Rainbow Children's Hospital

Birthright Rainbow

Rainbow Children's Hospital - Banjara Hills

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

ADMISSION SHEET

Registration Details :

Admission No : IP5-00175882 **Admit Date** : 02-Jul-2026 **Admit Time** : 01:46 PM **UHID** : BAH-00660514

Patient Details :

Patient Name	: Mrs MEESALA ARUNA	**Age**	: 31 Y 6 M 21 D
Guardian	: Mr SOMAPANGI LENIN	**DOB**	: 11-12-1994
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Married
Address (H)	: H NO 4-149, KATTAVARIGUDEM (V), GARIDEPALLY (M), SURYAPET(DIST) Garedepalli Nalgonda Telangana INDIA 508201	**Phone No**	: 9705595919
		E-mail	: NA@GMAIL.COM

Admission Details :

Bed Type : SHARED WARD **Bed No** : SW 419 **Ward Name** : 4F-BIRTHING CENTRE

Room No : SW 419 **Admission Type** : First Visit

Contact Details :

Name : Mr SOMAPANGI LENIN **Relationship** : Husband

Contact Address : H NO 4-149, KATTAVARIGUDEM (V), GARIDEPALLY (M), SURYAPET(DIST) Garedepalli Nalgonda Telangana INDIA 508201 **Phone No** : / 9705595919

S. Lenin
Signature

Doctor Details :

Doctor Name : Dr. ANNIE PRANUTHA P **Specialisation** : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

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ACTIVITY RECORD FOR BILLING

Name :___

BAH-00660514 IP5-00175882
Mrs MEESALA ARUNA
11-12-1994 31 Y 6 M 21 D (F)
Dr. ANNIE PRANUTHA P

UHID No. : _____ Consultant: _____ Dept : _____

Date of Adı _____ Date of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
2/7/26	5pm	OBS	OBGOT	Anita
2/7/26	6:30pm	OBGOT	OBS	Anita
3/7/26	4pm	OBS	Room (323B)	Kanna

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	NNC Nitasha	2/7/26	9685494	Anita
2				
3				
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
2/7/26	NST — ① (Twins)	2650330/6	
2/7/26	NST — ② (Twins)	2650330/7	
2/7/26	CBP, Electrolytes		Anita
2/7/26	LFT, LDH, PT/APTT	26666239	
2/7/26	Urea, Uric acid		
2/7/26	Creatine		
2/7/26	HVS	26066246	
2/7/26	CUE, Urine c/s	26066245	Anita
2/7/26	CRP	26666244	
2/7/26	Random blood (107mg/dl)	26066243	
2/7/	Growth scan	26503584	Anita
3/7/26	CBP 6Am	2606410	

Good morning doctor

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
2/7	Cardiac monitor	3:30pm	3/7 1pm	9685472	Anita
2/7	Infusion pump	3:30pm	5:00 pm		Anita

Crosschecking done

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
2/7/26	IV Placement	1	outside	Anita
2/7/26	Catheterization	1	outside	Anita
2/7/26	PAC	1	9685465	Anita
			Consent Obtained	

ANY OTHER INFORMATION

.....

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.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

BAH-00660514 IP5-00175882
Mrs MEESALA ARUNA
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A ☐ Khammam

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IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

Primigravida @ 28+2 wks
DCDA twins c/o Leaking PV 3:30 Am
H/O fever @ 2 Am

Obstetric Formula:

Obstetric History:

ML - 11 yrs, 2 CM.

Present Pregnancy Record:

I-IPP+IVF Conception. (1st cycle)
ET - 31/12/2026.
Unbooked case.

RISK FACTORS:

- IVF Conception
- Hello - Uterine fibroids
- Cx-stick placed @ 4" mouth
- DCPA twins, Hello-Short cervix.

Height: ..... cm
Weight: ..... kg
Allergies: ..... NKDA.
Breast: ☑ Normal ☐ Abnormal
General Examination:
Consciousness: Conscious Pallor: absent
Icterus: absent Edema: absent
Temp: Afebrile PR: 72
BP: 110/60 DTR: (+)
CVS: S1 S2 (+) RS BAE (+)
Liver/Spleen: Non palpable Urine Output: adequate.

LMP: 15/12/2026 EDD: 22/09/2026
Corrected EDD: 13/9/2026 GA: 28+2 wks
Menstrual History: Regular : ☑ Yes ☐ No

Obstetric Examination

Fundal Height: 28 - 30 wks
Ut. Activity: ☐ Relaxed ☐ Mild ☐ Mod ☐ Severe
Liquor: ☑ Adequate ☐ Oligo ☐ Poly
PP: ☑ Cephalic ☐ Breech Others _____
Head Fifths Palpable: _____
FHS: +1 +2 ☑ Normal ☐ Tachy ☐ Brady ☐ Absent

Per Speculum Examination Stitch intact wks

Draining: ☑ Present ☐ Absent ☐ Bleeding
Colour of Liquor: ☑ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination

Cervix: ☑ Long ☐ Partially effaced ☐ Effaced
Os: Closed _____ Dilated closed.
Membranes: ☐ Present ☐ Absent
Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained
Presenting Part: ☐ Vertex ☐ Breech ☐ Others
Sutton: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2
Pelvis: ☐ Adequate ☐ Doubtful

DIAGNOSIS

Primigravida @ DCDA twins @ IVF Conception @ Uterine fibroids @ Cx stitch insitu @ 28+2 wks @ PPROM for observation.

BAH-00660514 IP5-00175882
Mrs MEESALA ARUNA
11-12-1994 31 Y 6 M 21 D (F)
Dr. ANNIE PRANUTHA P

Family History:	Surgical History:
NIL	2014 Laproscopic Left ~~tube~~ Salphingectomy ∴ at 13yrs of age Left-oophorectomy? I/v/o - Mass? Infective?
Medical History:	**Medication History:**
NIL	T. Iron - OD T. Ecospirin - 150 OD; T. Calcium OD T. Dydrogest TID
Plan of Care:	**Investigations:**
• Monitor vitals - 4th ly • FHR - 4th ly • NST - 3rd day • Send PE-profile - CUE, Urine C/S, HVS • NNC - by Nitashu • NST - now • GRBS - 107 • Steroid - now • Growth scan. • Drug as charted. • prepare parts • foleys catheterisation • Ho charting - 4th ly • Leg end elevation.	O +ve Virals - NR 2/2/26 S.TSH → 0.94 RBS → 110 17/6/26 Hb - 10.9 plt: 3.12 WBC → 13,100, RBS - 107 ~~RBS - 107~~ 17/6/26 FTS - Low risk, MTAS - NAD, TWI → ? 26+1 wks, DCDA twins Cx → 3.1 cm. fetus - A: cephalic, AFI: 16 cm, EFW: 880 gm (39%) fetus B → cephalic, AFI: 16 cm, EFW - 926 gm (49%)

Doctor Name: Dr Sravathi
Signature: [signature]
Date & Time: 2/7/2026, 1:30 pm

Consultant Name: Dr. ANNIE
Signature: [signature]
Date & Time: 2/7/2026, 1:30 pm

Dr. ANNIE PRANUTHA P Reg. No. 51356

BAH-00660514 IP5-00175882
Mrs MEESALA ARUNA
11-12-1994 31 Y 6 M 24 D (F)
Dr. ANNIE PRANUTHA P

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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	2			
5	In-patient Medical record				
6	Doctors progress sheets	8			
7	Nursing plan of care and handover sheets	5			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation	2			
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)	1			
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	1			
24	Emergency Triage record	1 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	3			
30	Intake and Out take chart (fluid chart)	2			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart	1			
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale				
38	Braden Q Scale	2			
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				
	Obs Billing forms	2			
		1			
	Total No. of Pages	2 FT	FM		

Signature and Date : 05/7/26

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

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(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

BAH-00660514 IP5-00175882
Mrs MEESALA ARUNA
11-12-1994 31 Y 6 M 21 D (F)
Dr. ANNIE PRANUTHA P

Aruna, 30years

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PROGRESS NOTES AND DOCTOR'S ORDER

(28+2)

Date & Time	Progress Notes	Doctor's Order
		LMP - 15/12/2026
	ET - 31/12/2026	EDD - 22/09/2026
	Primigravida	S.EDD - 18/09/2026
	PCDA (12yrs - ML)	FTS - low risk NTAS - N.A.D.
	IVF conception	Twin 1 - ECF
	Cx stitch - 4 month	leaking : 3:30AM
	K/c/o uterine fibroids	VIRAL - NR (Oct, 2025)
		B4 - O positive
17/6	Hb - 10.9	Sr. TSH (2/2/26) - 0.94
	PLt - 3.12	RBS - 110.
	WBC - 13,100	
	RBS - 107	17/6/2026. Cx 3.1cm }26+1.
		DCDA
		Fetus A: Cephalic
		AFI - 16 cm
	Iron	EFW - 880g (39%)
	Calcium	Fetus B - Cephalic
	Ecosprin 150mg - OD	AFI - 16cm
	Dydrogest 10mg - TID.	EFW - 926g. 49%

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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	✓ PE Profile – CVG, Urine C/S, HCS.	
	✓ Piptaz, MTG,	
	✓ Steroid – PBS	✓ MgSO4 loading dose
	✓ growth scan	↓ f/b maintenance dose
		✓ NNC – Nitasha

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11-12-1994 31 Y 6 M 21 D (F)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/4/2026		
3:10PM	c/o/w Dr. Annie	
	Scan - 28+6 - Twin 1 - Breech	
	Anhydramnios	
	EFW - 806 g (<1%) AC <1%	
	Dopplers - ~~Inc~~ Resistance in umbilical artery	
	positive EDF.	
	Twin-2: Cephalic AF - SP - 4.6 cm	
	EFW - 1256 g (29%), AC ~ 40%.	
	~~AF~~ Dopplers - NAD	
	✓ Steroid 12hrs Apart	✓ Urine output Monitoring
	✓ Trace labs	
	✓ MgSO4 to be continued	
	✓ NNC - Dr Nitasha	
	✓ Inj piptaz 4.5grams BID / Inj MTG 500 mg IV TID	
	by (Dr. Deepika)	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/7/2026 4pm	History Reviewed.	
	H/o Temp today morning 100°F at 2:30Am	
	No H/o urinary (or) Respiratory (or) Bowel symptoms.	
	Noticed leaking per vagina since 3Am.	
	No pain.	
	No bleeding per vagina.	
	On Examination.	
	Temp - 96.7°F.	
	PR - 92/m	
	BP - 117/76 mmHg (MAP - 82)	
	RR - 22/min.	
	Chest - clear.	
Neonatal counselling	P/A - uterus Relaxed. Non tender	
	FHR1 → 142/m FHR2 - 150/m	
	L/E - pad dry	
	No foul smelling discharge	
	On	Add IV fluids - RL 1.5 litre Bolus
	- Inj. PIPTAZ.	Add 1) Inj. AMIKACIN 500mg IV BD
	- metrogyl.	
		2) Monitor maternal temp. PR, HR, RR every 2nd hourly
	- Steroid idea	
	- on IV MgSO4.	3) pad for observation watch
		for bleeding PV / foul smelling discharge.
		5) to watch for pain abdomen

Dr. ANNIE PRANUTHA P Reg. No: 51356

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

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Mrs MEESALA ARUNA
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/[illegible]/2026 4:10pm	Counselled family (Video Consulting)	
	• Leaking vagina with background history of fever => Indicates suspected Infection.	
	• High risk of chorioamnionitis due to ascending infection.	
	• Scan suggestive of No liquor (detectable) in sac 1.	
	• Tw 1 → growth restriction	
	• Tw 2 → growth & Doppler normal	
	• Labs. Elevated CRP.	
	• Close monitoring < maternal / fetal	• Need for steroid cover & MgSO4.
	- Any documented FEVER in mother	] for delivery.
	- Signs of LABOUR	
	- Bleeding	
	[leaking PV] - In v/o background H/o PPROM husband is concerned about mother and both babies.	
	- Insisting on urgency of delivery & does not want to wait for steroid cover / MgSO4.	
	- Neonatal outcomes to be explained by Neonatal team.	
	[signature]	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	2/7/26	
	28+6 wks.	
	DCDA.	
	806 gm 1256 22%	
	<1% AC - 40%	
	Anhydramnios DVP 4.6 cm	
	FGR doppler (N)	
	↑ Resistive	
	UmA - A - doppler	
	f/u EDF.	
	Labs.	
	Hb - 10.3	
	WBC - 15,440	
	plt - 3.17	
	CRP - 39	
	PT / INR - 14 / 1.0	
	APTT - 36	
	S. creatinine - 0.6	
	LDH - 258	
	Uric acid - 5.3	
	Blood urea - 4.	
	lytes - 141 / 3.4 / 114.	→

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Mrs MEESALA ARUNA
11-12-1994 31 Y 6 M 21 D (F)
Dr. ANNIE PRANUTHA P

Aruna

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/6/26 @4:20pm	Neonatal Counselling By Dr. Nikith	
	• Preterm (28+2 wks) → AS a preterm delivery maternal fever, leaking - PPROM - DCDA twins - Twin-1 → has decreased/Absent amniotic with Blood flow - ↑ Resistance fluid.	
	⇒ After Delivery If Baby less than 1kg → will be kept in Incubator	
	Respiration : Based on lung maturity - Baby might need ventilation / CPAP - Require Surfactant To improve lung maturation ~~Baby~~ mother needs to recieve 2 doses of Steroids	
	Feeding : For smaller baby requires umbilical lines and needs nutrition	
	Brain : 1st 3 days are very crucial as there are increased risk for Bleeding in Brain which • Baby requires Nicu Stay till baby reaches 34-35 weeks till reaches 1.5kgs and taking Spoon feeds • They can deliver anytime if there is any impending risk. • Antenatal Steroids are given to increase lung maturity, decrease	Nec risk, ↓ IVH risk S. Jenny

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Post operatively	
1]	IV fluids @ 150 ml/h	
2]	Continue W Piptaz / Metrogyl / Amikacin	
3]	Monitor maternal vital signs. MEOWS every 30 minutes for 2 hours & inform any Red flags	
4]	Watch for bleeding PV	
5]	CBP at 6 AM on 3/7/26	

Dr. ANNIE PRANUTHA P
Reg. No: 51356

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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/7/26 6:30pm	POD0 / Emg. USCS / P1C2 / Cx stitch removal.	
	O/E a.c. fair	Adv
	PR - 78bpm	- NBM till 9pm.
	BP - 113/68mmHg	- IV fluids @ 150ml/hr
I/O - 200ml (emptied)	(MAP 72)	- drugs as per charted
	SpO2 - 98% on RA	- vitals every 15min for 2hrs
	P/A uterus retracted well	f/b 2nd hrly
	L/E - Bleeding min	- Strict I/O charting
Send CBP @ 6AM on 3/7/26.		- Inform SOS
		Dr. Sameera
2/7/2026 9PM	C/o - Nil	Noted by Sis. Anita
	Gen - fair.	
	Vitals stable.	
	P - 87/min	- To give 500ml Bolus.
	Bp - 120/70mmHg	- Force urine output.
	P/A - uterus Retracted well	- Bp / P / urine output Monitoring.
	Pads 0	
	Plan - NAD.	
	U.O - 200ml.	Dr. Pranuthi

Dr. BHARGAVI REDDY K Reg. No: 93315

BAH-00660514 IP5-00175882
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11-12-1994 31 Y 6 M 22 D (F)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes		Doctor's Order
3/7/26 12:30AM	Pt sleeping		Adv
		O/E	- Allow liquids
		are-fair, afebrile	- IV fluids @100ml/hr
		PR - 75bpm	- drugs as
		BP - 112/68mmHg	prescribed
		(MAP-76)	- vitals and help
	C/o - 700ml	SpO2 - 98% RA	I/O charting
	from 9pm.	P/A uterus	- W/F active
		retracted	Bleeding PV
	CUE -	well	- Inform R/S
	Alb - 1+	L/E - Bleeding	
	pus cells 4-5	nil.	
	EC - 3-4		Dr. Annie
	CRP 39.		
	CBP - 10.3 / 15,440 / 3.17L		
	Send CBP @6Am on 3/7/26		
	- Trace Urine c/s HVS,		
	placenta membs c/s.		
	Placenta HPE		

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(P.T.O)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7/26		
4AM.	Pt sleeping O/E - a c fair PR - 69bpm BP: 117/73mmHg (83) SPO2 - 98% / RA U/O - 50ml. P/A - uterus retracted well	Adv - drugs as per charted - clear liquids - vitals 2nd hrly I/O charting - Inform DR Dr Sameer
	Trace CBP →	
3/7/26 6:45am.	POD1 / Emg. LSCS U/O from last 2hr. 56 - 40ml. ↓ Received Inj Lasix 10mg U/O - 60ml/ O/E a.c. fair, Temp - 97.8F PR - 71bpm BP - 101/64 mmHg (77) SPO2 - 99% / RA P/A uterus retracted well BS+D sluggish L/G - Bleeding min	Adv - Allow clear liquids - drugs as prescribed - vitals 2nd hrly - strict I/O charting - w/f active bleeding PV - Inform DR Dr Sameer

BAH-00660514 IP5-00175882
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9AM	8PM - 8AM	✓ Strict I/O hourly
	I 3000ml	✓ Vitals 2hrly
	O 1320ml	✓ IVF @ 100 ml/hr RL
	110ml/hr	✓ Oral clear liquids
		* To reassess IVF @ 12AM
Lasix 10+5	10PM (Morning)	
		Dr Yshehe
3/7/26 10 AM	POD-1 / EMLSCS	
		Rx
	GC: fair	1) Strict I/O chart
	B.P- 95/63 (75)	2) Vitals 2nd hrly
U/O: 30ml/hr +30	P.R- 72	3) I/V fluids 100 ml/hr
	SpO2 - 97% on RA	4) Drug as charted
Trace HVS,	P/A: Ut @ well	5) I4 for SOS
Urine C/S	S	
Placental membrane C/S		
Placental HPE		— Dr. Sranthi
109/22/12/3.26		

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

BAH-00660514 IP5-00175882
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7/2026 11:30AM	C/D/W Dr. Annie.	
	① Remove Foleys	
	② Ambulate	
	③ Supp. Dulcolax (2) PR stat	
	④ If passed flatus allow soft diet >3PM	
	⑤ Encourage voiding	
	⑥ Shift to room	
	⑦ Liquid diet now.	
		Dr Y. Sneha.
3/7/2026 12:00PM.		POD-1 / Em.LSCS / P1L2
Dulcosupp. PR kept	O/E C/C - fair	Adv stop IVF
	BP - 99/61 (74)	① liquid diet
	PR - 73 Bpm.	② Encourage voiding
CU - due	SpO2 - 98% RA.	③ Stop IVF
fx	P/A - U/T ® well	④ Soft diet after 3pm (only if passing flatus)
SY	P/V - BWNL	⑤ Drugs as charted
Inj. Pipta3 (D2)		⑥ Ambulation
Inj. Metrogyl (D2)		⑦ Hydration
		⑧ w/f active bleeding
Trace culture reports.		⑨ Monitor vitals
		⑩ Inform SOS
Shift to Room		
		Dr. Divya

BAH-00660514 IP5-00175882
Mrs MEESALA ARUNA
11-12-1994 31 Y 6 M 22 D (F)
Dr. ANNIE PRANUTHA P

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7/2026 7:30pm	POD-1 / EMLMS / PIL2	
		Rx
B-NICU	G C: fair	1) Monitor vitals - 4thly
	Vitals: Stable	2) Drug as charted
U ✓	P/A: Ut (12) wk	3) Soft diet
F ✓	BS (+)	4) W/f P/V Bleeding
S (x)	P/V: NAB	5) Ambulation
		6) Tinfem SOS
	Trace → HUS, uric s	
	Plate → HPE	noted by ... 7pm
		— Dr. Sravathi
4/7/26 10am	POD-2 / EMLMS / PIL2	
		Rx
	G C: fair	
	Vitals: Stable	1) Monitor vitals - 4thly
B2-NICU	P/A: Ut (1) wk	2) Drug as charted
	Soft	3) Soft / (N) diet
U ✓	BS (+)	4) W/f P/V Bleeding
F ✓	P/V: NAD	5) Ambulation.
S ✓		6) Tinfem SOS
D/E / S/E / due	Trace → HUS / uric s	
	Plate - HPE / Hogmuth.	— Dr. Sravathi
	plan discharge tomorrow	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/7/2026 10 AM	POD-2 Doing well. ambulant Meneed bowels.	voids freely.
	Afebrile vitals stable P/A - soft ut inv - well. Lochia - healthy	
Babies. NICU		
	Trace - placenta c/s - urine	- Continue PIPTAZ / Metrogyl / Amikacin till culture report
	Dr. ANNIE PRANUTHA P Reg. No: 51356	
4/7/2026 2:00 PM	POD-2 / Em-LSCS / PIH	
	Pt comfortable	
	GC fair	Ambulating well
Baby - NICU.	vital stable	
	P/A - ut Ⓡ well	Adv
VV	P/V BWNL	① Soft diet
TV SV		② Hydration
		③ Ambulation
DIE / DM		④ w/f active bleeding
SIE		⑤ Monitor vitals
	Trace - HVS / placental c/s / urine c/s - no growth	⑥ Drugs as charts
		⑦ Inform SD
		Dr. Divya

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/7/24 8:30AM	POD-3 / LSCS	
	O/E	Adv
P/F ✓ S/E Due	C/C fair	① Soft diet
✓✓	vitals stable	① Ambulation
N	P/A-U ⓡ mw	– Hydration
✓✓	P/V Bleeding	– w/f active bleeding
	P/A soft	– Drugs as charted
D4 pip + tz		monitor vitals 4th hrly
meropenem		– Encourage Breast pumping
Amikacin		–
Trail - ① plaunter mem ch		– Irritom sus
② trace HBs		Dr. Divya
	Bab - NICU	

Pati

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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Mrs MEESALA ARUNA
11-12-1994 31 Y 6 M 21 D (F)
Dr. ANNIE PRANUTHA P

RAINBOW
Children's Hospital & Perinatal Centre
Happy Mothers, Healthy Children

Neonatal Counseling

Date : 2/7/26
Time :

Name : Mrs. Meesala Aruna Age : 31y
Husband's Name : Lenin Years of Marriage :
Referral Doctor :
Address : Suryapet
Tel.: 9705595919

Maternal Risk Factors : ~~28~~ ML- 11yrs, IVF, fibroids, PPROM for 12hours

Fetal Details :

Gestational Age : 28+2wks Estimated Birth Weight : Twin-1-806, Twin-1256
Fetal Problem : DCDA, Preterm, Anhydramnios, Discordant.
Details of Prenatal Testing :
Amniotic Fluid Volume : AFI-0 (Twin-1) T-1-Arrest Doppler : T-2 (N) Cardiotocogram :
Steroid Cover : 2/7/26 Date and Time : AFI-4-6 LP (Twins)

Based on above details provided patient and her husband have been counseled in deatail about :

☑ Short Term Outcome. ☑ Long Term Outcome. ☑ Sequelae.

Based on the information and counseling received, we have decided :

☑ Provide all possible care for our baby after birth.

☐ We would like to deliver the baby in best possible condition, allow neonatal evaluation after birth and decide on further course of action based on evaluation.

☐ We do not want any aggressive management of the baby. We would like everything to be done in the best interests of the mother.

☐ We do not want any aggressive management of the baby including no aggressive obstetric interventions. We decline further fetal evaluation including fetal heart monitoring. We understand that this may lead to stillbirth.

Signature : S. Lenin

Neonatologist : Dr. Nilesh.

Parents :

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CAESAREAN SECTION OPERATIVE NOTES

Surgeon's Name:	Dr Annie pranutha	Date of Delivery:	2/07/2026
Assistant Surgeon:	Dr Sneha	Time of Delivery:	Twin - 1: 5:18 PM; Twin - 2: 5:19 PM
Anaesthetist's Name:	Dr Kiran	Gender of Baby:	Twin - 1: female; Twin - 2: male
Type of Anaesthesia:	L/S SA	Weight of Baby:	
Neonatologist:	Dr Nillesh, Dr Sneha	AGPAR Score:	Twin - 1: 7/8; Twin - 2: 7/8
Scrub Nurse:	Sr Rajeshwari	NICU Admission:	☐ Yes ☐ No

Pre-Operative Diagnosis:

☐ Elective ☑ Emergency Indication: preterm Premature Rupture of membranes in labor DCDA twins

Urgency
- ☐ Immediate Threat to life of woman or fetus
- ☑ Maternal or fetal compromise not immediately life threatening
- ☐ No maternal or fetal compromise but needs early delivery
- ☐ Delivery timed to suit woman and staff

Decision time: 4:20 pm Knief to rectus: 5:15 pm

CTG Description: Reassuring

If there was a delay give the reasons: None

Surgical Procedure: EM LSCS

Post Operative Diagnosis: POD-0 Em. LSCS

Peri-Operative Complications: Twin 1 - Footling presentation - ~~Foot~~ Breech extraction
Twin 2 - Cephalic

Left side Fallopian tube, ovary noted. Right side Fallopian tube, ovary not visualised

Amount of Blood Loss: 800 ml. Blood Transfused (in ML):

Name and Number of Surgical Specimen sent for examination:

placenta HPE
Placenta memb c/s

Posterior - Right - Broad ligament fibroid noted - highly vascular 4×4 cm
Cervical stitch removed

Examination Findings when Appropriate:

Presentation: ☐ Cephalic ☐ Breech ☐ Other ..... Cervical Dilatation: ..... cm

5th Palpable: ..... Fetal Position: .....

Station: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2 Moulding: ☐ None ☐ + ☐ ++ ☐ +++

Caput: ☐ + ☐ ++ ☐ +++ Meconium: ☐ None ☐ + ☐ ++ ☐ +++

Bladder Catheterized : ☐ Yes ☐ No Urine: ☐ Clear ☐ Blood Stained

Skin Incision: ☑ Pfannensteil ☐ Transverse ☐ Midline ☐ Other .....

Uterine Incision: ☑ Lower Segment ☐ Classical ☐ Inverted T ☐ J Incision

Previous Scar: ☐ Intact ☐ Thinnedout ☐ Ruptured ☐ No Scar

Incision Through Placenta: ☐ Yes ☑ No 1 w 1 - Breech Extraction

Delivery of head: ☐ Manual ☐ Forceps 1 w 2 - cephalic. Manual.

Liquor: ☑ Clear ☐ Meconium: ☐ I ☐ II ☐ III ☐ Blood ☐ Offensive ☐ Not Offensive

Delivery of Placenta: ☐ Manual ☑ CCT ..... ☑ Complete ☐ Incomplete ☐ Piecemeal

Cord Appearance: ..... N ..... Cord around the neck ☐ Yes ☑ No

Appearance of placenta: ..... N ..... Cavity explored ☑ Yes ☐ No

Uterus, tubes and ovaries: ☐ Normal ☑ Not Normal Sterilization: ☐ Yes ☑ No

Uterine Closure: ☐ One Layer ☑ Two Layers ..... 1-Vicryl ..... Suture

Peritoneal Closure: ☐ Pelvic ☑ Abdominal ☐ None ..... 2-0 vicryl rapide ..... Suture

Sheath Closure: ..... 1-Vicryl ..... Suture

Fat Closure: ☑ Yes ☐ No ..... 2-0 vicryl rapide ..... Suture

Skin Closure: ☑ Subcuticular ☐ Mattress ..... 2-0 vicryl rapid ..... Suture

Vaginal Evacuated ☑ Yes ☐ No

Drain: ☐ Yes ☑ No ☐ Remove in ..... days ☐ Await instructions

Ctheter ☑ Yes ☐ No ☐ Remove in 24 hrs days ☐ Await instructions

Swap & Instruments count correct? ☑ Yes ☐ No ☐ Post-op Antibiotics ☑ Yes ☐ No

Intra-Operative Antibiotics Cover: ☑ Yes ☐ No ☐ Thromboprophylaxis ☑ Yes ☐ No

Post-Operative Notes: .....

① NBM - 12 hrs

② IVF As Advised (150ml/hr RL)

③ Strict Vitals / Temp / RR 1/2 hrly

④ I/O hrly

⑤ Trace HVS, Urine c/s, CUE, Placenta HPE, Pl memb c/s

⑥ ~~Continue Fiptaz / MTG / Amikacin / Clexane~~

⑦ WF Bleeding PV

Doctor Name: Dr. Y. Sneha Doctor Signature: .....

Date & Time: 21/26 6PM

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POST-SURGICAL CARE PLAN FORM

Procedure Done: Gm uss

Post-Surgical Diagnosis: POD 0 Gm uss

Post-Operative Monitoring Parameters /Frequency:

Vitals I/O 1/2 hrly

Wound Care:

Dressing x 48 hrs

Drain /Special Lines/Catheters:

Foleys 24 hrs

Special Patient Positioning and Requirements:

can move side ways on bed

Nutritional Instructions:

NBM 12 hrs

When to Start Mobilization:

After foley removal

Special Referrals:

—

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

☑ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

—

Treating Surgeon
(Signature & Stamp)

Date: 2/7/26 Time: 6 PM

Note: Plan of care will be readjusted if necessary.

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RESULT SHEET

Date	2/7/26	3/7/26				
Time	2:02Pm	6:17Am				
Hb	10.3	10.9				
PCV		30.6				
RBC		3.62				
WBC	~~15~~.44	22.81				
N/L		88.4/8.5				
Platelets	317	3.26				
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Blood group	O+ve					
HIV & HBsAg	NR.					

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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MEDICATION RECONCILIATION FORM

Drug Allergies: NKDA ☐ Not known any Drug Allergies

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

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

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T. Iron	1tab	p/o	O.D	1/7	☐C ☑DC
2	T. Calcium	1tab	P/O	OD	1/7	☐C ☑DC
3	T. Ecosprin	150mg	P/O	OD	1/7	☐C ☑DC
4	T. Dydrogest	10mg	P/O	TID	1/7	☑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. Sravanthi

Date & Time : 2/7/2026, 7:30pm

Nurse Name & Signature: Anita

Date & Time : 2/7/26, 6pm

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DRUG CHART

Date of Admission: 2/7/26 Drug Allergies: NKDA ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

GENERAL - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.

DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line *I* through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG : TRAMADOL

Dose	Route	Frequency	Start Date
100mg	Oral	TID	2/7

Doctor's Signature: M. Bipod | Valid Period: | Pharm.:

Additional Instructions:

Date/Time: 2/7 12pm

Stop. Sudha Dr. Sudha 4/7/26 8:30 am

DRUG : T. TRAMADOL

Dose	Route	Frequency	Start Date
100mg	PO	SOS	4/7

Doctor's Signature: Sudha | Valid Period: | Pharm.:

Additional Instructions:

Date/Time: 4/7 10am Sud SOS

DRUG :

Dose	Route	Frequency	Start Date

Doctor's Signature: | Valid Period: | Pharm.:

Additional Instructions:

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

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REGULAR PRESCRIPTIONS

Weight. 66kgs Ward. OBS

DRUG : Inj PIPTAZ				Date / Time
Dose	Route	Frequency	Start Date	
4.5gm	IV	BD	2/7	
Name & Signature of the Doctor Starting the Drugs: Dr Sravanthi				Stop [signature]
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG : Inj METROGYL				Date / Time	2/7	3/7	4/7/26	5/7
Dose	Route	Frequency	Start Date	7am	X	Reddy sudi	Anand Puja	Maithe Puja
500mg	IV	TID	2/7					
Name & Signature of the Doctor Starting the Drugs: Dr Sravanthi				3pm	Anita	Reddy	Shil	
				11pm	Reddy sudi	Anand Puja	Maithe Puja	
Additional Instructions:								
Daily Doctor's Endorsement by a Sign						[signature]		

DRUG : INJ. AMIKACIN				Date / Time	2/7	3/7	4/7	5/7
Dose	Route	Frequency	Start Date	6am	X	Reddy sudi	Anand Puja	Maithe Puja
500mg	IV	BD	2/7					
Name & Signature of the Doctor Starting the Drugs: [signature]				6pm	Anita	Sobha	[signature]	Shil
Additional Instructions:								
Daily Doctor's Endorsement by a Sign						[signature]		

DRUG : INJ. PIPTAZ.				Date / Time	2/7	3/7	4/7/26	5/7
Dose	Route	Frequency	Start Date	12am	X	Reddy sudi	Anand Puja	Maithe Puja
4.5gm	IV	6th hrly	2/7	6am	X	Reddy sudi	Anand Puja	Maithe Puja
Name & Signature of the Doctor Starting the Drugs: [signature]				12pm	X	[signature]	[signature]	
Additional Instructions: PIPERACILLIN + TAZOBACTUM				6pm	Anita	[signature]	Shil	
Daily Doctor's Endorsement by a Sign						[signature]		

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Sheet No: 2 **REGULAR PRESCRIPTIONS** Weight 66 kgs Ward ORS

DRUG: Inj PANTOPRAZOLE

Dose	Route	Frequency	Start Dt.
40mg	IV	BD	2/7/26

Date: 2/7, 3/7, 4/7/26, 5/7
Time: 6am, 6pm

Name & Signature of the Doctor Starting the Drugs: Dr. Y Dr. Y. Sneha

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG: Inj CLEXANE

Dose	Route	Frequency	Start Dt.
40mg	S/C	OD	3/7

Date: 3/7, 4/7, 5/7
Time: 8am

Name & Signature of the Doctor Starting the Drugs: Dr. Sameera

Additional Instructions: @8AM after CBP.

Daily Doctor's Endorsement by a Sign

DRUG: T. PARACETAMOL

Dose	Route	Frequency	Start Dt.
1g	PO	TID	4/7/26

Name & Signature of the Doctor Starting the Drugs: Dr. Sw

Additional Instructions:

stop. Dr. Swathi Swathi 3/7/26 ; 8:30AM

Daily Doctor's Endorsement by a Sign

DRUG: T. PARACETMOL

Dose	Route	Frequency	Start Dt.
1gm	PO	TID	4/7/26

Date: 4/7, 5/7
Time: 6Am, 2:30Pm, 10Pm

Name & Signature of the Doctor Starting the Drugs: Dr. Divya

Additional Instructions:

Daily Doctor's Endorsement by a Sign

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

DRUG : T. DICLOFENAC				Date ▸ / Time ▾: 4/2 [illegible]; 7Am [initials]; 3Pm [initials]; 11Pm
Dose	Route	Frequency	Start Dt.	
50mg	PO	TID	4/2/26	
Name & Signature of the Doctor Starting the Drugs: Dr. D[illegible]				Dr. D[illegible] 4/7/26
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 ....

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Mrs MEESALA ARUNA
11-12-1994 31 Y 6 M 21 D (F)
Dr. ANNIE PRANUTHA P

Weight. 66kg Ward. OBS

	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
2/7/26	1:20 pm.	Inj BETAMETHASONE	12mg	I/m	[illegible]	[illegible] Anita 1:21 pm.
2/7/26	1:25 pm	Inj MgSO4	4mg	I/v	[illegible]	[illegible] Anita 1:26 pm
3/7/26	1:20 AM	INJ BETNASOL	12mg	IM	[illegible]	Not given
2/7/26	10:00 pm	Inj: CASIX	20mg	IV	[illegible]	Reddy Sadler
04/2/20		INJ TRAMADOL. NORMAL SALINE 100.	50mg	IV	[illegible]	Not given

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

SAH-00660514 IP5-00175882
Mrs MEESALA ARUNA
11-12-1994 31 Y 6 M 21 D (F)
Dr. ANNIE PRANUTHA P

I.V. FLUIDS CHART

Weight. 66kgs Ward. ORS

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
2/7/26	3:30 pm	Inj MgSO4 4ml in 46ml NS	I/V	25 ml/hr		Anita / Sobha	2/7		Anita / Shobha
2/7	5pm	RINGER LACTATE	IV	100 ml/h		Anita / Shobha	2/7		Anita / Shobha
2/7	8pm	RINGER LACTATE	IV	500 ml/h		Anjali / Radha	2/7		Radha / Anjali
2/7/26	10pm	RINGER LACTATE	IV	500 ml		Radha / Anjali	2/7		Radha / Anjali
3/7/26	12 AM	RINGER LACTATE	IV	100 ml		Radha / Anjali	3/7/26		Reddy / Sudha
3/7/26	3am	RINGER LACTATE	IV	125ml/hr		Reddy / Sudha	3/7/26		Reddy / Sudha
3/7/26	6am	RINGER LACTATE	IV	125ml/hr		Reddy / Sudha	3/7/26		Reddy / Sudha
3/7/26	11am	RINGER LACTATE	IV	100ml/hr		Reddy / Sudha	3/7/26		Reddy / Sudha

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

BAH-00660514 IP5-00175882
Mrs MEESALA ARUNA
11-12-1994 31 Y 6 M 21 D (F)
Dr. ANNIE PRANUTHA P

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FLUID CHART

Sheet No. : 0

2/7/26

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

Date	Time	Intake: Nature of Fluid	Intake: Route: Mouth	Intake: Route: I.V	Intake: Route: N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am								NIL			
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm		N									
	03:00 pm	Mgso4	B	25ml			NP			100ml	1	
	04:00 pm	mgso4		25ml							0	Amrita
	05:00 pm	mgso4	M	25ml								
	06:00 pm	RL	N	100ml						200ml	1	
	07:00 pm	RL	M	100ml						50ml	1	
al Intake :		Taken				**Total Output :**				350ml		
	08:00 pm			RL						26ml	0	
	09:00 pm			500ml						25ml	0	Reddy
	10:00 pm	NBM								300ml	0	
	11:00 pm			RL			NP			350ml	0	
	12:00 am			500ml						250ml	0	Reddy
	01:00 am	NP								200ml	0	
Total Intake :		NBM/NPO/Taken				**Total Output :**				U –		M–
	02:00 am	H2O		RL						75ml	0	
	03:00 am	H2O		100ml						300ml	0	
	04:00 am						NP			50ml	0	Reddy
	05:00 am			RL							0	
	06:00 am	H2O		25ml						10ml	0	Reddy
	07:00 am									75ml	0	
Total Intake :		Taken				**Total Output :**				U –		M– NP

Total 24 hrs. Intake	Taken

Total 24 hrs. Output	U – R – NP

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FLUID CHART

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Sheet No. : (2)

3/7/26

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

3/7/26.		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							
3/7/26	08:00 am									50ml	0	Priya
	09:00 am		RL 100ml							50ml	0	Priya
	10:00 am		H2O	100ml						60ml	0	Priya
	11:00 am			100ml.						35ml	0	Priya
	12:00 pm		H2O	100 ml (Stopped).						Passed	0	Priya
	01:00 pm									✓	0	Priya
Total Intake : Taken.						Total Output : passed						
3/7/26	02:00 pm						✓				0	Sneha
	03:00 pm		water								0	Sneha
	04:00 pm									✓	0	Jyothi
	05:00 pm		water								0	Jyothi
	06:00 pm										0	Jyothi
	07:00 pm		water.								0	Jyothi
Total Intake : taken						Total Output : U-1					M-1	
3/7/26	08:00 pm										0	Priya
	09:00 pm		water								0	Priya
	10:00 pm										0	Priya
	11:00 pm						✓				0	Priya
	12:00 am		water							✓	0	Priya
	01:00 am										0	Priya
Total Intake :						Total Output : U=1 M=1						
4/7/26	02:00 am										0	Priya
	03:00 am		water								0	Priya
	04:00 am						nil				0	Priya
	05:00 am										0	Priya
	06:00 am		water								0	Priya
	07:00 am									✓	0	Priya
Total Intake : Taken						Total Output : U=1 M=0						

Total 24 hrs. Intake	Taken	Total 24 hrs. Output	U=4 M=2

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FLUID CHART

Sheet No. : (3) 4/7/26.

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						0	
	08:00 am										0	Sushanth
	09:00 am		H_2O	100ml			✓			✓	0	
	10:00 am										0	
4/7	11:00 am		H_2O	100ml							0	
	12:00 pm									✓	0	Sushanth
	01:00 pm		H_2O	200ml							0	
Total Intake : Taken.						**Total Output :** m-1				u-2,		
	02:00 pm										0	
	03:00 pm		water							✓	0	Jyothy
4/7	04:00 pm						✓				0	
	05:00 pm		water							✓	0	
	06:00 pm									✓	0	Jyothy
	07:00 pm										0	
Total Intake : Taken						**Total Output :** u-3 m-1						
	08:00 pm										0	Priya
	09:00 pm		water				✓				0	Priya
	10:00 pm										0	Priya
4/7/26	11:00 pm										0	Priya
	12:00 am		water							✓	0	Priya
	01:00 am										0	Priya
Total Intake :						**Total Output :** V=1 m=1						
	02:00 am										0	Priya
	03:00 am		water							✓	0	Priya
5/7/26	04:00 am						NP				0	Priya
	05:00 am										0	Priya
	06:00 am		water								0	Priya
	07:00 am									✓	0	Priya
Total Intake :						**Total Output :** V=2 m=0						

Total 24 hrs. Intake		Total 24 hrs. Output	V=8 m=3

Patient Sticker

FLUID CHART

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Sheet No. : .....

1. All measurements in ml.
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3. 24 hrs. total to be entered in the kardex in RED.

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

Total 24 hrs. Intake		**Total 24 hrs. Output**	

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Mrs MEESALA ARUNA
11-12-1994 31 Y 6 M 22 D (F)
Dr. ANNIE PRANUTHA P

323-B

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NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 3/7/26 Time: 4:20pm

Origin: Indian Height: 155cm Weight: 58kg's BMI: 31.2kg/m²

Food Allergies: No

Diagnosis: POD-1 | Emg 2SCS (lower segment Cesarian section)

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

Diet Advised:

soft High protein diet
include plenty of oral liquids
Avoid spicy, chilled and outside foods

Patient's / Attendant's

Signature: K. Lakshmi

Name: K. Lakshmi

Date & Time: 3/7/26 4:20pm

Dietician's

Signature: Saima

Name: SAIMA

Date & Time: 3/7/26 4:20pm

DIETARY NOTES

Date	Time	Notes	Sign
4/7/26	2pm	patient is stable, oral intake is good	
		continue soft diet	saima