

Signature and Date : Anita, 22/7/26
(P.T.O)

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU /
2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

ADMISSION SHEET

Registration Details :



Admission No : IP5-00176598

Admit Date : 19-Jul-2026

Admit Time : 08:16 AM UHID : BAH-00455694

Patient Details :

Patient Name : Mrs SINDHURA REDDY

Age : 32 Y 3 M 11 D

Guardian : Mr VASISHT REDDY

DOB : 08-04-1994

Gender : Female

Religion :

Occupation :

Martial Status : Married

Address (H) : PLOT NO. 595, ROAD NO. 32 Jubilee Hills
Hyderabad Telangana INDIA 110005

Phone No : 9100008494/ 7799004444

E-mail : appidi97@yahoo.com

Admission Details :

Bed Type : PRESIDENTIAL SUITE

Bed No : PRESIDENTIAL SUITE 2 (423) Ward Name : 4F-BIRTHRIGHT

Room No : PRESIDENTIAL SUITE 2
(423)

Admission Type : First Visit

Contact Details :

Name : Mr VASISHT REDDY

Relationship : Husband

Contact Address : PLOT NO. 595, ROAD NO. 32 Jubilee Hills
Hyderabad Telangana INDIA 110005

Phone No : 9100008494 / 7799004444


Signature

Doctor Details :

Doctor Name : Dr. PRANATHI REDDY A

Specialisation : OBSTETRICS AND GYNECOLOGY

Referral Doctor : SELF

Phone No :

Co-Consultant :

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : SELFPAY

BAH-00455694 IP5-00176598
Mrs SINDHURA REDDY
08-04-1994 32 Y 3 M 11 D (F)
Dr. PRANATHI REDDY A



ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP No : _____ Consultant: _____ Dept : _____

Date of Admission: _____ Time : _____ Date of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	NHA	20/7/2026	9712923	
2	Dr. Brundavani	20/7/26	9712922	Swapna
3	Dr. Shreya	21/7/26	9715012	Swapna
4	Dr. Aruna Sharma	21/7/26	9715012	
5				
6				
7				
8				
9				
10				

[illegible]

Date _____

Investigations

Order No.

Signature

197/26

NST - ①

265-086254

Young

20/2

CBP

26072595

penis.

CBP creatinine

22/7

electrolytes

260 f8529 f8529

Date	Procedure	Quantity	Order No.	Signature
10/7/26	PAC	1	97-12918	Yanny
10/7/26	Catheterization	1		Yanning
10/7/26	IV placement	1		Yanning

ANY OTHER INFORMATION

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
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Date :

Time :

Prepared By :

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor

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PS-12

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NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 20/7/26

Time: 9am

Origin: Indian

Height: 159cms

Weight: 71 kgs

BMI: 28.1 kg/m²

Food Allergies: NO

Diagnosis: P00-1 (LSCS) [lower segment cesarean section]

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

Diet Advised:

Soft high protein diet
plenty of oral liquids
- Avoid spicy, chilled, outside foods

Patient's / Attendant's

Signature: [Signature]

Name: Sindhura

Date & Time: 20/7/26, 9am

Dietician's

Signature: [Signature]

Name: Nikitha

Date & Time: 20/7/26, 9am

DIETARY NOTES

[illegible]



IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

For elective VCS

Obstetric Formula:

G2P1L1

Obstetric History:

1 stp. Sep. 2021 - FTLCS (mat. Request)
Boy - 3.2kg, A + H

Present Pregnancy Record:

2ndp. P.P. Sp. Conception
Booked at 8th wky.

RISK FACTORS:

✓ No fever & Rash at 10wks
(measles) / varicella +ve
↓
treated w/ Acyclovir.

✓ Fetal medicine specialist consultation

Height: 159 cm

Weight: 71 kg

Allergies: NKA

Breast: ☒ Normal ☐ Abnormal

General Examination:

Consciousness: conscious Pallor: Absent

Icterus: absent Edema: absent

Temp: afebrile PR: 10 bpm

BP: 107/72 (80) DTR: NAD

CVS: NAD RS: NAD

Liver/Spleen: Not palpable Urine Output: Adequate, clear

DIAGNOSIS

G2P1L1 32th / Previous 1 VCS / elective VCS.

LMP: 21/10/2025

EDD:

Corrected EDD: 28.07.2026 GA: 38th 5

Menstrual History: Regular: ☒ Yes ☐ No

Obstetric Examination

Fundal Height: Term size

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

Liquor: ☒ Adequate ☐ Oligo ☐ Poly

PP: ☒ Cephalic ☐ Breech Others

Head Fifths Palpable:

FHS: ☒ Normal ☐ Tachy ☐ Brady ☐ Absent

Per Speculum Examination

Draining: ☐ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination

Cervix: ☐ Long ☐ Partially effaced ☐ Effaced

Os: Closed Dilated

Membranes: ☐ Present ☐ Absent

Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Presenting Part: ☐ Vertex ☐ Breech ☐ Others

Sutton: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Pelvis: ☐ Adequate ☐ Doubtful

Doctor Name: _____
Signature: _____
Date & Time: _____

Consultant Name: Dr. Pranathi Reddy
Signature: _____
Date & Time: 19/1/2026 8 AM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/12/26	<u>Pod - 01 P2121 E1.154</u>	
12 PM	PT - Stable G-c-fair Afebrile PR - 70/min BP - 110/70 mmHg PIA - ut (R) well LIE - NAB	<u>Adv:-</u> ① NBM x 4-6 hrs ② IV fluids - Axon ③ Drugs as charted ④ Monitor vitals every ⑤ w/ excessive Bleeding PR ⑥ I/O charting. ⑦ Inform SOS for (Dr. Lavanya)
Baby Mother Side.		
UO - 200ml clear		
CBP tomorrow 6 AM	Skin suturing with Prolene - 1 <u>Plan:-</u> Suture removal on day - 7. noted by Sr. Yasmine (018268)	
19/12/26	PT - comfortable.	
4 PM	G-c-fair Afebrile PR - 80/min BP - 110/70 mmHg PIA - ut (R) well LIE NAB	<u>Adv:-</u> ① Sips of oral fluids followed by liquids ② Soft diet at 6 PM. ③ Drugs as charted ④ Monitor vitals w/ ⑤ I/O charting. ⑥ Inform SOS for (Dr. Lavanya)
Baby - Mother Side.		
UO - 600ml clear.	Skin suturing & Prolene	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/12/26 8:30 AM	<u>Pod-01 P2121 EL-154</u> PT - stable G-c-fair Afebrile PR - 80/min BP - 110/70 mmHg PIA - ut @ well LLE - NAB	<u>Adv:-</u> ① Soft diet ② oral hydration ③ Ambulation ④ Drugs as charted ⑤ Monitor vitals uty ⑥ I/O charting ⑦ Inform SOS by (Dr. Lavanya)
	- Sutures Removal on Day-7 - CBP tomorrow 6 AM - Remove Foley's tomorrow at 6 AM	
20/12/26 9 AM	<u>Pod-31 P2121 EL-154</u> PT - stable G-c-fair Afebrile PR - 80/min BP - 110/70 mmHg PIA - ut @ well LLE - NAB	<u>Adv:-</u> ① Soft diet ② oral hydration ③ Ambulation ④ Drugs as charted ⑤ Monitor vitals uty ⑥ w/ excessive bleeding pr ⑦ Inform SOS by (Dr. Lavanya)
20/12/26 Hb - 12.0 (12.5) CBC - 9.46 (9.66) PH - 1.12 (1.32)		
	- Foley's removed - check voiding - Matus	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/12/26 2pm	c/s/B- Dr. Pranathi Pt is stable. No c/o O/C - AC - fair BP - 111/68 [78] PR - 88 bpm SpO₂ - 100% on RA. P/A - Ut well retracted. Deeking day contact soft distension @ c/c - lochia @ healthy	Advise 1) soft diet 2) Hydrate/Lambolator 3) Drops as charted 4) Vitale 4th day 5) W/B heavy bleed 6) T. Buscopan 10mg TID. 2 DULCOWASE sup 27 PR.
20/12/26 2pm	Pt comfortable O/C AC - fair vitah - stable PR - uterus retracted well c/c - lochia healthy	Adv - soft diet, plenty of oral fluids - drops as per charted - vitah 4th day - infusions

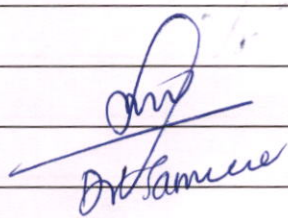
PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/4/20	POD 2 USUS	Adv
8:50 AM	o/e AC - fair vitals - stable P/A - uterus	- soft diet, plenty of oral fluids - drugs as per charted
W	retained well	- vitals stable
N	soft distension ⊕	- Ambulate
SV	46 - lochia	- w/f albie
Baby - well	healthy	Bleeding DV
		- Ambulate sup 2 stat
		- Inform AB
21/4/20		
2 PM	pt comfortable.	Adv
	o/e	- soft diet, plenty of oral fluids
	GC - fair	- drugs as per charted
W	vitals - stable	- vitals 6th day
N	P/A - uterus retracted	- Ambulate
SV	well	- w/f albie
Baby - well	soft distension ⊕	Bleeding DV
	BS ⊕	- Inform AB
	46 - lochia	
	healthy	
	noted by Sr. Nurse (signature)	

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08-04-1994 32 Y 3 M 11 D (F)
Dr. PRANATHI REDDY A

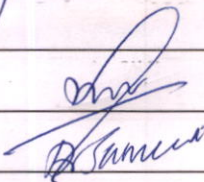


PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11 AM 22/7/26.	SOFT DISTENSION. BS ✓	
	ULTRASOUND SCAN ABDOMEN & PELVIS	
	CBP S- ELECTROLYTES S- CORTISOL.	
22/7 2:20 PM	Pt is sleeping do not wish to get disturbed	
		



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/06/20 2pm	Pt com fracture	Alv
Cx ↓ SV	O/E ac fac vitals - stable P/A uterus retacted well c/o lochia healthy	- soft dull pleural dorsal fluids - lungs as per chatted - vitals 6th way - Ambulate - w/f active Buddy w/ - before pt
Vg And spin @ CBP- 11.5 / 9.30 / 1.52 Nat/K+Ca-- B3/4.4/106 Creat 0.8		
Noted by Sis Anita		



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PROGRESS NOTES AND DOCTOR'S ORDER

Docu. No. : RCHBH /FRM / CLINICAL / 088

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PSTP


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CROSS CONSULTATION FORM

Doctor Name : Shruti Reddy Date : 22/04 Time : 4pm

Diagnosis :

Hospital :

Type of Referral :

☐ Emergency

☐ Urgent

☐ Non Urgent

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

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

CM

Signature:

Findings and Recommendations :

Consultant :

Name : Shruti Reddy Signature : [Signature] Date & Time : 22/04

4pm

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P001 - PARTUM ASSESSMENT FORM - IN-PATIENT

Date: 21/7/26

Chief Complaint: no complaints

Obstetric/ Birthing History: prev @ hus.

Previous Surgical/Medical History: -

Assessment :

On Observation: Mother seen in lying down /sitting/ reclined position

Mother is active & alert / drowsy / tired or exhausted / mobile by herself & ambulatory / needs assistance with mobility

Iv line + / -

Catheter + / -

Postural alignment - could not be assessed.

On Palpation : Edema - absent / up to ankle / up to knee/ above knee

On Examination : Breathing pattern - abdominal/ apical/ diaphragmatic

Diastasis recti abdominis - present / absent / could not be assessed

Able to initiate Pelvic Floor Activation - ☒ Yes ☐ No

Spl Notes -

Treatment Plan :

☒ Lateral Breathing

☒ Pelvic Floor Activation

☒ Transversus Abdominis Activation

☒ Gluteus Activation

☒ Active Motion for Limbs

☒ Transfer Training & Mobility

☐ Sit to Stand

☐ Monitored Walk

☐ Posture & Ergonomic Education

Signature: TS

Name: Dr. Tulheena Sharma

Date & Time: 21/7/26, 2:30 pm

Page 1
Date
Page

UNIT - PARTIAL ASSESSMENT FORM

Name: John Doe
Date: 10/15/2023
Teacher: Mr. Smith

Unit: Math
Lesson: 1.1
Assessment: Partial

Score: 85%
Comments: Good work on the unit.

Strengths: Understanding of the unit.
Weaknesses: None

Recommendations: Continue to work on the unit.
Next Steps: Review the unit.

Signature: Mr. Smith
Date: 10/15/2023

Parent Signature: Mr. Doe
Date: 10/15/2023

Teacher Signature: Mr. Smith
Date: 10/15/2023

Student Signature: John Doe
Date: 10/15/2023

Comments: Good work on the unit.
Date: 10/15/2023

Patient St

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CAESAREAN SECTION OPERATIVE NOTES

Surgeon's Name: <u>Dr. Pranathi Reddy</u>	Date of Delivery: <u>19/07/2026</u>
Assistant Surgeon: <u>Dr. Lenya</u>	Time of Delivery: <u>11.15 Am</u>
Anaesthetist's Name: <u>Dr. Subhramanyam</u>	Gender of Baby: <u>Female</u>
Type of Anaesthesia: <u>↓ spinal</u>	Weight of Baby: <u>3.063kg</u>
Neonatologist: <u>Dr. Somenya</u>	AGPAR Score: <u>9, 9</u>
Scrub Nurse: <u>Lenya</u>	NICU Admission: ☐ Yes ☒ No

Pre-Operative Diagnosis: Gest. / 38+5 wks / Pre-eclampsia for Eclampsia

☐ Elective ☐ Emergency Indication: Pre-eclampsia

Urgency

☐ Immediate Threat to life of woman or fetus

☐ Maternal or fetal compromise not immediately life threatening

☒ No maternal or fetal compromise but needs early delivery

☐ Delivery timed to suit woman and staff

Decision time: Knife to rectus: 2 mins

CTG Description: Reactive

If there was a delay give the reasons:

Surgical Procedure: Eclampsia + SA

Post Operative Diagnosis: POD-0 / P212 / Eclampsia + SA

Peri-Operative Complications: Nil

Amount of Blood Loss: <u>~ 500ml</u>	Blood Transfused (in ML): <u>Nil</u>
--------------------------------------	--------------------------------------

Name and Number of Surgical Specimen sent for examination:

Nil

Examination Findings when Appropriate:Presentation: ☐ Cephalic ☐ Breech ☐ Other

Cervical Dilatation: cm

5th Palpable:

Fetal Position:

Station: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2Moulding: ☐ None ☐ + ☐ ++ ☐ +++Caput: ☐ + ☐ ++ ☐ +++Meconium: ☐ None ☐ + ☐ ++ ☐ +++Bladder Catheterized: ☐ Yes ☐ NoUrine: ☐ Clear ☐ Blood StainedSkin Incision: ☒ Pfannenstiel ☐ Transverse ☐ Midline ☐ OtherUterine Incision: ☒ Lower Segment ☐ Classical ☐ Inverted T ☐ J IncisionPrevious Scar: ☐ Intact ☒ Thinnedout ☐ Ruptured ☐ No ScarIncision Through Placenta: ☐ Yes ☒ NoDelivery of head: ☒ Manual ☐ ForcepsLiquor: ☒ Clear ☐ Meconium: ☐ I ☐ II ☐ III ☐ Blood ☐ Offensive ☐ Not OffensiveDelivery of Placenta: ☐ Manual ☒ CCT ☒ Complete ☐ Incomplete ☐ PiecemealCord Appearance: Normal Cord around the neck ☐ Yes ☒ NoAppearance of placenta: Normal Cavity explored ☒ Yes ☐ NoUterus, tubes and ovaries: ☒ Normal ☐ Not Normal Sterilization: ☐ Yes ☒ NoUterine Closure: ☐ One Layer ☒ Two Layers Vicryl 1-0 SuturePeritoneal Closure: ☐ Pelvic ☐ Abdominal ☒ None SutureSheath Closure: Vicryl 1 SutureFat Closure: ☒ Yes ☒ No SutureSkin Closure: ☒ Subcuticular ☐ Mattress Prolene - 1 SutureVaginal Evacuated ☒ Yes ☐ NoDrain: ☐ Yes ☒ No ☐ Remove in days ☐ Await instructionsCatheter: ☒ Yes ☐ No ☐ Remove in 2 wks days ☐ Await instructionsSwap & Instruments count correct? ☒ Yes ☐ No ☐ Post-op Antibiotics ☐ Yes ☒ NoIntra-Operative Antibiotics Cover: ☒ Yes ☐ No ☐ Thromboprophylaxis ☐ Yes ☒ No

Post-Operative Notes:

- HBM x 4-6 hrs- IV fluids - Aron- Drugs as charted- Monitor vitals hourly- I/O charting- with excessive bleeding Plv.- Inform G.O.Doctor Name: Dr. Lavange Doctor Signature: hDate & Time: 10/2/26 12pm



RISK ASSESSMENT TOOL FOR DEEP VEIN THROMBOSIS (Postnatal Assessment and Management (to be assessed on delivery suite))

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

Signature of the Doctor: [Signature] Date: 19/7/26 Time: 12 PM

Action Plan: Hydration and Ambulation

Risk Assessment Tool for Deep Vein Thrombosis

- ☐ If total score ≥ 4 antenatally, consider thromboprophylaxis from the first trimester.
- ☐ If total score 3 antenatally, consider thromboprophylaxis from 28 weeks.
- ☐ If total score > 2 postnatally, consider thromboprophylaxis for at least 10 days.
- ☒ If total score = 2, Hydration & Ambulation.
- ☐ If admitted to hospital antenatally consider thromboprophylaxis.
- ☐ If prolonged admission (≥ 3 days) or readmission to hospital within the puerperium consider thromboprophylaxis.
- ☐ For patient with an identified bleeding risk, the balance of risks of bleeding and thrombosis should be discussed in consultation with a haematologist with expertise in thrombosis and bleeding in pregnancy.

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Patient Sticker


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POST-SURGICAL CARE PLAN FORM

Procedure Done: E.L. USG LSA.

Post-Surgical Diagnosis: Post-op P212 L.E.L. USG LSA.

Post-Operative Monitoring Parameters /Frequency:

- Monitor vitals hourly
- No charting

Wound Care:

- Check for wound Soakage

Drain /Special Lines/Catheters:

- Foley's insert

Special Patient Positioning and Requirements:

Nutritional Instructions:

- NBM x 6 hrs
- followed by liquids

When to Start Mobilization:

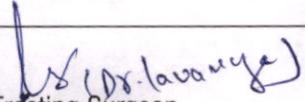
- After 12 hrs

Special Referrals:

The new order for all required medications documented in the doctor order/medication sheet:

☒ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up


Treating Surgeon
(Signature & Stamp)

Date: 12/7/26 Time: 12 pm

Note: Plan of care will be readjusted if necessary.

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 Mrs SINDHURA REDDY
 08-04-1994 32 Y 3 M 14 D (F)
 Dr. PRANATHI REDDY A



Caesarean Section Audit Format
(To be filled by doctor conducting C-Section)

Name of the Facility:

Encircle type of facility: MCH/DH and equivalent/SDH and equivalent/AH and equivalent/FRU-CHC and equivalent

Mention unit _____ (Applicable for medical college/tertiary setting/district hospital)

Date:

I	Patient Information	Response
1	Name of the woman undergone C-section	
2	Age of woman	
3	Hospital No./Patient identification no.	
4	G/P/L/A	
5	Booking status	Booked/Booked elsewhere/Un-booked
6	Maternal height and weight	Ht: cm Wt: Kg
7	Date of Admission	
8	Date and time of delivery by CS	Date: Time: ☐ 9am - 6pm ☐ 6pm - 9pm ☐ 9pm - 12am ☐ 12am - 6am ☐ 6am - 9am

II	Obstetric History	Response
1	Estimated gestation, in completed weeks	
1a	Encircle the appropriate basis of estimated gestational	
2	Number of previous stillbirths >24weeks, if any	
3	Was the mother referred to this hospital from another facility	
3a	Gestational age at the time of referral	
3b	If preterm, was AN corticosteroid given prior to referral	
4	Tick the appropriate group in which pregnant woman belongs to	☐ Group 1: Nulliparous, with a single cephalic pregnancy, ≥37 weeks gestation in spontaneous labour ☐ Group 2: Nulliparous, with a single cephalic pregnancy, ≥37 weeks gestation who had labour induced or were delivered by CS before labour ☐ Group 3: Multiparous, without a previous CS, with a single cephalic pregnancy, ≥37 weeks gestation in spontaneous labour

		☐ Group 4: Multiparous, without a previous CS, with a single cephalic pregnancy, ≥ 37 weeks gestation who had labour induced or were delivered by CS before labour ☐ Group 5: All multiparous, with at least one previous CS, with a single cephalic pregnancy, ≥ 37 weeks gestation ☐ Group 6: All multiparous, with a single breech pregnancy ☐ Group 7: All multi parous, with a single breech pregnancy including women with previous CS(s) ☐ Group 8: All women with multiple pregnancies including women with previous CS(s) ☐ Group 9: All women with a single pregnancy with a transverse or oblique lie, including women with previous CS(s) ☐ Group 10: All women with a single cephalic pregnancy < 37 weeks gestation, including women with previous CS(s)	
III	Details of Caesarean Section	Response	
1	Name the senior most obstetrician involved in the decision to perform the caesarean section?	Unit chief/ Duty assistant/HOD/Assoc. Professor/Assistant professor/Others	
2	Decision - delivery interval		
3	Which of the following best describes the indication for CS?	☐ Singleton breech ☐ Malpresentation / Unstable ☐ Multiple pregnancy ☐ Presumed fetal distress/IUGR/Abnormal CTG ☐ Cord prolapse ☐ Sepsis/Chorioamnionitis ☐ Placenta previa, actively bleeding ☐ Placenta previs, not actively bleeding ☐ Postdatism ☐ Oligohydramnios ☐ Previous Caesarean section ☐ Placental abruption ☐ Intrapartum haemorrhage ☐ Pre-eclampsia/eclampsia/HELLP ☐ Failure to progress (induction/in labour) ☐ Maternal medical disease (see key) ☐ Uterine rupture/scar dehiscence ☐ Previous poor obstetric outcome (BOH) ☐ Long period of infertility ☐ Others (Specify) _____	
4	Was partograph used prior to decision for CS (if Yes, attach a copy of filled photograph)		
5	Were the membranes ruptured (ROM) prior to the caesarean section?	Spontaneous ROM / ARM	
6	Duration of first stage of labour	Hr:	Mins:
7	Duration of second stage of labour	Hr:	Mins:

8	What cervical dilatation was reached prior to the caesarean section?	
9	Were prophylactic antibiotics given?	
10	What was the estimated blood loss?	
11	Blood / component transfusion	If so, mention no of units

IV	In case of previous caesarean delivery	Response
1	Mention the indication and gestation of previous LSCS (start from most recent LSCS)	LSCS 1 _____ Gestation _____ LSCS 2 _____ Gestation _____ N/A
2	Was the mother offered a trial of vaginal delivery during the pregnancy?	
3	Post OP complications, if any	

V	Current Status	Response
1	Does this mother require 'special' care post-caesarean section in addition to routine post-op care?	Yes / No
1a	If YES, where is she being managed currently?	Obs HDU / ICU General HDU / ICU Referred to another hospital
2	Whether fetal heart monitoring - Manual / Electronic was done (tick appropriately)	A) Normal B) Abnormal C) Severely abnormal D) Not done
3	Whether Meconium-stained liquor present (tick appropriately)	A) Yes B) No C) Not known
4	Other methods of delivery attempted (tick appropriately)	A) None B) Forceps C) Ventouse
5	Delivery outcome (tick appropriately)	A) Livebirth B) Stillbirth
6	Sex of the baby (tick appropriately)	A) Male B) Female C) Unknown
7	Birth weight	
8	Apgar score (tick appropriately)	A) Score at 1 minute _____ B) Score at 5 minutes _____ C) Not done
9	Transferred to SNCU/NICU (tick appropriately)	A) Yes _____, where _____ B) No
10	Maternal outcome (tick appropriately)	A) Stable and in satisfactory condition B) Shifted to Obstetric HDU/ICU due to any complications or for close monitoring C) Maternal near miss D) Maternal death. Mention cause of death _____

11	Newborn outcome (tick appropriately)	A) Stable and in satisfactory condition B) Admitted in SNCU due to complications or for close monitoring C) Still birth D) Born alive and died (Mention cause of death _____)
12	Tick appropriately on the need of C Section	A) Absolutely essential at that time B) More time could have been given before deciding for CS

Name and Designation of doctor

Signature with Seal

Date

*** Key for Medical Disorders:**

1. Heart disease complicating pregnancy
2. Past history of cardiac surgery like valve replacement
3. Jaundice complicating pregnancy
4. Bronchial asthma / COPD
5. Tuberculosis - pulmonary / extra pulmonary
6. Known seizure disorder - on treatment / not on treatment / treatment discontinued
7. Known hypertensive - on treatment / not on treatment / treatment discontinued
8. Known diabetic - on treatment / not on treatment / treatment discontinued
9. Chronic renal disease
10. Anemia other than iron deficiency anemia

Glossary

- Gravida denotes a pregnant state both present and past, irrespective of the period of gestation
- Parity denotes a state of previous pregnancy beyond the period of viability
- Nullipara: A nullipara is one who has never completed a pregnancy to the stage of viability. She may or may not have aborted previously
- Multipara: Multipara is one who has completed two or more pregnancies to the stage of viability or more

Patient Sticker

BAH-00455694 IP5-00176598
 Mrs SINDHURA REDDY
 08-04-1994 32 Y 3 M 14 D (F)
 Dr. PRANATHI REDDY A

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 19/02/2020

Department : Mrs SINDHURA REDDY
 08-04-1994 32 Y 3 M 11 D (F)

Duration of Procedure : 1 hr

Name of Surgeon : Dr. PRANATHI REDDY A

Date of Admission : 19/2/20

Bundle Care Criteria : (Tick (✓) if done)

		Staff Signature
1.	Antibiotic given prior to surgery ? ☒ Yes ☐ No ☒ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☒ Yes ☐ No Name of the Antibiotic : <u>Bi-Taxim 1gm</u>	<i>R. Litter</i>
2.	Hair Removal ☒ Yes ☐ No if Yes : Surgical Clipper Department where Hair Removed : ☒ Ward ☐ Operating Room ☐ Other : _____ Skin preparation done (cleanse surgical area with antiseptic agent) ? ☒ Yes ☐ No	<i>R. Litter</i>
3.	Patient's body temperature immediately post operation (Recovery Room) <u>36.2°C</u> ☐ Oral Or ☒ Axilla (Goal : 36-37 °C)	<i>R. Litter</i>
4.	Name of doctor or staff administering the antibiotic : <u>Dr. Deepika</u> Date & Time of antibiotic administration : <u>19/2/20 @ 10 AM</u> Date & Time procedure started : <u>19/2/20 @ 10.45 AM</u>	<i>R. Litter</i>

- Ensure form is filled in completely by assigned staff whenever patient had surgery
- If any bundle care criteria has not been observed or unmet, assigned staff must inform infection control nurse for management
- All forms (Bundle care and when required SSI form) are completed properly
- Forms must always be kept in Infection Control folder in respective department

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00455694 IP5-00176598 Mrs SINDHURA REDDY 08-04-1994 32 Y 3 M 11 D (F) Dr. PRANATHI REDDY A 		Date & Time of Admission 19/12/26 @ 8.16 AM	Date & Time of Transfer Order 19/12/26 @ 12 PM
		Transfer Ordered by Dr. Lavanya	Reason for Transfer post OP
From Unit ORG 05	To Unit PS-11	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 36	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If Yes, what?	Patient shifted with ID band: Yes ☐ No ☐ If No:	
Number of Imaging Films NST 7			
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Pending Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring S. Lakshmi		Name of Person Ordered Transfer Dr. Lavanya.	
Patient & Clinical Records Received by : S. Yamma			
Date & Time of Patient Received : 19/12/26 @ 11:55 AM			

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



DRUG CHART

Date of Admission: 11/7/2026 Drug Allergies: NKDA ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name Signature

REGULAR PRESCRIPTIONS

Weight. Ward. BRP

DRUG : Tab. PARACETAMOL

Date Time 19/7 2017

Dose 1g Route PO Frequency TID Start Date 19/7

Name & Signature of the Doctor Starting the Drugs:

Dr K Sri Surya

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : Tab. TRAMADOL

Date Time 19/7 2017

Dose 100mg Route PO Frequency TID Start Date 19/7

Name & Signature of the Doctor Starting the Drugs:

Dr K Sri Surya

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : Tab. DICOPIRAC

Date Time 19/7 2017

Dose 50mg Route PO Frequency TID Start Date 19/7

Name & Signature of the Doctor Starting the Drugs:

Dr K Sri Surya

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : INJ. CEFOTAXIME

Date Time 19/7 2017

Dose 1g Route IV Frequency BD Start Date 19/7/25

Name & Signature of the Doctor Starting the Drugs:

(Dr. Lavanya)

Additional Instructions:

x 2uhers followed by oral.

Daily Doctor's Endorsement by a Sign

BAH-00455694 IP5-00176598
Mrs SINDHURA REDDY
08-04-1994 32 Y 3 M 11 D (F)
Dr. PRANATHI REDDY A



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Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward BRP

DRUG : <u>T. PANTOPRAZOL</u>				Date Time	<u>19/7</u>	<u>20/7</u>	<u>21/7</u>	<u>22/7</u>											
Dose	Route	Frequency	Start Dt.																
<u>40mg</u>	<u>PO</u>	<u>BD</u>	<u>19/7</u>																
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Praveen</u>																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			

DRUG : <u>T. TAXIM</u>				Date Time	<u>20/7</u>	<u>21/7</u>	<u>22/7</u>												
Dose	Route	Frequency	Start Dt.																
<u>200mg</u>	<u>PO</u>	<u>BD</u>	<u>20/7/26</u>																
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Sath</u>																			
Additional Instructions: <u>(Cefexime)</u>																			
Daily Doctor's Endorsement by a Sign																			

DRUG : <u>T. BUSCOGAST</u>				Date Time	<u>20/7</u>	<u>21/7</u>	<u>22/7</u>												
Dose	Route	Frequency	Start Dt.																
<u>10mg</u>	<u>PO</u>	<u>TID</u>	<u>20/7/26</u>																
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Sath</u>																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			

DRUG :				Date Time															
Dose	Route	Frequency	Start Dt.																
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				



Weight. Ward.

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

VARIABLE DOSE		Date▶ Time▼									
			Nurse Sig.▼		Nurse Sig.▼		Nurse Sig.▼		Nurse Sig.▼		
			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
19/7/26	9:00 AM	INS. CEPOTAXIM	1 gram	IV	hp	Yamma 9:02 AM Swarna
19/7/26	8:30 AM	INS. PANTO PRazole	40mg	IV	hp	Yamma 8:35 AM Swarna
19/7/26	8:35 AM	INS. PERINDOM	10mg	IV	hp	Yamma Swarna
19/7/26	11:05 AM	Dij. ONDANSETRON	4mg	IV	✗	Swarna Rishi
19/7/26	11:05 AM	Dij. TRANEXAMIC ACID	1g	IV	✗	Rishi hp
19/7/26	11:45 AM	Supp. TRAMADOL	100mg	PIR	✗	Rishi Swarna
19/7/26	11:45 AM	Supp. DICLOFENAC	100mg	PIR	✗	Swarna Rishi
19/7	4 PM	INS. PARACETAMOL	1gm	IV	Swarna	Swarna Swarna
20/7/26	2 PM	DOLCOLAX Supp	(2T)	PIR	Swarna	Patient refused
21/7/26	9 AM	DOLCOLAX sup	2te	PIR	Swarna	

BAH-00455694
Mrs SINDHURA REDDY
08-04-1994 32 Y 3 M 11 D (F)
Dr. PRANATHI REDDY A

IPS-00176598

I.V. FLUIDS CHART

Weight. Ward.

B/c

[illegible]

Signature _____

Mrs SINDHURA REDDY
08-04-1994 32 Y 3 M 13 D (F)
Dr. PRANATHI REDDY A



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Name:

Weight: kgs

Sheet No:

[illegible]

10455394 IP5-00176598
 INDHL RA REDDY
 1994 32 Y 3 M 14 D (F)
 ANATHI REDDY A

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RESULT SHEET

Date	15/7/26	20/7/26	22/7/26			
Time	op basis	6am	12pm			
Hb	12.5	12.0	11.5			
PCV	37.1	35.8	35.0			
RBC	3.80	3.70	3.58			
WBC	9.66	9.46	9.55			
N/L			79.1/15.8			
Platelets	137	112	150			
CRP			.			
ESR						
PCT						
RBS						
Na			133			
K			4.4			
Cl			106			
Ca/Mg						
Phosphate						
Urea						
Creatinine			0.5			
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						



OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 10/7/26

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: Doctor Notified on Admission: ☒ Yes ☐ No
came for RL-Leg Name of the Doctor: Dr. Deepika
..... Time Notified: 8 AM,

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Nil	LSCS	Nil

Gynecology Assessment: ☐ Not Applicable Menstrual History: Regular Onset of Menarche: Menstrual Cycle: ☐ Regular ☒ Irregular Last Menstrual Period: 21/10/25	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 1 L 1 A

Previous LSCS: Yes

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

Family History: ☒ No Abnormalities Detected

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

Vital Signs / Measurements: Temp: 98.4°F HR: 71b/m RR: 20b/m
BP: 107/72(80) Weight: 71kgs Height: 5'6" BMI: 15.9

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 20 (complete the Morse Fall Risk Assessment Sheet)

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

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

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☒ No Abnormality Detected

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

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

Inform consultant for positive criteria

Cultural & Spiritual Needs: ☐ Yes ☒ No if Yes specify Inform consultant for positive criteria.

SOCIAL SCREENING:

1. **Marital Status:** ☐ Single ☒ Married ☐ Divorced ☐ Widow

2. **Special Habits:** **Smoker:** ☐ Yes ☒ No **Alcohol Abuse:** ☐ Yes ☒ No **Drug Abuse:** ☐ Yes ☒ No

Social History: Lives With Husband

Orientation has been given regarding the following aspects:

- Call Bell in Reach : ☒ Yes ☐ No Waste Disposal Explained: ☒ Yes ☐ No
Infusion Pump : ☐ Yes ☒ No Hand Hygiene Explained: ☒ Yes ☐ No ☐ Others

Above information given to Patient

Name of Person Orientation was given to: Mrs. Sindhura

Orientation not given Reason: Nil

Nurse Signature: Yamsel

Nurse Name: Yamsel

Date & Time: 19/12/24 @ 8:30am



OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 19/7/26 Time of Arrival: 7:50 AM Time Seen by Nurse: 7:55 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: Came for FL - USG

3) **Vital Signs:** Temperature: 98.5°F Pulse: 72 bpm RR: 20 bpm SpO₂: 100% BP: 107/81 Weight: 71 kgs

4) **Gestational Criteria:**

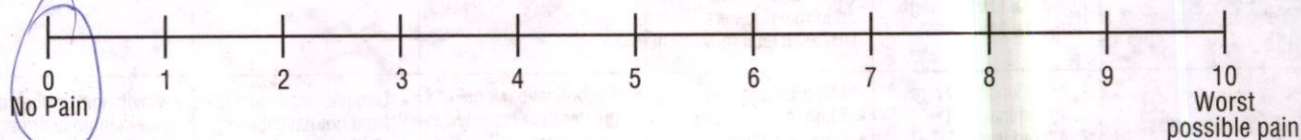
Gravida:	G <u>2</u>	P	L <u>1</u>	A
----------	------------	---	------------	---

LMP: 21/10/25 EDD: 28/07/2026 Gestational Age: 36+5 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: NA
- Duration: NA Days / Weeks/ Months (Strike out which is not applicable)
- Character: NA
- Frequency: NA
- Interventions: NA

6) **Past History:**

- a) Surgeries: LU (9021)
b) Medical: NA



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: 8:10 AM

Nurse Name : Yarnung Nurse Signature: Yarnung

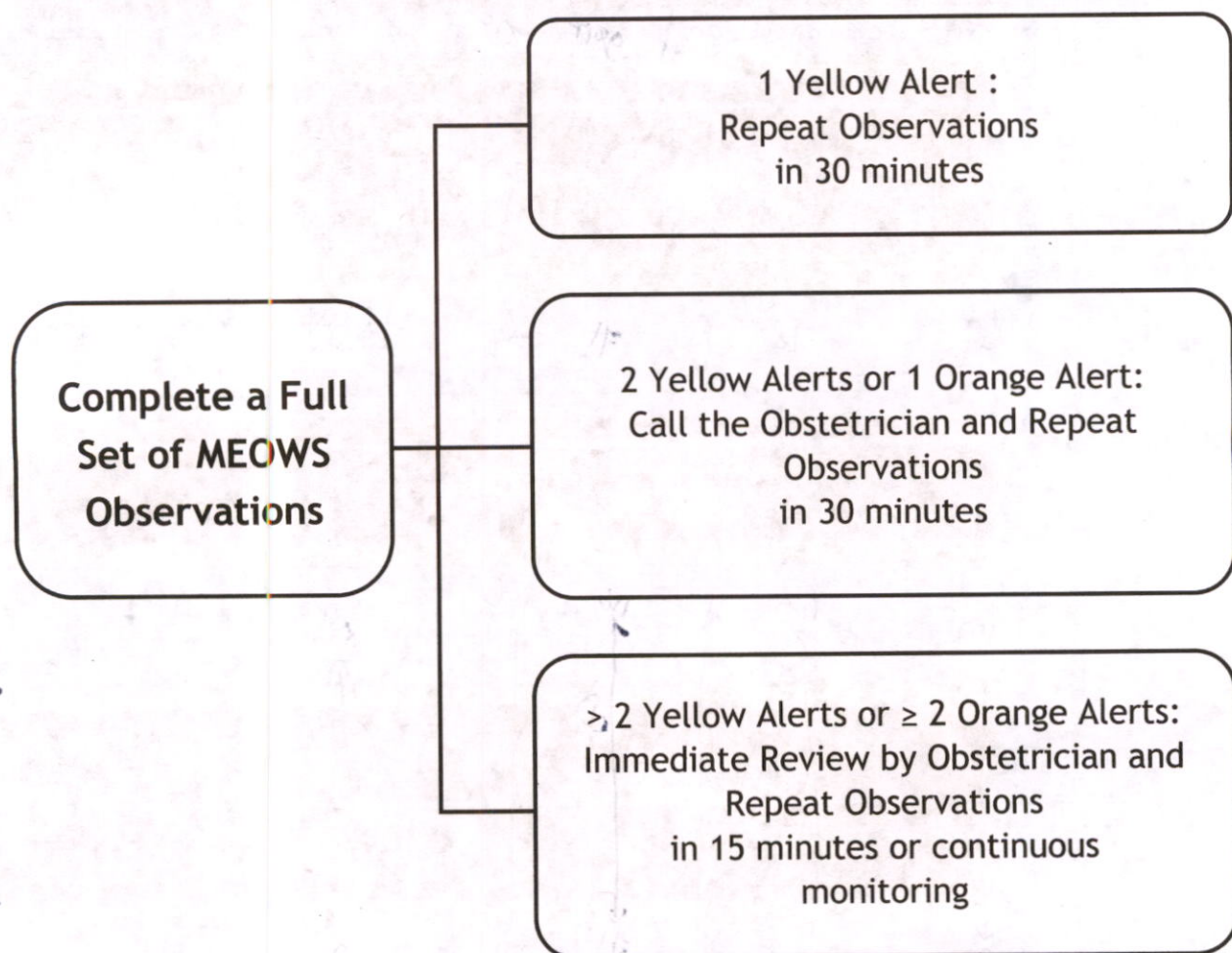
Date: 19/12/26 Time: 8:10 AM



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



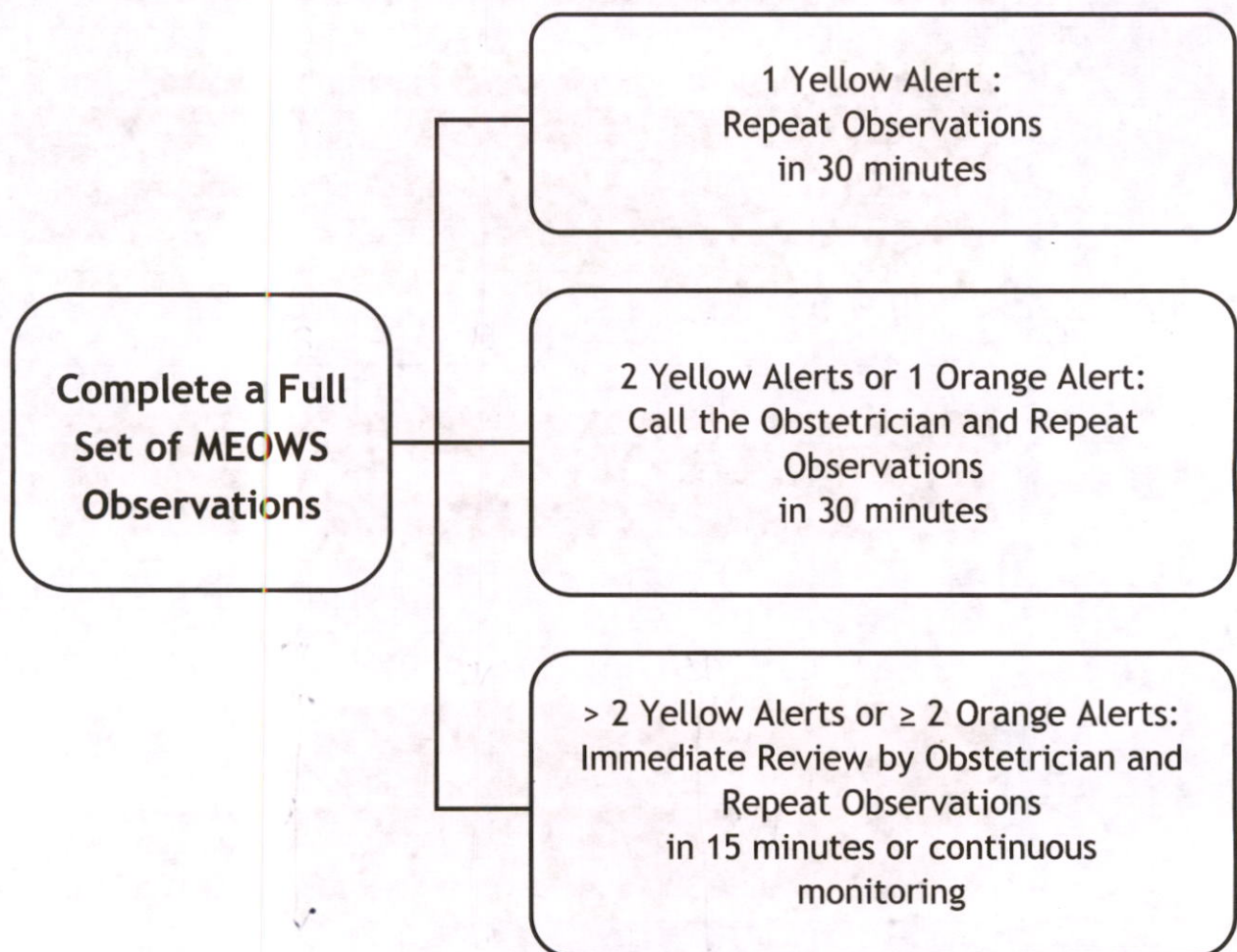
* The Modified Early Warning Score (MEOWS)



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

		Date	20-7-26																							
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20																									
	0 - 10																									
Saturations	94 - 100 %																									
	< 94 %																									
Administered O ₂ (L/min.)																										
Temp °C	40																									
	39																									
	38																									
	37																									
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
40																										
Systolic Blood Pressure	190																									
	180																									
	170																									
	160																									
	150																									

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

BAH-00455684

Mrs SINDHURA REDDY
08-04-1985

IP5-00176598

08-04-1994

32 Y 3 M 13 D

Dr. PRANATHI REDDY A

(F)

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Early Warning Observation Score Chart - Obstetrics

CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT

TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

[illegible]

Obstetrics and Gynaecology Early Warning Signs

Complete a Full
Set of MEOWS
Observations

1 Yellow Alert :
Repeat Observations
in 30 minutes

2 Yellow Alerts or 1 Orange Alert:
Call the Obstetrician and Repeat
Observations
in 30 minutes

> 2 Yellow Alerts or $\geq$ 2 Orange Alerts:
Immediate Review by Obstetrician and
Repeat Observations
in 15 minutes or continuous
monitoring

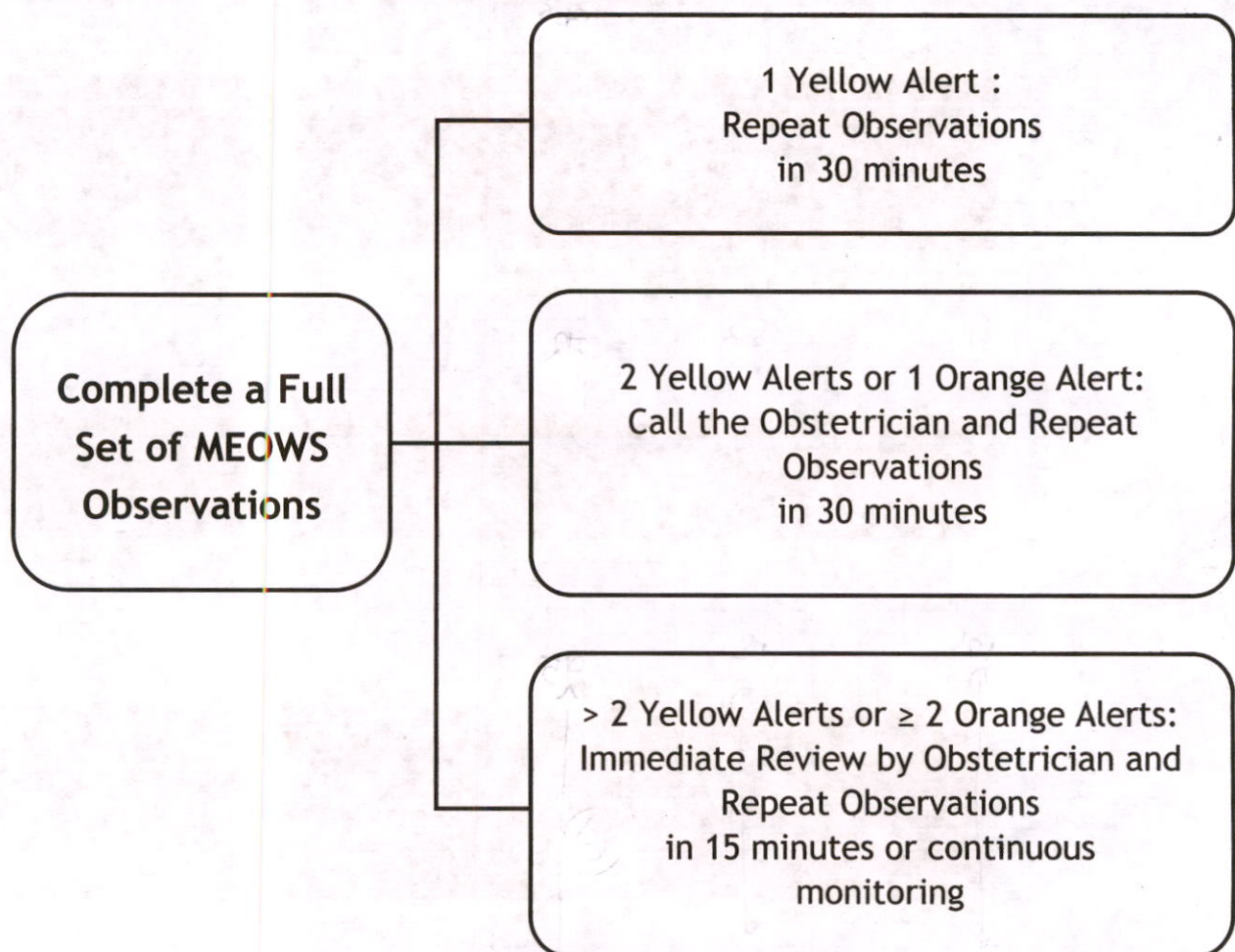
* The Modified Early Warning Score (MEOWS)



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)



FLUID CHART

Sheet No. : ①

19/7/26.

- All measurements in ml.
- 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	
			Mouth	I.V	N.G						
19/7/26	08:00 am	RL	NBM	100ml						✓	0 places
	09:00 am	RL	NBM	100ml							0
	10:00 am	RL	NBM	100ml			NP				0 places
	11:00 am	RL	NBM	100ml							0
	12:00 pm	RL	NBM	100ml						100ml	0 4 hrs
	01:00 pm	RL	NBM	100ml							0 4 hrs
Total Intake :			Taken			Total Output :			U-100ml M-O		
	02:00 pm	RL		100ml							0 Smellie
	03:00 pm	RL		100ml							0 Smellie
	04:00 pm	RL	H2O	100ml			NP			600ml	0 Smellie
	05:00 pm	RL		100ml							0 Smellie
	06:00 pm	RL	H2O	100ml						200ml	0 Smellie
	07:00 pm	RL		100ml							0
Total Intake :			Taken			Total Output :			Passed - 800ml		
	08:00 pm									500ml	0 priza
	09:00 pm		H2O								0 priza
	10:00 pm									500ml	0 priza
	11:00 pm		H2O				NP				0 priza
	12:00 am		H2O							400ml	0 priza
	01:00 am										0 priza
Total Intake :			TAKEN			Total Output :			1400 ml		
	02:00 am										0 priza
	03:00 am		H2O								0 priza
	04:00 am									400ml	0 priza
	05:00 am		H2O				NP				0 priza
	06:00 am										0 priza
	07:00 am		H2O							500ml	0 priza
Total Intake :			Taken			Total Output :			900 ml		

Total 24 hrs. Intake

Total 24 hrs. Output

3200ml

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 Dr. PRANATHI REDDY A



FLUID CHART

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Sheet No. : 2

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.

20-7-26		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							
20/7	08:00 am											
	09:00 am	water					1			✓	no	
	10:00 am						1				W	
	11:00 am											
	12:00 pm	water					1			✓		
	01:00 pm										passed	
Total Intake : <u>240</u>					Total Output : <u>passed</u>							
20/7	02:00 pm											
	03:00 pm	H2O									1	
	04:00 pm						✓			✓	no	
	05:00 pm	H2O									20	
	06:00 pm										connected	
	07:00 pm	H2O									1	
Total Intake : <u>Taken</u>					Total Output : <u>passed</u>							
	08:00 pm											
	09:00 pm	H2O					1			✓	no	
	10:00 pm										IV	
	11:00 pm	H2O					1					
	12:00 am									✓	1	
	01:00 am	H2O					1					
Total Intake : <u>taken</u>					Total Output : <u>passed</u>							
	02:00 am											
	03:00 am	H2O					1			✓		
	04:00 am											
	05:00 am	H2O					1					
	06:00 am									✓		
	07:00 am	H2O					1					
Total Intake : <u>Taken</u>					Total Output : <u>passed</u>							

Total 24 hrs. Intake

Total 24 hrs. Output

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Dr. PRANATHI REDDY A



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FLUID CHART

Sheet No. : 3

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

21/4		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						
21/4	08:00 am								✓		
	09:00 am	tho									
	10:00 am										
	11:00 am	tho				✓			✓	100	No output
	12:00 pm	tho								20	
	01:00 pm	tho									
Total Intake :			taken			Total Output :			Passed		
21/4	02:00 pm										
	03:00 pm	Water									
	04:00 pm								✓		
	05:00 pm	Water									
	06:00 pm								✓		
	07:00 pm	Water									
Total Intake :			Taken			Total Output :			No output		
21/4	08:00 pm										
	09:00 pm	H2O							✓		
	10:00 pm	H2O									
	11:00 pm										
	12:00 am	H2O							✓		
	01:00 am	H2O									
Total Intake :			Taken			Total Output :			No output		
21/4	02:00 am	H2O									
	03:00 am	H2O							✓		
	04:00 am										
	05:00 am	H2O									
	06:00 am	H2O							✓		
	07:00 am										
Total Intake :			Taken			Total Output :			No output		

Total 24 hrs. Intake

Total 24 hrs. Output



FLUID CHART

Sheet No. : 9

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.

22/7		Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am	tho										
	10:00 am											
	11:00 am	tho										
	12:00 pm											
	01:00 pm	tho										
Total Intake :			Taken			Total Output :			Passed			
	02:00 pm											
	03:00 pm	H2O										
	04:00 pm	H2O										
	05:00 pm											
	06:00 pm	H2O										
	07:00 pm											
Total Intake :			Taken			Total Output :			Passed			
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	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: 19/7/26

Assessment:

Patient having fear and anxiety about lscs

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 general condition of the patient	8:30 am	→ Assessed general condition of the patient.	→ Baby patient is stable
9am	→ monitor vitals.	9:30 am	→ monitored vitals.	
10am	→ administer medication as per order	10:30 am	→ Administered medication as per order	
11am	→ monitor I/O chart	11:30 am	→ monitored I/O chart	
12pm	→ Psychological support	12:30 pm	→ psychological support given	
1pm	→ Ensure safety	1:30 pm	→ ensured safety	

Re-Assessment:

Re-assessment done 2nd hrly

Special Notes:

NBM

Nurse Signature:

[Signature]

Nurse Name:

Yamuna

Date & Time:

19/7/26 @ 2pm

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Mrs SINDHURA REDDY
08-04-1994 32 Y 3 M 11 D (F)
Dr. PRANATHI REDDY A



NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 19/7/26

Assessment: patient complaint bear and 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
2pm	→ Assessed the pt general condition.	2:30pm	→ Assessed the pt general condition.	→ patient is fine.
3pm	→ Monitor vitals	3:30pm	→ Monitor vitals.	
4pm	→ Administer medication	4:30pm	→ Administer medication per doctor orders.	
5pm	→ I/O chart.	5:30pm	→ maintain I/O chart.	
6pm	→ given psychological support.	6:30pm	→ psychological support given.	
7pm	→ prevent infection.	7:30pm	→ Ensure safety.	
8pm	→ Ensure safety.			

Re-Assessment: Re-Assessment - done 2nd hourly.

Special Notes: vitals

Nurse Signature:

Nurse Name: Sulekha

Date & Time: 19/7/26 @ 7:30pm.



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 19/7/26

Assessment: patient Complaint 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	→ TO Assess the pt condition Monitor Vitals	8:30pm	→ TO Assess the pt condition Vitals checked & Recorded	
10pm	→ Maintain xlo chart	10:30pm	→ Maintained xlo charting	
12Am	→ Administer medication	12:30Am	→ medication given	
4Am	→ Soft diet	4:30Am	→ Soft diet given	
7Am	→ Ensure safety	7:30pm	→ provided side rails	

Re-Assessment: Re-Assess done

Special Notes:

Nurse Signature: [Signature]

Nurse Name: priya

Date & Time: 19/7/26 @ 8pm

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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 19/12/24

Assessment: patient having pain at surgical site

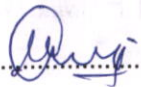
Goals

- ☐ 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
8 PM	Assess the patient general condition	8:10 PM	Assessed the patient general condition	Patient is stable.
10 PM	Vital check.	10:30 AM	Vital checked and documented	
12 PM	Relieve pain and discomfort	12:20 PM	Administer medication as per drug chart	
2 AM	ILo chart monitor	2:10 AM	ILo chart monitoring	
4 AM	Ambulation to reduce anxiety	4:10 PM	Ambulation done on bed moving leg	
6 AM	Prevent infection	6:20 AM	Maintaining hand hygiene	
8 AM	Ensure safety	8:12	Ensure safety needs	

Re-Assessment:

Special Notes: CRP Trace

Nurse Signature: 

Nurse Name: Nandini

Date & Time: 20/12/24 8 AM

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NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 20-7-26

Assessment: Patient is having less side pain

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	8:30AM	Assessed the Patient general condition	Patient is
9AM	Monitor vitals and Recorded	9:30AM	Monitoring vitals and Recorded	Stable
10AM	Administer medication as doctor advice	11AM	Administered medication as doctor advice	
12PM	Ambulation Done	2PM	Ambulation Done	

Re-Assessment: Patient less

Special Notes: Ambulation

Nurse Signature: [Signature]

Nurse Name: Preema

Date & Time: 20-7-26 2pm

BAH-00455694 IP5-00176598

Mrs SINDHURA REDDY

08-04-1994 32 Y 3 M 13 D (F)

Dr. PRANATHI REDDY A



NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 20/7/2026

Assessment: patient complaint pain at surgical site

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
2pm	→ assess the patient condition	2:10pm	→ assessed the patient condition	→ Patient stable
3pm	→ monitor vitals	3:10pm	→ monitored vitals	
4pm	→ Ensure safety	4:30pm	→ Provided side rails	
5pm	→ administration of medication	6pm	→ medication given as per drug chart	
7pm	→ I/O chart monitoring.	7:30pm	→ I/O chart monitored	
8pm	→ Ambulation.	8pm	→ Ambulation done	

Re-Assessment: done pt stable

Special Notes: nil significant

Nurse Signature: Sy

Nurse Name: Swapne

Date & Time: 20/7/2026 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 20/12/2026

Assessment: Patient leaving fear and anxiety during feeding

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 | | | | | |

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the patient general condition	8:10 M	Assessed the patient general condition	Patient is stable
10pm	Vital checks	10:15 PM	Vital checked and documented	
12AM	Relieve pain and discomfort	12:10 AM	Administer medication as per Drgy chart	
3AM	ILo chart monitoring	3:20 AM	ILo chart monitoring	
5AM	Prevent infection	5:10 AM	Maintaining hand hygiene	
7AM	Ambulation to reduce anxiety	7:10 AM	Ambulation every 2nd hour	
8AM	Ensure safety	8:10 AM	Ensured safety needs	

Re-Assessment: done pt stable

Special Notes: NA

Nurse Signature: [Signature] Nurse Name: Manika Date & Time: 21/12/2026 8AM

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Dr. PRANATHI REDDY A



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 21/1/2026

Assessment: patient complaint Pain at surgical site

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
8am	→ assess the patient condition	8:10am	→ assessed the Patient condition	→ Patient is stable
9am	→ monitored vitals	9:10am	→ monitored vitals	
10am	→ Ensure Safety.	10:20am	→ Provided side rails	
11am	→ administration of medication	11:30am	→ medication given as per drug chart	
2pm	→ I/O Chart monitoring	12:30 pm	→ I/O chart monitored	
1pm	→ Ambulation	1pm	→ Ambulation done	
2pm	→ Soft diet	2pm	→ Soft diet taken	

Re-Assessment: done patient is stable

Special Notes: Vitals monitoring

Nurse Signature: Sy

Nurse Name: Supra

Date & Time: 21/1/2026 2pm



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 21/7/26

Assessment: Patient is having lvs side pain

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 general condition	3pm	Assessed the patient general condition	Patient is stable
3:30pm	Monitor vitals and recorded	4pm	Monitoring vitals and recorded	
4:30pm	Administer medication as doctor advise	5pm	Administered the medication as doctor advise	
6pm	Ambulation	8pm	Ambulation Done	

Re-Assessment: reassessed done

Special Notes: Ambulation

Nurse Signature:

Nurse Name: Freema

Date & Time: 21/7/26 2.5pm

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Dr. PRANATHI REDDY A



NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 21/12/20

Assessment: Patient having pain at surgical site

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
8 PM	Assess the patient's general condition	8:10 PM	Assessed the patient's general condition	Patient is stable.
10 PM	Vital check.	10:20 PM	Vital checked and recorded	
12 AM	ILo chart monitoring	12:30 AM	ILo chart monitoring	
2 AM	Ambulation to toilet only	2:10 AM	Ambulation every 2nd to 3rd	
4 AM	Relieve pain & discomfort	4:10 AM	Administer medication as per drug chart	
6 AM	Prevent infection	6:20 AM	Maintaining hand hygiene	
8 AM	ILo chart monitoring	8:10 AM	Ensure safety needs	

Re-Assessment:

Special Notes: NA

Nurse Signature: *[Signature]*

Nurse Name: Nandini

Date & Time: 20/12/20 8 AM

BAH-00455694
Mrs SINDHURA REDDY
08-04-1994 32 Y 3 M 14 D (F)
Dr. PRANATHI REDDY A

NURSING CARE RECORD

Rainbow
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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 22/01/2026

Assessment: patient complaint fear and 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
8am	→ assess the patient condition	8:20am	→ assessed the patient condition	→ Patient stable
9am	→ monitor vitals	9:20am	→ monitored vitals	
10am	→ Ensure Safety	10:10am	→ Provided side rails	
11am	→ Ambulation	12pm	→ Ambulation done	
12pm	→ No chest monitoring.	12:20pm	→ No chest monitored	
2pm	→ administration of medication	2pm	→ medication given as per drug chart	

Re-Assessment: done pt stable

Special Notes: no significant

Nurse Signature: [Signature]

Nurse Name: Swapna

Date & Time: 22/01/2026 2pm

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NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 22/7/26

Assessment: patient having pain on 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	→ Assess the patient condition	2:30 pm	→ Assessed the patient general condition	→ Patient is fine
3pm	→ Monitor vitals	3:30 pm	→ checked vitals & recorded	
4pm	→ Regular diet	4:30 pm	→ Provided regular diet	
5pm	→ Administer medication	5:30 pm	→ Administered medication as per drug chart	
6pm	→ I/O chart	6:30 pm	→ I/O chart monitoring	
7pm	→ Ensure safety	7:30 pm	→ Provided side rails	

Re-Assessment: Patient comfortable pain reduced after taking medicine

Special Notes: No significant

Nurse Signature: @

Nurse Name:

Sis. Anita

Date & Time:

22/7/26 @ 8pm

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. pranathi reddy Department: BAP Date of Admission: 10/7/20

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:					
	<u>h21 L 38⁺ wks for EL-UG</u>							
BACKGROUND	Area	Shift Time	<u>BAP 8am-2pm</u>	<u>BAP 2pm-8pm</u>	<u>BAP 8pm-12am</u>	<u>BAP 12am-2pm</u>	<u>BAP 2pm-8pm</u>	<u>BAP 8pm-12am</u>
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
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:	<u>98.5°F</u>	<u>98.1°F</u>	<u>98.0°F</u>	<u>98.1°F</u>	<u>98.1°F</u>	<u>98.0°F</u>
		Res:	<u>19b/m</u>	<u>19b/m</u>	<u>20b/m</u>	<u>17</u>	<u>20b/m</u>	<u>19b/m</u>
		SpO ₂ :	<u>100%</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>	<u>98%</u>	<u>98%</u>
		Pulse:	<u>71b/m</u>	<u>75b/m</u>	<u>82b/m</u>	<u>84</u>	<u>85b/m</u>	<u>89b/m</u>
		BP:	<u>118/72</u>	<u>116/71</u>	<u>101/62</u>	<u>110/80</u>	<u>100/60</u>	<u>101/62</u>
		Fall Risk Score:	<u>20</u>	<u>20</u>	<u>20</u>	<u>20</u>	<u>20</u>	<u>20</u>
Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0</u>	<u>0</u>	<u>0</u>		
Recommendations	Safety Needs:	<u>side rails</u>	<u>side rails</u>	<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>	<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>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Hanning</u>	<u>Sulekha</u>	<u>Hanning</u>	<u>Priya</u>	<u>Swapna</u>	<u>Hanning</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>19/7/20</u>	<u>19/7/20</u>	<u>20/7</u>	<u>20/7</u>	<u>20/7</u>	<u>21/7</u>	
Time:		<u>2pm</u>	<u>2pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8pm</u>	
Taken Over By Name :		<u>Sulekha</u>	<u>Hanning</u>	<u>Priya</u>	<u>Swapna</u>	<u>Hanning</u>	<u>Swapna</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>19/7/20</u>	<u>19/7</u>	<u>20/7</u>	<u>20/7</u>	<u>20/7</u>	<u>20/7</u>	
Time:		<u>2pm</u>	<u>8pm</u>	<u>8AM</u>	<u>2pm</u>	<u>8pm</u>	<u>8:10AM</u>	

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Mrs SINDHURA REDDY
08-04-1994 32 Y 3 M 13 D (F)
Dr. PRANATHI REDDY A

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. pranathi Department: BRP Date of Admission: 19/1/2026

SITUATION	Diagnosis: <u>POD-II</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:				
BACKGROUND	Area	<u>BRP 8am-2pm</u>	<u>BRP 2pm-8pm</u>	<u>BRP 8pm-12am</u>	<u>BRP 12am-8am</u>	<u>BRP 8am-2pm</u>	
	Shift Time						
BACKGROUND	Medical Condition (Any special condition to be noted):	<u>NA</u>	<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°F</u>	<u>98.1°F</u>	<u>98.0°F</u>	<u>98.3°F</u>	<u>98.5°F</u>
		Res:	<u>20b/m</u>	<u>18b/m</u>	<u>18b/m</u>	<u>20</u>	<u>18b/m</u>
		SpO ₂ :	<u>99%</u>	<u>99%</u>	<u>100%</u>	<u>98</u>	<u>98%</u>
		Pulse:	<u>80b/m</u>	<u>81</u>	<u>82b/m</u>	<u>85</u>	<u>72b/m</u>
		BP:	<u>100/60</u>	<u>98/51</u>	<u>101/62</u>	<u>100/65</u>	<u>95/60</u>
	Fall Risk Score:	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	
	Pain Score:	<u>Scale 1-5</u>	<u>NA</u>	<u>NA</u>	<u>4/4</u>	<u>10/10</u>	
	Recommendations	Safety Needs:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>0</u>	<u>NA</u>
Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Others Specify:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Other Special Orders / Medications:		<u>NA</u>	<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>	<u>NA</u>	
Handed Over By Name :		<u>Swapna</u>	<u>Preem</u>	<u>Preem</u>	<u>Swapna</u>	<u>Anita</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>21/1/26</u>	<u>21/1</u>	<u>22/1</u>	<u>22/1</u>	<u>22/1</u>	
Time:		<u>2pm</u>	<u>3pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	
Taken Over By Name :		<u>Preem</u>	<u>Preem</u>	<u>Swapna</u>	<u>Anita</u>	<u>Anita</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>21/1</u>	<u>21/1</u>	<u>22/1</u>	<u>22/1/26</u>	<u>22/1</u>	
Time:		<u>2pm</u>	<u>8pm</u>	<u>8pm</u>	<u>2pm</u>	<u>2pm</u>	

BAH-00455694

IP5-00176598

Mrs SINDHURA REDDY

08-04-1994

32 Y 3 M 11 D

(F)

Dr. PRANATHI REDDY A



BRADEN 'Q' SCALE

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				Date :	19/7/21	19/7/21	19/7/21	19/7/21	
				Time :	8am	2pm	6pm	8pm	
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:treimity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	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 walking hours.	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: 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	
FRICITION-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	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23									
					TOTAL SCORE	28	28	28	28
					Evaluator's Name	Yay	2	Yay	Yay

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

BAH-00455694 IP5-00176598
 Mrs SINDHURA REDDY
 08-04-1994 32 Y 3 M 11 D (F)
 Dr. PRANATHI REDDY A

BRADEN 'Q' SCALE

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					Date :	20-7	20/7	20/7	21/7
					Time :	8 AM	2 pm	5 pm	8 pm
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
"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	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: 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 of 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	28	28	28
Evaluator's Name						P.D.	Ly	Dr. Swarna	

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

Docu. No. : RCHBH /FRM / CLINICAL / 119

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

-00455694

IP5-00176598

INDHURA REDDY

1994 32 Y 3 M 14 D (F)

NATHI REDDY A



BRADEN 'Q' SCALE

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					Date: 21/12/2023		
					Time: 8 PM	8 PM	6 PM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4
"Activity The degree of physical activity"	1. Bedfast: Confined to bed	2. Chairfast: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	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: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4
FRICITION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times.	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28	28
Docu. No. : RCHBH/FRM / CLINICAL / 119					Evaluator's Name	Dr. [Signature]	Dr. [Signature]

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

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	19/02/20 DAY-1			20/2 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 cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-	-	-	-	-	-	-			
Signature of the Nurse				Yamunadevi			S. S. S.						

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 : Sharada Name : Sharada

Signature of Ward In Charge :

Signature : Veena Name : Veena

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
19/7/26	8am	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Yamy
19/7/26	10am	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Yamy
19/7/26	12pm	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Yamy
19/7/26	2pm	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Yamy
19/7/26	4pm	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Smellie
19/7/26	6pm	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Smellie
19/7/26	7pm	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Smellie
19/7/26	8pm	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Smellie
19/7	10pm	2/10	Surgical side	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☒ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Ins: Transd	mark
19/7	11pm	1/10	Surgical side	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	mark

Re-assessment Frequency:

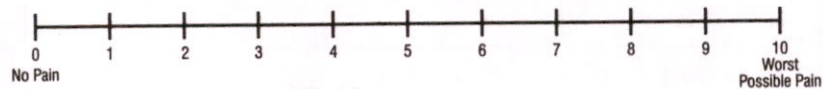
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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, 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 - slow recovery - 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
20/2	1AM	5/10	Left side	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☒ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Tab Diclo	Amiga
20/2	3AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	newb
20/2	6AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	newb
20/2	8AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Praya
20/2	10AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
20/2	2PM	1	Shin right	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Tab Diclo	
20/2	3PM	0/10	Surgical Site	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☒ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Tab. Pramox gels	Swapna
20/2	8PM	0	Swab Pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Swapna
20/2	10PM	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	newb
21/2	12AM	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	newb

Re-assessment Frequency:

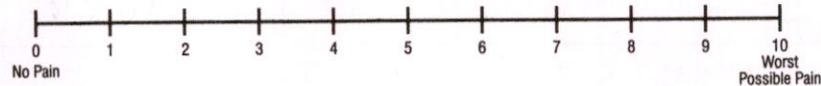
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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, 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

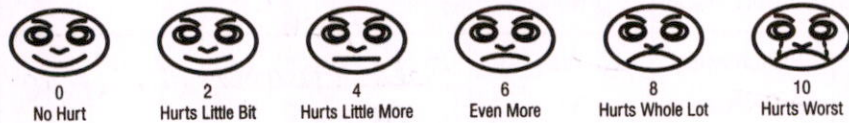
Numerical Pain Scale (Obstetric and Gynecology)



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 - slow recovery - 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
21/6	3AM	0/10	NA	☐ Continuous ☒ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Dr. Jay
21/6	7AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Dr. Jay
21/6	8am	0/10	Surgical Site	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Tab's Calpol given	Swapna
21/6/26	12pm	0	No Pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Swapna
21/6/26	2pm	0	No Pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Swapna
21/7	4PM	0	No Pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Pran
21/7	6PM	0	No Pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Pran
21/7	8PM	0	No Pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Pran
21/7	11PM	0/10	No Pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Dr. Jay
22/7	2AM	0/10	No Pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Dr. Jay

Re-assessment Frequency:

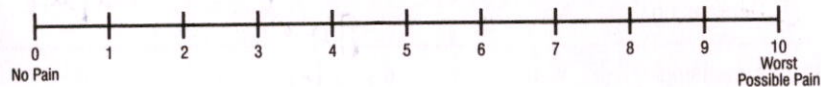
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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
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Numerical Pain Scale (Obstetric and Gynecology)



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

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



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
22/2	5 PM	6/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Any
22/2	8 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Any
22/2	9 AM	0/10	Surgical site	☐ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Pain relief given	By
22/2	4 PM	0	No Pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	By
22/7	4 PM	1/10	Surgical site	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☒ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Coventab Calpol	Anita
22/7	5 PM	1/10	Surgical site	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Coventab Diclofenac	Anita
22/7	6 PM	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Anita
22/7	7 PM	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Anita
				☐ 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:

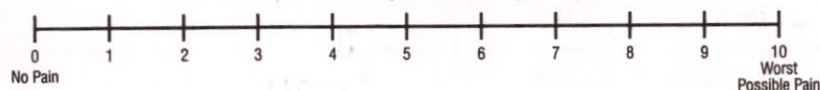
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PAIN ASSESSMENT TOOLS

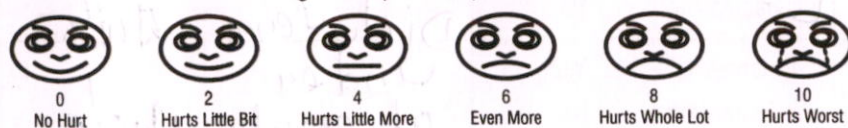
FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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 or 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)



Wong - Baker (Pediatrics) Above 7 Years



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

Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	19/7/26	19/7/26	19/7/26	Fall Risk Grading		
		Score	2pm	3pm	4pm	Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25				Low Risk	0 - 24	Standard Fall Precaution
	No	0	0	0	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0	0	0	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	0			
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0	0	0	0			
Total Morse Fall Scale Score:			20	20	20			
		Signature	Yammy					

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



Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	20/7/26	20/7/26	20/7/26	Fall Risk Grading		
		Score		2pm 8pm 9pm 6A				
History of Falling (immediately or w/in 3 months)	Yes	25				Risk Level	Morse Fall Score (MFS)	Action
	No	0		0				
Secondary Diagnosis (more than one diagnosis)	Yes	15				Low Risk	0 - 24	Standard Fall Precaution
	No	0		0				
Ambulatory Aid	Furniture	30				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0						
IV / Heparin Lock or Saline	Yes	20	20		20	High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	No	0		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						
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			PS	SL	Aug			

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
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- ☐ 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

Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	21/11/26	21/11/27	21/11/28	Fall Risk Grading		
		Score	8am-2pm	2PM-8PM	8PM-8AM	Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25				Low Risk	0 - 24	Standard Fall Precaution
	No	0	0	0	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0	0	0	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	0	0	0			
IV / Heparin Lock or Saline	Yes	20				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0	0	0	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	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:			0	0	0			
Signature			Swapne	Preema	Praty			

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

I-00455694 IP5-00176598
 SINDHURA REDDY
 4-1994 32 Y 3 M 14 D (F)
 PRANATHI REDDY A


Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	22/7	22/7	Fall Risk Grading		
		Score	Samyap	6pm	Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25			Low Risk	0 - 24	Standard Fall Precaution
	No	0	0	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15			Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0	0	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	0	0			
IV / Heparin Lock or Saline	Yes	20			Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0	0	0			
GAIT / Transferring	Impaired	20			High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10					
	Normal /On Bed Rest /Immobile	0	0	0			
Mental Status	Forgets limitations	15			High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0	0	0			
Total Morse Fall Scale Score:			0	0			
		Signature	Sej	Anita			

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

URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 19/12/20

Date of Removal: 20/12/20

Parameters	Date	Shift Time						
Need for the Catheter	19/12/20	2pm-8pm	19/12/20	2pm-8pm	19/12/20	8pm-12am		
Hand Hygiene	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Usage of Sterile Equipment	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the Collection bag below the level of bladder	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Check the Tube for Obstruction (Free of Kinking)	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Catheter dated as policy	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Collecting bag is been emptied regularly?	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Maintenance of closed system for the catheter	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing clean and dry?	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the line removed as Policy?	☒ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Performance of Perineal Care	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Onset of New Fever	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Asses for the leakage at the site of insertion	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Nurse	Mammy Sulekha							
Signature of the Nurse	Mammy Sulekha							



BREAST FEEDING HANDOVER AND ASSESSMENT FORM

1. Breastfeeding initiated?



a. Yes



b. No

2. If No, Reason

3. Nipple condition:



a. Nipple well formed



b. Flat nipple



c. Inverted nipple



d. Short nipple

4. Milk flow:



a. Good



b. Drops of colostrums



c. Dry

5. Steps for Positioning and attachment:



a. Baby goes to the breast



b. Mother always sits with a back support



c. Ear-shoulder-hip should be in a straight line



d. The baby takes a latch on the areola and not on the nipple



Feeding Positions:
Cross Cradle



Feeding Positions:
Football / Clutch

6. Was the position explained:

- ☒ a. Yes
☐ b. No

7. For Caesarian mothers:

- ☐ a. Mother is required sit and feed from the 4th feed
☐ b. Please explain football hold

8. NICU admission:

- ☐ a. Mother needs to stimulate her breast for 2 min every 2 hours

9. Additional notes:

Continuity of Care:

Date: 10/7/20

→ Breast feed initiated
→ 2-3rd hly feed.

Handover given by Yanning

Signature Yany

Date & Time: 10/7/20 @ 12pm

Handover taken by Smullen

Signature S

Date & Time: 10/7/20 @ 2pm

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Prasad Reddy
 Asst. Surgeon : Dr. Lavanya
 Anaesthetist : Dr. Subrahmanyan
 Scrub Nurse : Sri Ramani

Patient N
 UHID No
 Date : 10-09-2018

BAH-00455694 IP5-00176598
 Mrs SINDHURA REDDY
 08-04-1994 32 Y 3 M 11 (F)
 Dr. PRANATHI REDDY A

Gender :
 Out-time : 11:55am

Rainbow
 Children's
 Hospital

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Before Induction of Anaesthesia >>

SIGN IN	Time: <u>10:35am</u>
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 : <u>[Signature]</u>	
Name : <u>Dr. K. Sri Surya</u>	

Before Skin Incision >>

TIME OUT	Time: <u>10:40am</u>
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? <u>500ml</u> ☒ 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 : <u>[Signature]</u>	
Name : <u>Lavanya</u>	

Before Patient Leaves Operating Room

SIGN OUT	Time: <u>11:50am</u>
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 : <u>[Signature]</u>	
Name : <u>Dr. Lavanya</u>	

SURGICAL SAFETY CHECKLIST

Surgeon :
Asst. Surgeon :
Anaesthetist :
Scrub Nurse :

Patient Name : Age : Gender :
UHID No. : Surgery Name :
Date : In-time : Out-time :



Before Induction of Anaesthesia ➤ ➤

SIGN IN Time:.....	
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 :	
Name :	

Before Skin Incision ➤ ➤

TIME OUT Time:.....	
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? ☐ 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 :	
Name :	

Before Patient Leaves Operating Room

SIGN OUT Time:.....	
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 :	
Name :	

Department of Anaesthesiology PRE-ANAESTHETIC EVALUATION

BAH-00455694 IPS-00176598
Mrs SINDHURA REDDY
08-04-1994 32 Y 3 M 11 D (F)
Dr. PRANATHI REDDY A



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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: Sindhura Reddy Age: 31 Sex: F UHID.No: _____

Date: 19/9/2016 Time: 8:00 AM Proposed Operation: Elective LSCS

Diagnosis: G2 P1 - Prev. LSCS

B.P / CRT: 104/74 H.R: 70 Weight: 69 kg ASA Physical Status: ☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5

15/9/2016

Hgb: 12.5
PCV: _____
WBC: 9.66
Plate: 1.37
PT: _____
PTT: _____
INR: _____

SpO2 - 100%

A/G - 1.2

Laboratory Data:

Glucose: _____ Protein: 6.3
Urea: _____ Alb: 3.7
Creat: _____ Total Bil: 0.4
Na: _____ Dir. Bil: _____
K: _____ LDH: _____
Ca++: _____ Alk phos: _____
Mg++: _____ Amylase: _____
Cl-: _____ SGOT/SGPT: _____

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

X-Ray: _____
ECG: _____
2D Echo: EF 70%
Stress/Angio: _____
Other: _____

EF 70%
Normal
no cardiac
no clots

RDW-CV - 14.6

Allergies: None Allergy to
Augmentin

Medical History: CVS: _____ Diabetes: _____
RESP: _____
CNS: NS
Renal: _____
Hepatic / GE: _____
Others: _____
Physical Activity: > 2 light cont 180B

No H/O cold, cough, fever from recent

Past Anaesthetic History: 2011 - LSCS & SA uneventful

Physical Exam: Airway: MP 1 2 3 4 Mouth Opening: > 3 finger Mentohyoid Distance: 1.3 finger Neck: 2 Teeth: Central Inc
Artificial Incisor
Lateral Inc

Lungs: BAC & clear

Heart: S1, S2

CNS: Intact

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

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

- DVT Prophylaxis: Water / ORS 2 Hours Others 6 Hours Explained
- NIL ORAL: Standard ☐ High Risk
- Informed Consent: ☒ Discussed with Patient
- Post Operative Pain Management: ☐ Discussed with Patient
- Other Instructions: _____

18/9/2016 8:30 PM
last
water

Signature: [Signature] Name: DR. K. SRI RAMYA

Department of Anaesthesiology
EPIDURAL ANALGESIA RECORD

b)	Maternal	FUP	Comments
----------	----------	-----	----------

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

Catheter Removed by and Tip Inspected :

Patient Satisfaction :

Discharge /Shifting ordered by

Doctor Signature:

Doctor Name:

Date and Time :

CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☐ Patient Attendant

Operative Procedure: ELECTIVE LRCS

Anaesthesiologist: DR. K. SRI RAMYA

Surgeon:

Please read this before you consent for Anaesthesia

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery. Prolonged pain relief can be achieved by infusing weak solutions of local anaesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

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

- ☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders
☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease
☐ Others HYPOTENSION, PDPH

Declaration by Patient Attendant

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

Patient / Patient Attendant:

Signature: Sindhura Reddy
Name: Sindhura Reddy
Relationship with patient:
Date & Time: 19/7/2016 8:25 AM

Witness:

Signature: Vaishnavi Reddy Rammi
Name: Vaishnavi Reddy Rammi
Date & Time: 19/7/2016 8:25 AM

Doctor (who is taking consent):

Signature: DR. K. SRI RAMYA Name: DR. K. SRI RAMYA Date: 19/7/2016 Time: 8:25 AM

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స:

అనస్థీషియా వైద్యుడు: శస్త్రచికిత్స నిపుణుడు:

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

సాధారణ అనస్థీషియా అనేది శస్త్రచికిత్స ముందు రోగిని పూర్తిగా అవస్థాపక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోదు, నొప్పి అనుభవించదు. దీనిని శిరస్రావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు. రీజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్మల్ బ్లడ్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై రిస్క్:

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

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

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

☐ ఇతరవి:

రోగి / రోగి అటెండెంట్

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

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

Patient Name : Sindhura Reddy Gender: ☐ Male ☒ Female Age : 31 yrs.
UHID No : BAH-00455694 Date : 19/7/2026

Instruction:

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

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

Elective lower segment Caesarean section
upon
Sindhura Reddy

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.

Infection, Bleeding, Need for Blood transfusion
Injury to Bowel, Bladder & its Repair

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. Pranathi Reddy

Consentee :

Signature : Sindhura Reddy
Name : Sindhura Reddy
Date & Time : 19/7/26 @ 8am

Witness :

Signature : Aravind Reddy
Name : Aravind Reddy
Date & Time : 19/7/26 @ 8am

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

Patient Attendant :

Signature : Vasishth
Name : Vasishth
Relationship with Patient : husband
Date & Time : 19/7/2026 @ 8am

Doctor (who is taking the consent) :

Signature : Dr. Rupika
Name : Dr. Rupika
Date & Time : 19/7/2026, 8AM

DISCHARGE PLANNING FORM

Nationality: INDIAN

NOTES: * To be completed by a NURSE within (24) hours of admission.

1. Anticipated Date of Discharge: 23/7/26

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☒ Self Care ☐ Family Home Care ☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☐ Medication ☐ Yes ☒ No

☐ Bathing ☐ Yes ☒ No

☐ Eating ☐ Yes ☒ No

☐ Walking ☐ Yes ☒ No

☐ Dressing ☐ Yes ☒ No

☐ Toileting ☐ Yes ☒ No

need assistance

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: Hand hygiene

☐ Patient's Educational Topic/s discussed with the:

☐ Patient ☐ Family Member

☐ Others:

Nurse Signature: Chameli

Nurse Name: Chameli

Date and Time: 23/7/26 @ 8:30 am

Bethlehem
Children's
Hospital

Children's
Hospital

DISCHARGE PLANNING FORM

1/10/11

NOTES: To be completed by a nurse when a child is discharged from hospital.

1. Name of child (as on hospital card):

2. Date of birth:

3. Sex:

4. Address:

5. Telephone:

6. Name of parent/guardian:

7. Name of doctor:

8. Name of nurse:

9. Name of social worker:

10. Name of other person involved:

11. Name of hospital:

12. Date of discharge:

13. Time of discharge:

14. Name of person receiving child:

15. Signature of nurse:

16. Signature of doctor:

17. Signature of social worker:

18. Signature of other person involved:

19. Signature of parent/guardian:

20. Signature of hospital official: