

Patient Sticker

SURGERY DETAILS

BAH-00466037 IP5-00175865
Dr. PRANAVI BOMMIREDDY
08-07-1992 33 Y 11 M 24 D (F)
Dr. SASIKALA KOLA

Patient Name: Date: 2/7/26
Date of Birth: 8/7/1992 Age: 32yrs
Gender: UHID No.: BAH-00466037
Date of Surgery: 2/7/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☒ OBG OT-1 ☐ OBG OT-2
Name of the Surgery: EL. ucs + BTL ↓ spinal
(Tumor)
Time in: 11:50 AM Time Out: 12:50 PM

	NAME	AMOUNT
1. Surgeon	Dr. Sasikala Kola	
2. Anaesthetist	Dr. Chilpa	
3. Assistant Surgeon	Dr. Sneha	
4. OT Technician	Ex. Kalsum	
5. Circulating Nurse	Ex. Veene	
6. Assistant Nurse	Ex. Latomi	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9684213

Order by: [Signature]

STANDARD FORM NO. 64

1-1-1

22

1916

4-22-1916

1916 + 1917

1917

1917

CONSUMABLES OF OT

Date : 2/7 3685

Circulating staff : Technician : Kulsum Time :

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube			Major Pack <u>LS68</u>	01		Inj Vit.K		02
LMA			Sutures <u>2769</u>	01		Cord Clamp <u>800</u>		01
ECG leads : (A) / P / N	05		<u>2347 (DA) 180</u>	01		Suction Catheter <u>84</u>		01
HME filter : A / P / N			<u>2364</u>	01		Feeding Tube		
Syringes : 10 cc	03					Vacuum Suction Set		01
05 cc	05		Gloves <u>71642</u>	03		Surgical Gloves <u>71642</u>		03
02 cc	05					Gauze Pack <u>N</u>		01
01 cc			PF7	01		Syringe 1ml / 2ml		02
Cautery plate : (A) / P / N	01		Surgical blade <u>22</u>	01		Surgical Blade # 20		01
IV set	00		NG tube			Koochies (S) <u>1's</u>		01
RL	02		Cautery pencil	01		02 mask		01
NS : 10ml / 100ml / 500ml / 1000ml			Koochies <u>XL</u>	01		<u>2uj - Heparin</u>		01
<u>10x 27</u>	00		Ointments			<u>Underpad</u>		01
<u>Ephedrine</u>	01		Suction Catheter					
Fentanyl	01		Cap, Mask					
Morphine			Gauze Pack <u>NR</u>					
Ketamine			Mop Pack	03				
Propofol			Steristrip <u>Sterizone</u>	01				
Rocuronium			Underpad	01				
Glycopyrolate			Draw sheet <u>Quick cut</u>	01		<u>Adrenaline</u>		2
Myopyrolate			Abgel	01		<u>Atropine</u>		2
Ondansetron	01		Foleys catheter					
Pencan 25g Spinal Needle 22	01		Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)	01		Romodrain bag					
Antibiotics : <u>Omask</u>	01		Bandage					
			Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg	01		Vacuum Suction set	01				
Justin : 12.5 mg / 25mg / 100mg	01		Plastic Bed Sheet					
Tab. Misoprost : 200mg	01		Betadine Solution	02				
<u>oxytocin</u>	01		Microshield	00				
<u>glove (6)</u>	01		Cotton Balls	01				
<u>gauze</u>	01		Latex Gloves	00				
<u>Tranexa</u>	02		Ramdone Scrub					
			Saral <u>DPA</u>	01				

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. : 9685876Ordered by : Dr. R. R.

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

Patient Sticker

Smile (2)

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CROSS CONSULTATION FORM

Doctor Name : Shreya Daddatur Date : 04/07/2016 Time : 12pm

Diagnosis :

Hospital :

Type of Referral :

☐ Emergency

☐ Urgent

☐ Non Urgent

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

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

[Signature]
Signature:

Findings and Recommendations :

Breastfeeding amenment done.

Consultant :

Name : Shreya Signature : [Signature] Date & Time : 04/07/2016 12pm

ADMISSION SHEET

Registration Details :



Admission No : IP5-00175865

Admit Date : 02-Jul-2026

Admit Time : 09:52 AM UHID : BAH-00466037

Patient Details :

Patient Name : Dr. PRANAVI BOMMIREDDY

Age : 33 Y 11 M 24 D

Guardian : MR RAJESH REDDY PALETI

DOB : 08-07-1992

Gender : Female

Religion :

Occupation :

Martial Status : Married

Address (H) : PLOT NO. 792,VIVEKANANADA COLONY
Kukatpally Hyderabad Telangana INDIA
500072

Phone No : 9985696633/ 9000770005

E-mail : nomailid@gmail.com

Admission Details :

Bed Type : SUITE

Bed No : SUITE 3 (421)

Ward Name : 4F-BIRTHRIGHT
PREMIUM

Room No : SUITE 3 (421)

Admission Type : First Visit

Contact Details :

Name : MR RAJESH REDDY PALETI

Relationship : Husband

Contact Address : PLOT NO. 792,VIVEKANANADA COLONY
Kukatpally Hyderabad Telangana INDIA 500072

Phone No : / 9985696633


Signature

Doctor Details :

Doctor Name : Dr. SASIKALA KOLA

Specialisation : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ Consultant: _____ Dept : _____

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

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



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
2/8/26	11:00 AM	ICU	OT	Sushy
2/8/26	1:00 PM	OT	Suite (3)	Sushy

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Tulcharee Saeena	2/04/26	9685931	Saeena
2	NHA	2/02/26	9685932	Saeena
3	Dr. Shunya	2/02/26	9685931	Saeena
4	Dr. Brundavan	2/02/26	9685931	Saeena
5				
6				
7				
8				
9				
10				

[illegible]

[illegible]

[illegible]

Date :

Time :

Prepared By :

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor



Suite -3

NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 3/7/26 Time: 9am

Origin: Indian Height: 155cms Weight: 75kgs BMI: 31.25kg/m²

Food Allergies: No

Diagnosis: POD-1 (LSCS) lower segment cesarean section

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

Diet Advised:

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

Patient's / Attendant's

Signature: A. Shakila

Name: Pranavi

Date & Time: 3/7/26, 9am

Dietician's

Signature: Nikitha

Name: Nikitha

Date & Time: 3/7/26, 9am

DIETARY NOTES[illegible]



IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

G3P2L1D1 @ 37⁺ wks
for E.L. lvs.

Obstetric Formula:

Obstetric History: ML-2d9, NCM

I - 2010 EM lvs E preterm, MSL)
@ 32 wks, still birth, 10⁺
2.1 kg, Apollo Nelluru.

Present Pregnancy Record:

II - 2021, Lvs (34 wks) 10⁺
3.8 kg, w/o scar dehiscence.
GDM on OHA's

RISK FACTORS:

III - PP - SP. Conception. Booked
@ 22⁺ wks.

② previous Lvs.
w/o scar dehiscence.
GDM on OHA's: 300 mg
Diet: 2800

Height: cm

Weight: 75 kg

Allergies: ALLERGY

Breast: ☒ Normal ☐ Abnormal

General Examination:

Consciousness: Awake Pallor: absent

Icterus: absent Edema: absent

Temp: Afebrile PR: 72

BP: 115/71 DTR: (+)

CVS: S1S2 (+) RS: BAE (+)

Liver/Spleen: non-palpable Urine Output: adequate

DIAGNOSIS

G3P2L1D1 @ 37⁺ wks @ ② previous Lvs @
GDM on OHA. w/o scar dehiscence.
for E.L. lvs + BTL.

LMP: 15/10/2021 EDD: 22/7/2022

Corrected EDD: 22/7/2022 GA: 37⁺ wks.

Menstrual History: Regular: ☒ Yes ☐ No

Obstetric Examination

Fundal Height: Term

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

Liquor: ☒ Adequate ☐ Oligo ☐ Poly

PP: ☒ Cephalic ☐ Breech Others _____

Head Fifts Palpable: _____

FHS: ☒ Normal ☐ Tachy ☐ Brady ☐ Absent

Per Speculum Examination

Not done

Draining: ☐ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination

Not done

Cervix: ☐ Long ☐ Partially effaced ☐ Effaced

Os: Closed _____ Dilated _____

Membranes: ☐ Present ☐ Absent

Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Presenting Part: ☐ Vertex ☐ Breech ☐ Others

Sutton: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Pelvis: ☐ Adequate ☐ Doubtful

Family History: Mother - HTN father - DM.	Surgical History: LSCS 2021. 2020
Medical History: → GDM on OHA 30wks.	Medication History: → T. Iron O.D → T. Calcium O.D → T. Metformin 500mg TID
Plan of Care: - admission - DBM - IUCanda - foley's catheterisation - Consent - Et. M - Send - CBP - Prepare pails - PAC - Shift to OT/ICU.	Investigations: A+ve Vireb - NR HPLC - (N) <u>12/6/2021</u> Hb: 10.7 Plt: 3.1kcr WBC: 6630 NT: 1.8mm, TIEFA (N) <u>15/6/2021</u> SLT09, 34th wks, cephalic placenta - A/Rt L.H. AFI: 12.5cm EFW: 3041gm (93%) AC ~ 94% Doppler (N)

Doctor Name: Dr. Praveen
Signature: Praveen
Date & Time: 2/7/2026, 10 AM

Consultant Name: Dr. Sasikala Kola
Signature: Sasikala Kola
Date & Time: 2/7/2026, 10 AM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2-7-2026		
1:30 PM	POD-0 / elective LSC + B/L tubectomy GDM on DKA	
Baby NICU	P320,	
	Comfortable	Advice:
V/O - 100ml clear	Paracetamol / Ibuprofen	- NBM for 3-4 hours
	Vitals - BP - 106/74/80	- V/O monitoring
	PR - 92bpm	- Mobilization
PBS 7-7-2026	SpO2 - 100% on RA	- Monitor vitals
PBS	P/A - Vessels Retracted well	- Drugs as charted
	Soft	- w/f excessive bleeding
CRBS (12 PM) - 71 mg/dl	VVF Minimal Bleeding (+)	- Inform SBC
	↓ Check CRBS Now : 71 mg/dl	
		by Dr. Deepika
	Wound by Sushan	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/7/26 6:45pm	PE comfortable O/E ac fac PR - 76 bpm BP - 110/70 mmHg SpO₂ - 98% on RA P/A uterus retracted well BSH U/E - bleeding not	Adv - Allow s/s of labor - if tolerating liquids - soft diet from 9pm - w/F active Bleeding on - drugs as per charted - P/B charting - Inform R
FBS PPBS 4/8hs		
Removal Foley's @ 6AM on 3/7		
2/7/26 7:30 AM	I-Pon noted by Swapna Clo - Nil Circ - fair Ukals - stable. P/A - at @ all. BS & P/A - not Verdict	Adv - Request Diet - Ukals monitoring - Ambulation - Plenty of fluids Inform R



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7/26 1:00pm	POD-1 GDM on OHA. PT is stable No c/o BP- 106/71 (77) HR- 80bpm SpO₂- 100% on RA. PlA- Ut well retracted Decreasing day 2nd trimester 46- lochia (+) : healthy.	<u>Admin</u> - soft diet - Hydrate & ambulate - Drugs as charted - vitals with hwy - w/ active bleeding - Inform SOC <u>Sister</u>
3/7/26 7pm	POD-1 GDM on OHA. PT is stable. No c/o. Vitals stable. PlA- Ut well retracted Decreasing day 2nd trimester 46- lochia (+) healthy.	<u>Admin</u> - Continue Same treatment - Inform SOC - T. Dubalova 28 PM - Sanomax every 6 hours - doesn't pass stools <u>Sister</u> NB by Ashwini

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/26 9:45 AM	- POD 2 / ADM on OHA Pt is stable No dx BP - 110/78 (86) PR - 82 bpm SpO₂ - 100% on RA PIA - Lt well retracted Dressing dry contact 1/c. lochia @; healthy	<u>Adm's</u> ① Soft diet ② Hydrate fambols ③ Drugs as charted ④ vitals qth hly ⑤ w/p heavy bleed ⑥ 2 from PPBS ⑦ Discharge today <u>Suter</u>
BS - Bonyell		
PPBS - 120		

[illegible]



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MEDICATION RECONCILIATION FORM

Drug Allergies: None ☐ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ICU Shifted to: Ward

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. Metformin	500 _{mg}	PO	TID	30/6	☐ C ☒ DC
2	T. Iron	446	PO	O.D	1/2	☐ C ☒ DC
3	T. Calz	446	PO	O.D	1/2	☐ 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. Praveen

Date & Time: 2/7/2026, 10AM

Nurse Name & Signature: Nandee

Date & Time: 2/7/26 2 PM

7. SASIKALA KOLA



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Ward 601

VERIFIED

VERIFIED

VER

VERIFIED BY: Nan

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

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

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

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

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



DRUG CHART

Date of Admission: 2/7/2020 Drug Allergies: None ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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



REGULAR PRESCRIPTIONS

Weight. Ward. 308

DRUG : <u>TAB PARACETAMOL</u>				Date Time
Dose <u>1000</u>	Route <u>PO</u>	Frequency <u>QID</u>	Start Date <u>2/7/26</u>	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Sasikala</u>				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : <u>TAB RILUPENAC</u>				Date Time
Dose <u>50mg</u>	Route <u>PO</u>	Frequency <u>TID</u>	Start Date <u>2/7</u>	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Sasikala</u>				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : <u>TAB TRAMADOL</u>				Date Time
Dose <u>100mg</u>	Route <u>PO</u>	Frequency <u>TID</u>	Start Date <u>2/7</u>	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Sasikala</u>				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : <u>T. PANTOPRAZOLE</u>				Date Time
Dose <u>40mg</u>	Route <u>PO</u>	Frequency <u>OD</u>	Start Date <u>2/7/26</u>	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Y. Snelu</u>				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

VERIFIER



Weight. Ward. *66*

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
<i>2/7</i>	<i>11:30 AM</i>	<i>Ty CEFOTAXIME</i>	<i>1gm</i>	<i>Flw</i>	<i>[Signature]</i>	<i>sandhya nannika</i>
<i>2/7</i>	<i>11:32 AM</i>	<i>Ty PANTOPRAZOLE</i>	<i>40mg</i>	<i>Flw</i>	<i>[Signature]</i>	<i>sandhya nannika</i>
<i>2/7</i>	<i>11:32 AM</i>	<i>Ty PERINORM</i>	<i>10mg</i>	<i>Flw</i>	<i>[Signature]</i>	<i>sandhya nannika</i>
<i>2/7</i>	<i>12:50 PM</i>	<i>Sup. ALUCHEMINE</i>	<i>100mg</i>	<i>Plr</i>	<i>[Signature]</i>	<i>sandhya nannika</i>
<i>2/7</i>	<i>12:50 PM</i>	<i>Sup. TRAMADOL</i>	<i>100mg</i>	<i>Plr</i>	<i>[Signature]</i>	<i>sandhya nannika</i>

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Weight. Ward.

BR

Signature



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
2/7/20	9am	1237	O, R, Caesarean, pain relief Tissue & Care	PT	1	0	1	1	Nil	A
2/7	1pm	2	Infection control measure	PT	1	0	1	1	-	A
3/7/20	9am	9	Lactation diet	PT	1	0	1	1	-	Nitika

Part - III: CODES

Who was taught:		PT: Patient	F: Father	M: Mother	S: Spouse	Sn: Son	D: Daughter	C: Caregiver	O: Other (Specify)
Learning Barriers:									
1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice					
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)					
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing						
Teaching Tools Used:									
A: Audio	D: Demonstration	V: Video	O: Oral	P: Printed					
Mechanism/s to overcome barrier/s:									
1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify						
2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference							
Understanding:									
1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review							



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis:

G3 P2 L1 D1, 32nd wks, 2nd preterm, 1st GDM on OHA for FL. Lm + Bt

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
2/1/20	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	G3 P2 L1 D1 32 nd wks 2 nd preterm	Safe Pregnancy	FL. Lm + Bt	[Signature]	☐ Nursing ☐ Others:
2/2	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	1487	FAR monitor	2 nd HGT monitor	[Signature]	☒ Medical ☐ Others:
3/1/20 9am	☐ Medical ☐ Nursing ☒ Others: dietitian	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	POD - 1 CSCS	Soft diet	Soft high protein diet	[Signature]	☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☒ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

BAH-00466037 IP5-00175865
 Dr. PRANAVI BOMMIREDDY
 08-07-1992 33 Y 11 M 24 D (F)
 Dr. SASIKALA KOLA


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RESULT SHEET

Date	24/6/26				
Time					
Hb	10.7				
PCV					
RBC	6630				
WBC					
N/L					
Platelets	3-1				
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					



OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 2/2/26 Time of Arrival: 9:00 AM Time Seen by Nurse: 9:15 AM

1) **Level of Consciousness:** ☒ Conscious ☐ Semi-Conscious ☐ Unconscious

2) **Chief Complaint (Reason for Visit):** (Circle the item as appropriate)

- ☐ Severe Pain / Moderate Pain ☐ Preterm rupture of Membranes / Leaking Water PV
☐ Bleeding PV: Slight / Heavy ☐ Preterm Labor/ Labor
☐ Decreased Fetal Movement ☐ Spontaneous Rupture of Membrane / Leaking Water PV
☐ No Fetal Movement ☐ Other Reason: SL - LSC

3) **Vital Signs:** Temperature: 98.0°F Pulse: 72 RR: 18 SpO₂: 99% BP: 101/62 Weight: _____

4) **Gestational Criteria:**

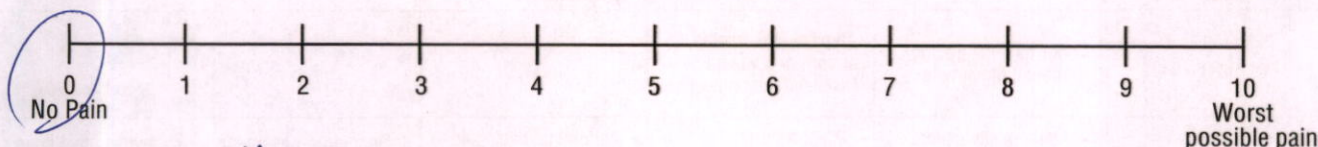
Gravida:	G <u>2</u>	P <u>1</u>	L <u>3</u>	A
----------	------------	------------	------------	---

LMP: 15/10/25 EDD: 22/7/26 Gestational Age: 35+1

Uterine Contraction	☐ Yes ☒ No	☐ NA	Onset	Time	Frequency:
Membrane Rupture	☐ Yes ☒ No	☐ NA	Onset	Time	Fluid Color:
Vaginal bleeding	☐ Yes ☒ No	☐ NA	Onset	Time	Amount:
Pre Eclampsia Symptoms	☐ Yes ☒ No	☐ NA	If Yes specify: Headache / Visual Symptoms / Pain Abdomen / Vomiting		
Good fetal Movement	☒ Yes ☐ No	☐ NA	If No specify:		

5) **Pain Screening:**

Numerical Pain Scale (NPS)



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

6) **Past History:**

- a) Surgeries: NIV - 2021, 2022
- b) Medical: GDM one time

7) Allergy: ☒ No, If Yes :

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

9) Prenatal Medical History:

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

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

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

Time seen by Doctor: 11:10 AM

Nurse Name : Heanika Nurse Signature: [Signature]

Date: 21/7/26 Time: 11 AM



OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: <u>2/2/26</u>		
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: <u>EL - WU</u>		Doctor Notified on Admission: ☒ Yes ☐ No
		Name of the Doctor: <u>Dr. Sraavathi</u>
		Time Notified: <u>11:50 AM</u>
Past Medical History: Obtained From ☒ Patient ☐ Family Member ☐ Medical Record ☐ Other (specify)		
Past Medical History	Past Surgical History	Previous Hospital Admission
<u>nil</u>	<u>Uterus - 2021 2020</u>	<u>nil</u>
Gynecology Assessment: ☒ Not Applicable	Gynecology Surgical History:	Gynecological History:
Menstrual History: <u>Regular</u>	Caesarean Section: ☐ No ☐ Yes	Contraceptives: ☒ No ☐ Yes
Onset of Menarche:	Cervical Cerclage: ☐ No ☐ Yes	Vaginal Discharge: ☒ No ☐ Yes
Menstrual Cycle: ☒ Regular ☐ Irregular	Ectopic Pregnancy: ☐ No ☐ Yes	Post-Coital Bleeding: ☒ No ☐ Yes
Last Menstrual Period: <u>12/10/25</u>	Myomectomy: ☐ No ☐ Yes	Infertility: ☒ No ☐ Yes
	Others:	If Yes Type: ☐ Primary ☐ Secondary
Obstetric History: G <u>2</u> P <u>1</u> L <u>1</u> A		
Previous LSCS: <u>1</u>		
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: <u>98.6 F</u>	HR: <u>78</u>
	BP: <u>101/64</u>	RR: <u>19</u>
	Weight:	Height: BMI:
Pain Assessment: Pain: ☒ Yes ☐ No (If Yes, complete the Pain Assessment / Reassessment Form)		



PHYSICAL ASSESSMENT

General Appearance: ☒ Healthy ☐ ill looking ☐ Anxious ☐ Agitated ☐ Others:

Fall Assessment: ☒ Yes ☐ No Score (complete the Morse Fall Risk Assessment Sheet)

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

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

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☒ No Abnormality Detected

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

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

Inform consultant for positive criteria

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

SOCIAL SCREENING:

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

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

Social History: Lives With husband

Orientation has been given regarding the following aspects:

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

Above information given to patient

Name of Person Orientation was given to: praveen

Orientation not given Reason:

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date & Time: 2/7/2020 12p

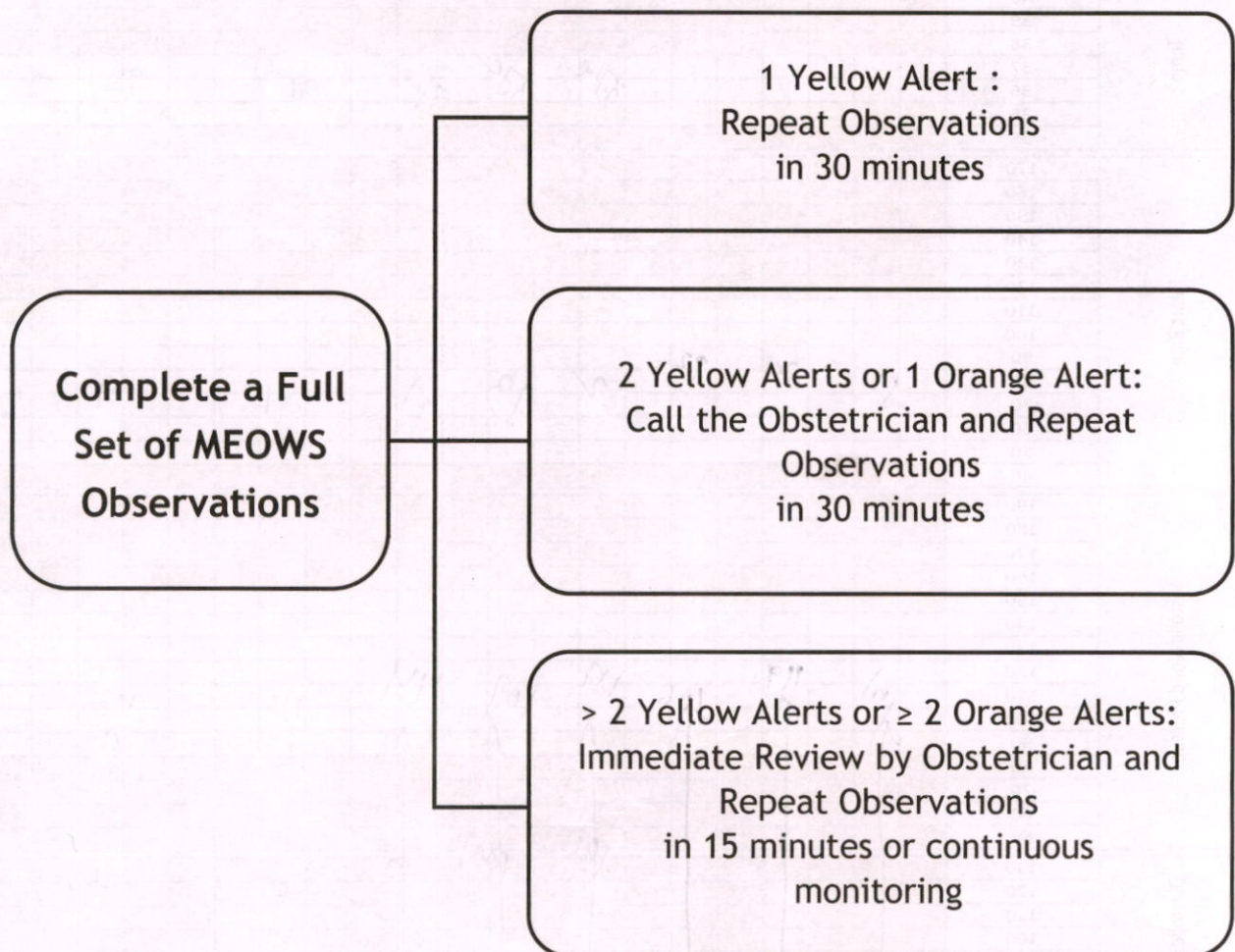


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CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

		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	19	19	20	19	19	19	20		20		20														
	0 - 10																									
Saturations	94 - 100 %	100	99	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	
	< 94 %																									
Administered O ₂ (L/min.)																										
Temp °C	40																									
	39																									
	38																									
	37																									
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90	82	84	92	82	82	81	81	81	81	81	81	81	81	81	81	81	81	81	81	81	81	81	81	81	
	80																									
	70																									
	60																									
	50																									
40																										
Systolic Blood Pressure	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120	101	119	106	117	109	114	115	113	101	101	101	101	101	101	101	101	101	101	101	101	101	101	101		
	110																									
	100																									
	90																									
	80																									
	70																									
60																										
50																										
Diastolic Blood Pressure	130																									
	120																									
	110																									
	100																									
	90																									
	80	62	61	61	61	61	61	61	61	61	61	61	61	61	61	61	61	61	61	61	61	61	61	61		
	70																									
	60																									
	50																									
	40																									
	NEURO RESPONSE [✓]	Alert	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
		Voice																								
		Pain																								
Unresponsive																										
URINE mls / hour	> 30	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
	< 30																									
Proteinuria	Protein ++																									
	Protein > ++																									
Lochia	Normal	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
	Heavy / Foul																									
Liquor	Clear / Pink	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
	Green																									
TOTAL YELLOW SCORES																										
TOTAL ORANGE SCORES																										
Nurse Initial																										

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

SASIKALA KOLA

Early Warning Observation Score Chart - Obstetrics

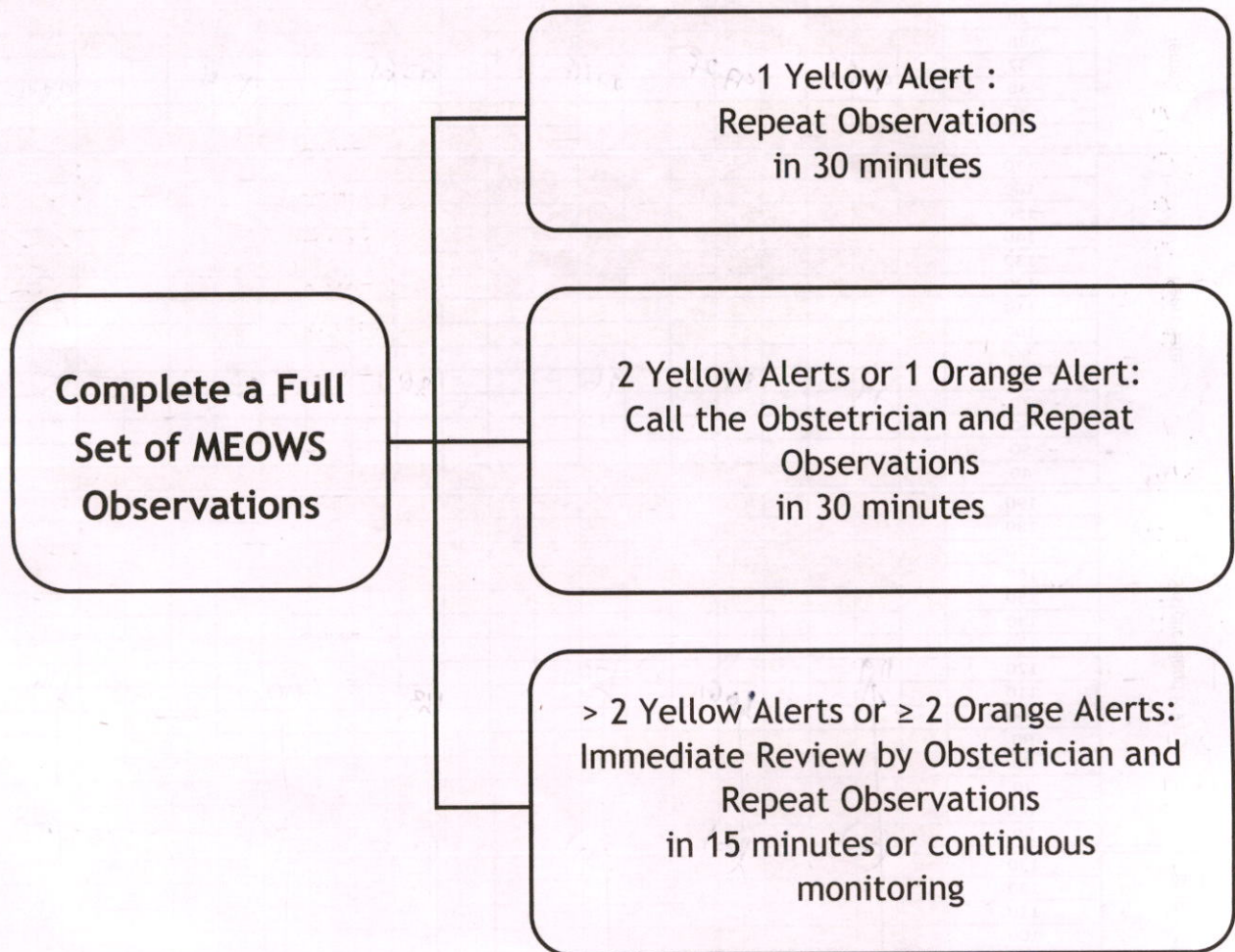
TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

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[illegible]

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

FLUID CHART

Sheet No. : 1

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	Nature of Fluid	Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am	PL	I	100ml						✓	0	hase	
	09:00 am	PL	I	100ml							0	hase	
	10:00 am	PL	I	100ml							0	hase	
	11:00 am	PL	B	100ml							0	hase	
	12:00 pm	PL		100ml							0	hase	
	01:00 pm	PL	M	100ml					100ml		0	hase	
Total Intake : <u>500ml</u>						Total Output : <u>100ml</u>							
	02:00 pm	PL	M	100ml							0	hase	
	03:00 pm	PL	B	100ml							0	hase	
	04:00 pm	PL		100ml							0	hase	
	05:00 pm	PL	M	100ml					450ml		0	hase	
	06:00 pm	PL		100ml							0	hase	
	07:00 pm	PL									0	hase	
Total Intake : <u>500ml</u>						Total Output : <u>450ml</u>							
	08:00 pm	PL									0	hase	
	09:00 pm	PL									0	hase	
	10:00 pm	PL							300ml		0	hase	
	11:00 pm	PL									0	hase	
	12:00 am	PL									0	hase	
	01:00 am	PL									0	hase	
Total Intake : <u>350ml</u>						Total Output :							
	02:00 am	PL									0	hase	
	03:00 am	PL									0	hase	
	04:00 am	PL									0	hase	
	05:00 am	PL									0	hase	
	06:00 am	PL							100ml		0	hase	
	07:00 am	PL									0	hase	
Total Intake : <u>350ml</u>						Total Output :							
Total 24 hrs. Intake		<u>1800ml</u>											
Total 24 hrs. Output		<u>1850ml</u>											



FLUID CHART

Sheet No. : 2

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
03/7/26											0	
	08:00 am	H ₂ O								✓	0	Sadhu
	09:00 am	H ₂ O									0	Sadhu
	10:00 am	H ₂ O									0	Sadhu
	11:00 am	H ₂ O							✓	0	Sadhu	
	12:00 pm	H ₂ O								0	Sadhu	
	01:00 pm	H ₂ O								0	Sadhu	
Total Intake: taken						Total Output: passed						
03/7/26	02:00 pm	H ₂ O								✓	0	Sadhu
	03:00 pm	H ₂ O									0	Sadhu
	04:00 pm										IV	Sadhu
	05:00 pm	H ₂ O							✓	0	Sadhu	
	06:00 pm	H ₂ O								0	Sadhu	
	07:00 pm	H ₂ O								0	Sadhu	
Total Intake: taken						Total Output: passed						
3/7/26	08:00 pm									✓	0	
	09:00 pm	H ₂ O									0	
	10:00 pm										0	
	11:00 pm	H ₂ O							✓	0		
	12:00 am									0		
	01:00 am	H ₂ O								0		
Total Intake: Taken						Total Output: Passed						
4/6/26	02:00 am										0	
	03:00 am	H ₂ O									0	
	04:00 am	H ₂ O									0	
	05:00 am								✓	0		
	06:00 am	H ₂ O								0		
	07:00 am									0		
Total Intake: Taken						Total Output: Passed						
Total 24 hrs. Intake												
Total 24 hrs. Output												

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NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 2/2/20

Assessment:

patient feeling fear and anxiety

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
9 AM	Assess the patient general condition	9:10 AM	Assessed the patient general condition	patient is stable
10 AM	IP chart	10:20 AM	IP chart monitoring	
11 AM	vital check	11:20 AM	vital checked and recorded	
12 PM	Prep medication	12:20 PM	Prep medication given	
1 PM	Prevent infection	1 PM	maintaining hand hygiene	
2 PM	Ensure safety	2 PM	Ensured safety needs	

Re-Assessment:

Special Notes:

on to bed

Nurse Signature: *[Signature]*

Nurse Name: Meenle

Date & Time: 2/2/20 @ 4



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 2/7/26

Assessment: patient came for mild pain in surgical site

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm →	Assess the pt condition	2pm →	Assessed the pt condition	
3pm →	No client	3:15pm →	No client maintained →	patient is
4pm →	Monitor for vitals	4:15pm →	vitals checked & recorded	comfortable
5pm →	IV fluids	5:30pm →	IV fluid ongoing	now
6pm →	Safety	6:45pm →	pt ensure safety	
7:15pm →	Wound	7:15pm →	Wound still further healed	
8pm →	Drug Administration	8:15pm →	Medication given as per drug chart	

Re-Assessment: now comfortable after giving medication

Special Notes: ① PRS, PPRS, 4/7/26.

Nurse Signature:

Nurse Name: Deepika

Date & Time: 2/7/26 @ 8pm

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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 2/7/2026

Assessment: patient complaint pain at surgical site

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ assess the patient condition	8:30pm	→ assessed the patient condition	→ Patient stable
10pm	→ monitor vitals	10:30pm	→ monitored vitals	
12am	→ Ensure Safety.	12:10am	→ Provided side rails	
2am	→ administration of medication	2:30am	→ medication given as per drug chart	
4am	→ 2/10 chart monitor	4:30am	→ 2/10 chart monitored	
6am	→ Ambulation	7am	→ Ambulation done	
7am	→ Soft diet	8am	→ Soft diet Taken	

Re-Assessment: done pt stable

Special Notes: vitals w/h hourly PRS PPRS 4/7/2026

Nurse Signature: [Signature]

Nurse Name: Swapna

Date & Time: 3/7/26 @ 8am

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NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 03/07/2026

Assessment: patient complaint pain at surgical site

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	⇒ Assess the patient condition	8:30am	⇒ Assessed the patient condition	⇒ Patient is stable.
9am	⇒ monitor the vitals	9:30am	⇒ monitoring vitals checked and recorded	
10am	⇒ Administer medication	10:30am	⇒ Administered medication as for drug chart	
11am	⇒ maintain I/O chart	11:30am	⇒ maintaining I/O chart	
12pm	⇒ maintain personal hygiene	12:30pm	⇒ maintaining personal hygiene	
1pm	⇒ ensure safety needs	1:30pm	⇒ Ensured safety needs	

Re-Assessment: Re-Assessment done.

Special Notes: monitoring vitals 4th hourly.

Nurse Signature:

Nurse Name: Sandhya

Date & Time: 03/07/26 @ 2pm

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 03/07/2026

Assessment: patient having pain at surgical site

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2 pm	⇒ Assess the patient condition and monitor vitals	2:30 pm	⇒ Assessed the patient condition and monitored vitals checked and record	⇒ patient is stable.
3 pm	⇒ Administer medication	3:30 pm	⇒ Administered medication as for drug chart.	
4 pm	⇒ maintain I/O chart	4:30 pm	⇒ maintaining I/O chart	
5 pm	⇒ provide soft diet	5:30 pm	⇒ provided soft diet	
6 pm	⇒ maintain personal Hygiene	6:30 pm	⇒ maintained personal Hygiene	
7 pm	⇒ ensure safety needs	7:30 pm	⇒ ensure safety needs	

Re-Assessment: Re-Assessment done.

Special Notes: monitoring vitals 4th hour

Nurse Signature: 

Nurse Name: sandhya

Date & Time: 03/07/2026 @ 8 pm.

H-00466037 IP5-00175865
PRANAVI BOMMIREDDY
07-1992 33 Y 11 M 25 D (F)
SASIKALA KOLA



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

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 3/2/26

Assessment: Patient Complaints of fear & Anxiety

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8:00pm	Assess the general condition	8:10pm	Assessed the general condition	Pt is stable
10:00am	monitor vitals	10:10am	Vitals checked BP, Pulse, SpO2, Resp	
11:00am	monitor I/O chart	12:10am	I/O chart monitored	
2:00am	Administer medications	2:10am	medication given as per drug chart	
4:00am	Ambulation	4:10am	Ambulation provided.	
6:00am	maintain personal hygiene	6:10am	maintained personal hygiene.	
8:00am	Ensure safety	8:10am	Ensured safety needs	

Re-Assessment: Re-assessment done

Special Notes: monitor vitals.

Nurse Signature: Ashwini

Nurse Name: Ashwini

Date & Time: 4/2/26 @ 8am



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Sasikala Kola Department: PLC Date of Admission: 2/7/26

SITUATION	Diagnosis: <u>G2 P1 L1 384-1 rule</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
BACKGROUND	Area	Shift Time	<u>BRP 8A-12P</u>	<u>BRP 12P-2PM</u>	<u>BRP 2PM-5PM</u>	<u>BRP 5PM-8PM</u>	<u>BRP 8PM-8AM</u>	
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	
	Vital Signs:	Temp:	<u>98.6 F</u>	<u>98.6 F</u>	<u>98.1 F</u>	<u>98.6 F</u>	<u>98.4 F</u>	
		Res:	<u>18</u>	<u>19 bpm</u>	<u>20 bpm</u>	<u>19 bpm</u>	<u>20 bpm</u>	
		SpO ₂ :	<u>99%</u>	<u>100%</u>	<u>99%</u>	<u>100%</u>	<u>99%</u>	
		Pulse:	<u>82</u>	<u>87 bpm</u>	<u>86 bpm</u>	<u>79 bpm</u>	<u>80 bpm</u>	
		BP:	<u>101/62</u>	<u>116/70</u>	<u>110/65</u>	<u>119/64</u>	<u>116/72</u>	
	Fall Risk Score:	<u>55</u>	<u>35</u>	<u>35</u>	<u>35</u>	<u>35</u>		
Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>			
Recommendations	Safety Needs:	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>		
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
Handed Over By Name :		<u>Sandhya</u>	<u>Puliy</u>	<u>Swapna</u>	<u>Sandhya</u>	<u>Ashwita</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>2/7/26</u>	<u>2/7</u>	<u>3/7/26</u>	<u>3/7/26</u>	<u>3/7/26</u>		
Time:		<u>2pm</u>	<u>8pm</u>	<u>@ 8AM</u>	<u>2pm</u>	<u>8AM</u>		
Taken Over By Name :		<u>Puliy</u>	<u>Swapna</u>	<u>Sandhya</u>	<u>Ashwita</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>2/7</u>	<u>2/7/26</u>	<u>3/7/26</u>	<u>3/7/26</u>			
Time:		<u>2pm</u>	<u>8:10PM</u>	<u>8AM</u>	<u>8pm</u>			

H-00466037 IP5-00175865
 PRANAVI BOMMI REDDY
 07-1992 33 Y 11 M 25 D (F)
 SASIKALA KOLA



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:							



BRADEN 'Q' SCALE

					Date :	2/1/25	2/7	2/12/25	3/1/26
					Time :	8A 20	2pm	3pm	2am 3/1
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	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	1	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	2	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	2	4	
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28	28	18	28
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	Dr. Sasi	Dr. Sasi	Dr. Sasi	Dr. Sasi

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



BRADEN 'Q' SCALE

					Date : 3/7/26			
					Time : 8:00 AM			
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:treimity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4			
"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.	1			
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.	2			
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.	2			
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			
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4			
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			
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	18		
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	Ashwika		

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



Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	2/7/26	2/7/26	2/7/26	Fall Risk Grading		
		Score	FA 20	2 put to 8	18 pm 8 am	Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25				Risk Level	Morse Fall Score (MFS)	Action
	No	0		0				
Secondary Diagnosis (more than one diagnosis)	Yes	15	15	15	15	Low Risk	0 - 24	Standard Fall Precaution
	No	0		0				
Ambulatory Aid	Furniture	30				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0		0	0			
IV / Heparin Lock or Saline	Yes	20	20	20	20	High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	No	0		0				
GAIT / Transferring	Impaired	20				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0		0	0			
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0		0	0			
Total Morse Fall Scale Score:			35	35	35			
Signature			<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>			

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



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
2/7	8am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Day
2/7	4pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Day
2/7/20	3pm	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Feelys
2/7	5pm	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Feelys
2/7	7pm	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Feelys
2/7	9pm	0/10	Suboxone site	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Tab: Pramadol given	Swapna
3/7	12AM	0	No Pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Swapna
3/7	4AM	0	No Pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Swapna
3/7	8AM	0	No Pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Swapna
3/7	10AM	0	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Sudhys

Re-assessment Frequency:

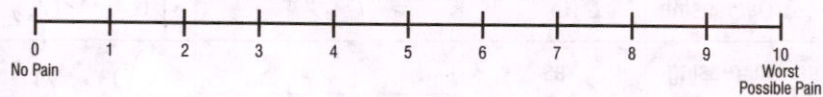
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
3/7/26	11am	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Sudhakar
3/7/26	1pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Sudhakar
3/7/26	3pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Sudhakar
3/7/26	6pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Sudhakar
3/7/26	10pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Ashwita
4/7/26	2am	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under Observation	Ashwita
4/7/26	6am	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Ashwita
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

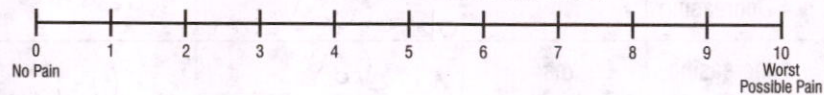
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

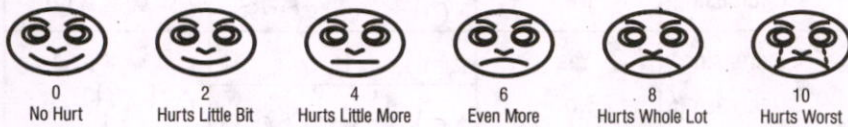
Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years





CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 <i>2/8</i>			DAY-2 <i>3/2/20</i>			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0	0	0					
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	—	—	—	—	—	—				
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	—	—	—	—	—	—				
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	—	—	—	—	—	—				
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	—	—	—	—	—	—				
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	—	—	—	—	—	—				
Signature of the Nurse				<i>[Signature]</i>			<i>[Signature]</i>			<i>[Signature]</i>			

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 : *Nilcitta* Name : *Nilcitta*

Signature of Ward In Charge :

Signature : *Umesh* Name : *Umesh*



URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 2/12/20

Date of Removal: 2/12/20

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



CAESAREAN SECTION OPERATIVE NOTES

Surgeon's Name: Dr. Sasikala Kola	Date of Delivery: 2/7/26
Assistant Surgeon: Dr. Sneha	Time of Delivery: 12.13 pm
Anaesthetist's Name: Dr. Shilpa	Gender of Baby: female
Type of Anaesthesia: ↓ Spinal	Weight of Baby: 3.22 kg
Neonatologist: Dr. Sneha	AGPAR Score: 8, 8
Scrub Nurse: Sr. Laxmi	NICU Admission: ☒ Yes ☐ No

Pre-Operative Diagnosis: G3 P2 L1 D1 37+1 | 2 prev ces | GDM OHA

☒ Elective ☐ Emergency Indication: prev 2 ces

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: Knief to rectus:

CTG Description:

If there was a delay give the reasons:

Surgical Procedure: E. ces + BTL

Post Operative Diagnosis: POD-0 A. ces + BTL

Peri-Operative Complications: ① Bladder drawn up
② B/L tubal sterilisation - Fallopie rings

Amount of Blood Loss: 200ml	Blood Transfused (in ML): -
-----------------------------	-----------------------------

Name and Number of Surgical Specimen sent for examination:

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

Cervical Dilatation: cm

5th Palpable:

Fetal Position:

Station: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2Moulding: ☐ None ☐ + ☐ ++ ☐ +++Caput: ☐ + ☐ ++ ☐ +++Meconium: ☐ None ☐ + ☐ ++ ☐ +++Bladder Catheterized: ☐ Yes ☐ NoUrine: ☐ Clear ☐ Blood StainedSkin Incision: ☐ Pfannenstiel ☐ Transverse☐ Midline ☒ Other *prev scar excised*Uterine Incision: ☒ Lower Segment☐ Classical☐ Inverted T☐ J IncisionPrevious Scar: ☒ Intact☐ Thinned out☐ Ruptured☐ No ScarIncision Through Placenta: ☐ Yes ☒ NoDelivery of head: ☐ Manual☒ ForcepsLiquor: ☒ Clear☐ Meconium: ☐ I ☐ II☐ III☐ Blood☐ Offensive☐ Not OffensiveDelivery of Placenta: ☐ Manual☒ CCT☒ Complete☐ Incomplete☐ PiecemealCord Appearance: *N* Cord around the neck ☒ Yes ☐ NoAppearance of placenta: *N* Cavity explored ☒ Yes ☐ NoUterus, tubes and ovaries: ☒ Normal ☐ Not NormalSterilization: ☒ Yes ☐ NoUterine Closure: ☐ One Layer ☒ Two LayersPeritoneal Closure: ☐ Pelvic☒ Abdominal☐ None

Sheath Closure:

Fat Closure: ☒ Yes ☐ NoSkin Closure: ☒ Subcuticular ☐ Mattress

Vaginal Evacuated

☒ Yes ☐ No

Drain:

☐ Yes ☒ No☐ Remove in days☐ Await instructions

Catheter

☒ Yes ☐ No☐ Remove in *2 wks* days☐ Await instructionsSwap & Instruments count correct? ☒ Yes ☐ No☐ Post-op Antibiotics☐ Yes☒ NoIntra-Operative Antibiotics Cover: ☒ Yes ☐ No☐ Thromboprophylaxis☐ Yes☒ No

Post-Operative Notes:

① WBM & hrs

② IVF @ 120 mls RL

③ Drugs as chart

④ FBS, PPBS 4/7/26

⑤ w/ Bleeding PV

⑥ Inform SAs

Doctor Name: *Dr. Y. Suen*Doctor Signature: *Dr. Y*Date & Time: *2/7/26 1PM*



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

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

Signature of the Doctor: Sh. Y Date: 2/7/26 Time: 1 pm

Action Plan: Ambulate Hydrate

Risk Assessment Tool for Deep Vein Thrombosis

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

Patient

BAH-00466037 IP5-00175865
Dr. PRANAVI BOMMIREDDY
08-07-1992 33 Y 11 M 24 D (F)
Dr. SASIKALA KOLA




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


BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

POST-SURGICAL CARE PLAN FORM

Procedure Done: EL. URS + BTL

Post-Surgical Diagnosis: POD-0 EL. URS + BTL

Post-Operative Monitoring Parameters /Frequency:

Vitals, I/O 1/2 hourly

Wound Care:

Dressing x 48 hrs

Drain /Special Lines/Catheters:

Foleys 24 hrs

Special Patient Positioning and Requirements:

can move sideways on bed

Nutritional Instructions:

NBM 4 hrs

When to Start Mobilization:

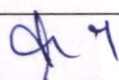
after foley removal

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: 2/7/20 Time: 1 PM

Note: Plan of care will be readjusted if necessary.

BAH-00466037 IP5-00175865
Dr. PRANAVI BOMMIREDDY
08-07-1992 33 Y 11 M 24 D (F)
Dr. SASIKALA KOLA



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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 02/06/2028

Department : OBG Duration of Procedure :

Name of Surgeon : Dr. Sasikala Kola Date of Admission : 02/06/2028

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

		Staff Signature
1.	Antibiotic given prior to surgery ? ☒ Yes ☐ No ☒ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☐ Yes ☐ No Name of the Antibiotic : Inj. - Taxim	
2.	Hair Removal ☒ Yes ☐ No if Yes : Surgical Clipper Department where Hair Removed : ☒ Ward ☐ Operating Room ☐ Other : Skin preparation done (cleanse surgical area with antiseptic agent)? ☒ Yes ☐ No	
3.	Patient's body temperature immediately post operation (Recovery Room) 36.6 °C ☐ Oral Or ☒ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : Dr. Sandhya Date & Time of antibiotic administration : 2/6/28 11:30 AM Date & Time procedure started : 2/6/28 11:45 AM	

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

Docu. No. : RCHBH/ FRM / CLINICAL / 038

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00466037 IP5-00175865 Dr. PRANAVI BOMMIREDDY 08-07-1992 33 Y 11 M 24 D (F) Dr. SASIKALA KOLA 		Date & Time of Admission 2/6/26 @ 9:52 AM	Date & Time of Transfer Order 2/6/26 @ 1 PM
		Transfer Ordered by Dr. sasikala kola	Reason for Transfer observation
From Unit OB G-OT	To Unit (suit-3)	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If Yes, what?	Patient shifted with ID band: Yes ☒ No ☐ If No:	
Number of Imaging Films - NA			
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring S.S. - sandhya		Name of Person Ordered Transfer Dr. sasikala kola	
Patient & Clinical Records Received by :			
Date & Time of Patient Received : Sandhya 2/6/26 1 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

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Lalila
Asst. Surgeon : Dr. Sneha
Anaesthetist : Dr. Silpa
Scrub Nurse : Dr. Lakshmi

BAH-00466037 IP5-00175865
Dr. PRANAVI BOMMIREDDY
08-07-1992 33 Y 11 M 24 D (F)
Dr. SAKILA KOLA


Age : Gender : F
Name :
Out-time : 1:40 PM


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Before Induction of Anaesthesia >>

SIGN IN		Time: <u>11:38 AM</u>
Patient Has Confirmed		
Identity	☒ Yes ☐ No	
Site	☐ Yes ☒ No	
Procedure	☒ Yes ☐ No	
Consent	☒ Yes ☐ No	
Site Marked	☐ Yes ☐ No ☒ NA	
Anaesthesia Safety Check Completed	☒ Yes ☐ No	
Pulse Oximeter on Patient & Functioning	☒ Yes ☐ No	
Does Patient have a:		
Known Allergy?	☐ Yes ☒ No	
Difficult Airway / Aspiration Risk?		
Yes, & Equipment / Assistance Available	☒ Yes ☐ No	
Risk of > 500ml Blood Loss (7ml/kg In Children)?		
Yes, and Adequate Intravenous Access and Fluids Planned	☒ Yes ☐ No ☐ NA	
Blood Units Reserved	☐ Yes ☒ No ☐ NA	
Has Antibiotic Prophylaxis been given within the last 60 minutes?	☒ Yes ☐ No ☐ NA	
Signature : <u>Dr Silpa</u>		
Name : <u>Dr Silpa</u>		

Before Skin Incision >>

TIME OUT		Time: <u>11:45 AM</u>
Confirm all team members have introduced themselves by Name and Role ☒ Yes ☐ No		
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm		
Correct Patient (Check ID Band)	☒ Yes ☐ No	
Correct Site	☒ Yes ☐ No	
Correct Procedure	☒ Yes ☐ No	
Anticipated Critical Events		
Surgeon Reviews:		
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? ☒ Yes ☐ No ☐ NA		
Anaesthesia Team Reviews:		
Are There Any Patient-specific Concerns? ☐ Yes ☐ No ☐ NA		
Nursing Team Reviews:		
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☒ Yes ☐ No ☐ NA		
Is Essential Imaging Displayed? ☒ Yes ☐ No ☐ NA		
Power Supply, Earthing, Power Backup and functioning of equipment checked. ☒ Yes ☐ No		
Signature : <u>Ch. Sandhya</u>		
Name : <u>Ch. Sandhya</u>		

Before Patient Leaves Operating Room

SIGN OUT		Time: <u>11:50 AM</u>
Nurse Verbally Confirms with the Team:		
The Name of the Procedure Recorded	☐ Yes ☒ No	
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	☒ Yes ☐ No ☐ NA	
The Specimen is Labelled (including patient name)	☐ Yes ☐ No ☐ NA	
Whether there are any Equipment Problems to be addressed	☐ Yes ☒ No ☐ NA	
To Surgeon, Anaesthetist and Nurse:		
What are the key concerns for recovery and management of this patient? ☐ Yes ☒ No		
Signature : <u>Dr. Sneha</u>		
Name : <u>Dr. Sneha</u>		



CONSENT FOR ANAESTHESIA

Authorization By ☒ Patient ☐ Patient Attendant

Operative Procedure: E.I. Caesarean Section

Anaesthesiologist: Dr Subor Annamparam Surgeon: Dr Sasikala Kola

Please read this before you consent for Anaesthesia

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

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

☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders

☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease

☐ Others Postdural puncture headache

Declaration by Patient Attendant

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

✓ Patient / Patient Attendant:

Signature: Pranavi

Name: Pranavi

Relationship with patient: Sister

Date & Time: 21/7/26 9AM

Witness:

Signature: [Signature]

Name: D. Rajesh Reddy

Date & Time: 21/7/26 9AM

Doctor (who is taking consent):

Signature: [Signature] Name: Dr Subor

Date 21/7/26 Time: 9AM

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స:

అనస్థీషియా వైద్యుడు: శస్త్రచికిత్స నిపుణుడు:

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

సాధారణ అనస్థీషియా అనేది శస్త్రచికిత్స ముందు రోగిని పూర్తిగా అపస్మారక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్రావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు.

లీజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్కోటిక్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై లిస్ట్:

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

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

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

☐ ఇతరవి:

రోగి / రోగి అటెండెంట్

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

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:



**Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION**

Name: Dr. Pranavi Age: 33yrs Sex: F UHID.No: BAH-466037

Date: 2/7/26 Time: 9:00AM Proposed Operation: EL US

Diagnosis: G3P24 D1 E pre-ecl. No scar dihesence

B.P / CRT: H.R: Weight: ASA Physical Status: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

24/8

Laboratory Data:

Hgb: 10.7 Glucose: Protein: HIV: X-Ray:
PCV: Urea: Alb: HBS Ag: ECG:
WBC: Creat: Total Bill: HCV: 2D Echo:
Plate: 303 Na: Dir. Bill: Blood group: A+ Stress/Angio:
PT: K: LDH: T3 Other:
PTT: Ca++: Alk phos: T4
INR: Mg++: Amylase: TSH
Cl -: SGOT/SGPT:

Allergies: NR

Medical History: CVS :

RESP : Diabetes : + on

CNS :

Renal : normal

Hepatic / GE : Physical Activity:

Others :

Past Anaesthetic History: + US 1 SAO. No scar dihesence

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: 72mm Mento-hyoid Distance: 72mm Neck: + Teeth: +

Lungs : normal

Heart:

CNS:

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

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

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

CURRENT MEDICATIONS	DOSAGE
<u>metformin</u>	

Pre-Operative Instructions:

- DVT Prophylaxis : 1 Adequate
- NIL ORAL Water / ORS 2 Hours
Others 6 Hours
- Informed Consent: ☒ Standard ☐ High Risk
- Post Operative Pain Management: ☐ Discussed with Patient
- Other Instructions:

Signature: [Signature] Name: Dr. Shripa

* To check GRBS.
* To check availability
of blood



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Dr. Praveen Time Received : 1pm Time Discharged : 2:45pm

250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 < RES • PULSE > BLOOD PRESSURE SPO ₂	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	IV Cannula Site : <u>Right Arm</u> ☐ O ₂ Mask ☐ Nasal Prongs ☐ Tracheostomy ☐ T-Piece ☐ Oral Airway ☐ Nasal Airway Vomiting : ☐ Yes ☒ No Drug : _____ NG Tube : ☐ Yes ☒ No Drain : ☐ Yes ☒ No Urinary Catheter : ☒ Yes ☐ No Chest Tube : ☐ Yes ☒ No Nil Oral ☐ Yes ☒ No IV Fluids : _____ Oral Feeds : <u>NBM</u>
	(Graph area with handwritten data points for BP, Pulse, Respiration, and SPO ₂)	

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
2/7/2024	1pm	0	N/A	Dr. Praveen
2/7/2024	2pm	0	N/A	Dr. Praveen

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

Anaesthesiologist Name : Dr. Praveen

Anaesthesiologist Signature: [Signature]

Date & Time: 04/07/24, 8:45 AM

PACU Nurse Name : Dr. Praveen

PACU Nurse Signature: [Signature]

Date & Time: 2/7/2024 1pm

Reassessment Frequency:

- Every eight hours for all hospitalized patients.
- For post surgical patient, patient with chronic pain, patient with severe pain
 - Every 2 hours for first 24 hours
 - After 24 hours every 4 hours
 - Prior to pain relieving intervention
 - With in 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU): Suite-3

Date & Time: 2/7/2024 1pm



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 :



INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

Patient Name : Dr. PRANAVI Gender: ☐ Male ☒ Female Age : 34 yrs
UHID No : BAH-00466037 Date : 2/7/2026

Instruction:

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

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

ELECTIVE LOWER SEGMENT CESAREAN SECTION
upon
(Name of the Patient) Dr. PRANAVI

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.

CHANCE OF BLEEDING, BLOOD AND BLOOD PRODUCTS TRANSFUSION, CHANCE OF INFECTION, INJURY TO ADJACENT ORGANS SUCH AS BOWEL AND BLADDER AND IT'S REPAIR

My signature on this form indicates that

1. I have read and understood the information provided in this form
2. My doctor had adequately explained to me the operation or procedure along with the complications written above, along with the risks, benefits and other information.
3. I have had a chance to ask my surgeon questions.
4. I have received all the information I desire concerning the operation or procedure and
5. I authorize the consent to the performance of the operation or procedure.

Name of the Doctor who is performing the Surgery / Procedure: Dr. SASIKALA KOLA

Consentee :

Signature : B. Pranavi
Name : B. PRANAVI
Date & Time : 2/7/2026, 10 AM

Patient Attendant :

Signature : [Signature]
Name : Rajesh Reddy
Relationship with Patient: Husband
Date & Time : 2/7/2026, 10 AM

Witness :

Signature : [Signature]
Name : Sandhya
Date & Time : 2/7/2026, 10 AM

Doctor (who is taking the consent) :

Signature : [Signature]
Name : Dr. Sravanthi
Date & Time : 2/7/2026, 10 AM

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

BAH-00466037 IP5-00175865
Dr. PRANAVI BOMMIREDDY
08-07-1992 33 Y 11 M 24 D (F)
Dr. SASIKALA KOLA



Hospital
It takes a lot to treat the little.



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient Name : Dr. PRANAVI Gender: ☐ Male ☒ Female Age : 34 yrs
UHID No : BAH-00466037 Date : 2/7/2026

Instruction:

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

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

BILATERAL FALLOPIAN TUBECTOMY

upon

(Name of the Patient)

Dr. PRANAVI

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.

CHANCE OF BLEEDING, CHANCE OF INFECTION
CHANCE OF FAILURE 1/300

My signature on this form indicates that

- I have read and understood the information provided in this form
- 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.
- I have had a chance to ask my surgeon questions.
- I have received all the information I desire concerning the operation or procedure and
- I authorize the consent to the performance of the operation or procedure.

Name of the Doctor who is performing the Surgery / Procedure: Dr. SASIKALA

Consentee :

Signature : B. Pranan
Name : B. PRANAVI
Date & Time : 2/7/2026, 10 Am

Witness :

Signature : [Signature]
Name : Sandhya
Date & Time : 2/7/2026

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

Patient Attendant :

Signature : [Signature]
Name : Rajesh Reddy
Relationship with Patient : Huband
Date & Time : 2/7/2026, 10 Am

Doctor (who is taking the consent) :

Signature : [Signature]
Name : Dr. Pravanthi
Date & Time : 2/7/2026, 10 M