td> <td>ACTIVITY</td> <td>1</td> <td>2</td> <td>2</td> <td></td> </tr> <tr> <td>Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0</td> <td>RESPIRATION</td> <td>2</td> <td>2</td> <td>2</td> <td></td> </tr> <tr> <td>BP $\pm$ 20 of Pre Anaesthetic level = 2 BP $\pm$ 20-50 of Pre Anaesthetic level = 1 BP $\pm$ 50 of Pre Anaesthetic level = 0</td> <td>CIRCULATION</td> <td>2</td> <td>2</td> <td>2</td> <td></td> </tr> <tr> <td>Fully awake = 2 Arousable on calling = 1 Not responding = 0</td> <td>CONSCIOUSNESS</td> <td>2</td> <td>2</td> <td>2</td> <td></td> </tr> <tr> <td>Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0</td> <td>COLOR</td> <td>2</td> <td>2</td> <td>2</td> <td></td> </tr> <tr> <td colspan="2">TOTAL</td> <td>9</td> <td>10</td> <td>10</td> <td></td> </tr> </tbody> </table>					IN	MINUTES			OUT			30	60	90		Able to move 4 extremities voluntary or on command = 2 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 0	ACTIVITY	1	2	2		Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0	RESPIRATION	2	2	2		BP $\pm$ 20 of Pre Anaesthetic level = 2 BP $\pm$ 20-50 of Pre Anaesthetic level = 1 BP $\pm$ 50 of Pre Anaesthetic level = 0	CIRCULATION	2	2	2		Fully awake = 2 Arousable on calling = 1 Not responding = 0	CONSCIOUSNESS	2	2	2		Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0	COLOR	2	2	2		TOTAL		9	10	10		SCORING INTERPRETATION A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
	IN	MINUTES			OUT																																																
		30	60	90																																																	
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PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
10/12	3pm	0	NS	Kanng
10/12	6pm	0	NS	Kanng

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

Anaesthesiologist Name : Dr. S. Kanng

Anaesthesiologist Signature: [Signature]

Date & Time: 10-6-26 2:40pm

PACU Nurse Name : Kanng

PACU Nurse Signature: [Signature]

Date & Time: 10/12/26

Reassessment Frequency:

- Every eight hours for all hospitalized patients.
- For post surgical patient, patient with chronic pain, patient with severe pain
 - Every 2 hours for first 24 hours
 - After 24 hours every 4 hours
 - Prior to pain relieving intervention
 - With in 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU): [Signature]

Date & Time: 10/12/26

naesthesiology
ANALGESIA RECORD

Date: Time: Procedure done by

CSE / Spinal epidural
Depth:
Position :
Catheter at Skin:
Procedure done by
Space :
Technique (LOR/LOS)

Depth: Catheter at Skin: Technique (LOR/LOS)
Paresthesia : Yes/No if yes details : Attempts :

Parasthesia : Yes/No if yes details : Attempts :

Solution Composition :

Amount :

Solution Composition :

Any other issues :

a)

a) _____

b) _____

[illegible][illegible]

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

Catheter Removed by and Tip Inspected :

Patient Satisfaction :

Discharge :

Catheter Removed by and Tip Inspected : APGAR: SVD / Instrumental / LSCS (if LSCS Details)

Patient Satisfaction :

Discharge :

Patient Satisfaction :

Discharge /Shifting ordered by

Doctor Signature:

Doctor Name: _____

PATIENT TRANSFER FORM

Patient Name & UHID No.		Date & Time of Admission	Date & Time of Transfer Order
BAH-00661087 IP5-00176166 Mrs KASTURI BABY NAGA 01-01-1977 49 Y 6 M 9 D (F) Dr. SAsIKALA KOLA 		9/7/20 @ 6:03 PM	9/7/20 @ 1:20 PM
		Transfer Ordered by	Reason for Transfer
		Dr. Sameer	AUB
From Unit	To Unit	Information to Attendant	
OBS	PD OT	Yes ☒ No ☐	
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant	
35	20	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	
SAs, Paser		Dr. Sameer	
Patient & Clinical Records Received by :			
Dr. Sameer			
Date & Time of Patient Received :			
10/7/20 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

ADMISSION SHEET



Registration Details :

Admission No : IP5-00176166 Admit Date : 09-Jul-2026 Admit Time : 06:03 PM UHID : BAH-00661087

Patient Details :

Patient Name	: Mrs KASTURI BABY NAGA ANUSURYA	Age	: 49 Y 6 M 8 D
Guardian	: Mr KASTURI NAGESWARA RAO	DOB	: 01-01-1977
Gender	: Female	Religion	:
Occupation	:	Martial Status	: Married
Address (H)	: H NO 18-54-9, AMMAVARI THOTA Nuzvid Krishna Andhra Pradesh INDIA 521201	Phone No	: 8500911728/ 9440983739
		E-mail	: SESHANK.K@GMAIL.COM

Admission Details :

Bed Type : MICU Bed No : MICU 426 Ward Name : 4F-BIRTHING CENTRE
Room No : MICU 426 Admission Type : First Visit

Contact Details :

Name	: Mr KASTURI NAGESWARA RAO	Relationship	: Husband
Contact Address	: H NO 18-54-9, AMMAVARI THOTA Nuzvid Krishna Andhra Pradesh INDIA 521201	Phone No	: 8500911728


Signature

Doctor Details :

Doctor Name	: Dr. SASIKALA KOLA	Specialisation	: OBSTETRICS AND GYNECOLOGY
Referral Doctor	: Self	Phone No	:
Co-Consultant	:		

Payment Details :

Payment Mode	: Cash	Deposit Amount	: 0.00
		Payor Name	: STAR HEALTH AND ALLIED INSURANCE CO LTD

ACTIVITY RECORD FOR BILLING

Name : _____
UHID No. : _____ IP : _____
Date of Admission : _____ Time : _____ Discharge : _____ Time : _____
Room / Bed No : _____ Ward : _____ Suggested Billable bed type : _____

BAH-00661087 IP5-00176166
Mrs KASTURI BABY NAGA
01-01-1977 49 Y 6 M 8 D (F)
Dr. SASIKALA KOLA

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
10/7/26	1:20 PM	OPD	paediatric	
	3 PM	paediatric	OPD	

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Brinivas Rao	10/7/26	9696042	Punraj
2	(Cardiologist)			
3	Dr. Nivedita (IC)	10/7/26	9696048	Suman
4				
5				
6				
7				
8				
9				
10				

Cross checked zone

INVESTIGATIONS			
Date	Investigations	Order No.	Signature
9/7/26	ECG	2696381 034163 034287	Tunn Tunn
	X-ray.		
	2D Echo		
9/7/26	Blood grouping, creatinine	26068741	Tunn
9/7/26	TSH, PT/APTT, CUE, uric acid/s	26068743	Tunn
9/7/26	HIV, HbsAg, HCV	26068775	Tunn
9/7/26	CBP		
9/7/26	8:00 PM pre dinner 189 mg/dl	26069158	Sucande
9/7/26	10 PM post dinner 223 mg/dl		Sucande
10/7/26	5:00 AM pre breakfast 144 mg/dl	26069168	Sucande
10/7/26	CBP	26068906	Ruh.
Cross checked down			

Cross checked? ☒ done