BAH-00629749 IP5-00176177
Mrs B RAMA PRASANNA
10-06-1992 34 Y 0 M 30 D (F)
Dr. KIRTI REDDY PATLOLLA

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DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	—			
5	In-patient Medical record	1			
6	Doctors progress sheets	1			
7	Nursing plan of care and handover sheets	1			
8	Consultation sheet	—			
9	General consent for treatment	—			
10	Consent for Surgery	—			
11	Consent for blood transfusion	—			
12	Consent for chemotherapy	—			
13	Consent for high risk	—			
14	Consent for Restraint	—			
15	LAMA consent	—			
16	Consent for special procedure / Sedation	—			
17	Consent for Formula feed	—			
18	Consent for MTP	—			
19	Consent for Radiological Investigations	—			
20	Consent for HIV test	—			
21	Anaestesia notes (Pre Anaesthesia& post)	—			
22	Neonatal Admission/Delivery/Physical Exam	—			
23	Medication Reconciliation	1			
24	Emergency Triage record	—			
25	Pre operative check list	—			
26	Surgical safety checklist	—			
27	Operation Theatre notes	—			
28	Nurses clinical Presentation	—			
29	TPR & BP chart	1			
30	Intake and Out take chart (fluid chart)	1			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart	—			
34	Nutritional review chart	—			
35	Intensive care unit (ICU Charts)	—			
36	Consent for Admission in PICU / NICU	—			
37	The Humpty dumpty scale	—			
38	Braden Q Scale	1			
39	Bed side check list	—			
40	PICU bed formula Dilution feeds	—			
41	Gastro monitoring chart	—			
42	Rch ED doctors note	—			
43	BP Monitoring chart	1			
44	RBS monitoring chart	—			
	Total No. of Pages	13			

Signature and Date : 10/7/26

(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

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Banjara Hills

8-2-120/103/1,2,3,4 and 5,Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad ,Telangana, India ,500034.
TEL NO :+91-40-4466 5555
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176177 **Admit Date** : 10-Jul-2026 **Admit Time** : 12:37 AM **UHID** : BAH-00629749

Patient Details :

Patient Name	: Mrs B RAMA PRASANNA	**Age**	: 34 Y 0 M 30 D
Guardian	: Mr B ROHIT	**DOB**	: 10-06-1992
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Married
Address (H)	: FLAT NO 403 , BLOCK 04, HIG DUPLEX, CHITRAPURI COLONY Manikonda Hyderabad Telangana INDIA 500089	**Phone No**	: 8519941336/ 9989655922
		E-mail	: prasanna90146@gmail.com

Admission Details :

Bed Type : MICU **Bed No** : MICU 427 **Ward Name** : 4F-BIRTHING CENTRE

Room No : MICU 427 **Admission Type** : First Visit

Contact Details :

Name : Mr B ROHIT **Relationship** : Husband

Contact Address : FLAT NO 403 , BLOCK 04, HIG DUPLEX, CHITRAPURI COLONY Manikonda Hyderabad Telangana INDIA 500089 **Phone No** : 8519941336 / 9989655922

Signature

Doctor Details :

Doctor Name : Dr. KIRTI REDDY PATLOLLA **Specialisation** : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

Payment Mode : Cash **Deposit Amount** : 0.00

Payor Name : STATE BANK OF INDIA

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ACTIVITY RECORD FOR BILLING

BAH-00629749 IP5-00176177
Mrs B RAMA PRASANNA
10-06-1992 34 Y 0 M 30 D (F)
Dr. KIRTI REDDY PATLOLLA

Name :_____ _____

UHID 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				
2				
3				
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
10/7/26	NST (1)	26503480	Suvarda
10/7/26	CBP (1)	26068807	Suvarda
10/7/26	NST (2)	26503483	Suvarda
10/7/26	NST (3)	26503422	
		Cross check	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
10/2/26	IV placement	01	9695524	Saad

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

BAH-00629749 IP5-00176177
Mrs B RAMA PRASANNA
10-06-1992 34 Y 0 M 30 D (F)
Dr. KIRTI REDDY PATLOLLA

Mrs. Patient Stick

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IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints Clo. Tightening. & spotting.

GzA1

Obstetric Formula:

Obstetric Hostory:

NA - 2024 - Biochemical.

2nd IVF. Booked at 16th.

Present Pregnancy Record:

Conceived DCIVF → Singleton (20+2wks)

GDM on Diet.

RISK FACTORS:

GDM on Diet.

Height: 159 cm

Weight: 77.6 kg

Allergies: Nil

Breast: ☒ Normal ☐ Abnormal

General Examination:

Consciousness: Pallor:

Icterus: Edema:

Temp: (N) PR: 80/m.

BP: 110/70 DTR:

CVS: RS

Liver/Spleen: Urine Output:

LMP: 25/10/2025 EDD:

Corrected EDD: 26/7/2026. GA: 37+5 wks.

Menstrual History: Regular : ☐ Yes ☐ No

Obstetric Examination

Fundal Height: Term. Irritable.

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 — NA.

Draining: ☐ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination

Cervix: ☒ Long ☐ Partially effaced ☐ Effaced

Os: Closed _____ Dilated 1 finger.

Membranes: ☐ Present ☐ Absent

Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Presenting Part: ☐ Vertex ☐ Breech ☐ Others

Sutton: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Pelvis: ☐ Adequate ☐ Doubtful

DIAGNOSIS

GzA1 at 37+5 wks with Hypothyroid with GDM on Diet in Early labour.

BAH-00629749 IP5-00176177
Mrs B RAMA PRASANNA
10-06-1992 34 Y 0 M 30 D (F)
Dr. KIRTI REDDY PATLOLLA

Family History: Father - HTN. Husband - Blurring of vision. - Retinitis pigmentosa - Genetic	Surgical History: Hysterolaparoscopy - 2021. Hysteroscopy - 2022. Cocorodeling done → Rpt WES → Deficit
Medical History: Hypothyroid - on Rx. TB Endometrium - 2021.	Medication History: Repeat - Referral Rept Cocorodeling. - Iron/ Calcium.
Plan of Care: - for Delivery. - Admission. - Preparation - NST. - W/f Progress. - CBP. - Uterus Monitoring - NBM. - Epidural SOS - Blood availability	Investigations: 'O' Rh positive. 6/7/2026 SLF, 37+1 cephalic. P1-P4. AFI - 15.6cm. 2964 (41 centile) AC - 47 centile. Doppler - B.

Doctor Name: Dr Bhagavi.
Signature: [signature]
Date & Time: 10/7/2024.

Consultant Name: Dr. Kirti. Reddy.
Signature: [signature]
Date & Time: 10/7/2026.

BAH-00629749 IP5-00176177
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/2026. 1:30 AM	Couple counselled.	
	- want to try for vaginal delivery.	
	- watch for spontaneous progress.	
	- SOS Augmentation.	
	-	
		[signature] (CH BHARGAVI)
		NB Sunanda
10/7/26 5:30 AM	c/s/by Dr Bhargavi	
	As there was no contractions, couple & patient is counselled for augmentation of labor. but the patient & husband refused.	
		Dr Arthy. L.
		NB Sunanda

BAH-00629749 IP5-00176177
Mrs B RAMA PRASANNA (F)
10-06-1992 34 Y 0 M 30 D
Dr. KIRTI REDDY PATLOLLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/26. 6Am	No complaints Afebrile BP 120/70 mmHg PR - 86/min SpO2 - 98% @ RA P/A - at (P) relaxed	adv - Spontaneous PR - Monitor vitals & - FHR 4thly - NST 3rdly - V/F PDL Dr Arshiya ~~NB suchand~~
10/7/26 9.20AM	NST - Reactive U/S - Same findings.	
	Discussed ō family Requesting LSCS on 12/7/26 (Sunday) 7-8AM Dr Kirti ... noted. Pre op instructions:- - T. Dulcolax 2 tab (orally) 10pm; 11/7/26 - Nil feed/water 12AM; 12/7/26 - Admit 4th floor 5AM; 12/7/26	

BAH-00629749 IP5-00176177
Mrs B RAMA PRASANNA
10-06-1992 34 Y 0 M 30 D (F)
Dr. KIRTI REDDY PATLOLLA

Patient S

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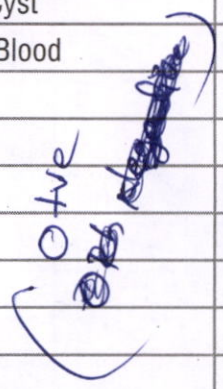
RESULT SHEET

Date	10/7/26					
Time						
Hb	12.8					
PCV	39.7					
RBC	4.82					
WBC	13.49					
N/L						
Platelets	310					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						



Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

Others (ECG, Contrast Studies etc.,) : .....

Patient

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MEDICATION RECONCILIATION FORM

Drug Allergies: Nil. ☐ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.
(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ..... Shifted to: .....

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	IRON	1tsp	oral	once.	9/7	☐ C ☐ ~~DC~~
2	CALCIM.	1tsp	oral	once	9/7	☐ C ☐ ~~DC~~
3	B Thyroxine	1tab	oral	once	9/7.	☐ C ~~☐ DC~~
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : .....

Date & Time : .....

Nurse Name & Signature: .....

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

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10-06-1992 34 Y 0 M 30 D (F)
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DRUG CHART

Date of Admission: 9/7/2026 Drug Allergies: Nil ☐ 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:				

Signat

VERIFIED BY : Name

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REGULAR PRESCRIPTIONS

Weight. .... Ward. ....

DRUG :

Date ▸ / Time ▾

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Date ▸ / Time ▾

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Date ▸ / Time ▾

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Date ▸ / Time ▾

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

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10-06-1992 34 Y 0 M 30 D (F)
Dr. KIRTI REDDY PATLOLLA

Weight. ..... Ward. .....

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
9/12/06	7:40 AM	Inj Tramadol in 100ml NS	100mg	IV	B	Gayathri 14 Sumanda AN

Signature .....

VERIFIED BY : Name .....

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Mrs B RAMA PRASANNA
10-06-1992 34 Y 0 M 30 D (F)
Dr. KIRTI REDDY PATLOLLA

I.V. FLUIDS CHART

Weight. ..... Ward. .....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
10/2/26	1:00 AM	RINGER LACTATE	IV		B	Sumanth Tonna	10/2		Sumanth Tonna

VERIFIED BY : Name ..... Signature .....

BAH-00629749 IP5-00176177
Mrs B RAMA PRASANNA
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MULTI-DISCIPLINARY PLAN OF CARE FORM

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Diagnosis: G2A1 at 37+5 wks

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
10/2/26	☑ Medical ☐ Nursing ☐ Others:	☑ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Clo Pain. Maturity - Admit for Delivery	- Safe Delivery	- Consent - Prepartu - w/t uterine Contraction	R	☑ Nursing ☐ Others:
10/2/26	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	- fear & Anxiety	- reduce to fear & Anxiety	- provided to safe care's	Sunanda	☐ Medical ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

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INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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Part - I.

Patient's / ..... Patient / Learner Literacy: ☐ Read ☐ Write ☐ Speak Willingness to Learn: ☐ Yes ☐ No Healthcare Literacy: ☐ Yes ☐ No

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
10/9	1:30 AM	1,2 3,1	Care Plan, Pain / Comfort	PT	1	0	1	1	-	
10/9	2PM	2	Infection control measures	PT	1	0	1	1	—	Sreenivasa

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C Caregiver O: Other (Specify) .....

Learning Barriers:

1. No Learning Barriers
2. Physical Impairment
3. Emotional Barriers
4. Language Barrier
5. Educational Level
6. Desire / Motivate to Learn
7. Impaired Thought Process/Cognitive limitations
8. Responsibilities at Home
9. Cultural Differences
10. Financial Difficulties
11. Beliefs and Values
12. Impaired Vision/ or Hearing
13. Cultural/Religion Practice
14. Others (Specify .....

Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed

Mechanism/s to overcome barrier/s:

1. None
2. Obtain translator
3. Reassurance & Support
4. Teach Family / Others
5. Respect values & beliefs
6. Respect Cultural / Religion Preference
7. Other, Specify .....

Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review

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OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 10/2/26   Time of Arrival: 12:00 AM   Time Seen by Nurse: 12:10 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: ....

3) Vital Signs: Temperature: 98.6°F Pulse: 80 RR: 20 SpO_2: 100 BP: 110/73 Weight: 77.6

4) Gestational Criteria:

Gravida:	G 2	P	L	A 1

LMP: 23/10/25   EDD: 26/7/26   Gestational Age: 37+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)**

0 No Pain — 1 (circled) — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 Worst possible pain

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

....

6) Past History:

a) Surgeries: R pt TWES –
b) Medical: p.epad pefeod BOP cousis - Irani calcium

Docu. No. : RCHBH /FRM / CLINICAL / 098 (P.T.O.)

BAH-00629749 IP5-0017617
Mrs B RAMA PRASANNA
10-06-1992 34 Y 0 M 30 D (F)
Dr. KIRTI REDDY PATLOLLA

7, **Allergy:** ☐ Yes ☐ No, If Yes : .....

8) **Current Medications:** ☐ Prenatal Vitamin ☐ None ☐ Others: .....

9) **Prenatal Medical History:**

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

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

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

Time seen by Doctor: 12:00 AM

Nurse Name : Sunanda Nurse Signature:

Date: 10/2/26 Time: 12:20 AM

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OBSTETRICS / GYNECOLOGY
NURSING INITIAL ASSESSMENT FORM

Date of Admission: 10/5/26

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: Abdominal pain

Doctor Notified on Admission: ☑ Yes ☐ No

Name of the Doctor: DR. Pushpa

Time Notified: 12:00 AM

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Repeat Referred BOP + Cardiology	NIL	

Gynecology Assessment: ☐ Not Applicable

Menstrual History: .....

Onset of Menarche: Regular

Menstrual Cycle: ☑ Regular ☐ Irregular

Last Menstrual Period: .....

Gynecology Surgical History:

Caesarean Section: ☑ No ☐ Yes

Cervical Cerclage: ☑ No ☐ Yes

Ectopic Pregnancy: ☑ No ☐ Yes

Myomectomy: ☐ No ☐ Yes

Others: _____

Gynecological History:

Contraceptives: ☐ No ☐ Yes

Vaginal Discharge: ☐ No ☐ Yes

Post-Coital Bleeding: ☐ No ☐ Yes

Infertility: ☐ No ☐ Yes

If Yes Type: ☐ Primary ☑ Secondary

Obstetric History: G 2 P ..... L ..... A 1

Previous LSCS: .....

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

Family History: ☑ No Abnormalities Detected

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

☐ Liver disease ☐ Other .....

Vital Signs / Measurements: Temp: 98.6°F HR: 86 RR: 20

BP: 110/72 Weight: 2.7 kg Height: F BMI: —

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

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PHYSICAL ASSESSMENT

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

Fall Assessment: ☐ Yes ☑ No Score ...25... (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore: ☐ Yes ☑ No Score ...20... (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 ...family...

Orientation has been given regarding the following aspects:

Call Bell in Reach : ☑ Yes ☐ No Waste Disposal Explained: ☑ Yes ☐ No

Infusion Pump : ☑ Yes ☐ No Hand Hygiene Explained: ☑ Yes ☐ No ☐ Others

Above information given to ...Husband...

Name of Person Orientation was given to: ...Mrs. RAMA prasanna...

Orientation not given Reason: ...Non Singificant...

Nurse Signature: .....

Nurse Name: ...Sunanda...

Date & Time: ...10/2/26 12:20 PM...

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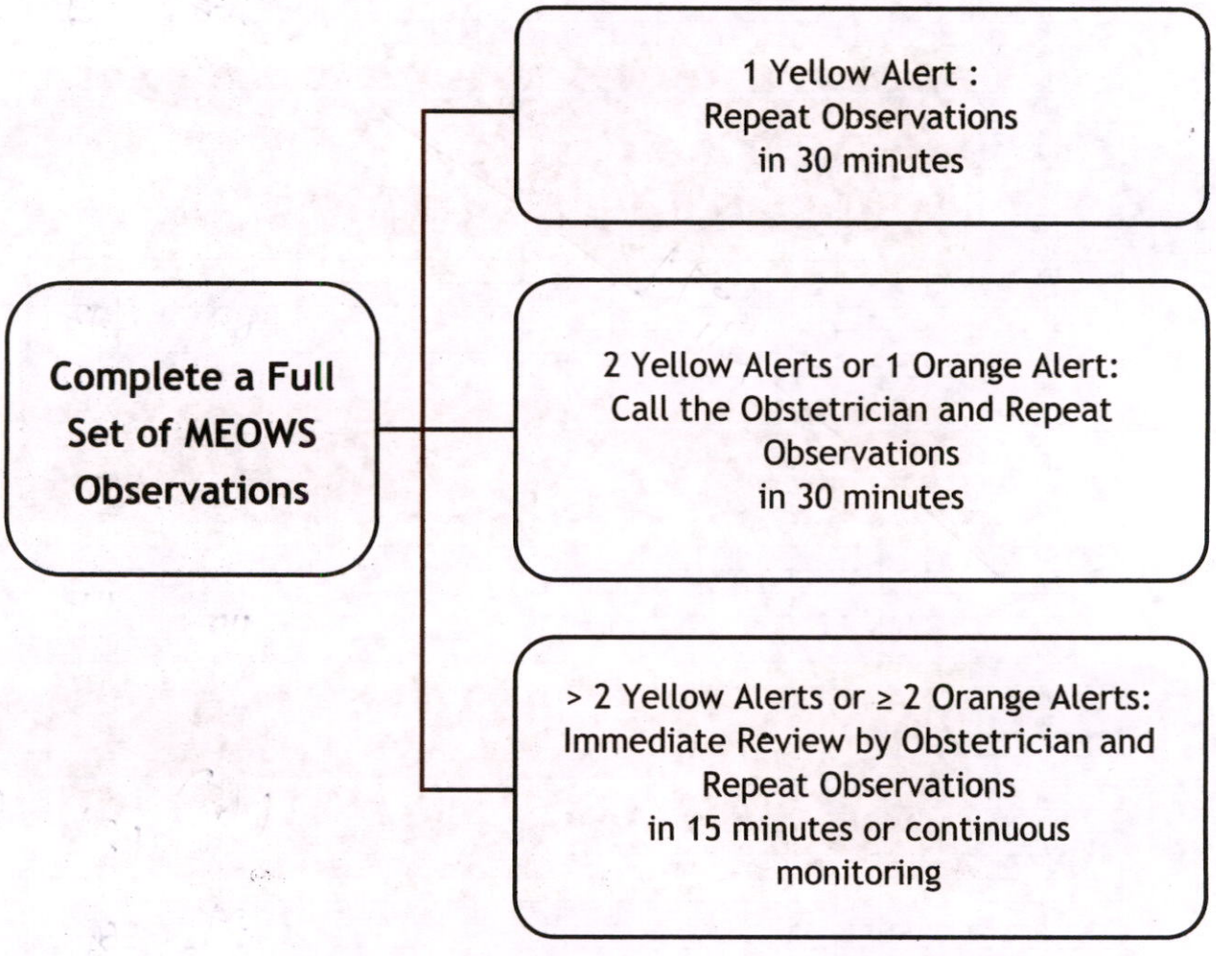
Early Warning Observation Score Chart - Obstetrics

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

10/4/26

		Date																								
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																		19			19			19	19
	11 - 20																									
	0 - 10																									
Saturations	94 - 100 %																		99			99			100	99
	< 94 %																									
Administered O_2 (L/min.)																										
Temp °c	40																									
	39																									
	38																									
	37																		98.6F			98.6F			98.6F	98.2F
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80																		80			72			79	80
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																		110			114			106	105
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																		(68)			(71)			(84)	68
	120																									
	110																									
	100																									
	90																									
	80																		74			69			70	73
	70																									
	60																									
	50																									
	40																									
NEURO RESPONSE [✓]	Alert																		A			A			A	A
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30																									
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal																									
	Heavy / Foul																									
Liquor	Clear / Pink																									
	Green																									
TOTAL YELLOW SCORES																			0			0			0	0
TOTAL ORANGE SCORES																			0			0			0	0
Nurse Initial																										

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score **(MEOWS)**

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		Date																								
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20			20																						
	0 - 10																									
Saturations	94 - 100 %			99																						
	< 94 %																									
Administered O, (L/min.)																										
Temp °c	40																									
	39																									
	38																									
	37																									
	36			36.5																						
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80			80																						
	70																									
	60																									
	50																									
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Systolic Blood Pressue ↑	190																									
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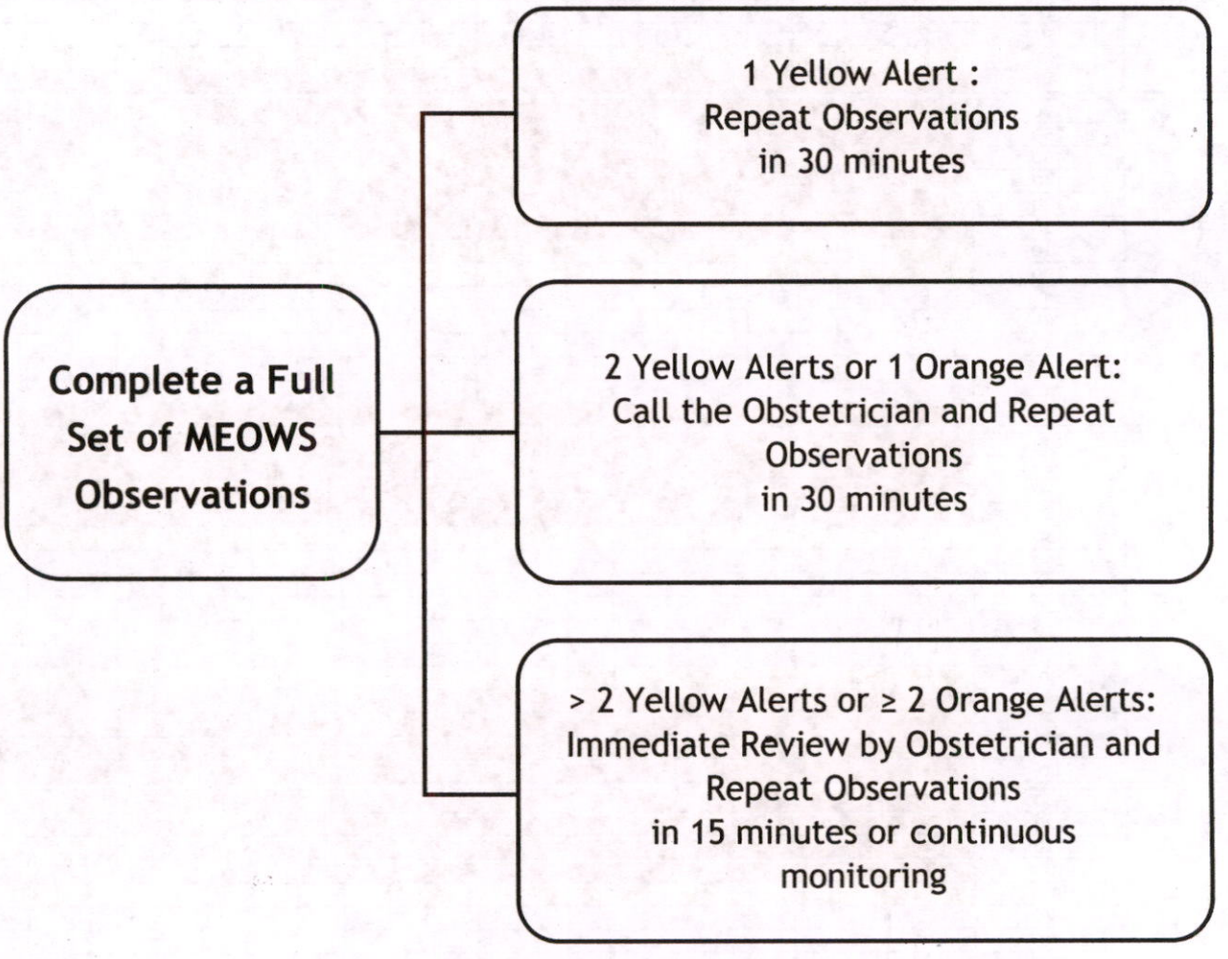
	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110			119																						
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70			71																						
	60																									
	50																									
	40																									
NEURO RESPONSE [✓]	Alert																									
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30																									
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal																									
	Heavy / Foul																									
Liquor	Clear / Pink																									
	Green																									
TOTAL YELLOW SCORES																										
TOTAL ORANGE SCORES																										
Nurse Initial																										

Obstetrics and Gynaecology Early Warning Signs



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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
10/6/26	12:00 am	RL	H20	100 ml			N			✓	0	Suvarda
	01:00 am	RL		100 ml			P			✓	0	
Total Intake :		taken				**Total Output :**						passed
	02:00 am	RL	H20	100 ml			N				0	
	03:00 am	RL		100 ml			P			✓	0	
10/6/26	04:00 am	RL	H20	100 ml			I			✓	0	Suvarda
	05:00 am		H20				N			✓	0	
	06:00 am		H20				P			✓	0	
	07:00 am		H20								0	
Total Intake :		taken				**Total Output :**						passed

Total 24 hrs. Intake	500 ml RL	**Total 24 hrs. Output**	6 times urine passed

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FLUID CHART

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Sheet No. : 0

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am	Edili					1			✓	0	
	09:00 am										0	M
	10:00 am	H2O									0	
	11:00 am						NP					
	12:00 pm											
	01:00 pm											
Total Intake : Nil						Total Output : Nyet						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	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	

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CHECKLIST FOR THROMBOPHLEBITIS

10/6/26 0600 hrs

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0						
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				Suvarna							

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 : ..... Name : Kranthi

Signature of Ward In Charge :

Signature : ..... Name : Veena

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Score	Date / Time		
			10/7/26 12:00 PM	10/7/26 8 PM	
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0	0		
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0			
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0	0		
IV / Heparin Lock or Saline	Yes	20	20	20	
	No	0			
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0	0		
Mental Status	Forgets limitations	15			
	Oriented to own ability	0	0		
Total Morse Fall Scale Score:			20	20	
		Signature	Sumadhura		

Fall Risk Grading

Risk Level	Morse Fall Score (MFS)	Action
Low Risk	0 - 24	Standard Fall Precaution
Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
High Risk	≥ 51	Implement High Risk Fall Prevention Intervention

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

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PAIN ASSESSMENT FORM

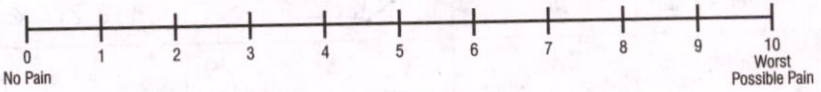
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
10/7/26	12:00 AM	01/10	Abdomen pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	INJ: Tramadol 100mg IV given	Sunanda
10/7/26	3AM	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sunanda
10/7/26	6AM	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sunanda
10/7/26	8AM	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sunanda
10/7/26	10am	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[illegible]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

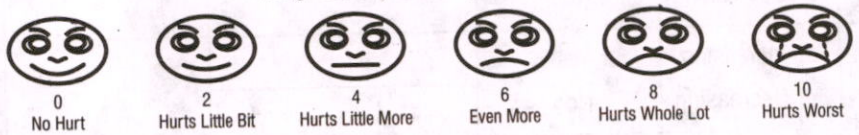
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
   - a) At least every 2 hours for the first 24 hours
   - b) Then every 4 hours.
   - c) Prior to pain pain-relieving intervention.
   - d) Within 30 – 60 minutes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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years



FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

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, SaO_2	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

BAH-00629749 IP5-00176177
Mrs B RAMA PRASANNA
10-06-1992 34 Y 0 M 30 D (F)
Dr. KIRTI REDDY PATLOLLA

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NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: 10/4/26

Assessment: patient c/o fear & anxiety

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
12AM	↳ Assess to pt condition.	4AM	↳ Assessed to pt condition dae	↳ Pt is comfortable
2AM	↳ I/O Hard	3AM	↳ I/O Hard monitoring dae	
4AM	↳ NST	5AM	↳ NST 3rd hourly dae	
6AM	↳ IV fluids	7AM	↳ PLNGER LACTATER 500mL IV paid dae	
8AM	↳ soft diet	8:30 AM	↳ soft diet given dae	

Re-Assessment: Re-assessment 2nd hourly vital's monitoring dae

Special Notes: NST 3rd hourly

Nurse Signature: ..... Nurse Name: Suvarda (606249) Date & Time: 10/4/26 8AM

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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: 10/7/26

Assessment: patient complaint pain region

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 pt condition	8:15 am	Assessed the pt Condition	pt is
	monitoring vitals		vitals checked & recorded	comfortable.
9am	Soft diet	9:30 am	soft diet given	
10am	oral hydration.	10:30 am	oral hydration done	
4pm	NST	11:30 am	NST done.	

Re-Assessment: Re-assessment 3 hourly.

Special Notes:

Nurse Signature: ..... Nurse Name: ..... Date & Time: 10/7/26 Am

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. KIRTI Department: OBS Date of Admission: 10/2/26

SITUATION	Diagnosis: U2A1 37+5 wks				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
BACKGROUND	Area / Shift Time	OBS 1pm-8pm	OBS 8pm-1pm				
	Medical Condition (Any special condition to be noted):	NA	NA				
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:	98.6	98.6				
	Res:	20	20				
	SpO_2:	100	99%				
	Pulse:	89	86 bpm				
	BP:	113/74	110/70				
	Fall Risk Score:	20	20				
	Pain Score:	0	0				
Recommendations	Safety Needs:	Side rails	Side rails				
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	NA	NA				
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	NA	NA				
Post Operative Procedure Special Orders:		NA	NA				
Handed Over By Name :		Suvarna	Reddy				
Signature :							
Date:		10/2/26	10/2/26				
Time:		8pm	12pm				
Taken Over By Name :		Reddy					
Signature :							
Date:		10/2/26					
Time:		8am					

Patient Sticker

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area / Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							

BAH-00629749 IP5-00176177
Mrs B RAMA PRASANNA
10-06-1992 34 Y 0 M 30 D (F)
Dr. KIRTI REDDY PATLOLLA

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INFORMED CONSENT FOR VAGINAL BIRTH

Patient Name : Mrs B. RAMA PRASANNA UHID No : BAH-00629749.

Gender: ☐ Male ☑ Female Date : 10/7/2026. Time : .....

I hereby authorized the performance of the following procedure:

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

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

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

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

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

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

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

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

Consentee :
Signature : Rama Prasanna
Name : .....
Date & Time : 10/7/26 1:30 AM

Witness :
Signature : .....
Name : Sumanda
Date & Time : 10/7/26 1:30 AM

Patient Attendant :
Signature : N. Thanesilakshmi
Name : N. Thanesilakshmi
Relationship with Patient: Mother
Date & Time : 10/7/26 1:30 AM

Doctor (who is taking the consent) :
Signature : .....
Name : Dr. KIRTI REDDY.
Date & Time : 10/7/2026 1:30 AM

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

సహజ ప్రసవం కొరకు సమ్మతి పత్రము

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రోగి పేరు : ..... వయస్సు ..... లింగం పు స్త్రీ

యు.హెచ్.ఐ.డి. .....విభాగము .....

తేదీ .....

ఈ ప్రక్రియ యొక్క వివరములను నేను ఆమోదించాను:

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

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

సహజ ప్రసవం విజయవంతం కాకపోతే, తగిన అనస్థీషియా ఇచ్చి పాత్తికడుపు కోతతో సిజేరియన్ ద్వారా డెలివరీ చేయవలసిన అవసరం కలగవచ్చు

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

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

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

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

ఈ ప్రక్రియను నిర్వహించే డాక్టరు పేరు: .....

సహాయకుడు(అటెండెంట్)

సంతకము .....

పేరు .....

సాక్షి

సంతకము .....

పేరు .....

తేదీ మరియు సమయము .....

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము .....

పేరు .....