Swathi
9154863024

Dr. Swathi

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

ESTIMATION SLIP

Date : 15/2/26 **UHID / IP No. :** HXIH-00016523 **Sl No.** 1703

Name of Patient : Mrs. Nagalakshmi Uppala **Age:** 42y **Gender:** F

Father's / Husband's Name : Mr. Laxmi Narayana **Corporate / Occupation :**

Address : **Phone :** **Email :** 9391041995 9

Procedure / Plan : TLH+BS **EDD/Dos:** July-26

MODE OF PAYMENT : ☑ SELF ☐ TPA : ☐ GIPSA : OTHER

TARIFF INFORMATION :

Particulars	Package Amounts (Rs.)	
Room Category	Normal Delivery	LSCS
Multi Shared Ward		
Shared Ward		
Twin Shared Ward	TLH+BS	
Private Room →	2.50 K	Including P&T
Super Deluxe Room		
Suite Room		
Package includes (Package starts from the time of admission)	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee and Labour Ward Charges	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee Anesthetist's Fees and OT Charges
	Length of Stay for :	Length of Stay for :
	Pharmacy up to	Pharmacy up to
	Investigations up to	Investigations up to
Others		

Neonatologist Charges : ☐ Covered ☐ Not Covered **Epidural / Entonox :** ☐ Covered ☐ Not Covered

Initial Minimum Deposit : 80'l. Advance time of Admission

REMARKS :

1. Room eligibility is purely subject to TPA approval and the Package / Room Tariff starts from the time of admission. The estimated amount may Change according to duration of stay, medical condition, investigations, pharmacy and any other procedure.
2. Proportionate difference of bill amount is applicable in case the patient opts for a category higher than the TPA approved, which has to be paid by the patient and may not be reimbursed by the TPA at later stage.
3. **Total baby charges are extra which include admission, pharmacy, vaccinations, investigations, disposables, consumables, equipments, speciality consultations, etc.**
4. In Case the patient gets discharged earlier than the packages permitted days, no refund of any type is applicable and if the length of stay is beyond the package permitted, additional payment is applicable for which kindly contact the Financial Counselling desk between 9am to 6pm
5. **For Non-medicals, Disposables, Consumables, Taxes, Kiwi Cup charges, Implants, Tubectomy charges, HIV/HbsAg, Anti-D, Medical Records, Double Occupancy and Registration Charges, etc. credit cannot be exchanged. These items are not payable to us as per Insurance company norms.**
6. Difference if any between the final bill amount and amount permitted/approved by TPA or total bill amount in case of denial from TPA has to be paid by the patient. In case of denial, cash tariff would be applicable.
7. Two attendants are permitted with patients in SDLX, DLX and PVT rooms and only one attendant is permitted in the rest of the categories of rooms and no attendant is permitted in ICU's
8. Tariffs are subject to revision
9. Kindly check your billing status on day to day basis at IP Billing Department.
10. Additional Charges on package are applicable for Non-working hours and Non-working days (sundays and public holidays)

DECLARATION

I Lakshmi Narayana Jaladugam have attended the Financial counseling desk and understood the expected costs and other conditions applicable. In case the TPA / Insurance Company rejects the claim for whatsoever reasons at any point of time I promise to settle the hospital bill with the hospital without any ambiguity.

J. N. Nagayana
Signature of the Client

Spouse
Signatory Relationship

Signature of the financial Counselor

Name	Mrs NAGALAKSHMI UPPALA	**UHID**	HNH-00016523
Father/Guardian	Mr LAKSHMI NARAYANA	**Age/Gender**	42 Y 10 M 3 D/ Female
Address	302,RADHA ENCLAVE ,STREET NO:16, Himayathnagar, Hyderabad, Telangana, INDIA, 500029		
IP No	IP26-00006907	**Admission Date**	21-07-2026
Ref Doctor	Self.		
Discharge Date	23.07.2026		

DISCHARGE SUMMARY

Consultant
Dr. Swathi H V
MBBS/MS
TSMC/FMR/15501

Diagnosis: ABNORMAL UTERINE BLEEDING - LEIOMYOMA FOR TOTAL LAPAROSCOPIC HYSTERECTOMY WITH BILATERAL SALPINGECTOMY

TOTAL LAPAROSCOPIC HYSTERECTOMY WITH BILATERAL SALPINGECTOMY done on 21.07.2026

History: She came with complain of heavy menstural bleeding on and off since 2 years, associated with clots, not associated with dysmenorrhoea, not relieved with medication. Pap smear done on 13.07.2026 showed NILM. USG (13.07.2026) showed Bulky uterus, Anteverted (105 x 44 x 54 mm) with heterogenous mass lesion m/s 79*62 mm in anterior fundus myometrium indenting endometrial cavity and pushing posterior myometrium , ET 11mm, cervix normal with bilateral adnexa normal, no fluid in POD. Patient admitted

Name	Mrs NAGALAKSHMI UPPALA	UHID	HNH-00016523
IP No	IP26-00006907	Admission Date	21-07-2026

for Total laparoscopic hysterectomy with bilateral salpingectomy.

Menstrual History:-
LMP- 05.07.2026
Previous cycles: Regular

Obstetric History: P2L2, 2NVD, LCB 14years ago

Medical History: Hypothyroid since 14 years , h/o iv iron therapy 2 years back
Surgical History: FESS , Polypectomy
Family History: Mother -DM

Investigations: Enclosed.
Blood group :A positive

Surgery Notes:
Operation performed: TOTAL LAPAROSCOPIC HYSTERECTOMY WITH BILATERAL SALPINGECTOMY under GA

Indication: Abnormal uterine bleeding (AUB- L)

Operative findings:
- Uterus - 14 weeks size
- Large fund anterior fibroid 9*10 cm noted
- Right fallopian tube and ovary -Normal
- Left ovary- cystic.
- Left fallopian tube- Normal

Name	Mrs NAGALAKSHMI UPPALA	**UHID**	HNH-00016523
IP No	IP26-00006907	**Admission Date**	21-07-2026

Procedure:

- Position: Low lithotomy
- Primary port : 10mm , 3 accessory ports inserted :5mm each
- Uterus - 14 weeks size
- Large fund anterior fibroid 9*10 cm noted
- Right fallopian tube and ovary -Normal
- Left ovary- cystic.
- Left fallopian tube- Normal
- Proceeded with Total laparoscopic hysterectomy+ bilateral salpingectomy
- Specimen retrieval done through vagina
- Vault sutured by stratafix No. 2
- Thorough irrigation and suction done
- Hemostasis secured
- Bilateral ureteric peristalsis visualised at the end of procedure
- Urine - clear
- Procedure uneventful
- Specimen: uterus+ cervix + bilateral fallopian tubes sent for HPE

Post-Operative Notes: She was closely monitored in the postoperative period. Her vital signs remained stable. She was encouraged to ambulate. She was shifted to room. Foleys removed and she voided spontaneously. Her general condition was satisfactory and she was found to be fit for discharge. Medications were explained to the patient supplemented by written information.

Advice:

1. T. Ceftum 500mg (Cefuroxime axetil) twice daily 9am-9pm till 28/7/2026

Name	Mrs NAGALAKSHMI UPPALA	UHID	HNH-00016523
IP No	IP26-00006907	Admission Date	21-07-2026

after food.

2. T. Pantop 40mg(Pantaprazole) once daily at 8am till __.2026 before food.
3. TAB ACELO- PLUS (9am-- 9pm) till 28/7/2026 after food.
4. Tab Zofer (Ondansetron) 8mg SOS (for nausea/ vomiting)
5. T. Zincovit once daily at 2 pm for 1 month.
6. Collect HPE report.
7. Syp duphalac 15 ml at bed time - sos if constipation,

Review with **Dr. SWATHI H V,** after **1 week** on **29/7/2026** at Rainbow Children's Hospital with **HPE report** with prior appointment **(Review consultation will be charged).**

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, when and how to obtain emergency care etc also have been explained by doctor ..... in a language that I can understand and I acknowledge.

Patient/ Attender

In case of emergency like bleeding, fever [please refer to postpartum book for further details - Chapter II page 6] kindly contact 9154865045 at Rainbow Children's Hospital Himayatnagar just dial one toll free number - 18002122. You can also take appointments at any time by going online to our website **www.rainbowhospitals.in**

Registrar/Resident/C.M.O

Consultant
Dr. Swathi H V

Rainbow® Children's Hospital
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Name	Mrs NAGALAKSHMI UPPALA	**UHID**	HNH-00016523
IP No	IP26-00006907	**Admission Date**	21-07-2026

MBBS/MS
TSMC/FMR/15501

HNH-00016523 IP26-00006907
Mrs NAGALAKSHMI UPPALA
18-09-1983 42 Y 10 M 3 D (F)
Dr. SWATHI H V

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SURGERY DETAILS

Date : 21-07-26

Patient Name: Mrs. Nagalakshmi uppala Date of Birth: 18-09-1993 Age: 42Yrs

Gender: Female Ward : OT UHID No.: HNH-00016523
IP26-00006907

Date of Surgery: 21-07-2026 ☐ OT -1 ☑ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Total Laparoscopic Hysterectomy + Bilateral Salpingectomy.

GA

Time in : 10:15 Am Time Out : 2:15 Pm

		NAME	AMOUNT
1.	Surgeon	Dr. Swathi H.V	
2.	Anaesthetist	Dr. Ayesha	
3.	Assistant Surgeon	Dr. Dua	
4.	OT Technician	Br. Saichandu	
5.	Circulating Nurse	Sr. Puja, Sr. Natasha	
6.	Assistant Nurse	Br. Balu, Sr. Sangeetha	

Mrs NAGALAKSHMI UPPALA (42 Y 10 M 3 D/F)
UTERS
NINV00213
HN26012212UTERS

Special Equipment:
☑ Laparascopy ☐ Broncoscope ☑ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others Vessel Sealer (26-0000215725/724)

Ananda for Dr. Swathi HV

Signature of the Surgeon

Puja.

Signature of Circulating Nurse

Order No: 26-0000215720/721 Order by: Archana 21/7/26 @ 14:15 pm

HNH-00016523 IP26-00006907
Mrs NAGALAKSHMI UPPALA
18-09-1983 42 Y 10 M 3 D (F)
Dr. SWATHI H V

TLH + BSO
uppala

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CONSUMABLES OF OT

Circulating staff : Swetha Karuna Technician : Saichandu Date : 21/7/26 Time :

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube 7.0		01	Major Pack		1	Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : A / P / N		03	~~Stratafix~~ 4/0		01	Suction Catheter		
HME filter : A / P / N			Stratafix 4/0			Feeding Tube		
Syringes : 10 cc		~~01~~	Stratafix 4/00	1		Vaccum Suction Set		
05 cc		04	Gloves SG 6.5		05	Surgical Gloves		
02 cc		~~02~~	Encore 6.5		1	Gauze Pack		
01 cc			S.G 7.0		3	Syringe 1ml / 2ml		
Cautery plate : A / P / N		01	Surgical blade 11		02	Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL		02	Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml		01+03	Koochies XXL		01	~~10 cc~~		2
Inj midaz		01	Ointments Lose Jelly		1	NS 500		4
~~Inj morphine~~		~~01~~	Suction Catheter			Transfix		4
Fentanyl		01	Cap, Mask		~~10~~ 10	Irrigation set		4
Morphine		01	Gauze Pack 7.5		4+3			
Ketamine			Mop Pack		1			
Propofol		04	Steristrip					
Rocuronium		02	Underpad		2			
Glycopyrolate		01	Draw sheet					
Myopyrolate		01	Abgel					
Ondansetron			Foleys catheter NO-16		1			
Pencan 25g/ Spinal Needle 22			Urobag		1+1			
Bupivacaine 0.25%		01	Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
~~Antibiotics~~ O2 mask (A)		01	Bandage Hip leggy		01			
Oral Airway 2		01	Tegaderm 8552		03			
Suppositories			Ioban Skin stapler		01			
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg		~~01~~	Vaccum Suction set		2			
Justin : 12.5 mg / 25mg / 100mg		01	Plastic Bed Sheet Aprons		05			
Tab. Misoprost : 200mg			Betadine Solution		2			
Inj PCM		01	Microshield		1			
200 ml Extension tube		01	Cotton Balls		1			
Nasal Airway 26		01	Latex Gloves		10			
Ryles Tube 16		01	Ramdione Scrub					
Lignocaine patch		02	Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 26-000215737/736 Ordered by : Archanna 21/7/26 @ 15:30 pm

Doc. No. : RCH / FRM / GENERAL / 125

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer,
Old MLA quarters road AP State Housing Board Himayatnagar ,
Hyderabad ,Telangana, INDIA ,500029.
040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	: HNH-00016523	**Name**	: Mrs NAGALAKSHMI UPPALA
Age / Sex	: 42 Y 10 M 3 D / Female	**Doctor**	: SWATHI H V
Adm/Reg Date/Time	: 21/07/2026 08:03	**Payor**	: SELFPAY
Order Date	: 21/07/2026 15:28	**Ordernumber**	: 26-0000215737
Visit ID	: IP26-00006907	**Ward/Bed No**	: 4F -OT / PPO-417
Patient Address	: 302,RADHA ENCLAVE ,STREET NO:16, Himayathnagar, Hyderabad, Telangana, INDIA, 500029		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	MYOPYROLATE-INJ-5ML		1 Nos	/ Once Daily	1 Days		1 Ampule	Dispensed
2	FACE MASK 3 LAYER - ELASTIC	FACE MASK 3 LAYER	1 Nos	External / Once Daily	1 Days		10 Nos	Dispensed
3	NITRILE EXAMINATION GLOVES P F- MEDIUM		1 Nos	External / Once Daily	1 Days		20 Nos	Dispensed
4	SURGEON CAP FEMALE SAFE SECURE		1 Nos	External / 10 AM	1 Days		10 Nos	Dispensed
5	MAJOR PACK (PROTECTCARE)		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
6	RL 500 ML CLOSED SYSTEM	RINGER LACTATE 500ML CLOSED	1 Bottle	/ Once Daily	2 Days		2 Bottle	Dispensed

SWATHI H V
OBSTETRICS AND GYNECOLOGY
Reg No : TSMC/FMR/15501

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Note

*** This prescription is valid only for specified duration.**

*** Do not refill medicines.**

Printed Date/Time : 21/07/2026 15:46 Printed By : SUNKARI SANGEETHA

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer,
Old MLA quarters road AP State Housing Board Himayatnagar ,
Hyderabad ,Telangana, INDIA ,500029.
040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	: HNH-00016523	Name	: Mrs NAGALAKSHMI UPPALA
Age / Sex	: 42 Y 10 M 3 D / Female	Doctor	: SWATHI H V
Adm/Reg Date/Time	: 21/07/2026 08:03	Payor	: SELFPAY
Order Date	: 21/07/2026 15:28	Ordernumber	: 26-0000215736
Visit ID	: IP26-00006907	Ward/Bed No	: 4F -OT / PPO-417
Patient Address	: 302,RADHA ENCLAVE ,STREET NO:16, Himayathnagar, Hyderabad, Telangana, INDIA, 500029		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	NS 1000 ML CLOSED EUROFLEX		1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
2	COTTON BALLS 2 GM 5 NOS		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
3	AIRWAY-2 80 MM	AIRWAY 2	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
4	MEZOLAM INJ 5 MG 5 ML		1 Vial	Injection / Once Daily	1 Days		2 Vial	Dispensed
5	VACCUME SUCTION SET		1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
6	UNDER PAD 60X90 10's Pack - MEDICUBE		1 Nos	External / 10 AM	1 Days		2 Nos	Dispensed
7	Encore Micropic gloves-6.5		1 Nos	/ Once Daily	1 Days		4 Nos	Dispensed
8	MCT-ROF 100MG 10ML		1 Nos	Injection / Once Daily	1 Days		4 Nos	Dispensed
9	RELIPARA(PARACETAMOL) 1000MG 100ML BOTTLE		1 Nos	Injection / Once Daily	1 Days		1 Nos	Dispensed
10	TEGADERM WITH PAD 5X7CMS (3582X8582)	TEGADERM 8582	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
11	BACTOPREP SOLUTIONS 100 ML		1 mL	/ Once Daily	2 Days		2 Nos	Dispensed
12	UROBAG (ADULT) -URODYNE		1 Nos	External / 10 AM	1 Days		2 Nos	Dispensed
13	ROCURIUM INJ 50 MG 5 ML		1 Vial	External / Once Daily	1 Days		2 Vial	Dispensed
14	SGLOVE # 7.0(SURGICARE)	SURGICAL GLOVES 7.0	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
15	GAUZE 7.5X7.5 12 PLY (5 NOS) NON XRAY	GAUZE 7.5X7.5 12 PLY 5 NOS	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
16	THEMPYRRNOM 0.2MG INJ		1 Nos	Injection / 10 AM	1 Days		1 Nos	Dispensed
17	RYLES TUBE 16 POLYMED		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
18	POVINANZ SOLUTION 10% 100 ML		1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
19	HIGH PRESSUR EXTENTION 200 CM PRYMAX		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
20	NS 500ML CLOSED BOTTLE		1 Bottle	External / Once Daily	1 Days		1 Bottle	Dispensed
21	NASOPHARYNGEAL TUBES 2	NASOPHARYNGEAL TUBE26	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
22	E.C.G ELECTRODES (ADULT)	ELECTRODES ADULT	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
23	ANAWIN INJ VIAL 0.25% 20 ML		1 Vial	Injection / Once Daily	1 Days		1 Vial	Dispensed
24	LEGGINGS DISPOSABLE (PROTECTCARE) BIG		1 Nos	/ 10 AM	1 Days		1 Nos	Dispensed
25	DSYRINGE 5ML(NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
26	LOX-LIDOCAIN-SPER PATCH 2S		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
27	OxygenMask With Tubing - Adult ROMSONS-FC		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
28	THEMICAINE 30GM JELLY		1 On Application	/ Once Daily	1 Days		1 Nos	Dispensed
29	IRRIGATTO(T.U.R SET)	IRRIGATTO(T.U.R SET)	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
30	ADULT DIAPERS-XXL		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
31	SURGICAL BLADE 11	SURGICAL BLADE 11	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
32	DISPOSABLE APRONS STERI XL	DISPOSABLE APPRON STERILE XL	1 Nos	/ Once Daily	5 Days		5 Nos	Dispensed
33	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		5 Nos	Dispensed
34	MOPS 30X30 8PLY SS X-RAY	MOPS 30X308 PLYDATT	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
35	FOLEYS CATHETER 16-UROCATH		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
36	JUSTIN SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
37	TRANSOFIX DEVICE-4090500		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
38	STRATAFIX SXPL2B400 1-0		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
39	NS 100ML ACCULIFE - EH	NORMALSALINE 0.9% SODIUMCHLORIDE100ML CLO	1 mL	/ Once Daily	1 Days		1 mL	Dispensed
40	PREGELLED SURGICAL PLATES(ADULT)	PREGELLED PLATED ADULT	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
41	ET TUBE 7.0 CUFFED RUSCH		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
42	PROXIMATE PLUS MD 3500 STAPLER(PMW35)	PROXIMATE PLUS MD 3500 STAPLERPMW35	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed

SWATHI H V
OBSTETRICS AND GYNECOLOGY
Reg No : TSMC/FMR/15501

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HNH-00016523 IP26-00006907
Mrs NAGALAKSHMI UPPALA
18-09-1983 42 Y 10 M 4 D (F)
Dr. SWATHI H V

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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	1			
5	In-patient Medical record	1			
6	Doctors progress sheets	3			
7	Nursing plan of care and handover sheets	2			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery	1			
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	1			
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)	3			
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list	1			
26	Surgical safety checklist	1			
27	Operation Theatre notes	1			
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				
44	RBS monitoring chart				
	Billing	1			
	Extras	6			
	Total No. of Pages	34			

Doc. No. : RCH/ FRM / GENERAL / 126

Signature and Date : 23/07/26

(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

PATIENT TRANSFER FORM

Rainbow® Children's Hospital
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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016523 IP26-00006907 Mrs NAGALAKSHMI UPPALA 18-09-1983 42 Y 10 M 3 D (F) Dr. SWATHI H V	21/7/26 @ 8:3 AM	21/7/26 @ 8 PM
	Transfer Ordered by DR. Swathi	Reason for Transfer Observation
From Unit Pre - Post	To Unit Room	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 30	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	RL 500ml	(1)
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sis. Sujatha	DR. Swathi

Patient & Clinical Records Received by : Sunanda @ 10pm

Date & Time of Patient Received : 21/7/26

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

PATIENT TRANSFER FORM

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Your Right to a Safe Delivery

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016523 IP26-00006907 Mrs NAGALAKSHMI UPPALA 18-09-1983 42 Y 10 M 3 D (F) Dr. SWATHI H V	21/7/26 @ 8:03 AM	21/7/26 @ 10 AM
	Transfer Ordered by Dr. Manisha.	Reason for Transfer TLH+TBSO
From Unit Pre & Post	To Unit OT	Information to Attendant Yes ☐ No ☐
Number of Sheets in Clinical File 25	Number of Imaging Films —	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	RL on flow	1
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Asha D	Dr. Manisha

Patient & Clinical Records Received by : Karuna
21/7/26 @ 10 AM

Date & Time of Patient Received :

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

☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar ,Hyderabad ,Telangana, INDIA ,500029.
TEL NO :040-48873000
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006907 **Admit Date** : 21-Jul-2026 **Admit Time** : 08:03 AM **UHID** : HNH-00016523

Patient Details :

Patient Name	: Mrs NAGALAKSHMI UPPALA	**Age**	: 42 Y 10 M 3 D
Guardian	: Mr LAKSHMI NARAYANA	**DOB**	: 18-09-1983
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 302,RADHA ENCLAVE ,STREET NO:16 Himayathnagar Hyderabad Telangana INDIA 500029	**Phone No**	: 9000511145/ 9391049959
		E-mail	: NA@GMAIL.COM

Admission Details :

Bed Type : TWIN SHARING **Bed No** : PPO-417 **Ward Name** : 4F -OT

Room No : PPO-417 **Admission Type** : First Visit

Contact Details :

Name : Mr LAKSHMI NARAYANA **Relationship** : Husband

Contact Address : 302,RADHA ENCLAVE ,STREET NO:16 Himayathnagar Hyderabad Telangana INDIA 500029 **Phone No** : 9000511145

J.L.Nelayana
Signature

Doctor Details :

Doctor Name : Dr. SWATHI H V **Specialisation** : OBSTETRICS AND GYNECOLOGY

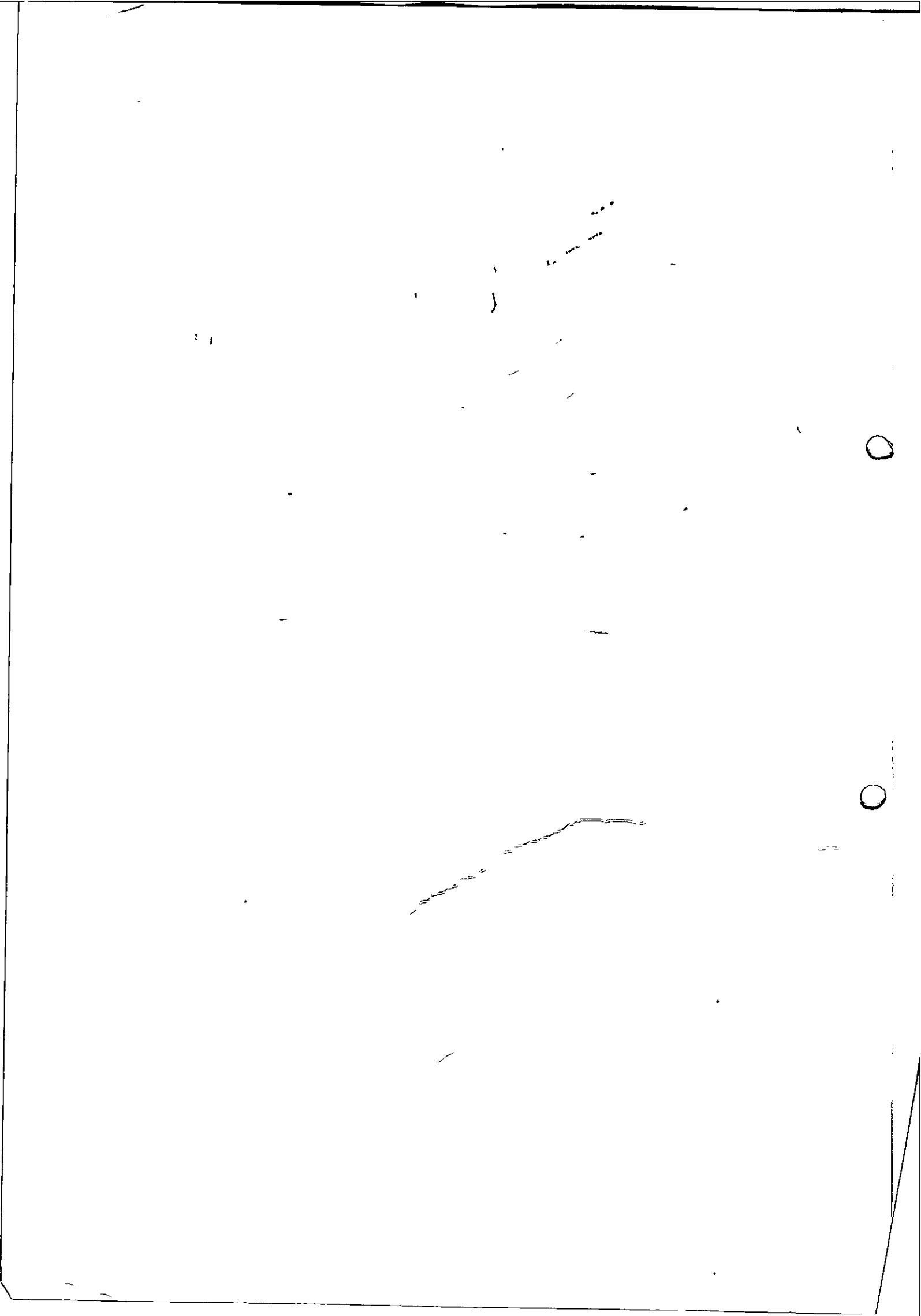
Referral Doctor : Self. **Phone No** :

Co-Consultant :

Payment Details :

Deposit Amount : 200000.00

Payment Mode : DC/CC Card **Payor Name** : SELFPAY



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ACTIVITY RECORD FOR BILLING

HNH-00016523 IP26-00006907
Mrs NAGALAKSHMI UPPALA
18-09-1983 42 Y 10 M 3 D (F)
Dr. SWATHI H V

Name :_____ W.

UHID No. : _____ sultant: _____ 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
21/7/26	10AM	Pre & Post	OT	madhu /
21/7/26	2:15PM	OT	Pre Post	Karuna / Mamta
21/7/26	10PM	Pre-Post	Room	Sujatha /

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
21/7/26	CBP, Creatinine, Urea Electrolytes, ~~Uric Acid~~ CRP	26012177	Mouni
21/7/26	GRBS 2nd upon (130mg/dL)	12211	Mouni
21/7/26	CBP	2224	Mouni
		Cross checked by Sujatha 21/7/26 @ 10pm	
	Cross checked by Sunanda		

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
21/7	Cardiac monitor	2.20 pm	10pm	15723	Mouni
21/7/26	Infusion pump		10PM	15723	
21/7/26	oxygen.	2:20 pm	3:20 pm	5779	Mouni

Cross checked by Sunanda

Cross checked by Sujatha

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
21/7	IV Placement	(1)	15722	
21/7	PAC (IP)	(1)	15721	Mouli
21/7	catheterisation	(1)	15722	
			cross checked by Sujatha	
22/7	NHA	(1)	16184 21/7/26 @ 10pm	
23/7	IV IRON Therapy	1	16180	Ashwini
23/7	iv placement	(1)	16183	
		Cross checked	by Sujatha	

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00016523 IP26-00006907
Mrs NAGALAKSHMI UPPALA
18-09-1983 42 Y 10 M 3 D (F)
Dr. SWATHI H V

hmi 9.

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I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 21/7/26 Time of Admission : 7:30 Am.

Allergies: CLINDAMYCIN ☐ ~~Not~~ know any drug allergies

PRESENTING COMPLAINTS :

c/o heavy menstrual bleeding.
USG pelvis done showed : bulky uterus with anterior wall fibroid indenting cavity measuring 78x69mm, ET 11mm
Admitted for TLH + BS

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage :	Parity : P2L2
Previous Periods : regular.	Mode of Delivery : SVDs.
LMP : 5/7/26.	Last Child Birth : 14 yrs
Contraception :	

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
H/o anemia due to AUB. Hypothyroidism.	- FESS - polypectomy

HNH-00016523 IP26-00006907
Mrs NAGALAKSHMI UPPALA
18-09-1983 42 Y 10 M 3 D (F)
Dr. SWATHI H V

mother: DM

MEDICATION HISTORY:

Tab thyronorm 100mg | OD

INITIAL ASSESSMENT :

Date 21/7/26 Ht. 152cm Wt. 62.60 kg BMI 27.09 B.P 130/74 mmHg Pallor (-) CVR S1S2 (+) Respiratory System BAE (+) Thyroid (N)	Breasts (N) Abdominal Examination (N)	Local/Speculum Examination Bimanual Pelvic Examination

PROVISIONAL DIAGNOSIS : Abnormal uterine bleeding (AUB-L)

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT
Blood investigation noted A+ve HIV, HCV, HbsAg } NR. CBC, CRP., Sr. Electrolytes, RFT. } to send	Total laparoscopic hysterectomy + bilateral salpingectomy - NBM - Consent for surgery - preparation of parts - preoperative medication - PAC - shift to OT on call

Dr. RAMYA THEJA KADIYALA
Reg. No: 01458

Name of the Doctor : Dr Ramya thaja
Signature of Doctor: [signature]
Date & Time : 21/7/26 @ 8Am

HNH-00016523 IP26-00006907
Mrs NAGALAKSHMI UPPALA
18-09-1983 42 Y 10 M 3 D (F)
Dr. SWATHI H V

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7/2024 2:30pm	C/S/D & Monitor	
		Adv
	GC For Afebrile	
	BP 124/74	- NBM till further order
	P/R 97	- Drips as charted
	P/A Soft	- Foley's & Drain till Further order
	L/E NAD	ⓐ Send CBP & SPm (today)
	U/O 400 (OT-Empty)	- IV Tranexamic Acid 710 x 24hr
GRBS - 130mg/dl (2PM)	D/O ~100cc	- Foley's care / Drain care
		- H/O monitoring
		- Inform SMO
(PPE - Sent ✓)		
		My Monitor
21/7/2024 5pm	C/S/D	& Monitor
	CC For Afebrile	Adv
	Vitals Stable	- Send CBP & 8pm
	P/A Soft NABD	- IV Tranexamic Acid 710 & 24hr
	L/E NAD	- NBM till further order
	U/O ~60cc/hr	- Foley's & Drain in situ till further
	D/O ~100cc (Serosanguinous)	order
		- Drips as charted
		- Inform SMO
		My Monitor

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7/26	C/I/B Dr Mrudula	
7pm	POD-0 TLH	
	o/E pt c/c/c	Adv
	oy cbnty	1. Allow sips of oral fluid
	PR - 99 bpm	2. Drugs as charted
	BP - 118/75 mmHg	3. IV fluids
	P/A - soft	4. I/O charting
	Bowel sound well heard	5. D/o monitoring
	U/O - 400ml :: 4pm	6. monitor vitals
	D/o - 100ml :: S/s	7. Spirometer
HB - 10.1 gm/dl		8. Send CBC @ 8pm
plat 2.42 lakh		[signature]
		Dr Mrudula.
21/7/26	C/I/B Dr Mrudula	
10pm	POD - 0	
	o/E pt c/c/c	Adv
	oy cbnty	1. Liquid diet
	SpO2 - 99% RA PR 84 bpm	2. Drugs as charted
	BP. 120/83 mmHg	3. IV fluid
	P/A soft	4. I/O charting
	BS (+)	5. D/o charting
	U/o - 400ml :: 3hrs	6. monitor vitals
	D/o - 100ml :: S/s	7. Spirometer
	Shift to Room	[signature]
		Dr Mrudula.
		noted by Swatha

21/7/26 @ 10pm

HNH-00016523 IP26-00006907
Mrs NAGALAKSHMI UPPALA
18-09-1983 42 Y 10 M 3 D (F)
Dr. SWATHI H V

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7 9am	C/B Dr. Mrudula	
	POD-1	
	o/e pt stable	Adv
	afebrile	→ liquid diet
	PR- 82bpm	→ Ambulation
	SpO2 - 99.1% RA BP- 110/70mmHg	→ Drugs as charted
	P/A - soft	→ I/O charting
	Bowel sounds heard	→ monitor vitals
	I/O = 800ml till 3am	→ Ergometrine.
	O/o - 100ml till 5x	
		Dr. Mrudula. N.B. Sunanda 22/7/26 @ 8:50AM
22/7 10AM	S/B Dr Swathi HV	
	- POD-1, T/H + BS.	
	-	
	pt seen and comfortable.	
	- Foleys removed now	
I/O ↓ 100cc serosanguinous		Adv
	O/E: vitals @	- Ambulation
	PA: soft.	- Encourage
	BS ⊕.	voiding.
Hb 2) 10.1		- soft diet by 12pm
	L/E: NAD	- inj Tramadol / pain
		- Perfalgan SOS
		N.B. Yaheshwari 22/7/26 @ 2:40pm

HNH-00016523 IP26-00006907
Mrs NAGALAKSHMI UPPALA
18-09-1983 42 Y 10 M 3 D (F)
Dr. SWATHI H V

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/07 4:30pm	S/B ANSWARDI.HV	
	- drain removed LAAP	
		plan
		- P/s tow morning
		- Inj FCM 1gm @ 5AM for Labor room
		Dr. Swathi H V Consultant Obstetrics and Gynecology Reg. No: 15501
		Informed. N/B Supriya @4:30pm
22/07/2026 7:15pm	c/s/by Dr. Naveena	
	O/E GC - fair	Adv
	Afebrile.	- Soft diet
	Vitals - stable	- Adequate hydration
V-✓	PA = soft, NT	- drugs as charted
F-✓	Dressing: dry & clean	- w/f P/V bleeding
S-✗	L/E: P/V bleeding WNL	- shift to 4th floor
		- T/M @ 5:30am for Inj. FCM 1gm iv infusion
		- Monitor Vitals
	Dr. Naveena	- Inform SOS

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

HNH-00016523 IP26-00006907
Mrs NAGALAKSHMI UPPALA
18-09-1983 42 Y 10 M 3 D (F)
Dr. SWATHI H V

(3)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/7/2026 6:00am	c/s/by	Dr. Naveena
	o/c GC - fair	Adv
	Afebrile	Soft diet
V - ✓	Vitals - stable	Adequate hydration
F ✓	PA - soft, NT	drugs as charted
S -	Dressing: dry & clean	Inj. PCM 1gm in
	L/E: NAD	100ml NS iv stat
		- Monitor Vitals
		- w/f PV bleeding
		- I/SOS
	Dr Naveena	
23/7/2026 7:30am	c/s/by	Dr. Naveena.
	o/c GC - fair	Adv.
	Afebrile SpO₂ - 99% on RA	- Soft diet, Adequate hydration
	PR: 80bpm.	- drugs as charted
V - ✓	BP: 127/86mmHg	- Ambulation
F - ✓	CVS/RS: NAD	- w/f PV bleeding.
S - ✓	PA: Soft, NT.	- Monitor Vitals I/SOS
	Dressing: dry & clean	
	L/E: NAD	
	patient can be shifted to room	Patient can be discharged — Dr Naveena

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Mrs NAGALAKSHMI UPPALA
18-09-1983 42 Y 10 M 3 D (F)
Dr. SWATHI H V

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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DRUG CHART

Date of Admission: 21/7/26 Drug Allergies: CLINDAMYCIN ☐ 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 / 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 .... Signa...

HNH-00016523 IP26-00006907
Mrs NAGALAKSHMI UPPALA
18-09-1983 42 Y 10 M 3 D (F)
Dr. SWATHI H V

REGULAR PRESCRIPTIONS Weight. 62kg 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 : INJ MAGNEX FORTE				Date / Time	21/7	22/7	23/7
Dose	Route	Frequency	Start Date				
1.5g	IV	BD	21/7	10 AM	[signature]	[signature]	[signature]
Name & Signature of the Doctor Starting the Drugs: [signature]							
Additional Instructions: (test dose) CEFOPERAZONE + SULBACTAM. x				10pm	[signature]	[signature]	
Daily Doctor's Endorsement by a Sign					[signature]	[signature]	

DRUG : INJ. PARACETAMOL				Date / Time	21/7	22/7	23/7
Dose	Route	Frequency	Start Date				
1gm	IV	TID	21/7	7am	X	[signature]	[signature]
Name & Signature of the Doctor Starting the Drugs: Dr. Amreen [signature]							
Additional Instructions:				3pm	X	[signature]	
				11pm	[signature]	[signature]	
Daily Doctor's Endorsement by a Sign					[signature]	[signature]	

DRUG : INJ. DICLOFENAC				Date / Time	21/7	22/7	23/7
Dose	Route	Frequency	Start Date				
75mg.	IV	BD	21/7	10AM	X	[signature]	[signature]
Name & Signature of the Doctor Starting the Drugs: Dr. Amreen [signature]							
Additional Instructions:				10pm	[signature]	[signature]	
Daily Doctor's Endorsement by a Sign					[signature]		

Verified by Dr. Dhakshayani

Verified by Dr. Dhakshayani

Verified by Dr. Dhakshayani

HNH-00016523 IP26-00006907
Mrs NAGALAKSHMI UPPALA
18-09-1983 42 Y 10 M 3 D (F)
Dr. SWATHI H V

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Verified by Dr. Dhakshayani

Sheet No: .....

REGULAR PRESCRIPTIONS

Weight 60kg Ward .....

				Date/Time	22/7	23/7
DRUG : INJ. CEXANE						
Dose	Route	Frequency	Start Dt.			
40mg	S/C	OD	22/7			
Name & Signature of the Doctor Starting the Drugs: Dr. AMREEN				8AM		
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						

				Date/Time	22/7	23/7
DRUG : INJ PANTOPRAZOLE						
Dose	Route	Frequency	Start Dt.			
40mg	IV	OD	22/7			
Name & Signature of the Doctor Starting the Drugs: Dr Amreen				6AM		
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						

				Date/Time	21/7	22/7	23/7
DRUG : INJ TRANEXAMIC ACID							
Dose	Route	Frequency	Start Dt.				
1g	IV	TID	21/7	6AM	X		
Name & Signature of the Doctor Starting the Drugs: Dr Amreen				2PM	X		
Additional Instructions: Date 21/7 (1st Dose-11AM) X 24hr → Flo stop				10PM			
Daily Doctor's Endorsement by a Sign							

				Date/Time	22/7	23/7
DRUG : T THYRONORM						
Dose	Route	Frequency	Start Dt.			
100mcg	PO	OD	22/7			
Name & Signature of the Doctor Starting the Drugs: Dr Amreen				6AM		
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						

Verified by Dr. Dhakshayani Signature

VERIFIED BY : Name .....

Patient Sticker

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

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

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

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

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

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

Docu. No. : RCH /FRM / CLINICAL / 108

(P.T.O.)

Patient Sticker

Weight. 62kg Ward. ....

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.	

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
21/7/26	9:40 AM	Inj. PORINORM	10mg	IV	Ramya	Anbu / Meghu
21/7/26	9:40 AM	Inj. PANTOPRAZOLE	40mg	IV	Ramya	Anbu / Meghu
21/7/26	10:20 AM	INJ. PARACETAMOL	1gm	IV	Amuea	Kar / Kar
21/7/26	10:40 AM.	Inj. MORPHINE	4.5mg	IV	Amuea	Kar / Kar
21/7/26	2: PM.	Sup. DICLOFENAC	100mg	P/R	Ayneu.	Kar / Kar
21/7/26	11 AM.	INJ. TRANEXEMIC ACID	1gm	IV	Amm	Kar / Kar
23/7	7AM	INJ. FCM. + 100ML NS	1GM.	IV	@.	Anbu / Aleti

HNH-00016523 IP26-00006907
Mrs NAGALAKSHMI UPPALA
18-09-1983 42 Y 10 M 3 D (F)
Dr. SWATHI H V

I.V. FLUIDS CHART

Weight. 60kg 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
21/7/26	8 AM	RINGER LACTATE	IV	100 ml/hr			21/7		
21/7/26	10:15AM	RINGER LACTATE	IV	1000ml/hr	1mm		21/7	1mm	
21/7/26	10:50AM	RINGER LACTATE	IV	500ml/hr.	1mm		21/7	1mm	
21/7/26	11:30	RINGER LACTATE	IV	500ml/hr	1mm		21/7		
21/7	1:30 PM	RINGER LACTATE	IV	100 ml/hr			21/7		
21/7	7PM	RINGER LACTATE	IV	80 ml/hr			21/7		
22/7	2AM	DNS DEXTROSE NORMAL SALINE	IV	70/hr	~~22/7~~		22/7		
22/7	7AM	RL RINGER LACTATE	IV	75ml/hr			22/7		
		STOP							
		Dr Naveen							

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

HNH-00016523 IP26-00006907
Mrs NAGALAKSHMI UPPALA
18-09-1983 42 Y 10 M 3 D (F)
Dr. SWATHI H V

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MEDICATION RECONCILIATION FORM

Drug Allergies: CLINDAMYCIN ☑ Not known any Drug Allergies

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

Shifting From: NA Shifted to: NA

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Tab THYRONORM	100mg	PO	OD		☑ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr ANVYA

Date & Time : 21/7/26 @ 8AM

Nurse Name & Signature: Sujatha

Date & Time : 21/7/26 @ 8AM

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

HNH-00016523 IP26-00006907
Mrs NAGALAKSHMI UPPALA
18-09-1983 42 Y 10 M 3 D (F)
Dr. SWATHI H V

305

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RESULT SHEET

Date	21/7	21/7				
Time		8:17pm				
Hb	10.3	10.1				
PCV		4.14				
RBC	4.28	29.0				
WBC	5.05	12.21				
N/L		89.1				
Platelets	2,73	242				
CRP	5.0					
ESR						
PCT						
RBS						
Na	138					
K	4.4					
Cl	102					
Ca/Mg						
Phosphate						
Urea	11					
Creatinine	0.9					
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid	4.4					
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

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

① PRBC Fever

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

Patient Sticker

HNH-00016523 IP26-00006907
Mrs NAGALAKSHMI UPPALA
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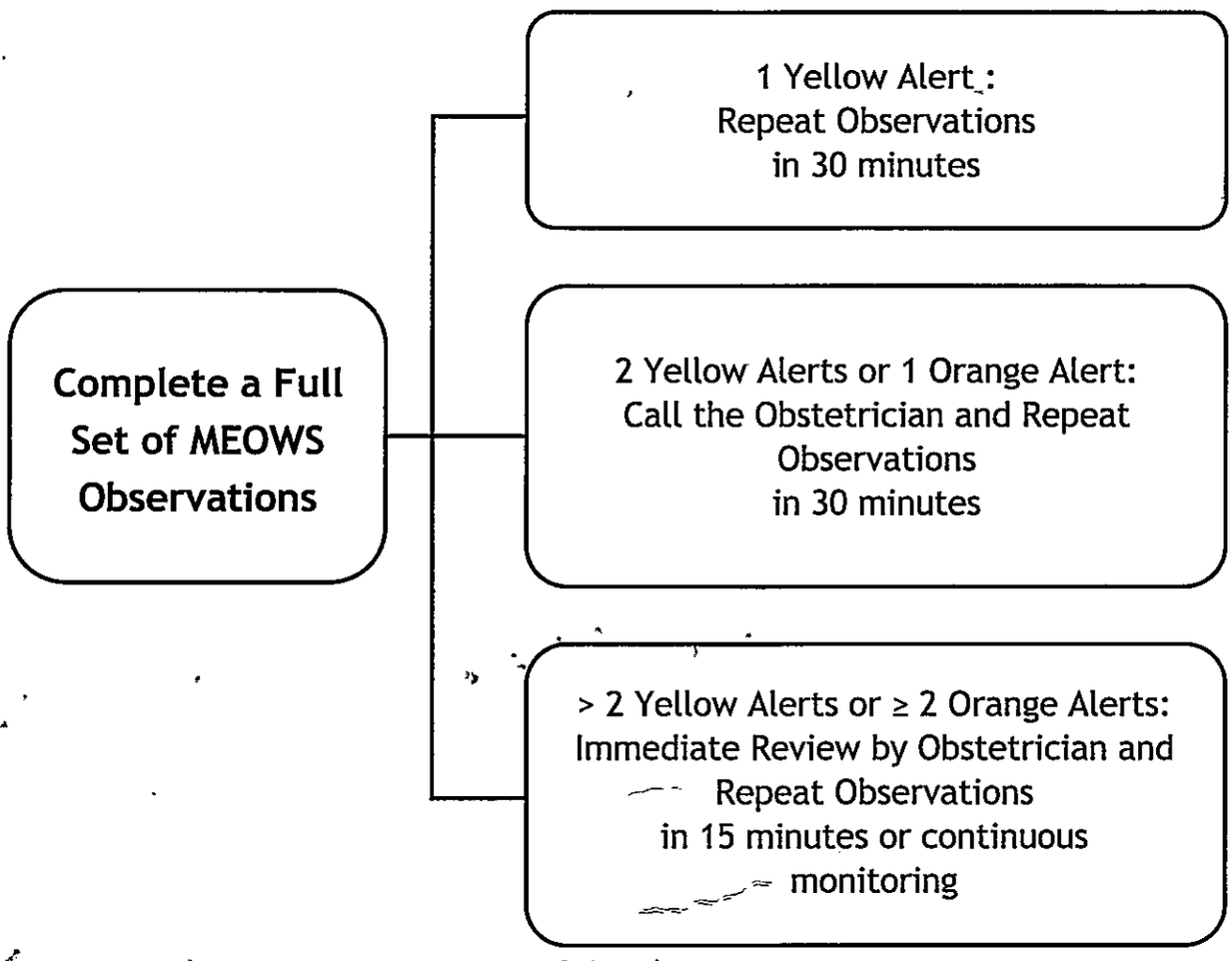
Early Warning Observation Score Chart - Obstetrics

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

21/7/26

	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																								
	11 - 20		20					20	20	20	20	20	20	20	20	20	20			20				20	
	0 - 10																								
Saturations	94 - 100 %							99	99	99	99	99	99	99	99%	99%	99%			99%				99%	
	< 94 %																								
Administered O_2 (L/min.)			99%-					36			[illegible]														
Temp°c	40																								
	39																								
	38																								
	37																								
	36		–					36			36			36		98F				36.6				98°F	
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80		80					87	76	80	82	77	89	72		75	98			76				76	
	70																								
	60																								
	50																								
	40																								
↑ Systolic Blood Pressure	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120		120					124	119	120	112	110	109	112		110	128								
	110																			114				112	
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
↓ Diastolic Blood Pressure	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70							76	79	81	70	72	80	72		75	83			76				70	
	60																								
	50		70																						
	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			0					0	0		0	0	0	[illegible]		0	0			0				0	
TOTAL ORANGE SCORES			[illegible]					[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]		0	0			0				0	
Nurse Initial			[illegible]					[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]			[illegible]				[illegible]	

Obstetrics and Gynaecology Early Warning Signs



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

Patient Sticker

HNH-00016523 IP26-00006907
Mrs NAGALAKSHMI UPPALA
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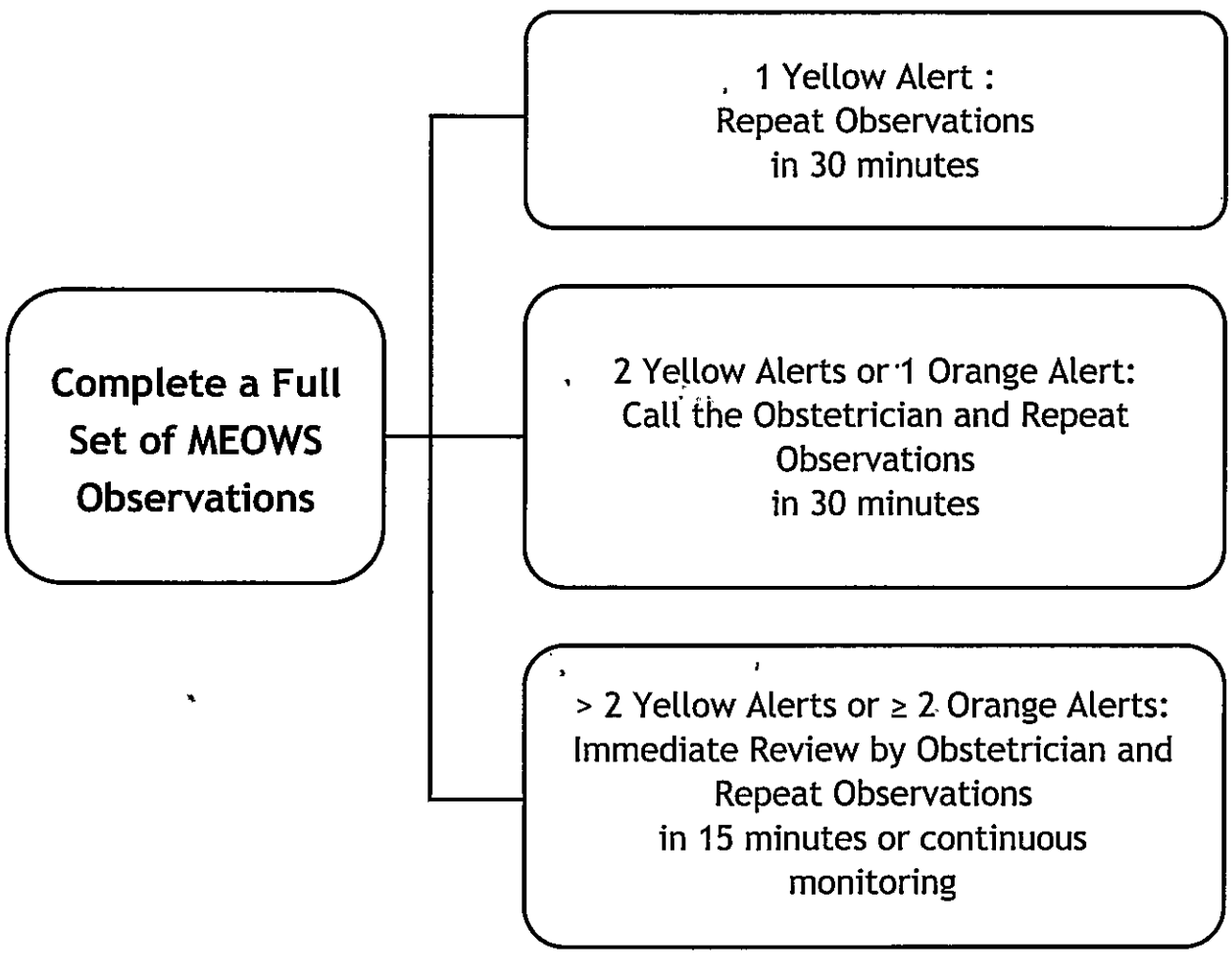
Early Warning Observation Score Chart - Obstetrics

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

22/7																									
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				20bpm				20				20				20				20	
	0 - 10																								
Saturations	94 - 100 %			99				99%				99%				99				99%				99%	
	< 94 %																								
Administered O_2 (L/min.)																								–	
Temp°c	40																								
	39																								
	38																								
	37			98.1°				98.4				98.2				36°				98.3				–	
	36																								
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80			71bpm				75bpm				80bpm				82				83				87	
	70																								
	60																								
	50																								
	40																								
Systolic Blood Pressue ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120			110				115				110				123				120				127	
	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70																								
	60			70				69				70				83				72				87	
	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				0				0				0				0				0				0	
TOTAL ORANGE SCORES				0				0				0				0				0				0	
Nurse Initial																									

Obstetrics and Gynaecology Early Warning Signs



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

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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							
21/7/26	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
21/7/26	02:00 pm	RL		80ml						400ml		Empty 2:20 pm
	03:00 pm	RL	NB	80ml								
	04:00 pm	RL	M	80ml						400ml		4:25 pm
	05:00 pm	RL		80ml								
	06:00 pm	RL		80ml								
	07:00 pm		Sips.	80ml						400ml		Empty
Total Intake :						**Total Output :**						
21/7/26	08:00 pm	RL	H2O	100ml								
	09:00 pm	RL		100ml								
	10:00 pm	RL	H2O	100ml						400ml		Empty
	11:00 pm	RL	liquid	100ml								
	12:00 am	RL		100ml								
	01:00 am	RL		100ml								
Total Intake :		taken				**Total Output :**						
22/7/26	02:00 am	↑		100ml								
	03:00 am			100ml						800ml		Empty
	04:00 am	DNS		100ml								
	05:00 am	↓		100ml								
	06:00 am			100ml						800ml		Empty
	07:00 am			100ml								
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

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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.

22/7		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							
22/7	08:00 am	↑		100ml						800ml		
	09:00 am			100ml								
	10:00 am	RL	Sup.	100ml								
	11:00 am			100ml		NA		NA	75ml	500ml		
	12:00 pm	↓		100ml								
	01:00 pm			100ml						✓		
Total Intake :						Total Output :						
22/7	02:00 pm			100ml								
	03:00 pm			100ml								
	04:00 pm	RL		100ml			0				0	
	05:00 pm			100ml				NA				
	06:00 pm			100ml								
	07:00 pm			100ml		NA						
Total Intake :						Total Output :						
22/7	08:00 pm											
	09:00 pm		idly									
	10:00 pm	0					0				0	
	11:00 pm		milk		NA			NA				
	12:00 am											
	01:00 am											
Total Intake :						Total Output : U– M–						
23/7	02:00 am											
	03:00 am											
	04:00 am	0	BID								0	
	05:00 am				NA			NA				
	06:00 am											
	07:00 am											
Total Intake :						Total Output : U– M–						

Total 24 hrs. Intake		Total 24 hrs. Output	

HNH-00016523 IP26-00006907
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Dr. SWATHI H V

NURSING CARE RECORD

Rainbow® Children's Hospital
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Date: 21/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am | 2pm	→Assess the Pt condition →monitor the vitals & record →Administration of medication →maintain I/O chart & record	8Am | 2pm	→Assessed the pt condition →monitored the vitals & recorded →Administered medication →maintained I/O chart & recorded	pt is stable	Maintain I/O chart & record	Akila
Afternoon	2pm to 8pm	→ Assess the pt condition → Monitor vitals → Maintained I/O Chart	2pm to 8pm	→ Assessed the pt condition → monitoring	Now pt is SL	Re-check vit	Nurse
Night	8pm To 8AM	→ Assess the pt condition → plan for vitals → plan for I/O chart → plan for medication	8pm To 8AM	→ Assessed the pt condition → vital are checked & recorded + all medication given	I/O chart maintained	patient is Stable	Sri Swatha

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NURSING CARE RECORD

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: 22/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM 2pm	→Assess the pt condition. →Monitor the vitals →Maintain I/O chart. →drugs give as per drug chart.	8Am 2pm	→Assessed the pt condition. →monitored the vitals →maintained I/O chart. →drugs given as per drug chart.	→pt is stable now	→Reassessed the vitals	
Afternoon				DAY			
Night	8pm to 8am	- Assess the pt condition - Monitor the v/s - Maintain the I/O - Drug as per chart	8pm to 8am	- Assess the pt condition - Monitor the v/s - Maintain the I/O - Drug as per chart	- Now pt is stable	- Rechecked the v/s	

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PAIN ASSESSMENT FORM

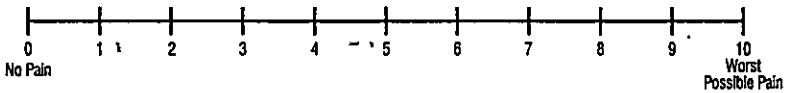
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
21/7/26	8Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
21/7	2pm	0/10	NR	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NR	[signature]
21/7	11Pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
22/7/26	12pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
22/7/26	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
23/7/26	2am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
23/7/26	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
				☐ 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

HNH-00016523 IP26-00006907
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Dr. SWATHI H V

BRADEN 'Q' SCALE

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					Date : 21/2	21/2	21/2	22/2
					Time : HG	6	8PM	M6
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 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 mean 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	24	28	28
				Evaluator's Name				

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

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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

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	21/7/26	21/7	21/7
		Score	H6	82	8PM
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0	0	0	
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0			
IV / Heparin Lock or Saline	Yes	20	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			
Total Morse Fall Scale Score:			20	20	20
		Signature			

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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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	NA	NA	NA	NA				
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	NA	NA	NA	NA	NA	NA				
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	NA	NA	NA	NA	NA	NA				
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	NA	NA	NA	NA	NA	NA				
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	NA	NA	NA	NA	NA	NA				
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	NA	NA	NA	NA	NA	NA				
			Signature of the Nurse										

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

Signature of Shift In Charge :

Signature : ..... Name : .....

Signature of Ward In Charge :

Signature : ..... Name : .....

Patient Sticker

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CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

Signature : ..... Name : .....

Signature of Ward In Charge :

Signature : ..... Name : .....

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NURSING SHIFT HAND OVER FORM - WARD

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

SITUATION

Diagnosis: TLH + BSO

Any Infection: ☐ Yes ☐ No ☐ Not Known
If Yes Specify: .....

BACKGROUND

Area / Shift Time	M6	E2	8PM	M6	M1	
	21/7/26	21/7	22/7	22/7		
Medical Condition (Any special condition to be noted):	NA	NA	NA	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:	at i°F	qn.	98F	98.1°C	98.3°F	
Res:	20bmt	20	20	20b/m	20b/m	
SpO_2:	99%	99	99%	99%	99%	
Pulse:	84bmt	88bt	85	86b/m	82b/m	
BP:	110/70	110/70	115/75	110/70	110/72	
Fall Risk Score:	—	-	-	—	—	
Pain Score:	0/10	-	—	—	—	

Recommendations

Safety Needs:	Yes	Yes	Yes	Yes	Yes	
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:	NA	—	NA	NA	NA	
Post Operative Procedure Special Orders:	NA	—	NA	NA	NA	
Handed Over By Name :	Akshy	Nouri	Srijatha	mahi	Sunanda	
Signature :			Sri			
Date:	21/7/26	21/7/26	22/7	22/7/26	22/7/26	
Time:	8AM	8pm	8AM	2pm	8pm	
Taken Over By Name :	Nouri	Srijatha	mahi			
Signature :		Sri				
Date:	21/7	21/7/26	22/7			
Time:	2pm	8PM	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:							

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URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 21/7/26 Date of Removal: .....

Parameters	Date / Shift Time	21/7 M6						
Need for the Catheter		☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hand Hygiene		☑ 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
Is the Collection bag below the level of bladder		☑ 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
Is Catheter dated as policy		☑ 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
Maintenance of closed system for the catheter		☑ 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
Is the line removed as Policy?		☑ 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
Onset of New Fever		☐ 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
Name of the Nurse		A Kelly						
Signature of the Nurse								

Removed

Docu. No. : RCH /FRM / CLINICAL / 114

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NUTRITIONAL ASSESSMENT FOR GYNEC PATIENTS

Date: 22/7/26 Time: 9:30am

Origin: Indian Height: 152 cm Weight: 62.60 Kg BMI: 27 Kg/m²

Food Allergies: NO

Diagnosis: TLH+BS

Medical History: H/O Thyroidism ; H/O Anemia due to AVB

Surgical History: polypectomy,

☐ Vegetarian ☑ Non-Vegetarian ☐ Vegan

Diet Advised: Liquid diet

Patient's / Attendant's

Signature: U. Nagalaxmi

Name: Nagalaxmi Uppala

Date & Time: 22/7/26 ; 9:30am

Dietician's

Signature: Sobiya

Name: Syeda Sobiya Zaheer

Date & Time: 22/7/26 ; 9:30am

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OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 21/2/26

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: ..... come for surgery .....

Doctor Notified on Admission: ☑ Yes ☐ No

Name of the Doctor: Dr. Ramyalaja

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
-	-	-

Gynecology Assessment: ☐ Not Applicable

Menstrual History: ..... Regular .....

Onset of Menarche: .....

Menstrual Cycle: ☐ Regular ☐ Irregular

Last Menstrual Period: .....

Gynecology Surgical History:

Caesarean Section: ☑ No ☐ Yes

Cervical Cerclage: ☑ No ☐ Yes

Ectopic Pregnancy: ☑ No ☐ Yes

Myomectomy: ☑ No ☐ Yes

Others: _____

Gynecological History:

Contraceptives: ☑ No ☐ Yes

Vaginal Discharge: ☑ No ☐ Yes

Post-Coital Bleeding: ☑ No ☐ Yes

Infertility: ☑ No ☐ Yes

If Yes Type: ☐ Primary ☐ Secondary

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

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: 97.1°F HR: 87bmt RR: 20bmt

BP: 110/70 Weight: ..... Height: ..... 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 ..... 0 ..... (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore: ☐ Yes ☑ No Score ..... 0 ..... (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

SOCIAL SCREENING:

1. **Marital Status:** ☐ Single ☑ Married ☐ Divorced ☐ Widow
2. **Special Habits:** **Smoker:** ☐ Yes ☑ No **Alcohol Abuse:** ☐ Yes ☑ No **Drug Abuse:** ☐ Yes ☑ No

Social History: Lives With ..... Family members .....

Orientation has been given regarding the following aspects:

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

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

Above information given to ..... Pt .....

Name of Person Orientation was given to: ..... Mrs. Nagalakshmi .....

Orientation not given Reason: .....

Nurse Signature: .....

Nurse Name: ..... Akhila .....

Date & Time: ..... 21/2/20 AM .....

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OPERATION NOTES

Surgeon : Dr. Swathi HV	Asst. Surgeon : Dr. Dua.
Pre-Operative Diagnosis: P_2L_2 ↑NVD	
Surgical Procedure : TLH + BS.	
Indications for Surgery : AUB-A	
Date : 21/7/26.	Start Time : / End Time :
Post Operative Diagnosis: POD-0 P_2L_2 (S/P TLH + BS	
Peri-Operative Complications:	
Amount of Blood Loss:	Blood Transfused (in ML)
Name and Number of Surgical Specimen sent for examination:	
Operation Notes: Pt in low lithotomy position Primary port - 10mm 3 accessory port - 5mm inserted	

Intra-op findings

→ Uterus ~ 14 wks size.

→ Large fundal anterior fibroid 9x10 cm noted.

→ Right ovary & tube - NAD

- left ovary ⇒ cystic ∴, tube normal.

→ Rest viscera appears (N).

- Proceeded with total laparoscopic hysterectomy + B/L Salpingectomy.

- Specimen retrieved through vagina.

- Vault sutured by. Stratafix - No. 2-0. / V-Lock - No. 2-0

- Thorough irrigation & suction done. Hemostasis secured.

- B/L ureteric peristalsis visualised at the end of procedure.

- Urine clear, procedure uneventful.

Specimen - Uterus + cervix + B/L fallopian tube.

Name of the Surgeon: Dr. Swathi HV

Signature of the Surgeon:

Date & Time: 21/7/26

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Swathi H.V
Asst. Surgeon : Dr. Dua
Anaesthetist : Dr. Ayesha
Scrub Nurse : Br. Babu, Sr. Sangeetha

Patient Name : HNH-00016523 IP26-00006907 Mrs NAGALAKSHMI UPPALA 18-09-1983 42 Y 10 M 3 D (F) Dr. SWATHI H V
UHID No. :
Date : 21/7/26

Gender : Female
THH+BSO
Time : 2:15 PM

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 10:10Am

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? CLINDAMYCIN ☑ 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 : Ayesha
Name : Dr. Sk. Ayesha

Before Skin Incision ➤➤

TIME OUT Time: 10:20Am

Confirm all team members have introduced themselves by Name and Role ☑ Yes ☐ No

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm
- Correct Patient (Check ID Band) ☑ Yes ☐ No
- Correct Site ☑ Yes ☐ No
- Correct Procedure ☑ Yes ☐ No

Anticipated Critical Events

Surgeon Reviews:
- What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? Bleeding, 2hrs, 5ml ☑ 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? Bleeding, Hypertension, Difficult extubation, Desaturation ☑ Yes ☐ No ☐ NA

Is Essential Imaging Displayed? ☐ Yes ☑ No ☐ NA

Signature : Natasha
Name : Dr. Natasha

Before Patient Leaves Operating Room

SIGN OUT Time: 10:45Am

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 : Dr. SWATHI. HV

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016523 IP26-00006907 Mrs NAGALAKSHMI UPPALA 18-09-1983 42 Y 10 M 3 D (F) Dr. SWATHI H V	21/01/26 @ 8:03 Am	21/01/26 @ 2:15 Pm
	Transfer Ordered by Dr. Ayesha	Reason for Transfer Observation
From Unit OT	To Unit Pre-post	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 30	Number of Imaging Films –	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	Rh	1
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☑ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sis. Puja	Dr. Ayesha.

Patient & Clinical Records Received by : Suvatha Fri

Date & Time of Patient Received : 21/1/26 @ 2:15 pm

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

☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : Mrs. NAGALAKSHMI UPPALA Age : 42 Gender : Male ☐ Female ☐

UHID NO: HNH-0001623 Surgeon Name: Dr. SWATHI

Anaesthesiologist : Dr. AYESHA / Dr. SAMIR

Operative procedure planned : TOTAL LAPAROSCOPIC HYSTERECTOMY

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief without numbness can be achieved by infusing weak solutions of local anesthetics arid narcotic drugs to particular parts of the body after surgery or injury, using catheters.

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

☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure

☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma / Renal Tubular Aacidosis

☐ Incapacitating Cronic Obstructive Pulmonary Disease

☐ Others : Bronchospasm, Desaturation, Bleeding, Need for transfusion

Comments : .....

- Doctor to document in medical record also if necessary (Cross-out if not applicable)

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient Mrs. NAGALAKSHMI UPPALA the above mentioned operation / Diagnostic / Therapeutic procedures TOTAL LAPAROSCOPIC HYSTERECTOMY

I authorize and give consent for anaesthesia (☐ Regional / ☐ General Anesthesia / ☐ Monitored Anesthesia Care as considered appropriate by the anaesthetic team.

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, risk, benefits and alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anesthesia.

I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, asthmatic reactions, headaches.

I authorize the anaesthetic team to perform any additional procedures (for example, Central Venous Pressure line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter in need arises.

I understand that the above mentioned consultant anesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

- Pregnant : ☐ Yes ☐ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

I declare that I have explained the nature of General Anaesthesia / Regional Anaesthesia / Monitored Anesthesia Care to be given and discussed the risks that particularly concern this patient.

I have given the patient an opportunity to ask questions and I have answered these.

Patient / Patient Attendant :

Signature : U. Nagalakshmi

Name : UPPALA NAGALAKSHMI

Relationship with Patient: Self

Date & Time : 16/7/26

Witness :

Signature : J.C. Narayana

Name : JALADURGAM LAKSHMI NARAYANA

Date & Time : 16/07/26 9:11 AM

Doctor (who is taking the consent) :

Signature :

Name : Dr: Sk. Ayesha

Date & Time : 16/7/26

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : Mrs. NAGALAKSHMI Gender: ☐ Male ☑ Female Age : 42yrs

UHID No : HNH - 0001652 3 Date : 21/7/26

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)

TOTAL LAPAROSCOPIC HYSTERECTOMY + BILATERAL SALPINGECTOMY

upon

(Name of the Patient) NAGALAKSHMI

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.

- Hemorrhage, need for blood/blood product transfusion
- inadvertent injury to bowel/bladder/ureters
- wound infection

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 SWATHI. H.V

Consentee :

Signature : U. Nagalakshmi

Name : UPPALA NAGALAKSHMI

Date & Time : 21/7/26

Witness :

Signature :

Name :

Date & Time :

Patient Attendant :

Signature : J. Lakshmi Narayana

Name : Lakshmi Narayana Taladurga

Relationship with Patient: SPOUSE

Date & Time : 21/07/2026 9:36 AM

Doctor (who is taking the consent) :

Signature :

Name : Dr Ramya Thyagu

Date & Time : 21/7/26 @ 8 AM

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: Mrs. NAGALAKSHMI UPPALA Age: 42y Sex: F UHID.No : HNH-00016523

Date: 16/2/26 Time: 8:45am Proposed Operation: Total Laparoscopic Hysterectomy

Diagnosis: AUB

B.P / CRT: 125/85 mmHg H.R: 93/min Weight: 62kg ASA Physical Status: ☑1 ☐2 ☐3 ☐4 ☐5

Laboratory Data:

Hgb: 10.4	Glucose: 85 mg/dl	Protein: 6.9	HIV:	X-Ray: (N) study
PCV: 32.4	Urea: 15 mg/dl	Alb: 4.0	HBS Ag: NR	ECG: (N) SR
WBC: 5300	Creat: 0.8 mg/dl	Total Bill: 0.4 mg/dl	HCV:	2D Echo: (N) study EF-63%
Plate: 2.84 lakh	Na:	Dir. Bill: 0.1	Blood group: A +ve	Stress/Anglo:
PT: 16.8	K:	LDH:	T3 1.18	Other:
PTT:	Ca++: 9.2	Alk phos: 73	T4 (Total) 12.9	LMP: 3/1/26
INR: 1.17	Mg++:	Amylase:	TSH 1.248	
	Cl -:	SGOT/SGPT: 25/23		

ESR - 6

Allergies: CLINDAMYCIN (Blood in Stools)

Medical History: CVS : NO H/O chestpain, SOB, Syncope

RESP :

CNS : NIL SIGNIFICANT

Renal :

Hepatic / GE : C/O (RT) upper quadrant pain K/C/O Gastritis - Endoscopy (11/7/26) - EROSIVE PANGASTRITIS RUT - NEGATIVE

Others :

Diabetes : - corrected Anemia, 3yrs ago (taken Iron Sucrose)

- H/O Loose stools : 12am (16/2/26) 6 episodes (+)

Physical Activity: METS >4

Past Anaesthetic History: H/O - FESS & CA, 10yr ago ? U/E, H/O Epidural for NVD - U/E

H/O POLYPECTOMY & [illegible]

Physical Exam:

Airway: MP 1 (2) 3 4 Mouth Opening: Adequate Mentohyoid Distance: 3FB Neck: (N) Teeth: (N) Alignment

Lungs : BAE (+), Clear

Heart: S_1S_2 (+)

CNS: NAD

pap smear: Negative for malig

USG: Bulky uterus - fibroid, Thickened endometrium 11mm

Pregnant: ☐ Yes ☑ No ☐ NA

Peripheral Venous Access Site (+)

Spine Exam for regional : Midline

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

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

CURRENT MEDICATIONS	DOSAGE
T. LEVOTHYROXINE	100mcg
T. ESOMEPRAZOLE-D	40
T. ECONORM SACHET	1-1-1

Pre-Operative Instructions:

1. DVT Prophylaxis : Explained
2. NIL ORAL → Water / ORS 2 Hours; Others 6 Hours
3. Informed Consent: ☐ Standard ☐ High Risk
4. Post Operative Pain Management: ☐ Discussed with Patient
5. Other Instructions:

Signature: Name: Dr. Jyeshe.

HNH-00016523 IP26-00006907
Mrs NAGALAKSHMI UPPALA
18-09-1983 42 Y 10 M 3 D (F)
Dr. SWATHI H V

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No		Fasting Status: Adequate.
Physical Status:	☑ Patient Identified	☑ Consent Present ☑ Chart Reviewed

H.R: 100/mt	B.P / CRT: 110/70 mg	SpO_2: 100%.	R.R: 26/mt	Last Feed: >6hr

Pre-OP Diagnosis: AUB Operation: Total Laparoscopic Hyste Date: 29/7/26.

Surgeon: Dr. Swathi Anaesthesiologist: Dr. Ayesha / Dr. Ameen Technician: Clarola

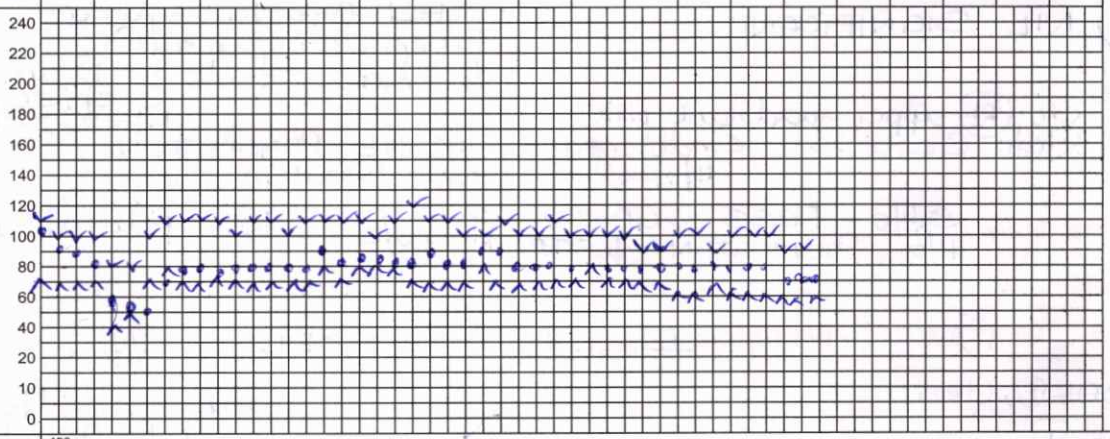
TIME	10:15	10:45	11:15	11:45	12:15	12:45	1:15	1:45	2pm
N_2O (AIR /O) LPM	0.6	→	→	→	→	→	→	→	→
HALO /SO (SEVO) MAC	0.9	→	→	→	→	→	→	→	→
Drugs:									
MIDAZOLAM	1mg								
FENTANYL	100 mcg								
PROPOFOL	100mg + 60mg								
ROCURONIUM	40mg			10mg		10mg			
PARACETAMOL	1gm								
MORPHINE		6mg							
B-GLYCOPYRROLATE		0.4mg.							
B-TRANEXEMIC ACID				1gm.					
FIO_2 / SaO_2	100	97	98	98	99	99	100	100	100	100	100	100	100	100	100
$ETCO_2$	34	32	36	34	34	36	38	38	38	36	36	36	36	37	34
ECG	SR	→	SR	→	SR	→	SR	→	SR	→	SR	→	SR	→	SR
Temperature	35.5		35.5		35.1		35.8		35.8		35.8		35.6	→	
Urine Output															
Fluids / Blood: RINGER LACTATE	1000	→	→	→	→	→	→	→	→	→	→	→	→	→	→
				1000					3000						

Antibiotic: Inj-MAGNEX FORTE
Suppository: 1.5gm PR

Blood Loss: @ 180 ml

NOTES

B.P
V Systolic
Λ Diastolic
X Mean
• Heart Rate
Tourniquet on Time
Tourniquet off Time
Throat Pack In
Throat Pack Out



LAB Values
ABG
GRBS 130 mg/dl
Others

☑ Equipment Checked and Functional
☐ BP
☑ Cuff Site: (L) UL
☐ Art Site:
☐ EKG Lead - Selected
☑ Temp Site - (R) axil
☑ FIO_2 Monitor
☑ Agent Monitor
☑ Pulse Oximeter
☑ Capnograph
☑ Ventilator
☐ Nerve Stimulator

Position: Supine
☑ Pressure Points Checked

Eye Care:
☐ Oint
☑ Tape
☑ Padding
☐ Awake

Temp:
☑ HME ☐ Fluid Warmer
☐ Cling Film ☐ OH Warmer
☐ Hugger's ☐ Cotton Wool
☑ Other

Times:
Anaes Start: 10:15 AM
OP Start: 10:30 AM
OP End:
Leave OR: 2:15 PM.

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP:
☐ ART:
☑ IV: (R) 18G Local
☐ IV:
☐ IV:

Induction
☑ IV ☐ Inhal
☐ Pre O_2 ☐ RSI
☐ Others

☑ Mask ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
ETT# 6.5mm at 19 cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug: B. ROCURONIUM.

☐ Awake ☐ Direct Vision
☑ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# 4 Attempts: 1
Difficulty Why?

☑ Bilat = BS
☐ Semi-Closed Circle
☑ Closed Circle
☐ Other

Regional:
Extremity Specify:
☐ Spinal ☐ Epidural ☐ Caudal
Others:
Position:
Site:
Needle Size: Depth:
Parasthesia ☐ Yes ☐ No
Catheter at skin cm
Drug Name & Conc:
Bolus:
Infusion:
Block Level:
Comments:

Transportation to
☐ PACU ☐ ICU ☑ Other
Relaxant Reversed ☑ Yes ☐ No ☐ NA

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

HNH-00016523 IP26-00006907
Mrs NAGALAKSHMI UPPALA
18-09-1983 42 Y 10 M 3 D (F)
Dr. SWATHI H V

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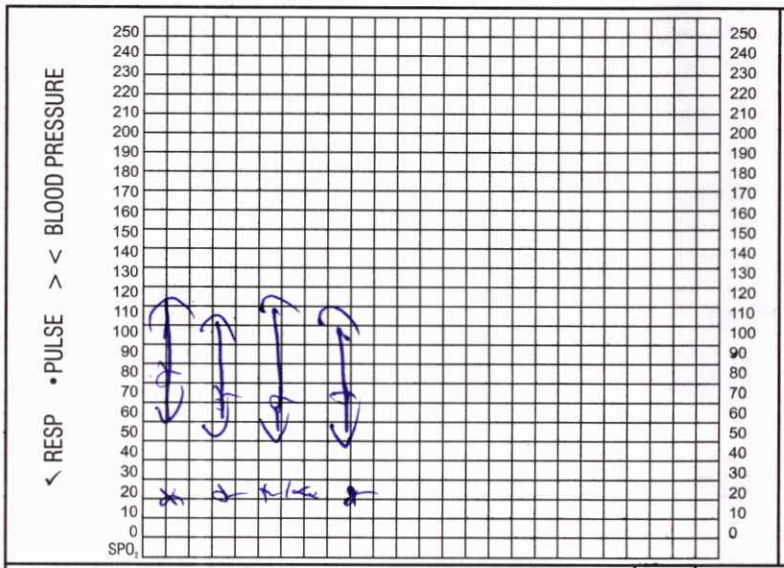
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Mounika. Time Received : 2:20pm Time Discharged : .....



IV Cannula Site : both hands.

- ☐ O_2 Mask
- ☐ Nasal Prongs
- ☐ Tracheostomy
- ☐ T-Piece
- ☐ Oral Airway
- ☐ Nasal Airway

Vomiting : ☐ Yes ☐ No Drug: Hipinex 1.5gm
NG Tube : ☐ Yes ☐ No
Drain: ☐ Yes ☐ No
Urinary Catheter: ☐ Yes ☐ No
Chest Tube: ☐ Yes ☐ No
Nil Oral ☐ Yes ☐ No
IV Fluids: RL - 100ml.
Oral Feeds: .....

POST ANAESTHESIA SCORE (Modified Aldrete Score)		IN	MINUTES 30	60	90	OUT	SCORING INTERPRETATION
Able to move 4 extremities voluntary or on command Able to move 2 extremities voluntary or on command Able to move 0 extremities voluntary or on command	= 2 = 1 = 0 ACTIVITY		1	2	2		A Minimum Total Score of 8 is Required for Discharge
Able to deep breathe & cough freely Dyspnea or limited breathing Apneic	= 2 = 1 = 0 RESPIRATION		2	2	2		Exceptions to this, are to be explained in the space below by the Discharging Physician:
BP ± 20 of Pre Anaesthetic leve BP ± 20-50 of Pre Anaesthetic leve BP ± 50 of Pre Anaesthetic leve	= 2 = 1 = 0 CIRCULATION		2	2	2		
Fully awake Arousable on calling Not responding	= 2 = 1 = 0 CONSCIOUSNESS		2	2	2		
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0 COLOR		2	2	2		
	TOTAL		9	10	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
21/7/26	2:30 pm	0/10	NA	Mouni
21/7/26	3pm	0/10	NA	Mouni
21/7/26	3:30 pm	0/10	NA	Mouni
21/7/26	4pm	0/10	NA	Mouni

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

Anaesthesiologist Name : Dr. Aneela
Anaesthesiologist Signature: Jmn
Date & Time: .....

PACU Nurse Name : Sujatha
PACU Nurse Signature: Sui
Date & Time: 21/7/26 @ 10 pm

Reassessment Frequency:
1. Every eight hours for all hospitalized patients.
2. For post surgical patient, patient with chronic pain, patient with severe pain
   a. Every 2 hours for first 24 hours
   b. After 24 hours every 4 hours
   c. Prior to pain reliving intervention
   d. With in 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU): 3rd floor (305)
Date & Time: 21/7/26 @ 10 pm

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: ..... Time: ..... Procedure done by .....

CSE /Spinal /Epidural Position : ..... Space :..... Technique (LOR/LOS) .....

Depth: ..... Catheter at Skin: ..... Attempts : .....

Parasthesia : Yes/No if yes details : .....

Solution Composition : .....

Any other issues :

a) .....

b) .....

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level		Maternal		FHR	Comments
			Left	Right	BP	Pulse		

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 : .....

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar ,Hyderabad ,Telangana, INDIA ,500029.
TEL NO :040-48873000
WEB : https://rainbowhospitals.in

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Mrs NAGALAKSHMI UPPALA**	**Age :**	**42 Y 10 M 3 D**
IP No:	**IP26-00006907**	**Sex:**	**Female**
Consultant:	**Dr. SWATHI H V**	**Ward/Bed No:**	**4F -OT/PPO-417**

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

Patient, be deemed advisable or necessary.

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

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

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

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

Note:
1 We do not allow use of medication brought from outside by the patient.
2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.
(Receivers Signature:.....)

3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.
4 Financial and billing counseling has been done to me.

Signature of Patient/Relative:

Name: Lakshmi Narayana Jaladurgam
Relationship: Spouse
Date: 21/07/2026 Time: 8:10 AM

Patient Address:
302,RADHA ENCLAVE ,STREET NO:16
Himayathnagar Hyderabad Telangana
INDIA 500029

Witness Name:

Witness Signature:

HNH-00016523 IP26-00006907
Mrs NAGALAKSHMI UPPALA
18-09-1983 42 Y 10 M 3 D (F)
Dr. SWATHI H V

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BILLING POLICY

- Billing cycle: - With effective from 1st January 2020, Our billing cycle to be start from 12 PM to 12 PM, Settlement post 12 PM, room rent will be charge for half day extra & post 6 pm, it will be charge for full day. Less than 24 hours stay will be considered as one day.
- As per the GOI guidelines, we can collect Rs 1,99,999/- only in cash mode, balance patient can pay through Card tpaIn the event of TPA/ Cashless denial or approval not received due to any reason then hospital tariff will be applicable and any discount or special rates given to TPA's / corporates won't be applicable.
- If the surgery / scans performed in Emergency hours (8pm - 7am), public holiday and on Sunday will be charged TPA processing charges Rs.720 for every TPA route cases.
- All charges vary as per Room category, except Pharmacy and consumables.
- We follows a "No Discounts Policy" kindly cooperate.
- No Duplicate/Second copy of OP OR IP bill is issued.
- ICU/Ward Charges DO NOT INCLUDE - Air Mattress, Monitor, Consultants/ Specialty Doctors Visit, Infusion/syringe pump, Ventilator/C pap, Oxygen, Investigations, Procedures, Consumables, Medicines or any other bedside equipment's/devices etc. (Detailed list can be taken from billing department).

Patient attendant can collect for Interim/provisional bill of the patient from the billing section on daily basis. Interim Bill shall be based on the acknowledged services in HIS. Final Bill of the patient may vary from the Interim bill based on actual update taken on the day of discharge. It is requested that patients/attendants inquire daily about the bill amount from billing section and pay the outstanding as on that day.

Patient bill outstanding should not be increase more than 10,000/-

You are requested to clear your outstanding amount on daily basis before 12 PM.

MODE OF PAYMENT & REFUNDS

- We accept payments by cash (up to Rs 1,99,999/- only), cards, online transfer and Demand Drafts.
- All refund more than Rs.2,000/- will be refund through NEFT in three Bank working days.

J.N.Narayana

Name & signature of Patient/Attendant

(Signature of Admission Desk executive)

NOTE: Self - attested Govt. ID proof is mandatory whosoever is signing the undertaking.

RAINBOW CHILDREN'S MEDICARE PRIVATE LIMITED

Registered Office: Road No.2, Banjara hills, Near Hotel Park Hyatt, Hyderabad - 500 034, T: +91 40 2233 4455.
Corporate Office: 8-2-19/1/A, Daulet Arcade, Karvy Line, Road No.11, Banjara Hills, Hyderabad - 500 034.
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NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name:	MRS. NAGALAKSHMI UPPALA	Age:	42 Y	Gender:	F
UHID No:	HNH-0001652	IP No:	IP26-00006907	Date:	21/7/26 Time: 8:31 Am
Diagnosis:	TLH				

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	100 MCG	ONE Amp
2.	Morphine Sulphate Inj. 15mg/Ml		
3.	Remifentanil Hydrochloride Inj. 2MG		
4.	Remifentanil Hydrochloride inj. 1MG		

Doctor Name: Dr. Ayesha

Doctor Registration No: TSNC/FMR/07725

Signature:

NARCOTIC DISPENSING FORM
APPENDIX 4 – FORM NO. 3E
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: IP26-00006907 **Date:** 21/7/26

Aadhaar No. of the Patient (Optional): .....

		Remarks
1.	**Name :** MRS. NAGALAKSHMI.	
2.	Complete postal address (with contact number, if any)	302, RADHA ENCLAVE, STREET NO 16 HIMAYATHNAGAR. HYD.
3.	Brief description of the illness	TLH.
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	NO.
5.	Details of essential Narcotic drug dispensed	FENTANYL

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
21/7/26	FENTANYL	ONE Amp	Nagalakshmi	

Dispensed by (Name & ID No.): ..... Signature: .....

Received by (Name & ID No.): SAI CHANDU 021153 Signature: .....

Time: .....

Docu. No: RCH / FRM / CLINICAL / 133

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NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name: MRS. NAGALAKSHMI VERMA		Age: 42 Y	Gender: F
UHID No: CMH-0001623	IP No: IP26-0006907	Date: 21/3/26	Time: 8:31 AM
Diagnosis: TLH			

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	100 mcg	2ML Amp
2.	Morphine Sulphate Inj. 15mg/Ml		
3.	Remifentanil Hydrochloride Inj. 2MG		
4.	Remifentanil Hydrochloride inj. 1MG		

Doctor Name: Dr. Sk. Ayesha

Doctor Registration No: TSMC/FMR/07725

Signature:

NARCOTIC DISPENSING FORM
APPENDIX 4 – FORM NO. 3E
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: IP26-0006907 **Date:** 21/3/26

Aadhaar No. of the Patient (Optional): .....

1.	**Name :** MRS. NAGALAKSHMI.	**Remarks**
2.	Complete postal address (with contact number, if any)	302, RADHA ENCLAVE, STREET NO 16 HANAMKONDA - 506
3.	Brief description of the illness	TLH.
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	NO
5.	Details of essential Narcotic drug dispensed	FENTANYL

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
21/3/26	FENTANYL	2ML Amp	Nagalakshmi	

Dispensed by (Name & ID No.): ..... Signature: .....

Received by (Name & ID No.): SAI CHANDU 02115 3 Signature: .....

Time: .....

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NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name:	MRS NAGALAKSHMI UPPALA	Age:	42 Y	Gender:	f
UHID No:	HN14 000165 23	IP No:	IP26-00006907	Date:	21/7/26
Time:	8:37 Am				
Diagnosis:	TLH				WARD: OT

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml		
2.	Morphine Sulphate Inj. 15mg/Ml	15 MG	ONE Amp
3.	Remifentanil Hydrochloride Inj. 2MG		
4.	Remifentanil Hydrochloride inj. 1MG		

Doctor Name: Dr Sk. Fayeshe

Doctor Registration No: TSMC/FMR/07725

Signature:

NARCOTIC DISPENSING FORM
APPENDIX 4 – FORM NO. 3E
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: IP26-00006907 **Date:** 21/7/26

Aadhaar No. of the Patient (Optional): .....

1.	**Name :** MRS NAGALAKSHMI UPPALA.	**Remarks**
2.	Complete postal address (with contact number, if any)	302. RADHA ENCLAVE, STREET NO:16 HIMAYATHNAGAR HYD
3.	Brief description of the illness	TLH.
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	NO
5.	Details of essential Narcotic drug dispensed	MORPHINE.

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
21/7/26	MORPHINE	ONE Amp	Nagalakshmi	

Dispensed by (Name & ID No.): ..... Signature: .....

Received by (Name & ID No.): Sai chandu 02 1153 Signature:

Time: .....

Docu. No: RCH / FRM / CLINICAL / 133

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NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name: MRS NAGALAKSHMI UPPALA		Age: 49 Y	Gender: F
UHID No: HYD 00016523	IP No: IP26-00006907	Date: 21/7/26	Time: 8:37 Am
Diagnosis: TLH			WARD: OT

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	\	\
2.	Morphine Sulphate Inj. 15mg/Ml	15 MG	ONE Amp
3.	Remifentanil Hydrochloride Inj. 2MG	\	\
4.	Remifentanil Hydrochloride inj. 1MG		

Doctor Name: Dr SK Ayesha

Signature: [signature]

Doctor Registration No: TSMC/FMR/07725

NARCOTIC DISPENSING FORM
APPENDIX 4 – FORM NO. 3E
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: IP26-00006907 **Date:** 21/7/26

Aadhaar No. of the Patient (Optional): ....

		Remarks
1.	**Name :** MRS NAGALAKSHMI UPPALA	
2.	Complete postal address (with contact number, if any)	302. RADHA ENCLAVE. 17 DEEX No:16 HIMAYATHNAGAR HYD
3.	Brief description of the illness	TLH
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	NO
5.	Details of essential Narcotic drug dispensed	MORPHINE.

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
21/7/26	MORPHINE	ONE Amp	Nagalakshmi	

Dispensed by (Name & ID No.): .... Signature: ....

Received by (Name & ID No.): Saichandu 02153 Signature: [signature]

Time: ....

Docu. No: RCH / FRM / CLINICAL / 133