

ADMISSION SHEET



Registration Details :

Admission No : IP26-00006677

Admit Date : 28-Jun-2026

Admit Time : 06:20 PM UHID : FDH-00010522

Patient Details :

Patient Name : Mrs DEEPIKA ORUGANTY

Age : 37 Y 8 M 2 D

Guardian : Mr RAGHU PRANEETH

DOB : 26-10-1988

Gender : Female

Religion :

Martial Status :

Address (H) : FLAT NOV 1006 C BLOCKN HONER AQUANTIS
 Serilingampally Hyderabad Telangana INDIA
 500019

Phone No : 8019641866

E-mail : na123@rainbowhospitals.in

Admission Details :

Room Type : TWIN SHARING

Bed No : LDR-416

Ward Name : 4F -OT

Room No : LDR-416

Admission Type : First Visit

Contact Details :

Contact Name : Mr RAGHU PRANEETH

Relationship : Husband

Contact Address : FLAT NOV 1006 C BLOCKN HONER
 AQUANTIS Serilingampally Hyderabad
 Telangana INDIA 500019

Phone No : 8019641866


 Signature

Doctor Details :

Doctor Name : Dr. KADIYALA RAMYA THEJA

Specialisation : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self.

Phone No :

Co-Consultant :

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : SELFPAY

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State
Housing Board Himayatnagar, Hyderabad- 500029

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

	TWIN SHARING / OBSERVATION(LDR) / SHARED WARD	PRIVATE / DELUXE ROOM	PICU / NICU / HDU	SEPARATED FROM TARIF	12 TO 12 NOON BILLING POLICY
BED CHARGES				PHARMACY ☒ INVESTIGATION ☒	
DOCTORS CHARGES				CROSS CONSULTATION ☒ CONSUMABLES ☒	PHONES ARE NOT ALLOWED IN PICU(PHOTOGRAPHY AND VIDEOGRAPHY STRICTLY PROHIBITED)
		PJT		BLOOD PRODUCTS ☒ OXYGEN ☒	VISITING HOURS 04:00pm TO 05:00pm.
NURSING CHARGES				HFNC / VENTILATOR / C PAP / HFO / NIV / NIV-C PAP ☒ EQUIPMENT ☒	IN ICU EITHER MOTHER OR FATHER-ALLOWED(NO VISITORS)
DIET CHARGES				PROCEDURE ☒ NEBULISATION ☒	OUTSIDE FOOD AND MEDICATION NOT ALLOWED
TOTAL		17250		MRD, DRUG ADMINISTRATION, INSURANCE PROCESSING FEE (IF ANY)	
PATIENT NAME	Deepika orugusa			AGE/SEX	37 y Female
UHID	FDIA - 00010522		INSURANCE NAME	Reliance	

1. Refrained

**CAUTION
DEPOSIT**

20 A

[Signature]
COUNSELLING PERSON SIGNATURE

ATTENDENT SIGNATURE

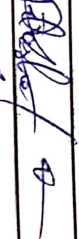


ACTIVITY RECORD FOR BILLING

Name : FDH-00010522 IP26-00006677
 Mrs DEEPIKA ORUGANTY
 28-10-1988 37 Y 8 M 2 D (F)
 UHID No. : Dr. KADIVALA RANAYA THEJA
 Date of Admi  Consultant: _____ Dept : _____
 Date of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
28/10/26	8:00 Am	PR & T Post	OT Bed Post	
29/10/26	8:00 AM	OT	One - Post	
29/10/26	12 pm	One - Post	Room (214)	

Cross Consultation Visit

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

Signature _____

28088 checked due

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
09/12/20	Cardiac monitor	5 minutes	1 hour	607144	Alexander
09/12/20	Infusion pump				

PROCEDURE				
Date	Procedure	Quantity	Order No.	Signature
29/6/28	Replacement	①	8992	Re
29/6/28	pac	①	9092	Allen
29/6/28	catheterisation	①	9093	
		①	9094	
		①	9325	

[illegible]

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
-------------	--------------	-------------------	--------------------

- Admission NST
- Oxygen as charted
- Antenatal steroid coverage
(1mg Betam 12mg 24hr apart in)
- Apply sterile Pad
- Send CBC, CRP
CUE, urine CFS
- Collect trvs
- Strict vitals hourly
- Tocolytic (Cap Dcpin 3dors
15min apart)

SRAC

Took Iron calcium / Septent
ing protein 500mg in weekly
M T W T F S S
Tues 25

BGT - Ave
QRB5 Q6m/dec

414
 416549
 4182
 4200 } 0 PR

$$SCF | 32 \text{ mK} | V_K$$

Pl. Funelo - Porters hgt
 Aff2 - 14.6cm. - Ac - 2%
 Eff2 - 1.631 (117%)
 Dppok (2)

Signature: W

Date & Time: 28/06/2024 @ 6pm

Dr. Ranyé

Signature: James

Date & Time: 28/6/25



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time

Progress Notes

Doctor's Order

28/6/22
8pm

Consulted Mrs. Deepika & her husband for husband's diagnosis of PKU with 1500mcU/L in newborn. - exposed the father's blood - from - fetal blood - risk of chorioamnionitis - oligohydramnios - fetal death - risk possibly of asphyxia and for 18 months - 24hrs, darkening, clear natural / pale mottling - need for steroid cover & diph. therapy - need for growth scan tomorrow. - New counseling tomorrow. - Having a mode of delivery to be decided based on maternal / fetal & wellbeing.

C/E

BP 98/65

PR 120 -> 112

PA at ~32w: capitate imbed in spine

PV - as fem: long soft Memb Absc

Vs - 3

Clear lung clearing.

[NBT Reactive] [Pm ⊕]

CU NO : RCH / RM / CLINICAL / 098



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/06/2022	C/S/B & Movable	
11:30pm	<u>Appt.</u> Regular Diet / Adeq Hydration Drugs as charted Growth Scan Cfm NST - TD Apply sterile PND Colic CSE / TRS / UCS mp Antenatal Steroid coverage (2nd & 3rd) NIEU counselly cfm Inform son <u>appt</u> <u>Baranaka</u>	
29/06/2022	C/S/B & Movable	
1 Am	Ce-fair Adequate Vitals stable BP - 110/70 PE - 105 P/A ut mld hctng FHS DE (140-150 bpm) L/E LCV @ 1ly clear 23C/30-35S/10min	<u>Appt.</u> Regula Diet / Adeq Hydration Inform Pediatrician Try Treamed 1 SDmg in stat soft vitals & progress of lab Apply sterile PND Antenatal Steroid coverage C/S NST Gt / FHS 2nd hctng Maturity Inform son

28

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/01/2020	c/s/b & manual	
3Am	Ce-Fin - Apendix	<u>Adx</u>
	GP-110/90	
	PE-110	- Regular Diet / Adeq Hydration
	p/a ut mild tend	- Reducetress Caution
	Fns @ 2	- IUF @ 5cm/hr
	C-2-3/30 sec / room	- Apply Sterile PPD
	LE - LPR @	- IGF vials 9 POL
NST Reaction		- Tocolysis Continue
	Patient's attitude unable to	- Anterated Steroid Coverage @ 06:50 pm 7. day
	transfer to Rainbow Bayview	- Neonatal counselling to do
	q/s/b - Dr Diny - Dr Kanya	- NST @ 6:15Am
	MAD	- Fns @ 2 & 10 hourly
	- Couple cancelled.	<u>My</u> <u>brnards</u>
29/01/2020		
6:30Am	pt 9 Attache were ready to transfer to (Bayview) Rainbow Hospital. Tender treat with Hibbard as wife cancelled and asked to go ahead @ 6:30Am Hospital RCA Ameyphogon.	

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Date & Time	Progress Notes	Doctor's Order
29/06/2020 6:30 AM	C/S/b & Range.	
	CC for appendicitis	Able
	Vitals stable	
	P/A ataching	- pt 4 attitude conversable / capla
	Finger	legally PV Pinsky
	PV - 2cm effused	Husbard / pt unable to go
	U-2	aband E ENMG start
	Legum dring clear	
	E show ⊕	- Relativism informed
NK, @ /	occasional drop	- Axon informed
	to 105 bpm	- clue for blood availability
		- Shift to OT ster
		- Foley's catheterization
		- Informed consent
		M/- <u>Dipomls</u>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/12/2024	C/S 1b Dr 7:45 pm	Range / Axon Dr Manohar
	Pain - 0 / 5 cm VLN	
	CE Fair Afebrile (97.4)	Adv
	BP 93/77	- NGM x4-6h
	PR - 130 → 105	- Drugs as charted
	PIA ut well retracted	- IV 10min + metro x4h
	ASD Dry	- Iry Enoxaparin 4mg x 3d @ 8pm
	Dr Bleeding wnt	- Fleg's retractor e 6pm cm
	yo - 200 ml (GT-empty)	- I/O monitoring
	(Placenta mems sent for C/S) ✓	- Iry Tranexamic Acid 1g @ 3pm
		- WIF vitals 1 BP
		- Inform SNS
26/12	clt/B Dr Verna	
	TDD-0/Em/SCS	
	PT is stable, No c/o	- Adv
	C/E ac-fair	oversee
	BR-100/65 w/ly	- Oral sips to be allowed
	PR-94 bpm	- Drugs as charted
	SpO ₂ 99% on RA	- 2U Abx for 48hrs.
	P/A - Ut well retracted	- T/O monitoring
	ASD-Dry	- Vital monitoring
	UC - Bwnt	- Iry Tranexamic acid @ 3pm
	UB - 40ml/hr, etc high coloured	- w/ly excessive bleeding plv
		- Inform SOS.

PROGRESS NOTES AND DOCTOR'S ORDER

Progress Notes

Doctor's Order

Date & Time	Progress Notes	Doctor's Order
	<u>Chelva Anitha (Paxan Trau)</u>	
	Adv: - Tufinda @ 200ml/hr - 2x lax @ 1V slot	
28/10/26	ble Gcfair vitals - stable	Adv - Oral sip 1/6 liquid diet - Drugs as charted.
28/10/26	u/e - Brown w/o albumin/hr etc	- Tufex for 48hrs - Tuf. Clearance @ 8pm x 3da
	asc - Russell's - 3-4 cells/hr. <u>stab clear</u>	- Vial monitoring - 1/6 clarity.
	ble Roseba etc HUS Urine etc.	- Tuf. Trazex @ 3pm - 1/6 form SOS - Shift to Brown
28/10/26	No complaints 9c lax @ 1/6 vitals - stable	
	In: soft, uua	
		Dr. Ranva



REGULAR PRESCRIPTIONS

Weight

60kg

Ward

10A

Verified by
Dr. DhakshayaniVerified by
Dr. DhakshayaniVerified by
Dr. DhakshayaniVerified by
Dr. Dhakshayani

DRUG : INJ CEFOTAXIM				Date	19/6/20
Dose	Route	Frequency	Start Date	Time	
1g	iv	3D	28/6		
Name & Signature of the Doctor					
Starting the Drugs:					
Additional Instructions:					
4-2 days					
Pfb and (After culture)					
Daily Doctor's Endorsement by a Sign					
DRUG : CAP NITROXIN				Date	19/6/20
Dose	Route	Frequency	Start Date	Time	
10mg	po	TID	28/6		
Name & Signature of the Doctor					
Starting the Drugs:					
Additional Instructions:					
(Continue - 2-10pm)					
Daily Doctor's Endorsement by a Sign					
DRUG : TAB PARACETAMOL				Date	19/6/20
Dose	Route	Frequency	Start Date	Time	
1gm	oral	QID 6hr	29/6		
Name & Signature of the Doctor					
Starting the Drugs:					
Dr. Arvind K. Chinn					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : TAB DICLOFENAC				Date	19/6/20
Dose	Route	Frequency	Start Date	Time	
10mg	oral	TID 8hr	29/6		
Name & Signature of the Doctor					
Starting the Drugs:					
Dr. Arvind K. Chinn					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : TAB PARACETAMOL				Date	19/6/20
Dose	Route	Frequency	Start Date	Time	
1gm	oral	QID 6hr	29/6		
Name & Signature of the Doctor					
Starting the Drugs:					
Dr. Arvind K. Chinn					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : TAB DICLOFENAC				Date	19/6/20
Dose	Route	Frequency	Start Date	Time	
10mg	oral	TID 8hr	29/6		
Name & Signature of the Doctor					
Starting the Drugs:					
Dr. Arvind K. Chinn					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					



REGULAR PRESCRIPTIONS

Weight

6.4kg

Ward

CD 2

Sheet No:

DRUG: 7. TRIMETHOPRIM 100mg

Date: 29/6

Dose: 100mg Route: oral Frequency: TID Start Dt. 29/6

Date: 29/6

Name & Signature of the Doctor

[Signature]

Starting the Drugs: Dr. Alexia K. (Elm)

Additional Instructions:

1st

Daily Doctor's Endorsement by a Sign

DRUG: 7. PANTOPRAZOLE

Date: 29/6

Dose: 40mg Route: PO Frequency: OD Start Dt. 29/6

Date: 29/6

Name & Signature of the Doctor

[Signature]

Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG: INS MEXIPENIDAZOLE

Date: 29/6

Dose: 500mg Route: IV Frequency: TID Start Dt. 29/6

Date: 29/6

Name & Signature of the Doctor

[Signature]

Starting the Drugs:

Additional Instructions:

x 2 days

176 oral

Daily Doctor's Endorsement by a Sign

DRUG: INS ENOXAPRIN

Date: 29/6

Dose: 40mg Route: SC Frequency: OD Start Dt. 29/6

Date: 29/6

Name & Signature of the Doctor

[Signature]

Starting the Drugs:

Additional Instructions:

8pm x 3d

Daily Doctor's Endorsement by a Sign

Weight: 61 kgs

Sheet No.:

Verified by
Dr. Dhakshayani

Weight **61kg**
 Ward **154**

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
28/11	6:55pm	INJ BENMECHOLAMINE	12mg	IM	<i>[Signature]</i>	-Alci Melli Melli
28/11	6:40pm	CAP DEPIN	10mg	P/O	<i>[Signature]</i>	-Alci Melli Melli
28/11	6:55pm	CAP DEPIN	10mg	P/O	<i>[Signature]</i>	Melli Melli Melli
28/11	7:10pm	CAP DEPIN	10mg	P/O	<i>[Signature]</i>	Melli Melli Melli
29/11	1:05am	INJ TRAMADOL	50mg	IM	<i>[Signature]</i>	Melli Melli Melli
29/11	6:30AM	INJ METOCLOPRAMIDE	10mg	IM	<i>[Signature]</i>	Melli Melli Melli
29/11	6:30AM	INJ ONTHANE 9200	4mg	IM	<i>[Signature]</i>	Melli Melli Melli
29/11	6:10AM	INJ TRAMADOL	50mg	IM	<i>[Signature]</i>	Melli Melli Melli
29/11	6:10AM	INJ TRAMADOL	50mg	IM	<i>[Signature]</i>	Melli Melli Melli

Dr. Dhakshayani

22

I.V. FLUIDS CHART									
DATE	TIME	FLUID	ROUTE	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Details Squeezing	Doctor Sign	Nurse Sign
29/6	6:35 am	RINGER LACTATE + 20IU of OXYTOCIN	IV	100ml/hr	Divi	☒	24/6	Divi	☒
29/6	9:30 am	RINGER LACTATE	IV	100ml/hr	Divi	☒		Divi	☒
29/6	12 pm	RINGER LACTATE	IV	100ml/hr	Divi	☒		Divi	☒
29/6	6 pm	RINGER LACTATE	IV	100ml/hr	Divi	☒		Divi	☒



MEDICATION RECONCILIATION FORM

Drug Allergies: None ☐ 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: NA Shifted to: NA

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	↑ Orofer XT	1 tab	PO	BD	28/11	☒ C ☐ DC
2	7 Supracel 2000	1 tab	PO	OD	28/11	☒ C ☐ DC
3	7 Supert	1 tab	PO	OD	28/11	☒ C ☐ DC
4	1mg Reduton	500mg	IM	Weekly	28/11	☒ C ☐ DC
5	L Arginine Solut	1solut	PO	BD	28/11	☐ C ☐ DC
6	T Hapyronom	50mg — 25mg	PO —	M/Tu/Wed. Th/Fr/Sa/S	28/11	☒ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

MEDICATION HISTORY RECORDED / VERIFIED BY

* C - Continue, DC - Discontinue

Doctor Name & Signature: M/Dr. Or. Manish

Date & Time: 28/11/2023 @ 6pm

Nurse Name & Signature: Aparna D. H.S.

Date & Time: 28/11/2023 @ 6:00pm

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

PATIENT TRANSFER FORM

Patient Name & (UHID) No.
 PCH-00010332 IP-29-00000077
 MR. DEEPIKA ORUGANTY (F)
 28-12-1988 37 Y 8 M 10
 DR. NAINVALA RANVA THIRUA



Date & Time of Admission		Date & Time of Transfer Order	
28/12/2020 6:10		29/12/2020 12:00 PM	
Transfer Ordered by		Reason for Transfer	
Dr. DUA.		Observation	
From Unit	To Unit	Information to Attendant	
Pre post	Room (307 cell)	Yes ☐ No ☐	
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant	
30	Nil (21)	Yes ☐ No ☐ If yes, what?	

Medications / Consumables / Surgical / Hand over

Sl. No.	Item Name	Quantity
1.	Pl- 100ml	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
Mounika	Dr. Veena

Patient & Clinical Records Received by :

Amontha

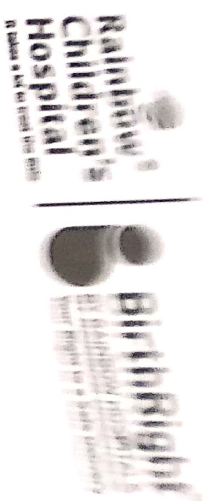
Date & Time of Patient Received : 28/12/2020 12:30 PM.

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

IP28-00000077
IP28-00000077
110532
EPKA ORUGANTY
37 Y 6 M
09/01/2025
RAYALA RANVA T

214



NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 29/6/25

Time: 2:30 PM

Height: 160 cm

Weight: 61.2 kg

BMI: ☒ ~ 26 kg/m²
☐ ~ 28 kg/m²
☐ ~ 30 kg/m²

Religion: Indian

Allergies: NO

Diagnosis: LSCs

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

Diet Advised:

Liquid Diet - ORS/ Coconut Water/ Buttermilk/ Buttery/ Water/ Soups

Normal Diet - Rice, Raddi, Dal and Soft Cooked Vegetables and Curd

Soft Diet - Soft Rice, Dal and Vegetable/ Curries/ Soft Cooked/ Curd

Diabetic Diet - Brown Rice/ Oats/ Buttermilk/ Raddi, Dal and Vegetables and Curd (Avoid Roots/ Tubers)

Patient's / Assistant's

Doctor's

Signature: *[Signature]*

Signature: *[Signature]*

Name: Deepika. Sreejith

Name: *[Signature]*

Date & Time: 29/6/25, 2:30 PM

Date & Time: 29/6/25, 2:30 PM

Doc. No.: IP28/1999/01/00000077



CAESAREAN SECTION OPERATIVE NOTES

Surgeon's Name:	Dr Ramya	Date of Delivery:	29/06/2024
Assistant Surgeon:	Dr Sreedhi	Time of Delivery:	06:52 Am
Anaesthetist's Name:	Dr Akhila	Gender of Baby:	Female
Type of Anaesthesia:	Spinal	Weight of Baby:	1.860 kg
Neonatologist:	Dr Anuoka, Dr Dilhara	AGPAR Score:	
Scrib Nurse:	Archana	NICU Admission:	☒ Yes ☐ No Prematurity

Pre-Operative Diagnosis: $C_2A_1 | 33^{14} | 1u^2$ pptom $\in$ Aretm (obau

☐ Elective
☒ Emergency

Indication: PRPOM $\pm$ Preterm labour

- ☐ 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: 10 min
 Knife to rectus: 2 min

CTG Description: Reactive

If there was a delay give the reasons: No delay

Surgical Procedure:

Emm

Post Operative Diagnosis: PND=0

Peri-Operative Complications:

Amount of Blood Loss:	2150-200cc
Blood Transfused (in ML):	—

Name and Number of Surgical Specimen sent for examination:

[Placenta memb. fr c/s]

OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 28/6/26 Time of Arrival: 5:20pm Time Seen by Nurse: 5:58pm

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

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

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

3) Vital Signs: Temperature: 97.5 Pulse: 100 RR: 20 SpO₂: 99 BP: 98/61 Weight:

4) Gestational Criteria:

Gravida: G 2 P 1 L 1 A 1

LMP: 8/11/2025 EDD: 12/12/26 Gestational Age: 32+3 weeks

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

5) Pain Screening: Numerical Pain Scale (NPS)



- Location: OPR
- Duration: 1 hour Days / Weeks/ Months (Strike out which is not applicable)
- Character: OPR
- Frequency: OPR
- Interventions: OPR

6) Past History:

a) Surgeries: CEAR

b) Medical: NGA

Docu No.: RCH / RM / CLINICAL / 098 (P.T.O.)

OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 28/6/26

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: Doctor Notified on Admission: ☒ Yes ☐ No

Name of the Doctor: Dr. Manasa Time Notified: 6:30 PM

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

Past Medical History: Past Surgical History: SEPP Previous Hospital Admission:

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 2 P L A 1

Previous LSCS: 1st

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: 97.6 HR: 100 RR: 20

BP: 98/61 Weight: Height: BMI:

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



IP26-00006677

PHYSICAL ASSESSMENT

☒ Healthy ☐ Ill looking ☐ Anxious ☐ Agitated ☐ Others:

General Appearance: ☒ Healthy ☐ NO Score 0 (complete the Morse Fall Risk Assessment Sheet)

Fall Assessment: ☒ Yes ☐ NO Score 0 (complete the Braden Q Sheet)

Risk of Pressure Sore: ☒ Yes ☐ NO Score 0 (complete the Braden Q Sheet) ☒ No Abnormally Detected

FUNCTIONAL SCREENING: If a patient needs assistance with any of the following inform consultant
☐ Mobility problem ☐ Walking Problem
☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality
Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☒ No Abnormally Detected ☐ Needs Therapeutic Diet.
☐ Overweight ☐ Poor Appetite > 3 Days ☐ Hyperemesis Gravidarum
☐ Under Weight ☐ Diabetes Mellitus
Inform consultant for positive criteria

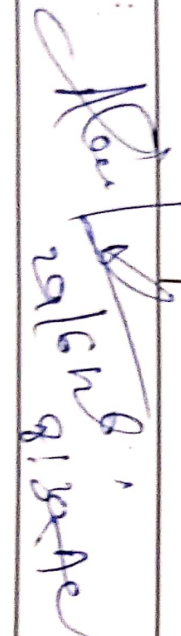
PSYCHOLOGICAL SCREENING:
☒ Calm & Cooperative ☐ Restless ☐ Depressed ☐ Agitated ☐ Confused
☐ Others:
Inform consultant for positive criteria

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 family members

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
Above information given to Patient
Name of Person Orientation was given to: Mrs. Deepika
Orientation not given Reason:

Nurse Signature: Mrs. Alex
Nurse Name: Alex
Date & Time: 28/6/2020. 6pm

PATIENT TRANSFER FORM

Patient Name & LHID No. NINA CHIRAGANTY 27 Y 8 M 3 D (F) DO: NAINVALA SAKHYA THEJA 		Date & Time of Admission 29/6/2020 6:20 PM		Date & Time of Transfer Order 29/6/2020 8:00 PM	
Dr. Praveen From Unit OT		Dr. Akila To Unit Post-Post		Reason for Transfer Dehydration	
Number of Sheets in Clinical File 32		Number of Imaging Films -		Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☒ If yes, what ?	
Medications / Consumables / Surgical / Hand over					
Sl No	Item Name	Quantity			
1	RI	1			
2					
3					
4					
5					
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐					
Name & Signature of Person who is Transferring Naina		Name of Person Ordered Transfer Dr. Akila			
Patient & Clinical Records Received by : 					
Date & Time of Patient Received :					

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

Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

No : RCH / RM / CLINICAL / 102

SURGICAL SAFETY CHECKLIST

Surgeon :
Asst. Surgeon :
Anaesthetist :
Scrub Nurse :

FDH-00810522 IP20-0006677
Mrs DEEPIKA GRUGANTY
26-10-1988 37 Y 8 M 3 (F)
Dr. KADYALA RAMYA THEJA
29/6/26

Age : 37 Gender : F
Name : CM/SCG
Out-time :

Rainbow Children's Hospital
18 Years & up to 18th Dec 2024

BirthRight
Your Right to a Safe Delivery

Before Induction of Anaesthesia >>

SIGN IN Time: 6:40 AM

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 : @Anvi

Name : Dr. AKHILA.K.

Before Skin Incision >>

TIME OUT Time: 6:42 AM

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? Bleeding ☒ 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 : Anusha

Name : Anusha

Before Patient Leaves Operating Room

SIGN OUT Time: 7:45 AM

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:

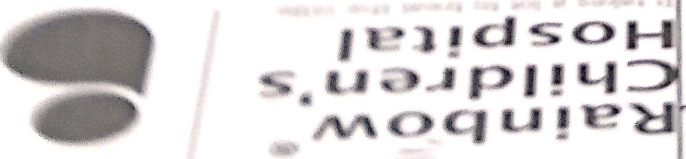
What are the key concerns for recovery and management of this patient? ☒ Yes ☐ No

Signature : For Dr. Ramya Theja

Name : 29/6/2026 @ 7:45 AM

COUNSELLING SHEET

Plot no. 34/267, opp. Cafe niloufer, Old MLA quarters road AP State
 Rainbow's Children's Hospital, Hyderabad - 500029



PRIVATE / DELUXE ROOM
 PICU / NICU / HDU
 SEPARATED FROM TARIF

PHARMACY
 INVESTIGATION
 CROSS CONSULTATION
 CONSUMABLES
 BLOOD PRODUCTS
 OXYGEN
 HFNC / VENTILATOR / C PAP / HFO /
 NIV / NIV-C PAP
 EQUIPMENT
 PROCEDURE
 NEBULISATION
 MRD, DRUG ADMINISTRATION,
 INSURANCE PROCESSING FEE (IF
 ANY)

PHONES ARE A
 PROHIBITED
 VISITING HOUR
 TO 05.00
 IN ICU EITHER NO
 FATHER ALLOW
 VISITORS)
 OUTSIDE FOOD AN
 MEDICATION NOT ALLOW

AGE/SEX 37 Y Female
 INSURANCE NAME
 CAUTION DEPOSIT

COUNSELLING PERSON SIGNATURE



FDH-00010522
IP26-00005677
(F)
Mrs DEEPIKA ORUGANTY
37 Y & M 2 D
26-10-1988
Dr. KADIVALA RAMYA THEJA

COUNSELLING SHEET

Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State
Housing Board Himayatnagar, Hyderabad-500029

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



BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

TWIN SHARING / OBSERVATION(LDR) / SHARED WARD	PRIVATE / DELUXE ROOM	PICU / NICU / HDU	SEPARATED FROM TARIF	PHARMACY	INVESTIGATION	12 TO 12 NOON BILLING POLICY					
BED CHARGES				CROSS CONSULTATION	CONSUMABLES	BLOOD PRODUCTS					
							OXYGEN	HFNC / VENTILATOR / C PAP / HFO / NIV / NIV-C PAP	EQUIPMENT		
										PROCEDURE	
DOCTORS CHARGES		13,700		MRD, DRUG ADMINISTRATION, INSURANCE PROCESSING FEE (IF ANY)	OUTSIDE FOOD AND MEDICATION NOT ALLOWED						
							DIET CHARGES				
PATIENT NAME	Deepika Oruganty	AGE/SEX	37 Y	Female	UHD	FDH - 00010522					
INSURANCE NAME											

ATTENDENT SIGNATURE

CAUTION
DEPOSIT

COUNSELLING PERSON SIGNATURE

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE



Patient Name : Mrs. Deepika Oruganty

Gender : ☐ Male ☒ Female

Age : 37y

UHID No : FDR-00010522

Date : 29/01/2022

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)

EMERGENCY LOWER SECTUMARY CESAREAN SECTION

upon

(Name of the Patient) Mrs. Deepika Oruganty

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 Bowel, Bladder or Blood vessel
Anemia of Blood or Blood product 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. Romya Theja

Consentee :

Patient Attendant :

Signature : Deepika

Signature : Lakshminarayanan

Name : Mrs. Deepika

Name : Lakshminarayanan

Date & Time : 29/01/2022 @ 6:30pm

Relationship with Patient : Husband

Witness :

Date & Time : 29/01/2022 @ 6:30pm

Signature : Romya

Doctor (who is taking the consent) :

Name : Romya

Signature : Romya

Date & Time : 29/01/2022

Name : Dr. Romya

Date & Time : 29/01/2022 @ 6:30pm

Department of Anaesthesiology PRE-ANAESTHETIC EVALUATION



UNIT NO: 001 00000000

Name: Deanna V. Ogden Age: 33y Sex: F
 Date: 2/16/2024 Time: 6:15 AM Proposed Operation: Myelogram
 Diagnosis: Sciatic Neuropathy Weight: 60kg ASA Physical Status: 1
 H/P / CRT: Relatively healthy

Laboratory Data:	
Hgb	11.8
Hct	36.0
WBC	11.9
Plate	208
PT	
PTT	
INR	
Glucose	96 mg/dl
Urea	
Creat	
Na	
K	
Ca++	
Mg++	
Cl-	
Alb	
BUN	
Cr	
ECG	
2D Echo	
Stress Echo	
Other	
Diabetes	NO
Physical Activity	active
Allergies	NI

Medical History: CNS

RESP: not significant

CNS: not significant

Renal: not significant

Hepatic / GI: not significant

Others: subcutaneous hyaluronidase

Past Anesthetic History: SEPIC & sedation, IV

Physical Exam:

Airway: MPI 4 Mouth Opening: SPB Mento-hyoid Distance: SPB Neck: NO Teeth: NO

Lungs: clear

Heart: sinus

CNS: clear

Pregnant: Yes ☐ No ☐ NA

Venous Access Site: accessible Spine Exam for regional: NO

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

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

CURRENT MEDICATIONS	DOSE
<u>1. Thymoviron</u>	<u>25mg + 50mg</u>

- Pre-Operative Instructions:
- DVT Prophylaxis: Water / ONS 2 hours
 - NIL ORAL: Others 6 hours
 - Informed Consent: Standard ☐ High Risk
 - Post Operative Pain Management: Discussed with Patient
 - Other Instructions:

Signature: [Signature] Name: Dr. ALEXIS

ANAESTHESIA CHART

Patient Sticker

Fasting Status: Adequate combined

Pre Induction Assessment: 6:41 AM

Consent Present ☒

Last Feed: 4 hrs

Change in Patient Condition: ☒ Yes ☒ No

R.R: 20

Date: 29/6/26

Physical Status: ☒ Patient Identified

B.P / CRT: 95/64

SP.O₂: 100

Operation: LM SCIS

Technician: Sai Chandu

Pre-OP Diagnosis: Small SSLS 5A.

Anaesthesiologist: D. Akshay

Surgeon: Dr. Ranga Raja Dr. Sivakumar

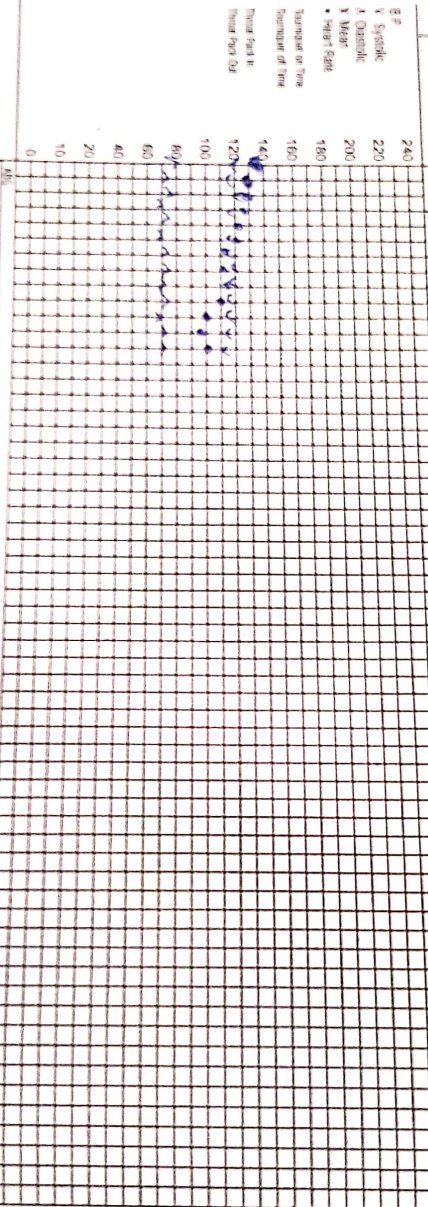
Drugs: Hydrocodone 15mg
Oxycodone 5mg
Hydrocodone 5mg

Antibiotic: 1 gm METRONIDAZOLE
Suppository: 500mg
S.P. DILLOFEN: 500mg
SVP-TRAMADOL

Blood Loss: ~300ml

NOTES

Few
6:54 AM
on 29/6/26



LAB Values

Equipment Checked and Functional

☒ BP
☒ ECG Lead
☒ Temp Site
☒ Agent Monitor
☒ Pulse Oximeter
☒ Capnograph
☒ Ventilator
☒ Nerve Stimulator

Position: Supine
Pressure Points Checked

Eye Care: ☒ Oint
☒ Tape
☒ Patches
☒ Lubricate

Temp: ☒ HMAE
☒ Cing Film
☒ Dri Warmer
☒ Muggers
☒ Other

Times: 6:45 PM
Anes Start
OP Start
OP End
Leave OR: 7:45 PM
Anesthesia: GA
☒ Monitored Anesthesia Care
☒ Regional

Line (Size & Location)

☒ AFT
☒ CVP
IV DVL 20G
☒ IV
☒ IV

Induction

☒ IV
☒ Pre O₂
☒ Others
☒ Mask
☒ Airway
☒ ETT #
☒ Oral
☒ Tracheostomy
☒ Drug
☒ Awake
☒ Video Laryngoscopy
☒ Blade #
☒ Difficulty Why?

Attempts:

☒ Blind = BS
☒ Semi-Closed Circle
☒ Closed Circle
☒ Other

Regional:

☒ Spinal
☒ Epidural
☒ Caudal
Position: Place
Site: L4/L5
Needle Size: 25G
Parathesia: ☒ Yes ☒ No
Catheter at skin: cm
Drug Name & Conc: 0.5% Bupivacaine 10mg + 25mg fentanyl
Bolus: 10mg + 25mg fentanyl
Infusion: 10mg + 25mg fentanyl
Block Level: T4
Comments: Adequate

Transportation to

☒ PACU
☒ ICU
☒ Other
Relaxant Reversed: ☒ Yes ☒ No

Name of the Doctor: Dr. Akshay
Signature of the Doctor: Akshay

Patient Sheet

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: Anesth Time Received: 8:45 Time Discharged: 1

RESPIRATORY		PULSE		BLOOD PRESSURE	
250		250		250	
240		240		240	
230		230		230	
220		220		220	
210		210		210	
200		200		200	
190		190		190	
180		180		180	
170		170		170	
160		160		160	
150		150		150	
140		140		140	
130		130		130	
120		120		120	
110		110		110	
100		100		100	
90		90		90	
80		80		80	
70		70		70	
60		60		60	
50		50		50	
40		40		40	
30		30		30	
20		20		20	
10		10		10	
0		0		0	

IV Cannula Site: Left Arm
☒ 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: Pl
 Oral Feeds: Pl

Drug: TOR

POST ANAESTHESIA SCORE (Modified Aldrete Score)	IN	MINUTES			OUT	SCORING INTERPRETATION
		30	60	90		
Ability to move 4 extremities voluntarily or on command = 2 Ability to move 2 extremities voluntarily or on command = 1 Ability to move 0 extremities voluntarily or on command = 0		1	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:
Ability to respond to deep breathing & cough freely = 2 Requires or limited breathing = 1 Apneic = 0		1	2	2		
SpO2 ≥ 90% of Pre Anesthetic level = 2 SpO2 ≥ 85-90% of Pre Anesthetic level = 1 SpO2 ≤ 85% of Pre Anesthetic level = 0		2	2	2		
Fully awake = 2 Awake on calling = 1 Not responding = 0		2	2	2		
Perk, daily history, jaundiced, other = 2 = 1 = 0		2	2	2		
TOTAL		10	10	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
29/6	8:45	0/10	Pl	<u>AD</u>
29/6	8:50	0/10	Pl	<u>AD</u>
29/6	9:15	0/10	Pl	<u>AD</u>
29/6	9:30	0/10	Pl	<u>AD</u>

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 relieving intervention
 d. With in 30-60 minutes after pain relief intervention

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

Anaesthesiologist Name: Dr. SK. Aysha
 Anaesthesiologist Signature: [Signature]

Date & Time: 29/6/24

PACU Nurse Name: Mouiller
 PACU Nurse Signature: [Signature]
 Date & Time: 29/6/24

Transferred to Unit by (PACU): 2nd floor 244
 Date & Time: 29/6/24

CONSENT FORM FOR GENERAL REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE



Patient Name: Dejia Pragny Age: 8y 5m Gender: Male ☐ Female ☒
 UMD NO: FOU-0710522 Surgeon Name: Dr. Raniga Raja

Anesthesiologist: Dr. Samir

Operative procedure planned: Em. USS

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 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 mellitus ☐ Renal failure
- ☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma / Renal Tubular Acidosis
- ☐ Incapacitating Chronic Obstructive Pulmonary Disease
- ☐ Others : hypertension, Bradycardia, PDPH

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 Dejia Pragny the above mentioned operation / Diagnostic / Therapeutic procedures Em. USS

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 anaesthesia.

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 anaesthesiologist 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 : 

Name : Debjana

Relationship with Patient : Sister

Date & Time : 29/6/2026 6:20AM

Witness :

Signature : 

Name : Dr. Anurag

Date & Time : 29/6/2026 6:20AM

Doctor (who is taking the consent) :

Signature : 

Name : Dr. Anurag K.

Date & Time : 29/6/2026 6:20AM

26.0000 209088
NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name: Ms. Suman Devi Age: 37 Y Gender: F
 IP No: 19160006677 Date: 29/6/26 Time: 6:15 PM
 Signature: Suman

PRESCRIPTION DETAILS (Tick only one of the following)			
Sl No	Drug Name	Dosage	Remarks
1	Paracetamol 500mg	100 mg	one time
2	Morphine Sulphate 15mg/ml		
3	Remifentanyl Hydrochloride 2mg		
4	Remifentanyl Hydrochloride 1mg		

Doctor Name: Dr. SK. DYESH Doctor Registration No: TSME/FR/09725
 Signature: [Signature]

NARCOTIC DISPENSING FORM
APPENDIX 4 - FORM NO. 3E

(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: 19160006677 Date: 29/6/26
 Author No. of the Patient (Optional):

Sl No	Name	Complete postal address (with contact number, if any)	Street description of the illness	Whether registered with any other registered medical practitioner / recognized medical institution (If yes, details of the recorded)	Details of essential Narcotic drug dispensed	Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
1	Name: <u>Ms. Suman</u>	<u>0000000000</u>								
2										
3										
4										
5										

Signature: [Signature]

Dispensed by (Name & ID No.): Sania (018041) Signature: [Signature]
 Received by (Name & ID No.): Sani Chandu 02153 Signature: [Signature]
 Time:

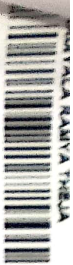
Scanned with OKEN Scanner

[illegible]

BY RAINBOW HOSPITAL'S
Your Begin to a Safe Delivery

BY RAINBOW HOSPITALS
Went Right to a Safe Delivery

TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME																											
Date		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	
21 30		11 20		0-10		94 100 %		< 94 %																			
21 30		11 20		0-10		94 100 %		< 94 %																			
21 30		11 20		0-10		94 100 %		< 94 %																			
21 30		11 20		0-10		94 100 %		< 94 %																			
21 30		11 20		0-10		94 100 %		< 94 %																			
21 30		11 20		0-10		94 100 %		< 94 %																			
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21 30		11 20		0-10		94 100 %		< 94 %																			
21 30		11 20		0-10		94 100 %		< 94 %																			
21 30		11 20		0-10		94 100 %		< 94 %																			



Early Warning Observation Score Chart - Obstetrics

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

Date		8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7		
RESPIR (write rate in corresp box)																											
Saturations																											
Administered O ₂ (L/min)																											
Temp °C																											
Heart Rate																											
Systolic Blood Pressure																											
Diastolic Blood Pressure																											
NEURO RESPONSE [✓]																											
URINE mls / hour																											
Proteinuria																											
Lochia																											
Liquor																											
TOTAL YELLOW SCORES																											
TOTAL ORANGE SCORES																											
Nurse Initial																											

FLUID CHART

Sheet No. :

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.

		Intake			Output						IV Site	Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine					
	08:00 am		Mouth	I.V	N.G									
	09:00 am													
	10:00 am													
	11:00 am													
	12:00 pm													
	01:00 pm													
Total Intake :					Total Output :									
28/05/20														
	02:00 pm													
	03:00 pm													
	04:00 pm													
	05:00 pm													
	06:00 pm													
	07:00 pm													
Total Intake :					Total Output :									
28/05/20														
	08:00 pm													
	09:00 pm													
	10:00 pm													
	11:00 pm													
	12:00 am													
	01:00 am													
Total Intake :					Total Output :									
29/05/20														
	02:00 am													
	03:00 am													
	04:00 am													
	05:00 am													
	06:00 am													
	07:00 am													
Total Intake :					Total Output :									
29/05/20														
Total 24 hrs. Intake					Total 24 hrs. Output									

Doco. No. : RCH /FRM / CLINICAL / 092



FLUID CHART

Sheet No. :

- 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.

Intake				Output					
Date	Time	Nature of Fluid	Route	NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score
8/6/20									
	08:00 am	IL	IV					300ml	1
	09:00 am	IL	IV					300ml	1
	10:00 am	IL	IV					300ml	1
	11:00 am	IL	IV					300ml	1
	12:00 pm	IL	IV					300ml	1
	01:00 pm	IL	IV					300ml	1
Total Intake : 1800ml				Total Output : 1800ml					
8/6/20									
	02:00 pm	IL	IV					400ml	1
	03:00 pm	IL	IV					400ml	1
	04:00 pm	IL	IV					400ml	1
	05:00 pm	IL	IV					400ml	1
	06:00 pm	IL	IV					400ml	1
	07:00 pm	IL	IV					400ml	1
Total Intake : 1800ml				Total Output : 1800ml					
8/6/20									
	08:00 pm	IL	IV					400ml	1
	09:00 pm	IL	IV					400ml	1
	10:00 pm	IL	IV					400ml	1
	11:00 pm	IL	IV					400ml	1
	12:00 am	IL	IV					400ml	1
	01:00 am	IL	IV					400ml	1
Total Intake : 1800ml				Total Output : 1800ml					
8/6/20									
	02:00 am	IL	IV					400ml	1
	03:00 am	IL	IV					400ml	1
	04:00 am	IL	IV					400ml	1
	05:00 am	IL	IV					400ml	1
	06:00 am	IL	IV					400ml	1
	07:00 am	IL	IV					400ml	1
Total Intake : 1800ml				Total Output : 1800ml					
Total 24 hrs. Intake				Total 24 hrs. Output					



NURSING CARE RECORD

Date: 28/6/22

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon	2pm	- Assess the patient for condition - plan for vital recorded. - plan for Tlo chest	4pm	- Assessed the patient condition - Maintain vitals - maintain Tlo chest.	- Patient stable	- vitals normal	[Signature]
Night	8pm	- plan for NST					
	8pm	- plan for vitals - plan for FHR - plan for NST - plan for medication	8pm	- plan for vitals - FHR checked - NST done - medication given as per chart	Stable	Normal	[Signature]
	8am		9am				

NURSING CARE RECORD

Date: 29/6

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

ne	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
am	Assess the patient's condition - plan for vital & record - plan for	8am	- Assess the patient's condition - Monitor vital - maintain	Now pt is stable	Re-check vital	mon
2pm	Assess the pt. condition - monitor vital & record - Maintain I/O chart - Give medication as prescribed by doctor	2pm	- Assessed the pt. condition - Monitored vital & record - Maintained I/O chart - Given medication as prescribed by doctor	Patient is stable now	Re-checked vital	[Signature]
8pm		8pm				
Night						



FORM-00010522
IP24-0000677
MR. DEEPIKA ORUGATTY
28-10-1988 37 Y 8 M 20 (F)
DR. KADRYALA RAMYA THEJA

BRADEN Q¹ SCALE

Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4	4
Activity The degree of physical activity	1. Bedfast: Confined to bed	2. Chairfast: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. All patients too young to ambulate: OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.	4	4	4	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation. OR, limited ability to feel pain over most of the body surface	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness. OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body	3. Slightly limited: cannot always communicate discomfort or need to be turned. OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities	4. No impairment: Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4	4
Moisture Degree to which skin is exposed	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes, linen only requires changing every 24 hours.	4	4	4	4	4
Friction-Shear	1. Significant problem: Skin moves against support surfaces when agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.	4	4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	4
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					 evaluator's Name				
					TOTAL SCORE				
					28				
					28				
					28				

Date :
Time :Rainbow
Children's
Hospital

KADRYALA RAJYA THIRU
0-1908 37 YAM20 (P)

CHECKLIST FOR THROMBOPHLEBITIS

08/6/2020
29/6Rainbow Children's Hospital
It takes a lot to treat the little.

Your biggest hope is a better tomorrow.

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										
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										

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 :

Mushe

Name :

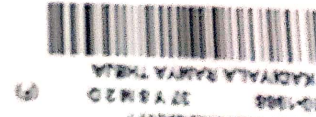
Mushe

Signature of Ward In Charge :

Kagatha

Name :

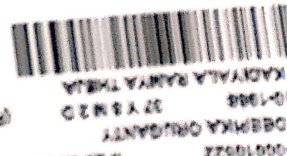
Kagatha



Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	Score	Risk Level		Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25	0	Low Risk	0	0 - 24	Standard Fall Prevention
	No	15	0				
Secondary Diagnosis (more than one diagnosis)	Yes	15	0	Moderate Risk	0	25 - 50	Implement Moderate Fall Prevention
	No	0	0				
Furniture	Yes	30	0	High Risk	0	≥ 51	Implement High Risk Fall Prevention
	No	0	0				
Ambulatory Aid	Crutches, Cane(S), Walker	15	0	High Risk	0	≥ 51	Implement High Risk Fall Prevention
	None / Bed Rest / Nurse Assist	0	0				
IV / Heparin Lock or Saline	Yes	20	20	Moderate Risk	20	25 - 50	Implement Moderate Fall Prevention
	No	0	0				
GAIT / Transferring	Impaired	20	20	High Risk	20	≥ 51	Implement High Risk Fall Prevention
	Weak (uses touch for balance)	10	0				
Mental Status	Forgets limitations	15	0	High Risk	20	≥ 51	Implement High Risk Fall Prevention
	Oriented to own ability	0	0				
Total Morse Fall Scale Score:		88/6		29/6		88/6	
Signature		Jhe		Jhe		Jhe	

- Trick (✓) 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 FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
28/6	2pm	0/10	Lower		☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ No ☐ Yes	☐
28/6	8pm	0	NA		☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ No ☐ Yes	☐
28/6	12pm	0/10	NA		☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ No ☐ Yes	☐
29/6	9pm	0/10	NA		☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ No ☐ Yes	☐
29/6	9pm	0/10	NA		☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ No ☐ Yes	☐
29/6	6pm	0/10	NA		☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ No ☐ Yes	☐
29/6					☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ No ☐ Yes	☐
29/6					☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ No ☐ Yes	☐

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 pain-relieving intervention.

Form No: BCH-FRM / CLINICAL / 152

- Then every 30 - 60 minutes after pain relief intervention.

NURSING SHIFT HAND OVER FORM - WARD

Department:

Date of Admission:

Area Doctor:

Diagnosis:

Any Infection: ☐ Yes ☐ No ☒ Not Known

If Yes Specify:

pprom

28/6/26 8:15 AM to 29/6/26 8:00 AM

BACKGROUND

Area Shift Time

Medical Condition
(Any special condition to be noted):

- NA

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: 97.8

Res: 20

SpO₂: 99

Pulse: 90

BP: 100/60

Fall Risk Score:

0/10

Pain Score:

yes

Safety Needs:

yes

Physiotherapy

☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

Others Specify:

NA

Special Diet:

☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

Other Special Orders / Medications:

-

Post Operative Procedure Special Orders:

-

Handed Over By Name :

Acc. Lowry Panyanta

Signature :

Acc. Lowry Panyanta

Date:

28/6/26 19:00 29/6/26

Time:

8:15 PM 8pm

Taken Over By Name :

Acc. Panyanta

Signature :

Acc. Panyanta

Date:

28/6/26 29/6/26

Time:

2pm

GENERAL CONSENT FOR TREATMENT

Name: Mrs DEEPIKA ORUGANTY **Age :** 37 Y 8 M 2 D
IP26-00006677 **Sex:** Female
Dr. KADIYALA RAMYA THEJA **Ward/Bed No:** 4F -OT/LDR-416
consultant:

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned also consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

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

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

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

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

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

Note:

1 We do not allow use of medication brought from outside by the patient.
2 I have received attendant passes as per my room category. I will pay 200/- Rs.

2 I have received attendant passes as per my room category. I will pay 200/- Rs.

3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.

4 Financial and billing counseling has been done to me.

Signature of Patient/Relative:

Patient Address:

FLAT NOV 1006 C BLOCKN HONER
AQUANTIS Serilingampally Hyderabad
Telangana INDIA 500019

Name: *Deepeeka Oruganty*

Relationship: *Person 2*

Date: *28/6/26.*

Time:

Witness Name:

Witness Signature: