

BAH-00654662 IP5-00176804
Mrs TAMSILA KHANAM FARHI
24-02-1995 31 Y 4 M 29 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA

Rainbow
Children's
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URGERY DETAILS

Date : 23/7/26
Patient Name: Mrs. Tamsila Khanam Date of Birth: 24/2/1995 Age: 31yrs
Gender: Female Ward : UHID No.: BAH-00654662
Date of Surgery: ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☒ OBG OT-1 ☐ OBG OT-2
Name of the Surgery : McDONALD'S CERCAGE & SPINAL

Time in : 11:00 AM

Time Out : 11:30 AM

	NAME	AMOUNT
1. Surgeon	Dr. Shruthi Reddy	
2. Anaesthetist	Dr. Vineetha	
3. Assistant Surgeon		
4. OT Technician	Bro. Aman	
5. Circulating Nurse	Sis. Brilatha	
6. Assistant Nurse	Sis. Rajeevar	

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: 9718769

Order by: Sis. Rajemi

Patient Sticker

Mrs. Tamsila Khanam
5912

Circulage

CONSUMABLES OF OT

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Circulating staff : Technician : Date : 23/7/26 Time :

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube			Major Pack <i>Major</i>	01		Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : A / P / N		03	Troubond 622	01		Suction Catheter		
HME filter : A / P / N						Feeding Tube		
Syringes : 10 cc						Vaccum Suction Set		
05 cc			Gloves 642	02		Surgical Gloves		
02 cc						Gauze Pack		
01 cc			Leggins	01		Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade			Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL			Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml			Koochies					
			Ointments					
			Suction Catheter					
Fentanyl			Cap, Mask	5+5				
Morphine			Gauze Pack N	01				
Ketamine			Mop Pack					
Propofol			Steristrip					
Rocuronium			Underpad	01				
Glycopyrolate			Draw sheet quicksuit	01				
Myopyrolate			Abgel					
Ondansetron			Foleys catheter					
Percan 25g/ Spinal Needle 22		01	Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)		01	Romodrain bag					
Antibiotics			Bandage					
gaug + glove (6 1/2)		1+1	Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg		01	Vaccum Suction set					
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution	01				
			Microshield					
			Cotton Balls	01				
			Latex Gloves	10				
			Ramdione Scrub					
			Saral					

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. : 9718185/126

Ordered by : S.S. Rpr

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

ADMISSION SHEET

Registration Details :



Admission No : IP5-00176804

Admit Date : 23-Jul-2026

Admit Time : 08:56 AM UHID : BAH-00654662

Patient Details :

Patient Name	: Mrs TAMSILA KHANAM FARHI	Age	: 31 Y 4 M 29 D
Guardian	: ABDUL HANIF SIDDIQUE	DOB	: 24-02-1995
Gender	: Female	Religion	:
Occupation	:	Martial Status	: Married
Address (H)	: H NO 4-744/9, PAYAN DARGA ROAD, BEHIND NATIONAL COLLEGE HAFTH GUMBAD, Gulbarga Darga Gulbarga Karnataka INDIA 585104	Phone No	: 9945747880/ 9945747880
		E-mail	: abdulhanif9945@gmail.com

Admission Details :

Bed Type : DAY CARE

Bed No : BC DC 419

Ward Name : 4F-BIRTHING CENTRE

Room No : BC DC 419

Admission Type : First Visit

Contact Details :

Name : ABDUL HANIF SIDDIQUE

Relationship : Husband

Contact Address :

Phone No : / 9945747880



Signature

Doctor Details :

Doctor Name : Dr. SHRUTHI REDDY/Dr.LAVANYA
JANAGAMA

Specialisation : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAID

ACTIVITY RECORD FOR BILLING

Name : _____

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

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
22/1/26	SW placement			[Signature]
23/1/26	PAL			

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 23/2/26 Time of Admission : 8:45 AM

Allergies: NKDA ☒ Not know any drug allergies

PRESENTING COMPLAINTS :

- Admitted for prophylactic circlage.
- NT scan done on 17/2/26 - SRM, 24wks, NT - 1.7mm.
Abnormal at doppler med resistance to blood flow
Cervix length - 27mm.

MENSTRUAL HISTORY

Year of Marriage : 2021, NCM.
Previous Periods : Regular
LMP : 17/4/26, EDD - 22/1/27
Contraception : None.
Booked at SRM.

OBSTETRIC HISTORY

Parity : G2A1
Mode of Delivery : G1 - inevitable abortion, Olanap,
Last Child Birth : 17wks, SRM Boy, WD @ Gulbarga
G2 - PP. of amniocentesis

PAST MEDICAL HISTORY

K/O PWD

PAST SURGICAL HISTORY

No!

FAMILY HISTORY:

Nil

MEDICATION HISTORY:

see Medical
reconciliation form.

INITIAL ASSESSMENT :

Date <u>23/7/20</u> Ht. _____ Wt. _____ BMI _____ B.P. _____ Pallor _____ CVR _____ Respiratory System _____ Thyroid _____	Breasts (N) Abdominal Examination <u>soft non tender</u>	Local/Speculum Examination Bimanual Pelvic Examination
---	---	---

PROVISIONAL DIAGNOSIS :

G2A1 | 13 weeks | 01 conception for prophylactic
centage.

INVESTIGATIONS ORDERED

AB positive

17/6 CBP 12.1 | 10,430/3.08.

Vorab NR

TSH -1.25

PLAN OF MANAGEMENT

- Admission
- NBM
- IV fluids @ 150ml/hr
- PAC
- Prepare patient
- drugs as per charted
- pre-op medications
- shift to OT on call

Name of the Doctor :

Dr. Samir

Signature of Doctor



Date & Time :

23/7/20 2pm



Date & Time	Progress Notes	Doctor's Order
23/2/2018		
11:45 AM	PODO cerclage o/b ac-fai 12- 75gms BP- 112/70mmHg (18) 59g - 99g/mg P/A 10/11 unattended	Adv - NBM for 4hrs - vitals every 15min for 2hrs - f/b 2nd half - deeps as per charted - W/F active Bleeding PV - Encourage voiding - Inform R/S <i>[Signature]</i> Dr. Samir

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

SHRUTHI REDDY/DR. LAVAN



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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

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Patient St

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MEDICATION RECONCILIATION FORM

Drug Allergies: NEKA

☐ Not known any Drug Allergies

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

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

Shifting From: NA

Shifted to: NA

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Tab' FOLICACID		PO	OD	22/7	☐ C ☒ DC
2	Tab' SYSTENI	2mg	PO	OD	24/7	☐ C ☒ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Rameen

Date & Time : 23/7/26 @ 9am

Nurse Name & Signature : Swapne

Date & Time : 23/7/26 12pm

DRUG CHART

Date of Admission: 22/7/20 Drug Allergies: NKDA ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

REGULAR PRESCRIPTIONS

Weight. Ward. Obs

DRUG : TAB. PARALLETAMOL				Date Time
Dose	Route	Frequency	Start Date	
1gm	PO	BARLY	22/07	
Name & Signature of the Doctor Starting the Drugs:				
 DR. M. VINKEETHA				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

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

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

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

Weight. Ward. OBs

STAT / ONCE ONLY DRUGS[illegible]

Patient Sticker

I.V. FLUIDS CHART

Weight. Ward. OB

[illegible]

Signature

MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis:

G2H1 / Bt6wks / 01 concept for prophylactic cerclage.

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
23/6/26 8:45 AM	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	G2H1 / Bt6wks / 01 concept	for safe procedure	prophylactic cerclage	[Signature]	☐ Nursing ☐ Others:
23/6/26 1:20 PM	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	fear and anxiety	→ To reduce fear & anxiety	→ Provided psychol support	[Signature]	☐ Medical ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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Part - I,

Patient's / Learner Language : Patient / Learner Literacy : ☐ Read ☒ Write ☐ Sp

es ☐ No Healthcare Literacy : ☐ Yes ☐ No

Identified Education Needs :

- | | | | |
|----------------------------|--|--|---|
| 1. Diagnosis | 5. Medication / Terapy (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 Barries	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
28/10/20	9 AM	1,2,4	Diagnosis, Treatment & care plan, Informed consent	PT, S	1	0	1	1		
28/10	11 AM	4	Infection control measures	PT, S	1	0	1	1	0	

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 Barries 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 Barries 6. Desire / Motivate to Learn 9. Cultural Difference 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							

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OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 23/7/26		
Baseline Information:		
Admission From: ☐ ER ☐ OPD ☒ Admission Desk ☐ Others, specify		
Primary Language: ☐ Telugu ☐ English ☒ Hindi ☐ Others, specify		
Do you require an interpreter? ☐ Yes ☒ No if Yes specify		
Source of Information: ☒ Patient ☐ Family ☐ Others, specify		
Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: If yes, identify		
Chief Complaints: cerclage		Doctor Notified on Admission: ☒ Yes ☐ No
		Name of the Doctor: Dr. Sameena
		Time Notified: 8:20 AM
Past Medical History: Obtained From ☐ Patient ☐ Family Member ☐ Medical Record ☐ Other (specify)		
Past Medical History	Past Surgical History	Previous Hospital Admission
PCOD PCOD	nil	nil
Gynecology Assessment: ☐ Not Applicable	Gynecology Surgical History:	Gynecological History:
Menstrual History: Regular	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: 17/6/26	Myomectomy: ☒ No ☐ Yes	Infertility: ☐ No ☐ Yes
	Others:	If Yes Type: ☐ Primary ☐ Secondary
Obstetric History: G 6 P L A 1		
Previous LSCS:		
Current Medication: ☒ None ☐ Yes, If Yes, Fill the reconciliation form		
Family History: ☒ No Abnormalities Detected		
☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Stroke ☐ Seizures ☐ Kidney disease		
☐ Liver disease ☐ Other		
Vital Signs / Measurements:		
Temp: 98°F	HR: 90/min	RR: 18/min
BP: 102/60	Weight: 67.4 kg	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 Score0..... (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore: ☐ Yes ☐ No Score0..... (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

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 P. Singh & Family

Name of Person Orientation was given to: P. Singh

Orientation not given Reason:

Nurse Signature: P. Singh

Nurse Name: P. Singh

Date & Time: 22/12/26 2:40 PM

OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 23/12/2024 Time of Arrival: 8:40pm Time Seen by Nurse: 8:45pm

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: Cerclage

3) **Vital Signs:** Temperature: 98.1 Pulse: 80 RR: 20 SpO₂: 99% BP: 100/65 Weight:

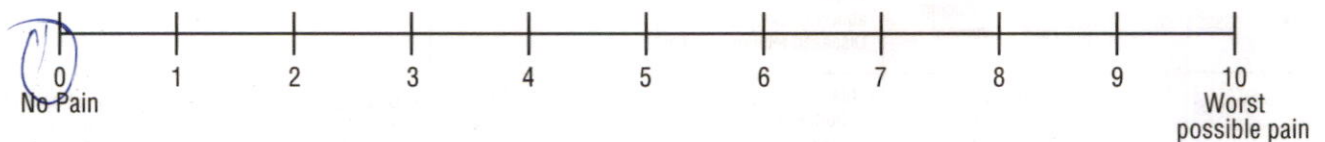
4) **Gestational Criteria:**

Gravida:	G ₂	P	L	A ₁
----------	----------------	---	---	----------------

LMP: 17/4/2024 EDD: 22/12/2024 Gestational Age: 13+6 weeks

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

6) **Past History:**

- a) Surgeries: 2014
- b) Medical: —

7) Allergy: ☐ Yes ☒ No, If Yes :

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

9) Prenatal Medical History:

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

Triage Category: (Please tick on the category)

Refer to **OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)**

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

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

Time seen by Doctor: Dr. Sameena

Nurse Name : Swapna Nurse Signature: [Signature]

Date: 23/12/2026 Time: 1pm

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Mrs TAMSILA KHANAM FARHI
24-02-1995 31 Y 4 M 29 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA



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RESULT SHEET

Date	12/1/26				
Time					
Hb	12.9				
PCV					
RBC					
WBC	10.430				
N/L					
Platelets	3.08				
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Blood group- AB ⁺ positiv						
HBV						
HBsAg						
HCV						
VDRL						

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :

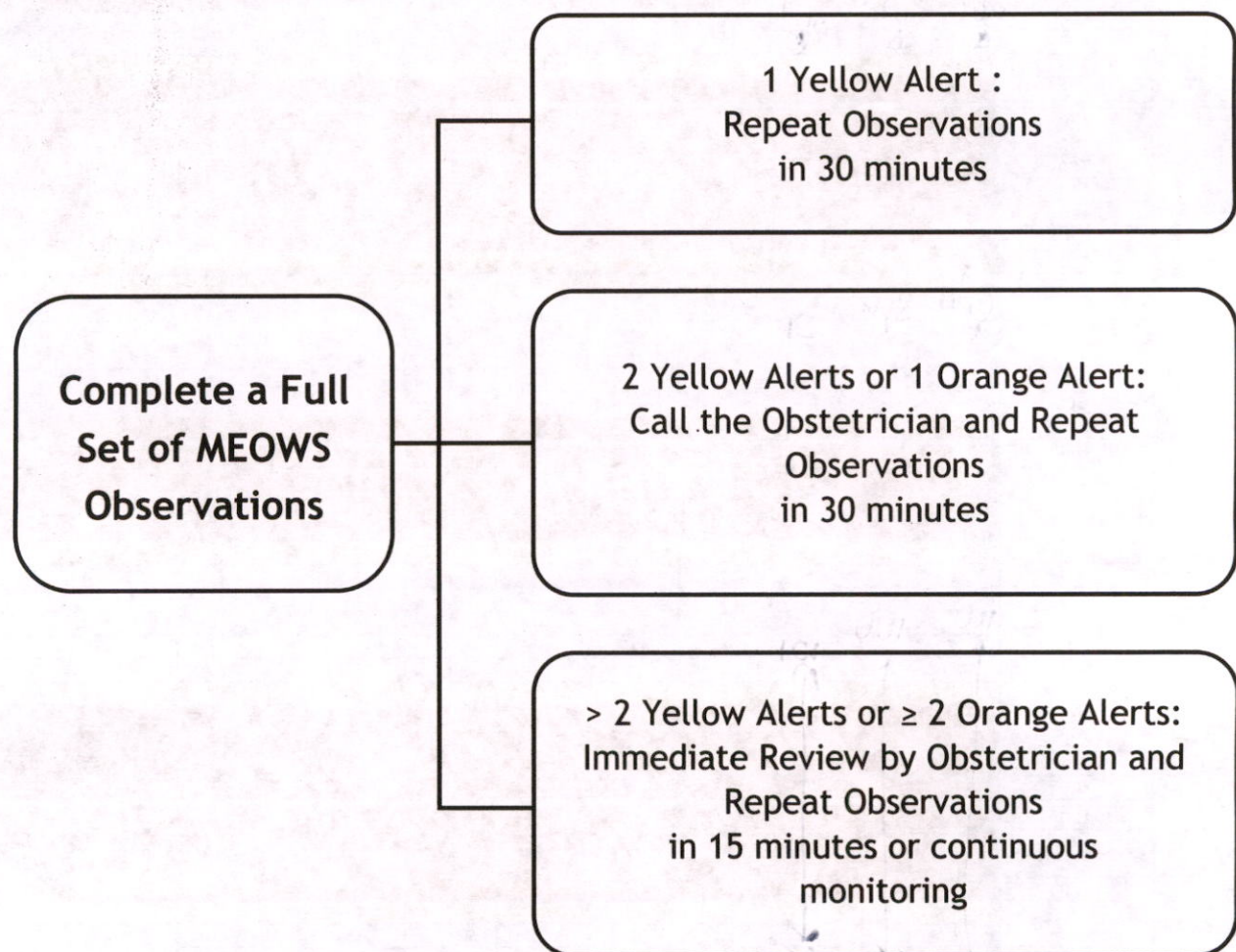


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CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

[illegible]

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

BAH-00654662 IP5-00176804
 Mrs TAMSILA KHANAM FARHI
 24-02-1993 31 Y 4 M 29 D (F)
 Dr. SHRUTHI REDDY/Dr. LAVANYA



FLUID CHART

Sheet No. : 08

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am										0	 Dr. Shruthi Reddy 22/1/20	
	09:00 am	RL		100ml						✓	0		
	10:00 am	RL		100ml						✓	0		
	11:00 am	RL		100ml							0		
	12:00 pm	RL		100ml							0		
	01:00 pm	RL		100ml							0		
Total Intake :						Total Output :						0-2 m - Ni.	
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
	Total Intake :						Total Output :						
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake													
Total 24 hrs. Output													

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NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 23/7/2026

Assessment: Patient complaint fear and anxiety

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	→ assess the patient condition	8:30am	→ assessed the patient condition	→ Patient is stable
9am	→ monitor vitals	9:10am	→ monitored vitals	
	→ ensure safety	11:10am	→ Provided side rails	
11am	→ administration of medication	12:30pm	→ medication given as per drug chart	
12pm	→ Ambulation	2pm	→ Ambulation done	
2pm	→ PRR monitoring	4pm	→ PRR. monitored	
3pm	→ I/O chart monitoring.	5pm	→ I/O chart monitored	

Re-Assessment: done pt stable

Special Notes: vitals monitoring PRR monitoring

Nurse Signature: [Signature] Nurse Name: Swapna Date & Time: 23/7/2026 2pm

Patient Sticker

NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

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

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

CHECKLIST FOR THROMBOPHLEBITIS

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

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 : W Name : Shruthi

Signature of Ward In Charge :

Signature : M Name : reena

Patient+ sticker

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PAIN ASSESSMENT FORM

Date	Time	Location	Activity	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
23/7	8am	0	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	§
23/7	12pm	0	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	§
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

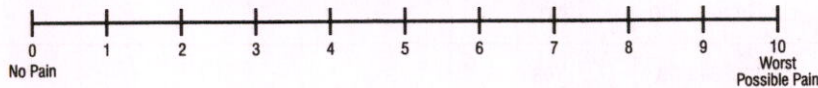
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 - a) At least every 2 hours for the first 24 hours
 - b) Then every 4 hours.
 - c) Prior to pain pain-relieving intervention.
 - d) Within 30 – 60 minutes after pain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

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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



Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	Score	Fall Risk Grading		
History of Falling (immediately or w/in 3 months)	Yes	25		Risk Level	Morse Fall Score (MFS)	Action
	No	0	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15		Low Risk	0 - 24	Standard Fall Precaution
	No	0	0			
Ambulatory Aid	Furniture	30		Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	Crutches, Cane(S), Walker	15				
	None /Bed Rest /Nurse Assist	0	0			
IV / Heparin Lock or Saline	Yes	20	20	High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	No	0				
GAIT / Transferring	Impaired	20		Signature	84	
	Weak (uses touch for balance)	10				
	Normal /On Bed Rest /Immobile	0	0			
Mental Status	Forgets limitations	15		Total Morse Fall Scale Score:	20	
	Oriented to own ability	0	0			

Tick (✓) whichever precaution taken.

Risk Level and Interventions

Low Risk (0 - 24) (Standard Falls Precautions)

- ☒ Ensure patients use their prescribed eye glasses if any, in the hospital
- ☒ Use chairs with arm rests
- ☐ Use safety straps on stretchers and wheelchairs while transporting patients

Moderate Risk (25-50) Apply all low risk intervention and

- ☐ Assist and/or supervise ambulation. Reinforce to always call for assistance
- ☐ Hourly safety check
- ☐ Assess patient after visitors, leave to ensure safety measures in place

High Risk (≥ 51) Apply all low and moderate risk interventions, and.

- ☐ Initiate constant observation by healthcare provider as appropriate to patient's needs

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BRADEN 'Q' SCALE

				Date : 23/7			
				Time : 8:20 PM			
Mobility	Does not make any changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	1		
"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 of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4		
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	
					Evaluator's Name	5	

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

Surgeon :

Dr. Shanthi Reddy

Asst. Surgeon :

Pre-Operative Diagnosis:

Q24 | 13th wks | 01 conception.

Surgical Procedure :

Mc Donald's cerclage

Indications for Surgery :

prophylactic cerclage

Date :

23/7/22

Start Time :

End Time :

Post Operative Diagnosis:

-Pr op medications

Peri-Operative Complications:

Operation Notes:

↓ SA, Patient put in lithotomy position

- Parts painted & draped

- Anterior & posterior vaginal wall retracted
 c. Sm's speculum

- Anterior ^{apertures} dip of max held c sponge body.

- Mc Donald's stitch put wrong
Marselline cap. Knot placed

- Patient ^{Anteriorly} withstood the procedure well.

Amount of Blood Loss:	Blood Transfused (in ML) <u>—</u>
Name and Number of Surgical Specimen sent for examination: <u>—</u>	
Peri-Operative Complications:	
Di: - NBM for 4hrs - w/ fluids @ 150ml/hr - drugs as per charted - w/ active Bleeding or Pain Abdomen - vitals every 15min for 1hr flb and lucy	
<u>Discharge</u> <u>admission</u>	
- Tab. Taxim - 0 20mg BD for 5 days - Tab. Parlop 40mg OD for 5 days - Cap. Suster 40mg P/V OD till further order - Hy. Protion 100mg IM mee weekly till further order	

Name of the Surgeon: Dr. Lunese

Signature of the Surgeon: Ru

Date & Time: 23/3/20 @ 12pm

Patient Stic

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POST-SURGICAL CARE PLAN FORM

Procedure Done:

McDonald's anastomosis

Post-Surgical Diagnosis:

G2A1 / 13+6wks / 01 concept / per day output

Post-Operative Monitoring Parameters /Frequency:

- NBM vitals every 15 min for 1st 24 hours

Wound Care:

-

Drain /Special Lines/Catheters:

IV line @

Special Patient Positioning and Requirements:

Nutritional Instructions:

NBM for 24 hrs

When to Start Mobilization:

After 24 hrs

Special Referrals:

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

☐ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

Treating Surgeon
(Signature & Stamp)

Date: 23/2/20 Time: 12pm

Note: Plan of care will be readjusted if necessary.

Patient Sticker

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 23/7/26

Department : OB/GYN Duration of Procedure : 1/2 hr

Name of Surgeon : Dr. Smrithi Reddy Date of Admission :

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

		Staff Signature
1.	Antibiotic given prior to surgery ? ☒ Yes ☐ No ☐ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☒ Yes ☐ No Name of the Antibiotic : <u>Suf. cefotaxim</u>	Dr. Ravi
2.	Hair Removal ☒ Yes ☐ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☐ Operating Room ☐ Other : <u>OR</u> Skin preparation done (cleanse surgical area with antiseptic agent) ? ☒ Yes ☐ No	Dr. Ravi
3.	Patient's body temperature immediately post operation (Recovery Room) <u>36.2</u> °C ☐ Oral Or ☐ Axilla (Goal : 36-37 °C)	Dr. Ravi
4.	Name of doctor or staff administering the antibiotic : <u>Dr. Sritha</u> Date & Time of antibiotic administration : <u>23/7/26 @ 9:20am</u> Date & Time procedure started : <u>23/7/26 @ 11:00 am to 11:30 am</u>	Dr. Ravi

- 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-00654662 IP5-00176804 Mrs TAMSILA KHANAM FARHI 24-02-1995 31 Y 4 M 29 D (F) Dr. SHRUTHI REDDY/Dr. LAVANYA 		Date & Time of Admission 23/7/26 @	Date & Time of Transfer Order 23/7/26 @ 11:40 AM
		Transfer Ordered by Dr. Vineetha	Reason for Transfer For post- of observation
From Unit OBG	To Unit OBG	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 20	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 Nil			
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. Reddy		Name of Person Ordered Transfer Dr. Vineetha	
Patient & Clinical Records Received by :			
Date & Time of Patient Received :			

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

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

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Smita
Asst. Surgeon : Dr. Vinay
Anaesthetist : Dr. Vinay
Scrub Nurse : Raj Choudhary

Patient Name : BAH-00654662 IP5-00176804
Mrs TAMSILA KHANAM FARHI
UHID No. : 24-02-1995 31 Y 4 M 29 D (F)
Date : Dr. SHRUTHI REDDY/Dr. LAVANYA


Gender :
time : 11:30 AM

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Before Induction of Anaesthesia ➤ ➤

SIGN IN		Time: <u>10:32 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. M. Vinay</u>		
Name : <u>DR. M. VINAY</u>		

Before Skin Incision ➤ ➤

TIME OUT		Time: <u>10:35 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>Dr. Smita</u>		
Name : <u>Dr. Smita</u>		

Before Patient Leaves Operating Room

SIGN OUT		Time: <u>11:40 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. Smita</u>		
Name : <u>Dr. Smita</u>		

SURGICAL SAFETY CHECKLIST

Surgeon :
Asst. Surgeon :
Anaesthetist :
Scrub Nurse :

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



Before Induction of Anaesthesia ➤ ➤

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

Before Skin Incision ➤ ➤

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

Before Patient Leaves Operating Room

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

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

BAH-00654662 IP5-00176804
Mrs TAMSILA KHANAM FARHI
24-02-1993 31 Y 4 M 29 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA


BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient Name : Tamsila Khanam Gender: ☐ Male ☒ Female Age : 31

UHID No : BAH-00654662 Date : 23/7/2026

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)

CERVICAL CIRCUMCISION

upon

TAMSILA KHANAM (Name of Patient)

I have been advised of the benefits and reason of the procedure(s) as indicated by the clinical observations and / or diagnostics performed. I recognized that the practice of medicine is as much an art as a science and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcomes. My questions regarding the condition, the proposed surgery and the outcome have been answered to my satisfaction prior to signing this form by the surgeon.

I have been explained the risks of this surgery / procedure and also about the reasonable alternative and the relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment.

I have been explained that the following complications though rare are possible and will not hold Surgeon, Anesthesiologist or the hospital staff responsible for any untoward event thereof.

Hemorrhage. Scar. Injury to Bone & Bladder. Injury to major blood vessels. Need for blood & blood products. need for prolonged Hospital stay

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. Shmitha Reddy

Consentee :

Signature : [Signature]

Name : Tamsila

Date & Time : 23/7/2026 @ 9am

Witness :

Signature : [Signature]

Name : Lavanya

Date & Time : 23/7/2026 @ 9am

Patient Attendant :

Signature : [Signature]

Name : Shruthi Reddy

Relationship with Patient : Husband

Date & Time : 23/7/2026 @ 9am

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Shmitha Reddy

Date & Time : 23/7/2026 @ 9am

CONSENT FOR ANAESTHESIA

Authorization By: ☒ Patient ☐ Patient Attendant

Operative Procedure: Cervical Encircilage

Anaesthesiologist: Dr. Sundhara Surgeon: Dr. Shanthi

Please read this before you consent for Anaesthesia

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

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

- ☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders
☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease
☐ Others: Hypotension

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: [Signature]
Name: Tamsila Khanam Farhi
Relationship with patient: Self
Date & Time: 23/7/26, 9:30 AM

Witness:

Signature: [Signature]
Name: Abdul Hanif
Date & Time: 23/7/26, 9:30 AM
Husband

Doctor (who is taking consent):

Signature: [Signature] Name: Dr. Sundhara Date: 23/7/26 Time: 9:30 AM

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అబెండెంట్

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 తెలుసుకోదు, నొప్పి అనుభవించదు. దీనిని శిరస్రావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు. రీజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి పీక్ లోకల్ అనస్థీషియా లేదా నార్మల్ టెక్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై రిస్క్:

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

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

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

☐ ఇతరవి:

రోగి / రోగి అబెండెంట్

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

రోగి / రోగి అబెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

BAH-00654662 IP5-00176804
Mrs TAMSILA KHANAM FARHI
24-02-1993 31 Y 4 M 29 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: Tamsila Khanam Age: 31y Sex: F UHID.No :
Date: 23/7/26 Time: 9:30 Am Proposed Operation: Cervical Electrodage
Diagnosis: G2A1-13 wks, 02 conception & Short Cervix
B.P / CRT: H.R: Weight: 64kg ASA Physical Status: ☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

17/6 Hgb: 12-9 Glucose: Protein: HIV: X-Ray:
PCV: Urea: Alb: HBS Ag: 1 NR ECG:
WBC: 10430 Creat: Total Bill: HCV: Agene 2D Echo:
Plate: 3.08 Na: Dir. Bill: Blood group: Stress/Angle:
PT: K: LDH: T3 Other:
PTT: Ca++: Alk phos: T4
INR: Mg++: Amylase: TSH
Cl -: SGOT/SGPT:

Allergies: —

Medical History: CVS:

RESP: Mouth breathing & Snoring Diabetes: —

CNS: 20 SA

Renal: NAD

Hepatic / GE: Physical Activity: Active

Others:

Past Anaesthetic History:

Physical Exam: —

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

Lungs: clear

Heart: Sub

CNS: NAD

Pregnant: ☒ Yes ☐ No ☐ NA Venous Access Site: (P) Spine Exam for regional: (N)

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

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

CURRENT MEDICATIONS	DOSAGE
<u>/</u>	<u>/</u>
<u>/</u>	<u>/</u>
<u>/</u>	<u>/</u>
<u>/</u>	<u>/</u>

Pre-Operative Instructions:

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

Signature: Sundhar Name: Dr Sundhar

Patient Sticker

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Time Received : Time Discharged :

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 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 : ☐ 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:
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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					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						
Dyspnea or limited breathing	= 1							
Apneic	= 0							
BP $\pm$ 20 of Pre Anaesthetic leve	= 2	CIRCULATION						
BP $\pm$ 20-50 of Pre Anaesthetic leve	= 1							
BP $\pm$ 50 of Pre Anaesthetic leve	= 0							
Fully awake	= 2	CONSCIOUSNESS						
Arousable on calling	= 1							
Not responding	= 0							
Pink	= 2	COLOR						
Pale, dusky, blotchy, jaundiced, other	= 1							
Cyanotic	= 0							
TOTAL								

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature

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

Anaesthesiologist Name :

Anaesthesiologist Signature:

Date & Time:

PACU Nurse Name :

PACU Nurse Signature:

Date & Time:

Reassessment Frequency:

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

Transferred to Unit by (PACU):

Date & Time:

Patient Sticker

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 :

BAH-00654662 IP5-00176804
Mrs TAMSILA KHANAM FARHI
24-02-1993 31 Y 4 M 29 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA

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Your Right to a Safe Delivery

DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: 23/11/2026

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

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

☐ Needs Assistance In:

Remarks

☐ Medication ☐ Yes ☐ No

☐ Bathing ☐ Yes ☐ No

☐ Eating ☐ Yes ☐ No

☐ Walking ☐ Yes ☐ No

☐ Dressing ☐ Yes ☐ No

☐ Toileting ☐ Yes ☐ No

no need assistance

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: Personal hygiene

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

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: Swapna

Date and Time: 23/11/2026 9 AM