

ADMISSION SHEET

Registration Details :



Admission No : IP5-00176253

Admit Date : 11-Jul-2026

Admit Time : 10:21 AM UHID : BAH-00643120

Patient Details :

Patient Name : Mrs SHUSHMA DAKURI

Age : 29 Y 7 M 14 D

Guardian : Mr SUDHAMSH THOKALA

DOB : 27-11-1996

Gender : Female

Religion :

Occupation :

Marital Status : Married

Address (H) : H.no: 5-89, housing board colony,
mutrajpal, siddipet district, Gujvail Bus
Stand Medak Telangana INDIA 502278

Phone No : 9000404477/

E-mail : NO@GMAIL.COM

Admission Details :

Bed Type : SHARED WARD

Bed No : SW 416

Ward Name : 4F-BIRTHING CENTRE

Room No : SW 416

Admission Type : First Visit

Contact Details :

Name : Mr SUDHAMSH THOKALA

Relationship : Husband

Contact Address :

Phone No : / 9000404477

Sudhama
Signature

Doctor Details :

Doctor Name : Dr. SHRUTHI REDDY/Dr.LAVANYA
JANAGAMA

Specialisation : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 20000.00

Payment Mode : DC/CC Card

Payor Name : HEALTHINDIA INSURANCE TPA
SERVICES PVT LTD

0

ACTIVITY RECORD FOR BILLING

Name : _____ BAH-00643120 IP5-00176253
Mrs SHUSHMA DAKURI
27-11-1996 29 Y 7 M 14 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA
UHID No. : _____ Consultant: _____ Dept : _____
Date of Admission: _____ Date of Discharge : _____ Time: _____
Room / Bed No : _____ Ward : _____ Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
11/07/26	11:30pm	BB - II	3rd floor [338]	[Signature]

Cross Consultation Visit

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

[illegible]

~~Cross checked by~~
C.R.S. R.P.C.

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
11/7/26	Replacement	1	9698613	[Signature]
11/2/26	PAC	1		[Signature]
11/7/26	cathe.fermentary	1		[Signature]

ANY OTHER INFORMATION

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Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

G3A2E 38 wks - 2/6 leading plb
- 6 AM

Obstetric Formula: Pain abdomen
- 8 AM

Obstetric History:

M1-2022, NCM

I → 2024, mixed miscarriage
5-6 wks, MERPC

Present Pregnancy Record:

II → 2025, mixed miscarriage, 6-7 wks
MERPC

III → PP → SP. Conception.

RISK FACTORS:

Booked at 11th wks

LMP: 20/10/2025

EDD: 25/12/2026

Corrected EDD: 20/12/2026

GA: 38 wks

Menstrual History: Regular: ☒ Yes ☐ No

Obstetric Examination

Fundal Height: Term

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

Liquor: ☒ Adequate ☐ Oligo ☐ Poly

PP: ☒ Cephalic ☐ Breech Others _____

Head Fifts Palpable: _____

FHS: ☒ Normal ☐ Tachy ☐ Brady ☐ Absent

Per Speculum Examination

Draining: ☐ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination

Cervix: ☐ Long ☒ Partially effaced ☐ Effaced

Os: Closed 2cm Dilated _____

Membranes: ☐ Present ☒ Absent

Liquor: ☒ Clear ☐ Meconium ☐ Blood Stained

Presenting Part: ☒ Vertex ☐ Breech ☐ Others

Sutton: ☐ -3 ☒ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Pelvis: ☒ Adequate ☐ Doubtful

Height: 154 cm

Weight: 69 kg

Allergies: _____

Breast: ☒ Normal ☐ Abnormal

General Examination:

Consciousness: conscious Pallor: absent

Icterus: absent Edema: absent

Temp: Afebrile PR: _____

BP: _____ DTR: (+)

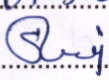
CVS: S1S2 (+) RS BAE (+)

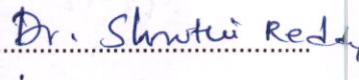
Liver/Spleen: non-palpable Urine Output: adequate

DIAGNOSIS

G3A2E 38 wks E SRM In early Labour

Family History: father - DM, hypothyroid Brother - hypothyroid	Surgical History: —
Medical History: —	Medication History: T. Iron o.d T. Calcium o.d
Plan of Care: ✓ admission. ✓ send CBP ✓ ABG Monitor vitals - 4th ✓ FHR - 4th ✓ NST - 3rd day ✓ Ethena ✓ Drug as charted ✓ Monitor w/ f POC ✓ Prepare part ✓ Epidural (SOS) ✓ Ibuprofen SOS	Investigations: O +ve vitals - NR 12/6/26 Hb :- 11.7 Plt : 1.45 WBC - 8500 NT : 1.4mm TIFFT: NAD 16/7/26: 30wks, Cephalic EFW: 1647 gm (67%) AC ~ 43% AFI: 11.2cm Placenta - A/H. Doppler - (D)

Doctor Name: Dr. Sravanthi
 Signature: 
 Date & Time: 11/7/2026, 11Am

Consultant Name: Dr. Shruthi Reddy
 Signature: 
 Date & Time: 11/7/2026, 11Am

BAH-00643120 IP5-00176253
Mrs SHUSHMA DAKURI
27-11-1996 29 Y 7 M 14 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA

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STETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 11/7/26

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: Sprom Doctor Notified on Admission: ☒ Yes ☐ No
Name of the Doctor: Sravanthi
Time Notified: 11 AM

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

Past Medical History	Past Surgical History	Previous Hospital Admission
nil.	nil.	-

Gynecology Assessment: ☐ Not Applicable Menstrual History: Regular Onset of Menarche: Menstrual Cycle: ☒ Regular ☐ Irregular Last Menstrual Period: 20/10/25	Gynecology Surgical History: Caesarean Section: ☐ No ☐ Yes Cervical Cerclage: ☐ No ☐ Yes Ectopic Pregnancy: ☐ No ☐ Yes Myomectomy: ☐ No ☐ Yes Others: A	Gynecological History: Contraceptives: ☐ No ☐ Yes Vaginal Discharge: ☐ No ☐ Yes Post-Coital Bleeding: ☐ No ☐ Yes Infertility: ☐ No ☐ Yes If Yes Type: ☐ Primary ☐ Secondary
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Obstetric History: G 3 P L A 2

Previous LSCS: nil

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

Family History: ☐ No Abnormalities Detected Father
☐ Heart Disease ☒ Hypertension ☐ Diabetes ☐ Stroke ☐ Seizures ☐ Kidney disease
☐ Liver disease ☐ Other

Vital Signs / Measurements: Temp: 98.6 HR: 89 4h RR: 19
BP: 110/60 Weight: 62 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 (complete the Morse Fall Risk Assessment Sheet)

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

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

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☒ No Abnormality Detected

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

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

Inform consultant for positive criteria

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 with family*

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: *Patient*

Orientation not given Reason:

Nurse Signature: *[Signature]*

Nurse Name: *[Signature]*

Date & Time: *11/7/2020 @ 11:30 AM*

Date & Time	Progress Notes	Doctor's Order
11/16/66 2pm	cl/b Dr. Butcher PA comfortable cl/b air vitals stable PA - uterus comfortable FHR ⊕	AW - w/f POL - vitals closely - OTC 3 hourly - Tab PGE₁ 2mg po 2nd only - infuse 10 Dr. Sauer
11/16/66 4:45pm	C13A2 / 38 wks / 5800g / early labor cl/b: pain abdomen. GC: fair B.P. - 110/70 P.R. - 72 SpO₂ - 100% on RA PA: ut - acting FHR ⊕ cephalic 3 doses of PGE₁ given	R 1) w/f POL 2) Monitor vitals 3) Drug as charted 4) Infuse 10 5) T. PGE₁ - 25mg - 2nd dose Dr. Butcher

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/7/2026 8:30 PM	PND-O / SUP / P/LIA ₂	
		R
	Gc: fair	
B-wet	B.P - 110/90	1) Monitor vitals - 4x/2 hrs
	P-R: 72	2) Drug as charted
U/O: 200ml	Spa - 100% on RA	3) W/F P/W Bleeding
	P/A: UT (R) out	4) Soft diet & plenty
	Soft	of liquid
	BS (R)	5) Flt charting
	P/V: NAB	6) Breast feeding
		7) Ambulation
		8) T/Flex sys
		- Dr. Sruvanti
11/8/26 10 PM	PND-O / SUP / P/LIA ₂	
		R
	Gc: fair	1) Soft diet & plenty of
U/O: 200ml	B.P - 106/74 (85)	oral fluid
	P-R - 100bpm	2) Drug as charted
B-wet	Spa - 100% on RA	3) W/F P/W Bleeding
	P/A: UT (R) wet	4) Ambulation
	Soft	5) Breast feeding
V/E ✓	BS (R)	6) Flt charting
Shift for room Temp:	P/V: NAB	

Date & Time	Progress Notes	Doctor's Order
12/1/86	PND-1 / SVD / P.L.A.	
Bowl voiled V/ S/ VLE-	C/C: per vitals: stable P/A: Ut @ end soft B/P ⊕ P/V: NAB plan discharge.	R 1) Soft diet & plenty of oral fluid 2) Drug aschated 3) w/t Plw Bleeding 4) Analgesia 5) Temp 80° Dr. Sravanti N.B. Dugg 607557
12/1/86 3:00 PM W/ R/	O/B ac fair vital - Hctm. PA ulcers retracted well C/O - lochia healthy	Adv = CST - Anticulate - Infusion [Signature] D. Sane



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[illegible]

[illegible]



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BAH-00643120 IP5-00176253
 Mrs SHUSHMA DAKURI
 27-11-1996 29 Y 7 M 14 D (F)
 Dr. SHRUTHI REDDY/Dr.LAVANYA




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RESULT SHEET

Date	11/7/26.				
Time	10:47 AM.				
Hb	13.5				
PCV					
RBC	4.63.				
WBC	12.01				
N/L					
Platelets	1.74				
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Blood group →	OTC					
HIV	}	NR				
HbsAg						
HCV						
VDRL						

Culture and Sensitivities :

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Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :

Patient

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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: Shifted to:

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T-Iron	146b	PO	O-D	10/18	☐ C ☒ DC
2	T-calcium	146b	PO	O-D	10/17	☐ 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. Shruthi

Date & Time : 11/12/2026, 11 AM

Nurse Name & Signature: Sudha

Date & Time : 11/7/26 @ 11:30 AM

SHRUTHI REDDY/DR. LAVANYA



Weight Ward

VERIFIED BY: *ivame*

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

Signature
VERIFIED BY : Name

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																				

BAH-00643120
Mrs SHUSHMA DAKURI
27-11-1996 29 Y 7 M 14 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA



DRUG CHART

Date of Admission: Drug Allergies: ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
 - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
- 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

REGULAR PRESCRIPTIONS

Weight. 64kg Ward. 2

DRUG : <u>IV-LEFOTAXIME</u>				Date Time	<u>11/7</u>
Dose	Route	Frequency	Start Date		
<u>1gm</u>	<u>IV</u>	<u>BD</u>	<u>11/7</u>	<u>12 AM</u>	<u>X</u>
Name & Signature of the Doctor Starting the Drugs:					
<u>Dr. Sumeet R</u>					
Additional Instructions:					
<u>After test done.</u>					
Daily Doctor's Endorsement by a Sign					

STOP

BAH-00643120 (F)
 Mrs SHUSHMA DAKURI
 29 Y 7 M 14 D
 27-11-1996
 Dr. SHRUTHI REDDY/Dr.LAVANYA

DRUG : <u>T-PARACETAMOL</u>				Date Time	<u>12/7</u>
Dose	Route	Frequency	Start Date		
<u>1gm</u>	<u>PO</u>	<u>TID</u>	<u>11/7</u>	<u>6 AM</u>	<u>12 PM</u>
Name & Signature of the Doctor Starting the Drugs:					
<u>Dr. Sumeet R</u>					
Additional Instructions:					
<u>10 PM</u>					
Daily Doctor's Endorsement by a Sign					

DRUG : <u>T-DICLOFENAC</u>				Date Time	<u>12/7</u>
Dose	Route	Frequency	Start Date		
<u>50mg</u>	<u>PO</u>	<u>TID</u>	<u>11/7</u>	<u>7 AM</u>	<u>3 PM</u>
Name & Signature of the Doctor Starting the Drugs:					
<u>Dr. Sumeet R</u>					
Additional Instructions:					
<u>11 PM</u>					
Daily Doctor's Endorsement by a Sign					

DRUG : <u>T-PANTOPRAZOLE</u>				Date Time	<u>12/7</u>
Dose	Route	Frequency	Start Date		
<u>40mg</u>	<u>PO</u>	<u>O-D</u>	<u>11/7</u>		
Name & Signature of the Doctor Starting the Drugs:					
<u>Dr. Sumeet R</u>					
Additional Instructions:					
<u>12 PM</u>					
Daily Doctor's Endorsement by a Sign					



Date							
Time		Nurse Sig.		Nurse Sig.		Nurse Sig.	

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

VARIABLE DOSE		Date					
		Time		Nurse Sig.		Nurse Sig.	

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
11/7	10:30am	Tab. PCE	50mg	P/O	[Signature]	Sudha Anjali
11/7	2:30pm	Tab. PCE	25mg	P/O	[Signature]	Sudha Anjali
11/7	11am	PC Enema	1	P/R	[Signature]	Sudha Anjali
11/7	4:40pm	Tab. PCE	25mg	P/O	[Signature]	Sudha Anjali
11/7	8:40pm	Supp DICTOFEN	100mg	P/R	[Signature]	Sandhya Swarna
11/7	8:41pm	T- PGE	400mg	P/R	[Signature]	Sandhya Swarna
11/7	8:00pm	Tg SYNTOLIN	10 tabs	I/V	[Signature]	Sandhya Swarna
11/7	8:45pm	Tg. Tranexamic acid	1gm	I/V	[Signature]	Sandhya Swarna

Weight. 64 kg Ward. 25



Nurse
Sign

[illegible]

Signature _____

Patient Sticker

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

BAH-00643120 IP5-00176253
Mrs SHUSHMA DAKURI
27-11-1996 28 Y 7 M 14 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA



rainbow
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Part - I.

Patient's / Learner Language: Telugu/Kannada 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		
11/2/2026	11 Am	1/43 4	Δ, R, care plan, pain management, Infection	PT	1	0	1	1	nil	Dr
11/2/26	12:00	3	Pain management	PT	1	0	1	1	—	Dr
12/2/26	9:30 am	9	Lactation diet	PT	1	0	1	1	—	Seeing

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									



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: G3A2 E 38 wks T SRM in Early Labor

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
11/6/2016	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	G3A2 E 38 wks T SRM in Early Labor	Safe pregnancy	Delivery	Dr	☐ Nursing ☐ Others:
11/7/26	☐ Medical ☒ Nursing ☐ Others:	☐ Initial ☒ Modified ☐ Per-Op ☐ Post Op	Fear & Anxiety	TO Reduce the fear	NST 3rd hourly done		☒ Medical ☐ Others:
12/7/26 9:30 am	☐ Medical ☒ Nursing ☐ Others: dietitian	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	PND-1 SVD	Soft diet	Soft High protein diet	Saini	☐ 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:



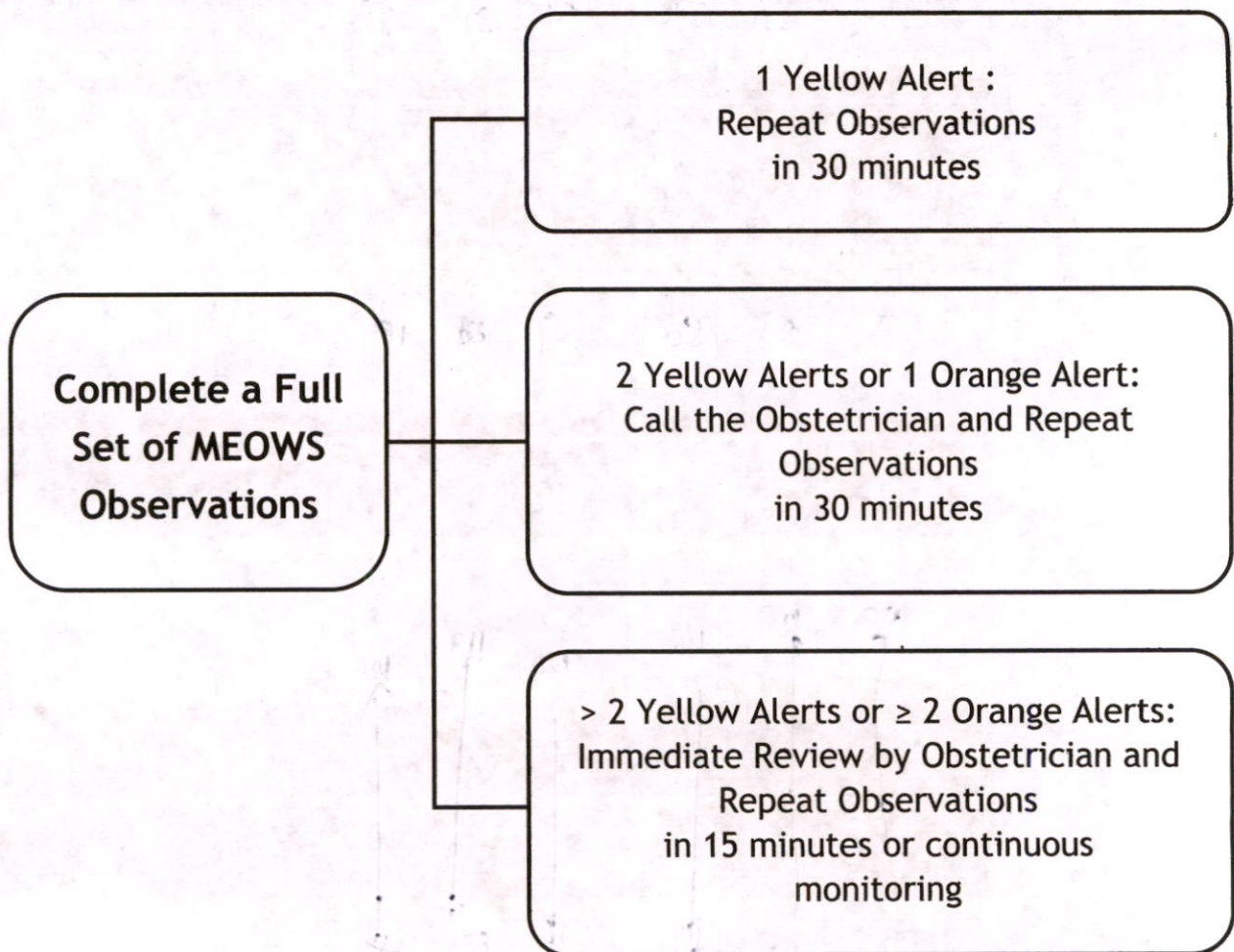
9 788120 329111



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



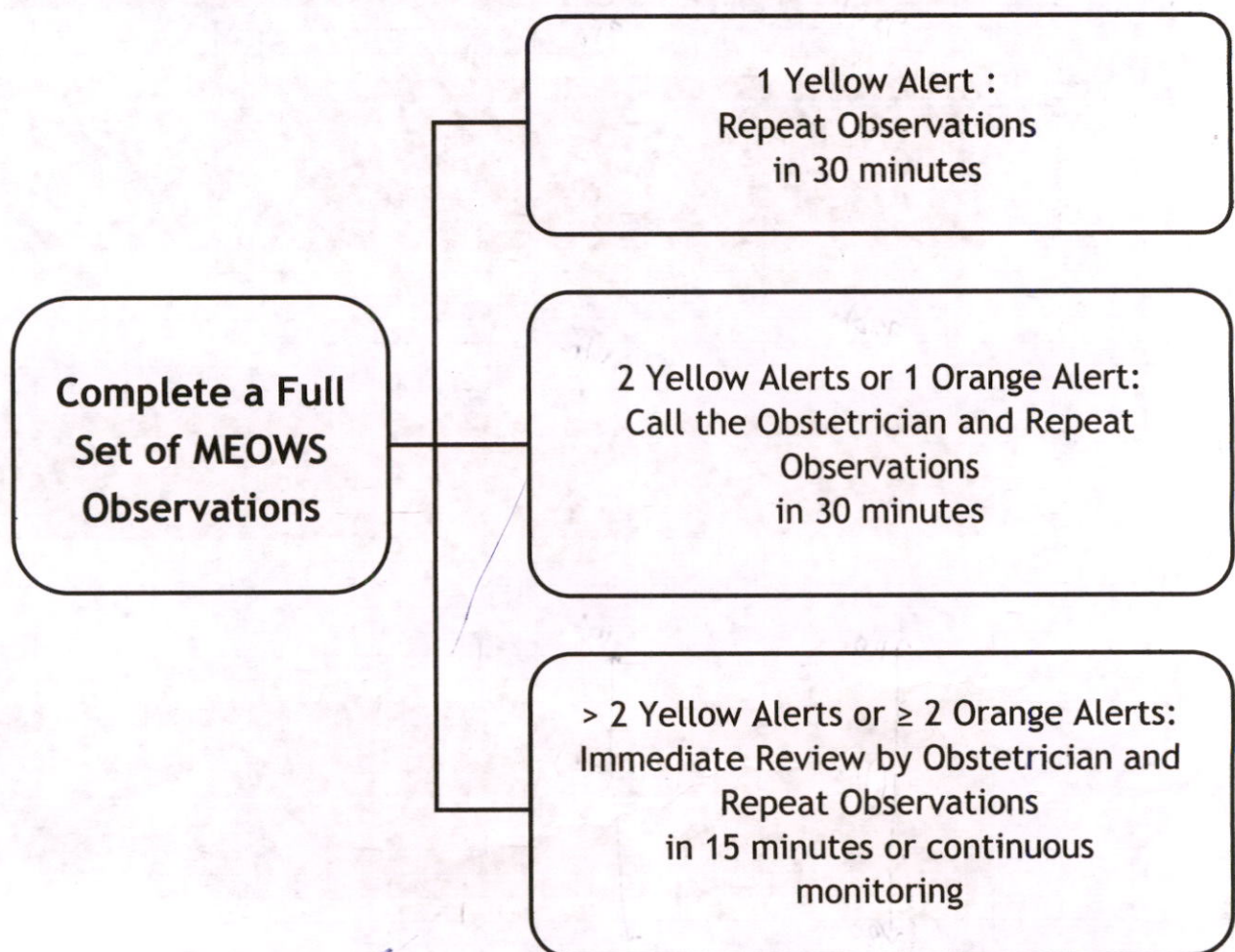
* The Modified Early Warning Score (MEOWS)



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[illegible]

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

BAH-00643120 IP5-00176253
 Mrs SHUSHMA DAKURI
 27-11-1996 29 Y 7 M 14 D (F)
 Dr. SHRUTHI REDDY/Dr. LAVANYA

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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.

Date	Time	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am	Tdly								0	0	0
	11:00 am									0	0	0
	12:00 pm									0	0	0
	01:00 pm									0	0	0
Total Intake :					Total Output :							
	02:00 pm	DL	Teg.	100ml						✓	0	0
	03:00 pm	PL	Went	100ml							0	0
	04:00 pm	PL		100ml						✓	0	0
	05:00 pm	PL	Jyil	100ml							0	0
	06:00 pm	PL		100ml						✓	0	0
	07:00 pm	PL		100ml							0	0
Total Intake :					Total Output : passed u-3							
	08:00 pm	PL	h2o	100ml							0	0
	09:00 pm	PL	Tdly	100ml						200ml	0	0
	10:00 pm										0	0
	11:00 pm		rich	rich						200ml	0	0
	12:00 am										0	0
	01:00 am		H2O							100ml	0	0
Total Intake :					Total Output : m - 500ml							
	02:00 am									300ml	0	0
	03:00 am		H2O								0	0
	04:00 am									100ml	0	0
	05:00 am		H2O							300ml	0	0
	06:00 am									200ml	0	0
	07:00 am		H2O								0	0
Total Intake :					Total Output : m - 900ml							
Total 24 hrs. Intake												
Total 24 hrs. Output		m - 1000ml										

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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.
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							
12/7	08:00 am										0	Diary
	09:00 am	Food							✓	0		
	10:00 am	H ₂ O								0		
	11:00 am								✓	0		
	12:00 pm	H ₂ O								0		
	01:00 pm									0		
	Total Intake :					Total Output : m-o 0-2						
12/7	02:00 pm											
	03:00 pm	H ₂ O										
	04:00 pm								✓			
	05:00 pm											
	06:00 pm											
	07:00 pm											
	Total Intake :					Total Output :						
12/7	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
	Total Intake :					Total Output :						
12/7	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
	Total Intake :					Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 11/7/26

Assessment: Patient complains 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
10am	* Assess the pt general condition	10am	* Assessed the pt general condition	* Patient is Stable
11am	* Monitor vitals	11am	* Monitored vitals	
12pm	* Monitor NGT 3rd hr	12pm	* Monitored NGT 3rd hr	
1pm	* Administer medication	1pm	* Administered Medication	
2pm	* Provide diet	2pm	* Provided soft diet	
	* Ensure patient safety		* Provided pt safety	

Re-Assessment: Re-assessed was done

Special Notes: NGT 3rd hr

Nurse Signature:

Nurse Name: Kanika Lakshmi

Date & Time: 11/7/2026

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NURSING CARE RECORD


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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date:

Assessment: Acute pain related to delivery

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
2pm	* Assess the patient condition.	2:10 pm	* Assessed the patient condition	patient is comfortable.
3pm	* NST 3rdly	3:10 pm	* NST doing every 3rdly	
4pm	* Wt progress of labour.	4:10 pm	* 5-6cm.	
6pm	* IV fluids as flow	6:10 pm	* R/w is consented and Syntocin started.	

Re-Assessment: Reassess every

Special Notes: NST, 3rdly.

Nurse Signature: Shubh

Nurse Name: Shubh

Date & Time: 11/11/20 6pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 11/07/20

Assessment: patient is having 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 the general condition of the patient	8:05pm	Assessed the general condition of the patient	* patient is stable
10pm	* monitor vitals	10:05pm	* monitored vitals	
12am	* Maintain I/O chart	12:05AM	* maintained I/O chart	
2am	* Soft Diet	2:05AM	* Soft Diet given	
4am	* Ambulation	4:05AM	* ambulation done	
6am	* Prevent infection	6:05AM	* prevented infection	
9am	* Safety	7:05AM	* ensured safety provided	

Re-Assessment: Re-assessed done
Other: Providing comfortable position Patient well stable
toilet removed 6AM

Nurse Signature:

Nurse Name: Sandhya

Date & Time: 11/07/20 2:08pm

BAH-00643120 IPS-00176253

Mrs SHUSHMA DAKURI

27-11-1996

29 Y 7 M 14 D

(F)

Dr. SHRUTHI REDDY/Dr. LAVANYA



NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 12/7/26

Assessment: patient patient having pain & discomfort

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 patient General condition	8:10 Am	=> Assessed the patient General condition	patient is comfortable
10am	=> Assess the patient vitals signs	10:10 Am	=> Assessed the patient vitals signs	
12pm	=> To maintain I/O chart	12:10 pm	=> maintained I/O chart	
1pm	=> To encourage oral intake	1:20 pm	=> Encouraged oral intake	
2pm	=> To provide comfortable position	2pm	=> provided comfortable position	
	=> Ensure safety		=> Ensure safety	

Re-Assessment:

patient is Good & Ambulated

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Alaya

Date & Time: 12/7/26 @ 2pm

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 12/7/26

Assessment: mild pain and discomfort at surgical 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
2pm	→ To assess the general condition of the patient	2:10pm	→ Assessed the general condition of the patient	Patient stable
3pm	→ To monitor vital signs	3:20pm	→ Monitored vitals and recorded	
4pm	→ To encourage oral intake	4pm	→ She had soft diet	
5pm	→ To maintain I/O chart		→ Maintained I/O chart	
6pm	→ To administer medicines.	6pm	→ Administered medicines	

Re-Assessment: Pain reduced after given Tab Diclofenac

Special Notes: nil

Nurse Signature: 

Nurse Name: Lavanya

Date & Time: 12/7/26 at 6pm

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NURSING CARE RECORD


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Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

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

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Shruthi Reddy Department: OBG Date of Admission: 11/11/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known			
	<u>DOZ</u>		If Yes Specify:			
BACKGROUND	Area	Shift Time	<u>OBG</u> <u>802</u>	<u>OBG</u> <u>7am to 3pm</u>	<u>OBG</u> <u>3pm to 10pm</u>	<u>OBG</u> <u>10pm to 8am</u>
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
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:	<u>98.1</u>	<u>98.1</u>	<u>98.1</u>	<u>98.0</u>
		Res:	<u>20/m</u>	<u>18</u>	<u>18/m</u>	<u>19/m</u>
		SpO ₂ :	<u>100</u>	<u>99</u>	<u>99</u>	<u>98</u>
		Pulse:	<u>80/m</u>	<u>84/m</u>	<u>100/m</u>	<u>90/m</u>
		BP:	<u>118/72</u>		<u>106/34</u>	<u>100/80</u>
	Fall Risk Score:	<u>-</u>		<u>-</u>	<u>-</u>	
Pain Score:	<u>-</u>		<u>-</u>	<u>-</u>		
Recommendations	Safety Needs:	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Sandhya</u>	<u>Sandhya</u>	<u>Sandhya</u>	<u>Devi</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>11/11/26</u>	<u>11/11/26</u>	<u>11/11/26</u>	<u>12/11/26</u>	
Time:		<u>2pm</u>	<u>8pm</u>	<u>8am</u>	<u>2pm</u>	
Taken Over By Name :		<u>Sandhya</u>	<u>Sandhya</u>	<u>Devi</u>	<u>Kalyani</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>11/11/26</u>	<u>11/11/26</u>	<u>11/11/26</u>	<u>12/11/26</u>	
Time:		<u>2pm</u>	<u>8pm</u>	<u>8am</u>	<u>2pm</u>	

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:						



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
11/1/20	10am	0	new pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Kany
11/1/20	1pm	0	new pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Kany
11/1/20	3pm	1/10	Gastrointestinal pain	☐ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☒ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Breathless	Drugs
11/1/20	5pm	3/10	Abdominal pain	☐ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☒ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Spicy food	Drugs
11/1/20	7pm	2/10	Lower abdomen	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Breathless	Sandhya
11/1/20	9pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sandhya
11/2/20	11pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sandhya
12/1/20	6Am	2/10	Abdominal pain	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Tab: paracetamol	Shinsh
12/1/20	7Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Shinsh
12/1/20	12Am	2/10	Abdominal	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Tab: Diclofenac	Drugs

Re-assessment Frequency:

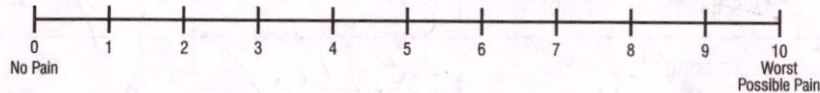
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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

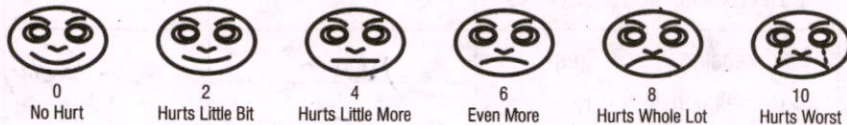
Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-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
12/26	12pm	0/10	REP	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under Observation	Plugs
12/7	3pm	3/10	SLs	☒ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Tab - Diclofenac	Calypso
12/7	4pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under Observation	Calypso
				☐ 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:

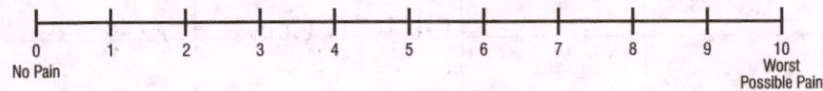
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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 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

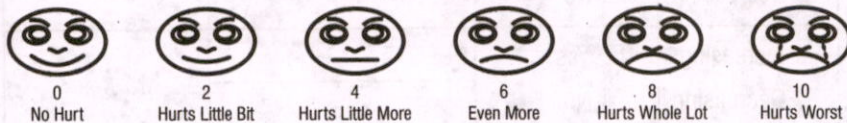
Numerical Pain Scale (Obstetric and Gynecology)



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



Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	11/12/20	11/2/26	11/3/26	Fall Risk Grading		
		Score				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						
Secondary Diagnosis (more than one diagnosis)	Yes	15	0		0	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					
Total Morse Fall Scale Score:			20	20	20			
Signature			Shanvi	Sy	condy			

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

CHECKLIST FOR THROMBOPHLEBITIS

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	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 cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-	-	-	-	-					
Signature of the Nurse				Reek	Lee	Sandhya	Deepa	Kalyani					

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 : Rebecca Name : Rebecca

Signature of Ward In Charge :

Signature : Uday Name : Uday

BAH-00643120 IP5-00176253
 Mrs SHUSHMA DAKURI
 27-11-1996 29 Y 7 M 14 D (F)
 Dr. SHRUTHI REDDY/Dr. LAVANYA



BRADEN 'Q' SCALE

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

					Date :	11/11/26	11/11/26	11/11/26	11/11/26
					Time :	8:45	2:00 PM	8:00 PM	8:45
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 e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	2	4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	1	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: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4	
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	
TOTAL SCORE					28	23	28	28	
Evaluator's Name					Kan	my	Sandhya	Sh	

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



OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 11/7/26 Time of Arrival: 10:10 AM Time Seen by Nurse: 10:15 AM

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: Sham

3) **Vital Signs:** Temperature: 98.6 Pulse: 89 RR: 19 SpO₂: 100% BP: 100/60 Weight:

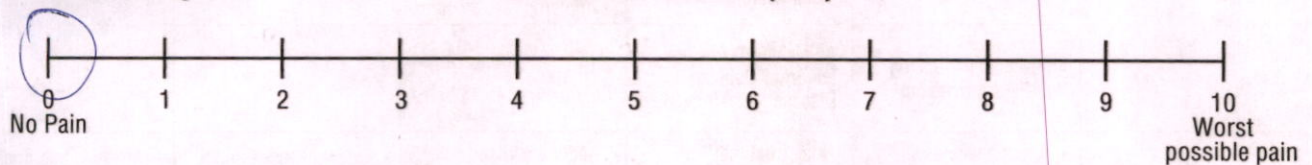
4) **Gestational Criteria:**

Gravida:	G <u>3</u>	P	<u>—</u>	L	<u>—</u>	A	<u>2</u>
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LMP: 20/10/25 EDD: 25/7/26 Gestational Age: 38 wks

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

6) **Past History:**

- a) Surgeries: nil
b) Medical: nil



7) Allergy: ☐ Yes ☒ No, If Yes :

8) Current Medications: ☒ Prenatal Vitamin ☐ None ☐ Others:

9) Prenatal Medical History:

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

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

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

Time seen by Doctor: 11:45 AM

Nurse Name : Nurse Signature: 11:30 AM

Date: 11/7/2020 Time: 11:30 AM

INFORMED CONSENT FOR VAGINAL BIRTH

Patient Name : Mrs. Sushma Dakuri UHID No : 643120
Gender: ☐ Male ☒ Female Date : 11/7/2020 Time : 11Am

I hereby authorized the performance of the following procedure:

- The Procedure has been explained to me in general terms and I understand that:
- The indication requiring the procedure of vaginal birth is pregnancy.
- The purpose of this procedure of vaginal birth pregnancy.
- The purpose of this procedure is to deliver the bay vaginally.

The outcome of the vaginal birth is the delivery of infant through birth canal either naturally or with possible use of force vacuum extraction. An episiotomy (a cut performed for enlarging of the vaginal opening in the space between the vaginal and the rectum) may be performed as part of a vaginal delivery.

Should vaginal delivery be unsuccessful, delivery by cesarean section with an abdominal incision under appropriate anesthesia may be necessary.

In an attempt to deliver the baby either naturally or with the help of instrument i.e. forceps or vacuum, there may be risks of: infection, allergic reaction, scarring, blood loss, need for blood transfusion, pain and discomfort, injury to urinary tract, possible injury to the baby (laceration, hematoma, skull fracture, nerve injury and brain injury) and possible future pelvic floor dysfunction,

I understand and accept that there are complications, benefits, alternatives including the remote risk of death or serious disability, which exists for me and my baby.

I am aware that in most cases, vaginal delivery results in a healthy mother and baby; however, I realize that there are no guarantees.

I voluntarily consent to the procedures described or otherwise referred to herein. I am aware that they will be performed by a qualified gynecologist.

Name of the Doctor performing the procedure: Dr. Shrutti Reddy

Consentee :

Signature : [Signature]

Name : D. Sushma

Date & Time : 11/7/2020, 11Am

Witness :

Signature : [Signature]

Name : Sushma

Date & Time : 11/7/2020

Docu. No. : RCHBH / FRM / CLINICAL / 028

Patient Attendant :

Signature : [Signature]

Name : DAKURI. UMA DEVI

Relationship with Patient: Mother

Date & Time : 11/7/2020, 11Am

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Sravanti

Date & Time : 11/7/2020, 11Am

సహజ ప్రసవం కొరకు సమ్మతి పత్రము

రోగి పేరు : వయస్సు లింగం పు స్త్రీ
యు.హెచ్.ఐ.డి. విభాగము

తేదీ

ఈ ప్రక్రియ యొక్క వివరములను నేను ఆమోదించాను:

- ఈ ప్రక్రియ నాకు సాధారణ పద్ధతిలో వివరించబడింది మరియు నేను అర్థం చేసుకున్నాను:
- గర్భం దాల్చిన వారికి సహజ ప్రసవ ప్రక్రియ అవసరమవుతుంది.
- ఈ ప్రక్రియ యొక్క ఉద్దేశ్యం (యోని) ద్వారా సహజ ప్రసవం చేయడం.
- ఈ ప్రక్రియ యొక్క ఉద్దేశ్యం బిడ్డను సహజమయిన పద్ధతిలో ప్రసవించటం

సహజ ప్రసవం (యోని జననం) యొక్క ప్రక్రియ సహజంగా లేదా శక్తిని ఉపయోగించి గర్భాశయం ద్వారా శిశువును ప్రసవించడం. వాక్యూమ్ ద్వారా శిశువును వెలికితీయడం, ఎపిసియోటమీ (యోని మరియు యోని మధ్య ఖాళీలో యోని మార్గమును సుగమం చేయుట కొరకు చేసిన కోత (కట్). సహజ ప్రసవం కొరకు చేయు ప్రక్రియలలో భాగము.

సహజ ప్రసవం విజయవంతం కాకపోతే, తగిన అనస్థీసియా ఇచ్చి పాత్రికడుపు కోతతో సిజేరియన్ ద్వారా డెలివరీ చేయవలసిన అవసరం కలగవచ్చు

సహజంగా లేదా పరికరం సహాయంతో అంటే ఫోర్సెప్స్ లేదా వాక్యూమ్ సహాయంతో బిడ్డను ప్రసవించే ప్రయత్నంలో, ప్రమాదాలు ఉండవచ్చు; అంటువ్యాదులు, అలెర్జిక్, మచ్చలు, రక్త నష్టం, రక్త మార్పిడి అవసరం పడటం, నొప్పి మరియు అసౌకర్యం, మూత్ర నాళానికి గాయం, శిశువుకు గాయం అయ్యే అవకాశం (ట్రెసరేషన్, హెమటోమా, పుర్రె గాయం ఆయె అవకాశం, నరాలకు గాయం మరియు మెదడు గాయం) మరియు భవిష్యత్తులో కటి ప్రదేశంలోని ఎముకల వలయం పనిచేయకపోవడం

నాకు మరియు నా బిడ్డకు మరణం లేదా తీవ్రమైన వైకల్యం వంటి సమస్యలు తలెత్తు అవకాశం, ప్రయోజనాలు మరియు ప్రత్యామ్నాయాలు ఉన్నాయని నేను అర్థం చేసుకుని అంగీకరిస్తున్నాను.

చాలా సందర్భాలలో, యోని ద్వారా ప్రసవించడం వల్ల తల్లి మరియు బిడ్డ ఆరోగ్యంగా ఉంటారని నాకు తెలుసు; అయితే, ఎటువంటి హామీలు ఇవ్వలేరని నేను గ్రహించాను

ఇక్కడ వివరించిన లేదా సూచించిన విధానాలకు నేను స్వచ్ఛందంగా సమ్మతిస్తున్నాను. ఈ ప్రక్రియ అర్హతగల గైనకాలజిస్ట్ చేత నిర్వహించబడతాయని నేను తెలుసుకున్నాను

ఈ ప్రక్రియను నిర్వహించే డాక్టరు పేరు:

సహాయకుడు(అటెండెంట్)

సాక్షి

సంతకము

సంతకము

పేరు

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

తేదీ మరియు సమయము

సంతకము

పేరు



CONSENT FOR LABOUR ANALGESIA

Authorization By: ☒ Patient ☐ Patient Attendant

I, the undersigned do hereby acknowledge the following:

- I have been made aware by the doctors in language known to me the details of the procedure as follows:

☒ Epidural Analgesia ☐ Intravenous Analgesia (Remifentanyl)

- I have been made aware of the possible complications from the procedures as follows:

For Epidural: Fall in blood Pressure, Numbness, Itching, Headache, Shivering, Occasional incomplete pain relief, Need for Re-Siting the epidural.

For Remifentanyl: Drowsiness, nausea, vomiting, need for oxygen supplementation, itching, fall in blood pressure, heart rate and Respiratory Rate.

- I understand that labour analgesia is offered to reduce labour pain and make the birthing process more comfortable, by reducing pain and stress and promoting better cooperation during childbirth.
- I have been clearly explained about the benefits, risk, and alternative of the procedures.
- I authorize Dr. Subhramanyam and his / her team to perform the above procedure(s) upon the patient / myself.
- 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: D. Shushma

Name: D. Shushma

Relationship with patient:

Date & Time: 11/7/26 @ 12:30 pm

Witness:

Signature: T. Sudhansh Reddy

Name: T. Sudhansh Reddy

Date & Time: 11/7/26 @ 12:30 pm

Doctor (who is taking consent):

Signature: D. K. Srinivas Name: D. K. Srinivas

Date: 11/7/26 Time: 12:30 pm

ప్రసవ నొప్పి నివారణ కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

వైద్యులు నాకు తెలిసిన భాషలో క్రింది విధానాల గురించి సమగ్రంగా వివరించారు:

- ☐ ఎపిడ్యూరల్ అనాల్జీసియా
☐ శిరస్రావం ద్వారా నొప్పి నివారణ (రెమిఫెంటానిల్)

- ఈ విధానాల వల్ల సంభవించగలిగే సమస్యలను కూడా నాకు వివరించారు:

ఎపిడ్యూరల్ సంబంధించినవి:

రక్తపోటు తగ్గడం, మందత్వం/ స్వల్పలేమి, దద్దుర్లు/ దురద, తలనొప్పి, వణుకు, అప్పుడప్పుడు పూర్తిగా నొప్పి తగ్గకపోవడం, ఎపిడ్యూరల్ మళ్ళీ పెట్టాల్సిన అవసరం.

రెమిఫెంటానిల్ సంబంధించినవి:

నిద్రమత్తు, వాంతి భావం, వాంతులు, ఆక్సిజన్ అవసరం పెరగడం, దద్దుర్లు/ దురద, రక్తపోటు తగ్గడం, గుండె వేగం తగ్గడం, శ్వాస రేటు తగ్గడం.

- ప్రసవ నొప్పిని తగ్గించడం, ప్రసవ ప్రక్రియను సాకర్వచంతంగా చేయడం, 'నొప్పి మరియు ఒత్తిడిని తగ్గించడం, ప్రసవ సమయంలో సహకారం మెరుగు పరచడం కోసం లేబర్ అనాల్జీసియా అందించబడుతుందని నేను అర్థం చేసుకున్నాను.
- ఈ విధానాల ప్రయోజనాలు, ప్రమాదాలు మరియు ప్రత్యామ్నాయాల గురించి నాకు స్పష్టంగా వివరించబడింది.
- డాక్టర్ _____ గారికి మరియు వారి బృందానికి, పై విధానం(లు)ను నాకు / రోగికి నిర్వహించడానికి నేను అనుమతి ఇస్తున్నాను.
- పై సమాచారాన్ని నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు ఆ ప్రశ్నలకు నాకు అర్థమయ్యే భాషలో సంతృప్తికరంగా సమాధానాలు అందాయి. ఈ అనుమతి నేను పూర్తిగా స్వచ్ఛమైన చిత్తంతో ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

BAH-00643120 IP5-00176253
Mrs SHUSHMA DAKURI
27-11-1996 29 Y 7 M 14 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA



PROCEDURE SAFETY CHECK LIST (TIMEOUT OUTSIDE OT)

Procedure Name: Epidural Analgesia Date: 11/7/26 In-Time: Out-Time:
Doctor Performing Procedure: Dr. K. Sri Surya Doctor Giving Sedation: Assisting Nurse: Anjali

SIGN IN	Time: <u>12:35pm</u>	Yes	No	NA
Patient is verified using two identifiers (Name & UHID)	☒	☐	☐	
All required documents, images, studies are available	☒	☐	☐	
NPO Status Checked from Patient / Patient Attendant	☒	☐	☐	
Consent is Signed	☒	☐	☐	
Any need for blood products	☐	☒	☐	
If Yes Comment:				
Any Risk of Hemodynamic Compromise	☐	☒	☐	
If Yes Comment:				
Any drug or food allergy	☐	☒	☐	
If Yes Comment:				
Correct Site of Procedure Marked	☒	☐	☐	
All resources required are correct, available and functioning	☒	☐	☐	
Signature of the Doctor: <u>Dr. K. Sri Surya</u>				
Name of the Doctor: <u>Dr. K. Sri Surya</u>				

TIME OUT	Time: <u>12:35pm</u>	Yes	No	NA
Correct Patient	☒	☐	☐	
Correct Site	☒	☐	☐	
Correct Procedure	☒	☐	☐	
All the team members introduced	☒	☐	☐	
Signature of the Nurse: <u>Anjali</u>				
Name of the Nurse: <u>Anjali</u>				

SIGN OUT	Time:	Yes	No	NA
Name of the Surgical / Invasive Procedure is recorded	☒	☐	☐	
Instrument, Sponge and Needle Count Completed	☒	☐	☐	
Specimens are labeled	☐	☐	☒	
Any equipment problems are addressed	☐	☒	☐	
Signature of the Nurse: <u>Anjali</u>				
Name of the Nurse: <u>Anjali</u>				

Any Adverse / Unexpected Events

.....
.....
.....



Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

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Name: Shushma Dakuri Age: 29y Sex: F UHID.No: BAH-00643120
Date: 11/7/26 Time: 12:20 pm Proposed Operation: _____
Diagnosis: G3 A2 T 38 weeks T SPANA in early labour
B.P / CRT: _____ H.R: _____ Weight: 69kg ASA Physical Status: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: <u>13.5</u>	Glucose: _____	Protein: _____	HIV: _____	X-Ray: _____
PCV: <u>41.8</u>	Urea: _____	Alb: _____	HBS Ag: <u>GNR</u>	ECG: _____
WBC: <u>12.01</u>	Creat: _____	Total Bill: _____	HCV: _____	2D Echo: _____
Plate: <u>174 lakh</u>	Na: _____	Dir. Bill: _____	Blood group: <u>O positive</u>	Stress/Angio: _____
PT: _____	K: _____	LDH: _____	T3: _____	Other: _____
PTT: _____	Ca++: _____	Alk phos: _____	T4: _____	
INR: _____	Mg++: _____	Amylase: _____	TSH: _____	
	Cl -: _____	SGOT/SGPT: _____		

Allergies: NKDA

Medical History: CVS: Not Significant

RESP: _____

Diabetes: Nil

CNS: _____

Renal: _____

Hepatic / GE: _____

Physical Activity: METS 24

Others: _____

Past Anaesthetic History: _____

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: > 3fb Mento-hyoid Distance: (N) Neck: (N) Teeth: All teeth intact
Lungs: BARE ⊕, clear
Heart: S S ⊕
CNS: Grossly Intact
Pregnant: ☒ Yes ☐ No ☐ NA Venous Access Site: (+) Spine Exam for regional: (N)

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

- DVT Prophylaxis: _____
- NIL ORAL $\left\{ \begin{array}{l} \text{Water / ORS 2 Hours} \\ \text{Others 6 Hours} \end{array} \right.$
- Informed Consent: ☒ Standard ☐ High Risk
- Post Operative Pain Management: ☒ Discussed with Patient
- Other Instructions: _____

last med! @ 7:45 AM
liquid: 12:00 PM

Signature: [Signature] Name: Dr. S. S. Sengupta

Patient Sticker

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Time Received : Time Discharged :

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 SP0 ₂											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 : ☐ O ₂ Mask ☐ Nasal Prongs ☐ Tracheostomy ☐ T-Piece ☐ Oral Airway ☐ Nasal Airway Vomiting : ☐ Yes ☐ No Drug: NG Tube : ☐ Yes ☐ No Drain: ☐ Yes ☐ No Urinary Catheter: ☐ Yes ☐ No Chest Tube: ☐ Yes ☐ No Nil Oral ☐ Yes ☐ No IV Fluids: Oral Feeds:										

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature

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

Anaesthesiologist Name :

Anaesthesiologist Signature:

Date & Time:

PACU Nurse Name :

PACU Nurse Signature:

Date & Time:

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):

Date & Time:

BAH-00643120
Mrs SHUSHMA DAKURI
27-11-1996 29 Y 7 M 14 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA



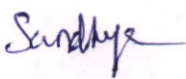
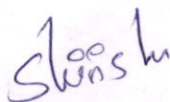
EPIDURAL ANALGESIA RECORD

b)

[illegible]

Date and Time : 11/7/26 11:00pm

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00643120 IP5-00176253 Mrs SHUSHMA DAKURI 27-11-1996 29 Y 7 M 14 D (F) Dr. SHRUTHI REDDY/Dr. LAVANYA 		Date & Time of Admission 11/7/26 @ 11:21 am	Date & Time of Transfer Order 11/7/26 @ 11:30 pm
		Transfer Ordered by Dr Shruthi Reddy	Reason for Transfer observation
From Unit BB-II	To Unit 3rd Floor Room No (335)	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 35	Number of Imaging Films 4	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 		Name of Person Ordered Transfer Dr Sravanthi	
Patient & Clinical Records Received by :			
Date & Time of Patient Received :		11/7/26 11:30 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

BAH-00643120 IP5-00176253
Mrs SHUSHMA DAKURI
27-11-1996 29 Y 7 M 15 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA

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NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 12/7/26

Time: 9:30am

Origin: Indian

Height: 154cm

Weight: 64kg's

BMI: 27 kg/m²

Food Allergies: No

Diagnosis: PND-1 / SVD (spontaneous vaginal delivery)

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

Diet Advised:

Soft High protein diet

Include plenty of oral liquids

Avoid spicy, chilled and outside foods.

Patient's / Attendant's

Signature: D. Shushma

Name: D. Shushma

Date & Time: 12/7/26

9:40 am

Dietician's

Signature: Saima

Name: SAIMA

Date & Time: 12/7/26

9:30 am

DIETARY NOTES

[illegible]

BAH-00643120 IP5-00176253
Mrs SHUSHMA DAKURI
27-11-1996 29 Y 7 M 14 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA



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SURGERY DETAILS

Date : 11/7/2026
Patient Name: Mrs. Shushma Dakuri Date of Birth: 27/11/1996 Age: 29 y
Gender: Female Ward: BC UHID No: BAH-00643120
Date of Surgery: 11/7/26 ☐ OT-1 ☒ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2
Name of the Surgery: NVD + Epidural

Time in : 8pm

Time Out : 9pm

	NAME	AMOUNT
1. Surgeon	Dr. Kirti Reddy	
2. Anaesthetist	Dr. Sunidhara	
3. Assistant Surgeon	Dr. Sravanthi	
4. OT Technician		
5. Circulating Nurse	Sis. Rajeshwari	
6. Assistant Nurse	Sis. Swarna	

Special Equipment: ☐ Laparoscopy ☐ Bronchoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9698534

Order by: Swarna