

BAH-00525134 IP5-00175850
Mrs MEGHA AGARWAL
30-11-1993 32 Y 7 M 2 D (F)
Dr. HIMABINDU VEERLA



SURGERY DETAILS

Date : 21/12/26

Patient Name: Mrs. megha agarwal Date of Birth: 30/11/1993 Age: 32 yrs

Gender: F Ward : UHID No: BAH-00525134

Date of Surgery: 21/12/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☒ OBG OT-2

Name of the Surgery : Elective Ls & Spliel LSA

Time in : 8.40 AM

Time Out : 8.40 AM

	NAME	AMOUNT
1. Surgeon	Dr. Himabindu	
2. Anaesthetist	Dr. Aditi	
3. Assistant Surgeon	Dr. Bhargava	
4. OT Technician	Sis. Gauthami	
5. Circulating Nurse	Sis. Priya	
6. Assistant Nurse	Sis. Rajashwari Sis. Srilatha	

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

Signature of the Surgeon (Dr. Himabindu)

Signature of Circulating Nurse

Order No: 9684109

Order by: [Signature]

CONSUMABLES OF OT

Circulating staff : Technician : Date : **3682** Time :

Anaesthesia Disposables		Qty	Surgical Disposables		Qty	Disposables (Baby Side)		Qty
Issued	Used		Issued	Used		Issued	Used	
ET tube			Major Pack LSCS	✓	01	Inj Vit.K	✓	02
LMA			Sutures 2346	✓	01	Cord Clamp	✓	01
ECG leads : A / P / N	✓	3	2364	✓	01	Suction Catheter 89	✓	01
HME filter : A / P / N			2762	✓	01	Feeding Tube	✓	
Syringes : 10 cc	✓	3		✓		Vaccum Suction Set	✓	01
05 cc	✓	3	Gloves 7/642	✓	213	Surgical Gloves 7/642	✓	1+1
02 cc	✓	3		✓		Gauze Pack N	✓	01
01 cc			PF 7	✓	01	Syringe 1ml / 2ml	✓	02
Cautery plate : A / P / N	✓	1	Surgical blade 22	✓	02	Surgical Blade # 20	✓	02
IV set	✓	1	NG tube	✓		Koochies (S) M'S	✓	01
RL	✓	24	Cautery pencil	✓	01	Sup-Heparin	✓	01
NS : 10ml / 100ml / 500ml / 1000ml	✓	1	Koochies XL	✓	01	Underpad	✓	01
mini pice	✓	0	Ointments			02 mask	✓	0
box 2	✓	0	Suction Catheter			10 Hottle	✓	
Fentanyl	✓	1	Cap, Mask			03	✓	
Morphine			Gauze Pack R	✓	03	9685971	✓	
Ketamine			Mop Pack	✓	03			
Propofol			Steristrip sterizone	✓	01			
Rocuronium			Underpad	✓	01			
Glycopyrolate	✓	1	Draw sheet oneck suite	✓	01			
Myopyrolate			Abgel					
Ondansetron	✓	1	Foleys catheter					
Pencan 25g/ Spinal Needle 22	✓	1	Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)	✓	1	Romodrain bag					
Antibiotics			Bandage					
Oxytocine	✓	3	Tegaderm			P.C	✓	
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set	✓	01			
Justin : 12.5 mg / 25mg / 100mg	✓	1	Plastic Bed Sheet					
Tab. Misoprost : 200mg	✓	2	Betadine Solution	✓	02			
Adrenaline	✓	1	Microshield	✓	00			
Atropine	✓	1	Cotton Balls	✓	01			
Ephedrine	✓	1	Latex Gloves	✓	20			
Glove (6.0)	✓	2	Ramdone Scrub					
Manexa	✓	2	Sara	✓	02			

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. : **9685954**Ordered by : **8.2.2.2**

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

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HIMABINDU VEERLA



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POST – PARTUM ASSESSMENT FORM – IN-PATIENT

Date: 8/7/26

Chief Complaint: pain at suture site.

Obstetric/ Birthing History: G2 P1 L1, EL - LSCS, P0D2

Previous Surgical/Medical History: -

Assessment :

On Observation: Mother seen in lying down /sitting/ reclined position ✓

Mother is active & alert / drowsy / tired or exhausted / mobile by herself & ambulatory / needs assistance with mobility ✓

Iv line + / - ✓

Catheter + / - ✓

Postural alignment ✓

On Palpation : Edema – absent / up to ankle / up to knee/ above knee ✓

On Examination : Breathing pattern – abdominal/ apical/ diaphragmatic ✓

Diastasis recti abdominis – present / absent / could not be assessed ✓

Able to initiate Pelvic Floor Activation – ☒ Yes ☐ No

Spl Notes -

Treatment Plan :

☒ Lateral Breathing

☒ Pelvic Floor Activation

☒ Transversus Abdominis Activation

☒ Gluteus Activation

☒ Active Motion for Limbs

☒ Transfer Training & Mobility

☒ Sit to Stand

☒ Monitored Walk

☒ Posture & Ergonomic Education

Signature: [Signature]

Name: Dr. Rheena Sharma (PT)

Date & Time: 8/7/26, 4:30 PM

ADMISSION SHEET

Registration Details :


Admission No : IP5-00175850 Admit Date : 02-Jul-2026 Admit Time : 02:11 AM UHID : BAH-00525134

Patient Details :

Patient Name	: Mrs MEGHA AGARWAL	Age	: 32 Y 7 M 2 D
Guardian	: MR YASH AGARWAL	DOB	: 30-11-1993
Gender	: Female	Religion	:
Occupation	:	Martial Status	: Married
Address (H)	: VILLA NO 129,SUNRISE VALLEY VILALLAS Attapur Hyderabad Telangana INDIA 500048	Phone No	: 9909506666/ 9550106666
		E-mail	: MEGHA30.AGARWAL@GMAIL.COM

Admission Details :

Bed Type	: SUITE	Bed No	: SUITE 5 (425)	Ward Name	: 4F-BIRTHRIGHT PREMIUM
Room No	: SUITE 5 (425)	Admission Type	: First Visit		

Contact Details :

Name	: MR YASH AGARWAL	Relationship	: Husband
Contact Address	: VILLA NO 129,SUNRISE VALLEY VILALLAS Attapur Hyderabad Telangana INDIA 500048	Phone No	: 9909506666


Signature

Doctor Details :

Doctor Name	: Dr. HIMABINDU VEERLA	Specialisation	: OBSTETRICS AND GYNECOLOGY
Referral Doctor	: Self	Phone No	:
Co-Consultant	:		

Payment Details :

Payment Mode	: Cash	Deposit Amount	: 0.00
		Payor Name	: SELF PAY

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ Consultant: _____ Dept : _____

Date of Admissi _____ Date of Discharge : _____ Time: _____

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

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WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
21/7/26	4 AM	Suite-5	OBG-07	[Signature]
21/7/26	9 AM	OBG-07	Suite-5	[Signature] / priya

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Tuhena	3/6/26	9685940	[Signature]
2	NEHA	3/6/26	9685939	[Signature]
3	Dr. Brundavanē	2/6/26	9685940	[Signature]
4	Dr. Sheyer	2/6/26	9685940	[Signature]
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

[illegible]

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
2/7/26	IV placement	01	9685946	polya
2/7/26	PAC	01	9685947	poly
2/7/26	Catheterization	01	9685946	polya

ANY OTHER INFORMATION

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.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



Suite-5

NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 3/2/26

Time: 9am

Origin: Indian

Height: 166 cms

Weight: 76.3 kgs

BMI: 27.7 kg/m²

Food Allergies: No

Diagnosis: P00 -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 food

Patient's / Attendant's

Signature:

Name:

Megha

Date & Time:

3/2/26, 9am

Dietician's

Signature:

Name:

Nikitha

Date & Time:

3/2/26, 9am

DIETARY NOTES[illegible]

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IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

for Flies

Obstetric Formula:

G₂P₁L₄

Obstetric History:

1- Sp conception, Flies, god. 2.12.19
(Fem) B.M.

Present Pregnancy Record:

2- Sp conception booked at
14 wks.

RISK FACTORS:

1 p_{re}u l_{es}

Height: 166 cm

Weight: 76.3 kg

Allergies: Nil

Breast: ☒ Normal ☐ Abnormal

General Examination:

Consciousness: Conscious Pallor: ☒

Icterus: absent Edema: absent

Temp: 100.4 PR: 82/min

BP: 119/72 mmHg DTR: ☒

CVS: S₁S₂ (+) RS: B₂S₂ (+)

Liver/Spleen: not palpable Urine Output: adequate

DIAGNOSIS

G₂P₁L₄ 38⁺4 wks. 1 p_{re}u l_{es} for Flies.

LMP: 05/11/20

EDD: 05/10/25

Corrected EDD: 12/11/20

GA: 38⁺4

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 Fifths Palpable:

FHS: ☒ Normal ☐ Tachy ☐ Brady ☐ Absent

Per Speculum Examination

not indicated

Draining: ☐ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination

not indicated

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

SpO₂ - 99% on RA

BAH-00525134

IP5-00175850

Mrs MEGHA AGARWAL

30-11-1993

32 Y 7 M 2 D

(F)

Dr. HIMABINDU VEERLA



Family History:

Father - HIN.

Surgical History:

LCS - 2022

Medical History:

Nil.

Medication History:

T. Iron
T. Mucal.

Plan of Care:

Admission, NH.
Informed consent
PAC
Prep of parts.
Check blood availability
Vitals & FHR Monitor.
Send or on call.

Investigations:

BONE
urals - NH.

13/6/22, 35th / 2.5kg 2w.
AC - 9% / AFI - 10.4 / PL-post / 10/
Lopple (N)

Doctor Name:

Dr. Ananya

Signature:

[Signature]

Date & Time:

27/22, 6AM

Consultant Name:

Dr. Himabindu

Signature:

[Signature]

Date & Time:

27/22, 6AM

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>2/1/2026</u>	<u>POD-1 / Elective VCE / P2K2</u>	<u>Advice:</u>
<u>9:30AM</u>	Comfortable Gastric AF	✓ NBM for 4-5 hours
<u>Baby well</u>	Vitals - BP - 100/62 (40)	✓ Drugs as charted
<u>V/O - 150ml</u>	PR - 82 bpm	✓ V/O monitoring
<u>clean</u>	SpO ₂ - 100% on RA	✓ Mobilization
<u>(emptied at 9AM)</u>	P/A - Vessels Retracted well	✓ Monitor vitals
	soft	✓ w/o excessive Bleeding
	VVE - Minimal Bleeding ⊕	✓ Inform SDC
		By (Dr Deepika)
<u>2/1/2026</u>	<u>POD-1 / Elective VCE / P2K2</u>	<u>Advice</u>
<u>1:30PM</u>	Comfortable	✓ Allow sips of water x 2pm
<u>Baby well</u>	Gastric / Abdominal	✓ followed by liquid diet
<u>V/O - 200ml (12pm emptied)</u>	Vitals - BP - 101/69 (80)	✓ soft diet x 6 PM
	PR - 86 bpm	✓ Mobilization
	SpO ₂ - 100% on RA	✓ Monitor vitals
<u>Now - 100ml clean</u>	P/A - Vessels Retracted well	✓ w/o excessive Bleeding
	soft Bowel sounds ⊕	✓ V/O monitoring
	VVE - Minimal Bleeding ⊕	✓ Inform SDC
		By (Dr Deepika)



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/12/26	POD 1 ELUSIS	Adv
4pm	A comfortable	- soft duct, from plenty of milk - dugs as
	PR 82 bpm	pro charted
	BP - 100/80 mmHg (MAP 60)	- vitals uterine
10-500ml	SpO ₂ - 98% on RA	- 1/2 charting
(clear)	PIA uterus	- soft active
Babym	retracted	Bleeding IV
	new BS@	- Infants not
	4/5 - Bleeding m	
	- Remax Foley's @ 6am on 3/12/26	
	Noted by Pijja 607191	Dr. Samir
3/12/26	I-POD	Adv
7:50am	10-100ml	- soft duct
	every four	- Auscultate
	vitals - stable	- Plenty of liquor
	PIA cut @ 100	- stable
	1/2	charting
	PIA - 100	
	voided	
	Rashy - 10	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/12/26 10:15 AM	8/8. Dr. Himabindu Pt. - Comfortable Ambulating Passed urine & flatus PA - Soft - BS + Wound involuting PU - Lochia healthy	① Soft diet & plenty of oral fluids ② Remove - IV. Cannula
3/12/26 1:00 PM	POD-1 Pt is stable No c/o BP - 100/72 [80] PR - 90bpm SpO ₂ - 100% on RA P/A - UT well retracted. c/o - BOUND.	Admission: ① Soft diet. ② Hydrate & ambulate ③ Drugs as charted ④ Monitor vitals & WBC ⑤ W/B heavy bleeding ⑥ Keep rest
3/12/26		Soft



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7/26 4pm	POD-1. - Pt is stable. - Vitals stable. - P/A - VT well tolerated - U/L - BUN 12 Cochran (+); healthy	Adm Continue Same treatment
UV		
FV		
SV		
		Smiles
4/7/26 9:45 AM	POD-2 Pt is stable Mo c/o BP - 100/71 [86] PR - 90 bpm. SpO₂ - 98% on RA P/A - vt well tolerated Deeply dry intact U/L - Cochran (+); healthy	Adm 1) Soft diet 2) Hydrate & ambulate 3) Drugs as charted 4) Vitals qth wly 5) W/P heavy bleeding 6) Tylenol qos Can be discharged Smiles
UV		
FV		
SV		



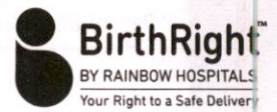
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/1/26 10 AM	s/p. Dr. Hema Bhandari pt - Comfortable. Ambulating passed flange PA - Soft Wound dressing PV - Lochia healthy	① No diet ② Handu (Dr. Hema Bhandari)



P

[illegible]



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Weight Ward

Daily Doctor's Endorsement by a Sign

Daily Doctor's Endorsement by a Sign

Daily Doctor's Endorsement by a Sign

Daily Doctor's Endorsement by a Sign

VERIFIED BY : Name

VERIFIED

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																				

Signature
VERIFIED BY : Name

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DRUG CHART

Date of Admission: 2/7/20 Drug Allergies: NA ☒ 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:																			

VERIFIED BY : Name _____



REGULAR PRESCRIPTIONS

Weight. Ward.

VERIFIED

VERIFIED

VERIFIED

VERIFIED

DRUG: <u>1g Cefotaxime</u>				Date Time	2/7	3/7														
Dose	Route	Frequency	Start Date	2/7	3/7	4/7														
1g	IV	BD	2/7	6 AM	6 PM	6 PM														
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Anshu Kumar</u>				6 PM Cong Stop Additional Instructions: (Dr. Anshu Kumar)																
Daily Doctor's Endorsement by a Sign				1 2																
DRUG: <u>T. PARACETAMOL</u>				Date Time	2/7	3/7	4/7													
Dose	Route	Frequency	Start Date	2/7	3/7	4/7														
1g	P/O	QID	2/7	12 AM	6 AM	12 PM														
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Sunanda</u>				6 AM 12 PM 6 PM Additional Instructions:																
Daily Doctor's Endorsement by a Sign				1 2																
DRUG: <u>T. TRAMADOL</u>				Date Time	2/7	3/7	4/7													
Dose	Route	Frequency	Start Date	2/7	3/7	4/7														
100mg	P/O	TID	2/7	12 AM	6 AM	12 PM														
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Sunanda</u>				8 AM 12 PM 6 PM Additional Instructions:																
Daily Doctor's Endorsement by a Sign				1 2																
DRUG: <u>T. DICLOFENAC</u>				Date Time	2/7	3/7	4/7													
Dose	Route	Frequency	Start Date	2/7	3/7	4/7														
50mg	P/O	TID	2/7	4 AM	12 PM	6 PM														
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Sunanda</u>				3 PM 12 PM 6 PM Additional Instructions:																
Daily Doctor's Endorsement by a Sign				1 2																



Date
Time

Nurse Sig.

Nurse Sig.

Nurse Sig.

Nurse Sig.

DRUG :

Route

Start Date

Name & Signature of the Doctor

Additional Instructions:

Dose

Dr. Sign.

Dose

Dr. Sign.

Dose

Dr. Sign.

Dose

Dr. Sign.

Dose

Dr. Sign.

Dose

Dr. Sign.

Dose

Dr. Sign.

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Dr. Sign.

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Dr. Sign.

Dose

Dr. Sign.

Dose

Dr. Sign.

Dose

Dr. Sign.

Dose

Dr. Sign.

Dose

Dr. Sign.

Dose

Dr. Sign.

Dose

Dr. Sign.

VARIABLE DOSE

Date
Time

Nurse Sig.

Nurse Sig.

Nurse Sig.

Nurse Sig.

DRUG :

Route

Start Date

Name & Signature of the Doctor

Additional Instructions:

Dose

Dr. Sign.

Dose

Dr. Sign.

Dose

Dr. Sign.

Dose

Dr. Sign.

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Dr. Sign.

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Dr. Sign.

Dose

Dr. Sign.

Dose

Dr. Sign.

Dose

Dr. Sign.

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
21/7/26	6:30 AM	Tij PANTOP	40mg	IV	[Signature]	Priya Sudha
21/7/26	6:35 AM	Tij PERINDOM	10mg	IV	[Signature]	Priya Sudha
21/7/26	3 AM	Tij PARACETAMOL	1gm	IV	[Signature]	Priya Sudha
21/7	8:30 AM	TRAMADOL	100 mg	P/R	[Signature]	Sona Laxmi
21/7	8:30 AM	DICLOFENAC	100 mg	P/R	[Signature]	Sona Laxmi
21/7	7:45 AM	INT. TRANEXAMIC ACID	1g	IV	[Signature]	Sona Laxmi
21/7	7:50 AM	INT. OXYTOCIN	3IU	IV	[Signature]	Sona Laxmi
21/7	12:30 PM	INT. PARACETAMOL	1gram	IV	[Signature]	Sona Swapna



I.V. FLUIDS CHART

Weight. Ward.

Date	Time	Composition of I.V. Fluid (If infusion, mention ml/hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
2/7	7 Am	RINGER LACTATE	IV	150 ml/hr	S	priga Suresh	2/7	S	priga Suresh
2/7	7 ⁴⁵ Am	RINGER LACTATE	IV	500 ml/hr	S	song prema	2/7	L	song Suresh
2/7/26	9 Am	RINGER LACTATE. IV 250ml			Andu	song prema	2/7	V	song Suresh
2/7/26	11 Am	RINGER LACTATE. IV 250ml			Andu	song prema	2/7	V	song Suresh
2/7/26	1 PM	RINGER LACTATE. IV 150ml			Andu	song prema	2/7	V	song Suresh
2/7/26	4 PM	RINGER LACTATE. IV 150ml			Andu	song prema	2/7	V	song Suresh
2/7/26	6:30 PM	RINGER LACTATE	IV	100ml/hr	Ey	priga Suresh	2/7	V	

Signature

VERIFIED BY : Name

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Mrs MEGHA AGARWAL
30-11-1993 32 Y 7 M 2 D (F)
Dr. HIMABINDU VEERLA



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MEDICATION RECONCILIATION FORM

Drug Allergies:

☒ Not known any Drug Allergies

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

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

Shifting From:

Shifted to:

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T. Iron	1 tab	PO	BD		☐ C ☒ DC
2	T. Skeletal	1 tab	PO	BD		☐ C ☒ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature :

Dr. Ashu

& Time :

2/7/2020 6 AM

Name & Signature:

Priya

Time :

2/7/2020 6 AM

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

134
MEGHA AGARWAL
30-11-1993 32 Y 7 M 2 D
Dr. HIMABINDU VEERLA (F)
IP5-00175850

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	6 AM	6 AM	Informed consent	PT	1	0	1	1		
2/7/20	6 AM	1.7	Infection control measure	01	1	0	1	1		Page
3/7/20	9 AM	9	Lactation diet	PT	1	0	1	1		W/Write

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:	<table border="0"> <tr> <td>1. No Learning Barriers</td> <td>4. Language Barrier</td> <td>7. Impaired Thought Process/Cognitive limitations</td> <td>10. Financial Difficulties</td> <td>13. Cultural/Religion Practice</td> </tr> <tr> <td>2. Physical Impairment</td> <td>5. Educational Level</td> <td>8. Responsibilities at Home</td> <td>11. Beliefs and Values</td> <td>14. Others (Specify)</td> </tr> <tr> <td>3. Emotional Barriers</td> <td>6. Desire / Motivate to Learn</td> <td>9. Cultural Differences</td> <td>12. Impaired Vision/ or Hearing</td> <td></td> </tr> </table>								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	
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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:	<table border="0"> <tr> <td>1. None</td> <td>3. Reassurance & Support</td> <td>5. Respect values & beliefs</td> <td>7. Other, Specify</td> </tr> <tr> <td>2. Obtain translator</td> <td>4. Teach Family / Others</td> <td>6. Respect Cultural / Religion Preference</td> <td></td> </tr> </table>								1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify	2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference								
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Understanding:	<table border="0"> <tr> <td>1. Verbalizes Understanding</td> <td>2. Demonstrates Understanding</td> <td>3. Needs Review</td> </tr> </table>								1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review												
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Mrs MEGHA AGARWAL

30-11-1993 32 Y 7 M 2 D (F)

Dr. HIMABINDU VEERLA



MULTI-DISCIPLINARY PLAN OF CARE FORM

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Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
2/7/20	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	For Flies	safe delivery	Flies	L	☐ Nursing ☐ Others:
2A	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	→ patient is having fear & anxiety	→ to reduce fear & anxiety	→ Psychological support dose given.	SH	☐ Medical ☐ Others:
3/7/20 9am	☐ Medical ☐ Nursing ☒ Others: dietitian	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	POD - 1 LSCS	soft diet	soft high protein diet	Nibittu	☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

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RESULT SHEET

Date	11/7/26					
Time	2:10 PM					
Hb	10.9					
PCV	33.1					
RBC	3.80					
WBC	11.8					
N/L						
Platelets	315					
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						

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BSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 21/7/26

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: Come for 1st LSCS Doctor Notified on Admission: ☒ Yes ☐ No
Name of the Doctor: Dr. Arshya
Time Notified:

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Nil	previous 1 LSCS	previous 1 LSCS
Gynecology Assessment: ☐ Not Applicable Menstrual History: Onset of Menarche: Menstrual Cycle: ☒ Regular ☐ Irregular Last Menstrual Period:	Gynecology Surgical History: Caesarean Section: ☐ No ☒ Yes Cervical Cerclage: ☒ No ☐ Yes Ectopic Pregnancy: ☒ No ☐ Yes Myomectomy: ☒ No ☐ Yes Others:	Gynecological History: Contraceptives: ☒ No ☐ Yes Vaginal Discharge: ☒ No ☐ Yes Post-Coital Bleeding: ☐ No ☒ Yes Infertility: ☒ No ☐ Yes If Yes Type: ☐ Primary ☐ Secondary

Obstetric History: G 2 P 1 L 1 A

Previous LSCS: 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: 97.6° HR: 89 bpm RR: 19
BP: 109/72 (G.S) 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 35 (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore: ☒ Yes ☐ No Score 28 (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: Patient - Attends

Orientation not given Reason: Nil

Nurse Signature: [Signature]

Nurse Name: [Name]

Date & Time: 21/12/2026 2 AM



OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 2/7/25 Time of Arrival: 12:35 PM Time Seen by Nurse: 1:40 PM

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

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

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

3) **Vital Signs:** Temperature: 98.4 Pulse: 88 RR: 18 SpO₂: 100% BP: 112/70 Weight: 58 kg

4) **Gestational Criteria:**

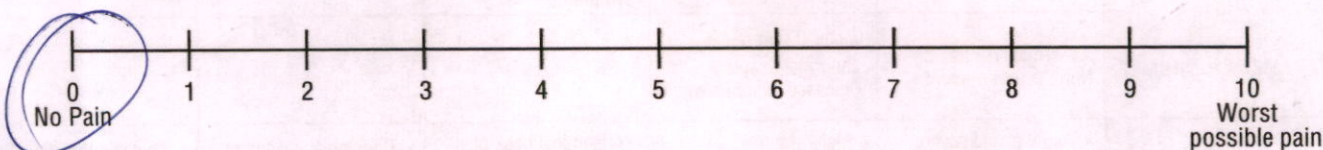
Gravida:	G <u>2</u>	P	L	A
----------	------------	---	---	---

LMP: 5/10/24 EDD: 12/7/25 Gestational Age: 28+4

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: GOVA
- Frequency:
- Interventions:

6) **Past History:**

- a) Surgeries: CS
- b) Medical: HTL



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

Time seen by Doctor: 12:00 PM

Nurse Name: Nurse Signature: Pray

Date: 2/2/26 Time: 2 am

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30-11-1993

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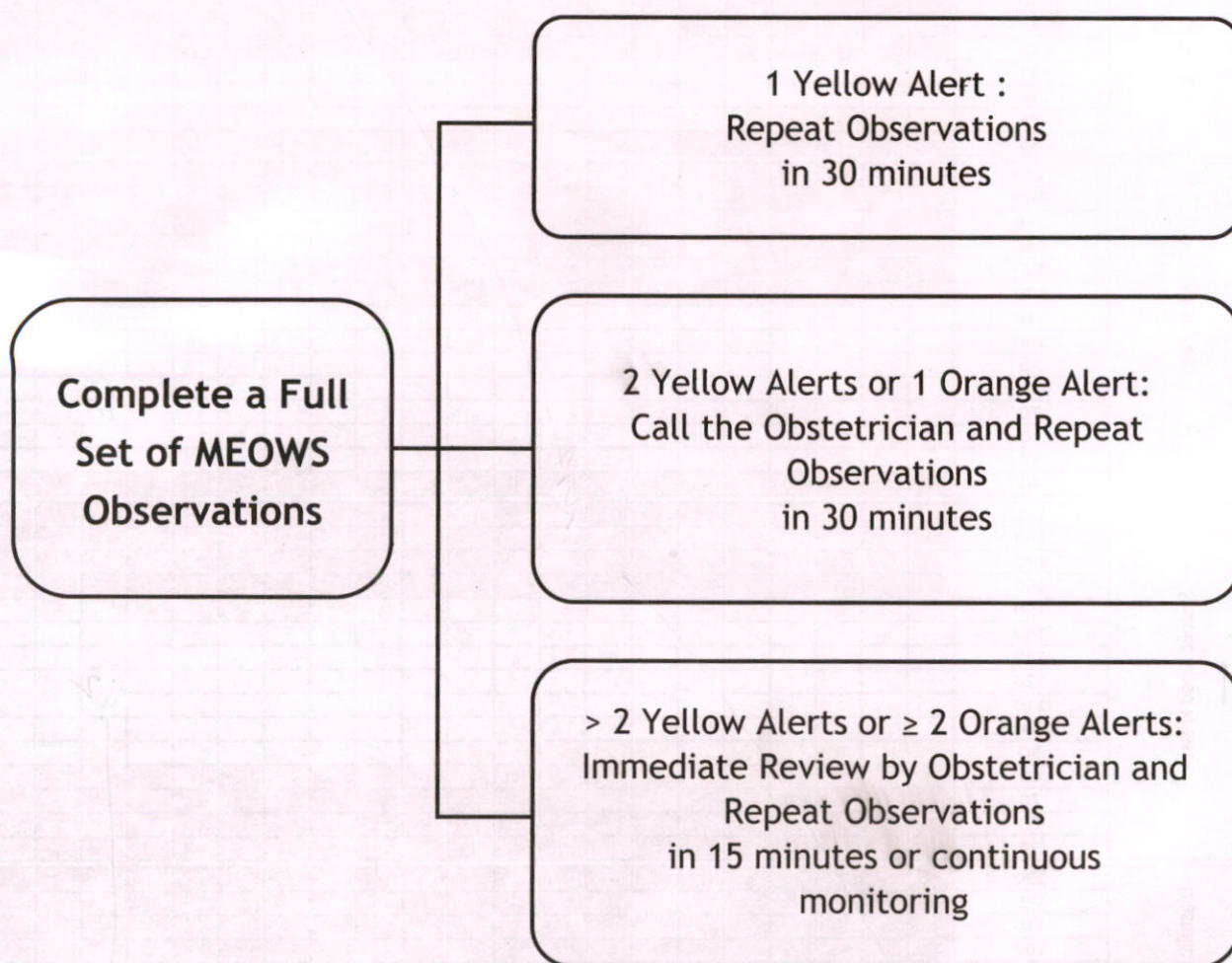
Early warning Observation Score Chart - Obstetrics

CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT

TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

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																									
	0 - 10																									
Saturations	94 - 100 %																									
	< 94 %																									
Administered O ₂ (L/min.)																										
Temp °C	40																									
	39																									
	38																									
	37																									
	36																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
Systolic Blood Pressure ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	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)

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IP5-00175850

Mrs MEGHA AGARWAL

30-11-1993

32 Y 7 M 2 D

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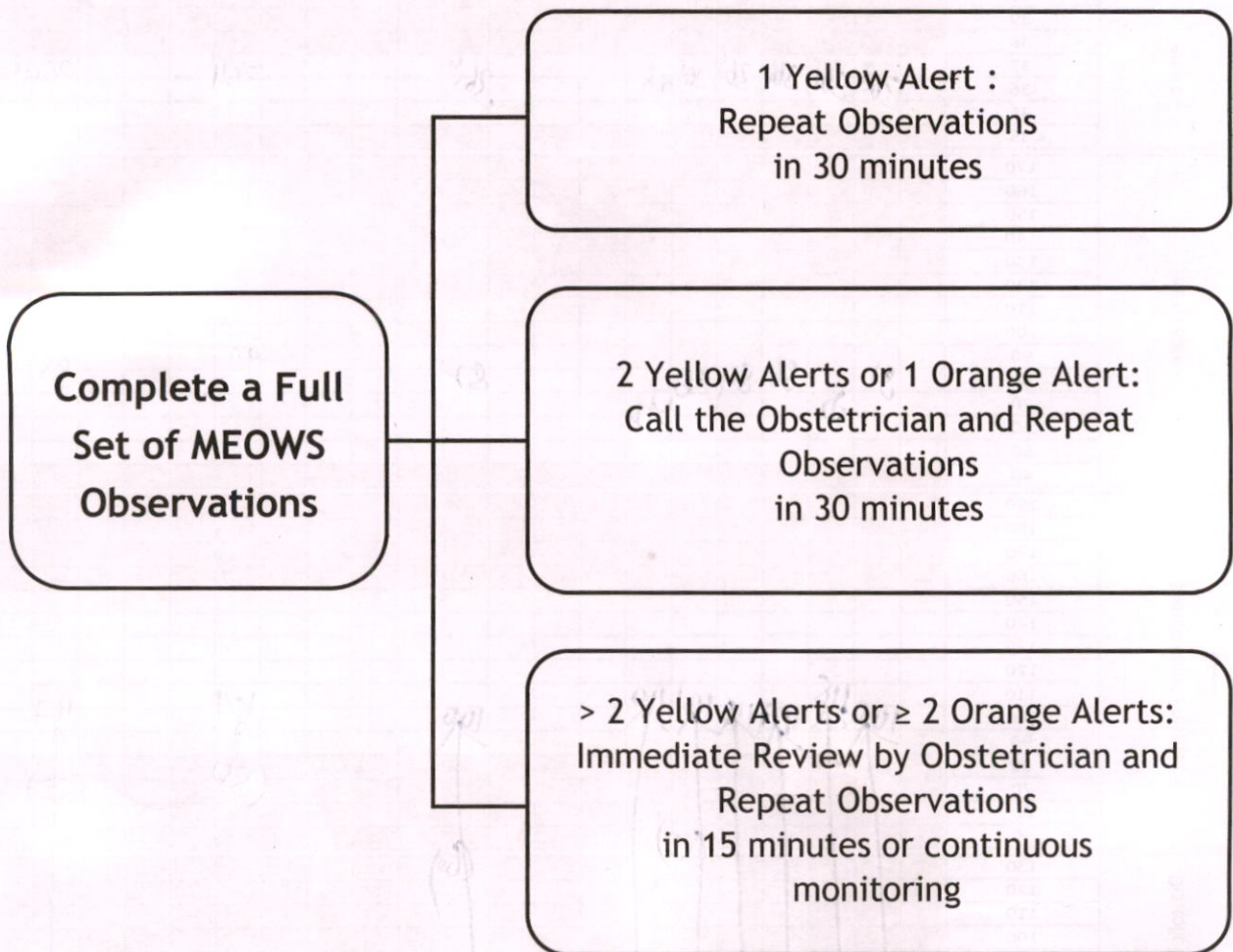


CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT

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-00525134 IP5-00175850
 Mrs MEGHA AGARWAL
 30-11-1993 32 Y 7 M 2 D (F)
 Dr. HIMABINDU VEERLA

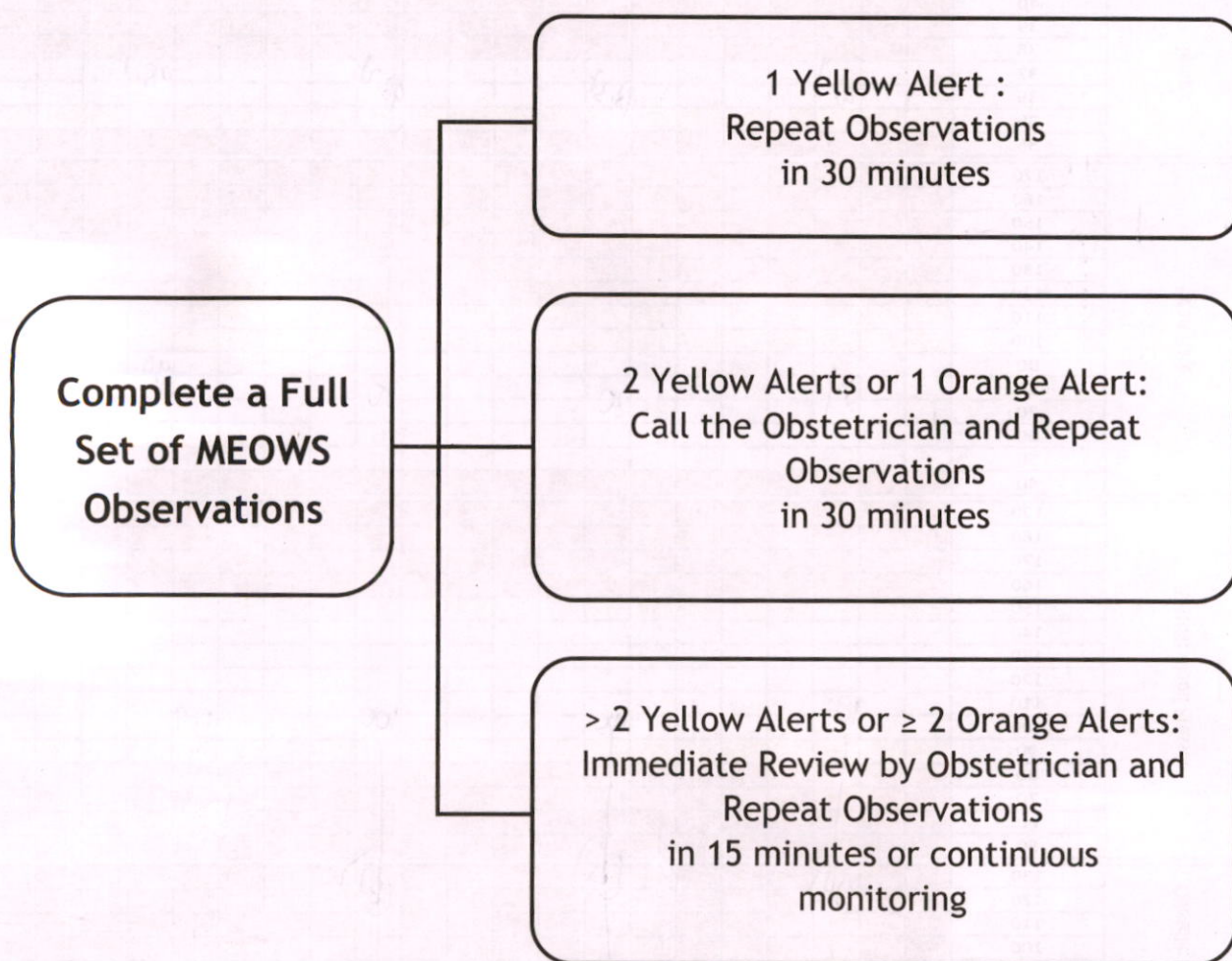


Early Warning Observation Score Chart - Obstetrics

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

3/7/26		Date	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
		Time																								
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20			19					20						20				20					20		
	0 - 10																									
Saturations	94 - 100 %			99					100						98				98					98		
	< 94 %																									
Administered O ₂ (L/min.)																										
Temp °C	40																									
	39																									
	38																									
	37			36.5					36.5						36.5				36.5					36.5		
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80			84					80						80				90					89		
	70																									
	60																									
	50																									
	40																									
↑ Systolic Blood Pressure	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100			116					115						100				119					118		
	90																									
	80																									
	70																									
	60																									
50																										
↓ Diastolic Blood Pressure	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	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				0					0						0				0						0	
TOTAL ORANGE SCORES																										
Nurse Initial				SV					SV						SV				SV						SV	

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

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Mrs MEGHA AGARWAL
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Dr. HIMABINDU VEERLA



FLUID CHART

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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	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	
			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	RL	N	100ml							
	04:00 am	RL	B	100ml							
	05:00 am	RL	M	100ml							
	06:00 am	RL		100ml							
	07:00 am										
Total Intake :					Total Output :						
Total 24 hrs. Intake					Total 24 hrs. Output						



FLUID CHART

Sheet No. : 2

26/12

- All measurements in ml.
- 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			
26/12	08:00 am	RL	H		250ml							0	Sing	
	09:00 am	RL			250ml						150ml	0	Sing	
	10:00 am	RL	B		200ml			atp				0	Sing	
	11:00 am	RL			150ml							0	Sing	
	12:00 pm	RL	M		150ml						200ml	0	Sing	
	01:00 pm	RL			150ml							0	Sing	
Total Intake :				1050ml			Total Output : passed						350ml in 2	
26/12	02:00 pm	RL	H2O		150ml							0	Sing	
	03:00 pm	RL			100ml							0	Sing	
	04:00 pm	RL	H2O		100ml			N/P			600ml	0	Sing	
	05:00 pm	RL			100ml							0	Sing	
	06:00 pm	RL	H2O		100ml							0	Sing	
	07:00 pm											0	Sing	
Total Intake :				500ml			Total Output : passed						500ml in 2	
26/12	08:00 pm	RL	Pill + H2O		150ml							0	Pill	
	09:00 pm	RL	H2O		150ml						1200ml	0	Pill	
	10:00 pm	RL			150ml			N				0	Pill	
	11:00 pm	RL			150ml			P				0	Pill	
	12:00 am		H2O		150ml						600ml	0	Pill	
	01:00 am				150ml							0	Pill	
Total Intake :				750ml			Total Output : passed						1700ml in 1	
26/12	02:00 am											0		
	03:00 am											0		
	04:00 am		H2O					N			500ml	0		
	05:00 am							P				0		
	06:00 am											0		
	07:00 am		H2O								300ml	0		
Total Intake :				0ml			Total Output : 800ml						200ml	
Total 24 hrs. Intake							Total 24 hrs. Output				3450ml			



FLUID CHART

Sheet No. : (3)

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	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	
			Mouth	I.V	N.G						
	08:00 am								✓	0	[Signature]
	09:00 am	H ₂ O							✓	0	
	10:00 am									0	
	11:00 am	H ₂ O								0	
	12:00 pm								✓	0	
	01:00 pm	H ₂ O								0	
Total Intake :			Taken			Total Output :			U-3 M-		
	02:00 pm										[Signature]
	03:00 pm	H ₂ O							✓	1	
	04:00 pm									no	
	05:00 pm	H ₂ O							✓	1	
	06:00 pm										
	07:00 pm	H ₂ O								1	
Total Intake :			Taken			Total Output :			U-2 M-		
	08:00 pm										priya priya priya priya priya
	09:00 pm								✓	1	
	10:00 pm	H ₂ O								NO	
	11:00 pm									IV	
	12:00 am								✓	1	
	01:00 am	H ₂ O								1	
Total Intake :			Taken			Total Output :			U-2 m-0		
	02:00 am										priya priya priya priya
	03:00 am								✓	1	
	04:00 am	H ₂ O								NO	
	05:00 am								✓	IV	
	06:00 am	H ₂ O								1	
	07:00 am								✓	1	
Total Intake :			Taken			Total Output :			U-3 m-0		
Total 24 hrs. Intake						Total 24 hrs. Output			(U-10) (m-0)		

BAH-00525134 IP5-00175850
 Mrs MEGHA AGARWAL
 30-11-1993 32 Y 7 M 4 D (F)
 Dr. HIMABINDU VEERLA

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FLUID CHART

Sheet No. : 4

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						
4/12	08:00 am					1			✓	1	long
	09:00 am	tho								20	long
	10:00 am					100			✓	20	long
	11:00 am	tho									long
	12:00 pm										long
	01:00 pm								✓		long
Total Intake : 200					Total Output : passed						
	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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 30-11-1993 32 Y 7 M 2 D (F)
 Dr. HIMABINDU VEERLA

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 2/7/26

Assessment: Patient clo fear & Anxiety

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2am	Assess the general condition of the patient	2am	Assessed the general condition of the patient	pt is stable
4am	Rest	30 May	Rest taken.	
5am	1/2 chart.	5am	Maintained 1/2 chart	
6am	Administer the medication.	6am	Administered the medication as per doctor order.	
7am	IV placement.	7am	IV placement done.	

Re-Assessment: Pt is comfortable

Special Notes: ABR

Nurse Signature: [Signature]

Nurse Name: Priya

Date & Time: 2/7/26 2pm

BAH-00525134 IP5-00175850

Mrs MEGHA AGARWAL

30-11-1993 32 Y 7 M 2 D (F)

Dr. HIMABINDU VEERLA



NURSING CARE RECORD

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Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 2/7/26

Assessment:

patient is having mild 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 General condition	8:30 AM	- Assessed the patient General condition	- patient is stable & comfortable
10AM	- monitor vitals	10:30 AM	- monitoring vitals Bp, PR, RR SpO2 checked & recorded.	
2pm	- Soft diet	2:30 pm	- Soft diet from 6pm	
4pm	- Iv medication	4:30 pm	- Iv medication given as per doctor order	
7pm	- Ensure Safety	7:30pm	- Ensure safety provided	

Re-Assessment:

Special Notes:

Bleeding

Nurse Signature: SlNurse Name: Sona

Date & Time: 2/7/26 @ 5pm

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NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 21/12/26

Assessment: patient is having mild 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 monitor vitals	8:30pm	⇒ Assess the patient condition vitals checked	Pt is stable
10pm	⇒ Maintain xlo chart	10:30pm	⇒ maintain xlo charting	
12am	⇒ Administer medication	12:30am	⇒ medication given	
4am	⇒ soft diet	4:30am	⇒ soft diet given	
7am	⇒ ensure safety	7:30am	⇒ provided side rails	

Re-Assessment: Re-Assessment done pt is stable

Special Notes: Remove pillow

Nurse Signature: [Signature]

Nurse Name: priya

Date & Time: 21/12/26 @ 8pm

BAH-00525134

IP5-00175850

Mrs MEGHA AGARWAL

30-11-1993

32 Y 7 M 2 D

(F)

Dr. HIMABINDU VEERLA



NURSING CARE RECORD

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Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 2/2/26

Assessment: Infant complains on feed & 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
8 AM	→ Assess the pt condition	8:10 AM	→ Assess the pt condition	+ pt is stable
10 AM	→ monitor vitals	10:10 AM	→ vitals checked and recorded	
12 PM	→ No chut	12:10 PM	→ No chut maintained	
2 PM	→ Administer medication	2:10 PM	→ Administered 2 medications	
4 PM	→ Regular diet	4:10 PM	→ provided regular diet	
6 PM	→ Sleepy	6:10 PM	→ Good Sleepy	
8 PM	→ Side suck	8:10 PM	→ Side suck provided	

Re-Assessment:

Vitals checked and recorded

Special Notes:

Nurse Signature: *[Signature]*Nurse Name: *[Signature]*

Date & Time: 2/2/26 @ 2 PM

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 3.12.20

Assessment: patient complaint 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
8pm	=> TO ASSES the patient condition	8:30pm	=> TO ASSES the patient condition	Patient is stable
10pm	=> Maintain x10 chart	10:30pm	=> maintained x10 charting	
12am	=> Administer medication as per order	12:30am	=> medication given	
2am	=> Regular diet	2:30am	=> Regular diet given	
4am	=> ENSURE safety	4:30am	=> provided side rails	

Re-Assessment: Re-assessment done patient is stable

Special Notes:

Nurse Signature: [Signature]

Nurse Name: priya

Date & Time: 3/12/20 @ 5pm

BAH-00525134 IPS-00175850
Mrs. MECHA AGARWAL
30-11-1993 32 Y 7 M 3 D (F)
Dr. HIMABINDU VEERLA



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:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Himabindu Department: BRP Date of Admission: 2/6/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
	<u>Gr. P. U. C 38 w/h</u>							
BACKGROUND	Area	Shift Time	<u>BRP 2am</u>	<u>BRP 3am-8pm</u>	<u>BRP 8am-1pm</u>	<u>BRP 1pm-4pm</u>	<u>BRP 4pm-8pm</u>	<u>BRP 8pm-1am</u>
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<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	☐ Yes ☒ No
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	<u>98.2°f</u>	<u>98.0°f</u>	<u>98.5°f</u>	<u>98.0°f</u>	<u>98.2°f</u>	<u>98.0°f</u>
		Res:	<u>18/hr</u>	<u>19b/m</u>	<u>19b/m</u>	<u>20b/m</u>	<u>19b/m</u>	<u>19b/m</u>
		SpO ₂ :	<u>100%</u>	<u>100</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>
		Pulse:	<u>80b/m</u>	<u>86b/m</u>	<u>89b/m</u>	<u>82b/m</u>	<u>80b/m</u>	<u>76b/m</u>
		BP:	<u>112/70</u>	<u>101/69</u>	<u>107/76(89)</u>	<u>100/75</u>	<u>118/72(85)</u>	<u>102/68</u>
	Fall Risk Score:	<u>35</u>	<u>35</u>	<u>35</u>	<u>35</u>	<u>35</u>	<u>35</u>	
Pain Score:	<u>1</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>		
Recommendations	Safety Needs:	<u>side rails</u>	<u>side rails</u>	<u>side rails</u>	<u>side rails</u>	<u>side rails</u>	<u>side rails</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>	<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>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Priya</u>	<u>Song</u>	<u>Priya</u>	<u>Suapna</u>	<u>Priya</u>	<u>Song</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>2/6/26</u>	<u>2/6/26</u>	<u>3/6/26</u>	<u>2/6/26</u>	<u>4/6/26</u>	<u>4/6/26</u>	
Time:		<u>8AM</u>	<u>8PM</u>	<u>8AM</u>	<u>8PM</u>	<u>8AM</u>	<u>8PM</u>	
Taken Over By Name :		<u>Song</u>	<u>Priya</u>	<u>Suapna</u>	<u>Priya</u>	<u>Song</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>2/6/26</u>	<u>2/6/26</u>	<u>3/6/26</u>	<u>3/6/26</u>	<u>4/6/26</u>		
Time:		<u>8:50AM</u>	<u>8PM</u>	<u>8AM</u>	<u>8PM</u>	<u>8:50AM</u>		

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:						

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0	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			-	0	-	-	-			
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 cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			-	-	-	-	-			
Signature of the Nurse						pritya	gl	ex	pritya				

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 : SV Name : Sudha

Signature of Ward In Charge :

Signature : V Name : Veena



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
2/7/26	2 Am	2/10	Abdomen	☐ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☒ Sharp ☐ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	Inj. Pcm	prya
2/7/26	2:30 Am	1/10	Abdomen	☐ Continuous ☒ Intermittent	☐ Acute ☒ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	Observation	prya
2/7/26	6 Am	1/10	Abdomen	☐ Continuous ☒ Intermittent	☐ Acute ☒ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Observation	prya
2/7/26	9 Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sona
2/7/26	12 Pm	02/10	Surgical site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Inj. Pcm given	Sona
2/7/26	3 Pm	0/10	Surgical site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Tab. Diclofenac	Sona
2/7/26	6 Pm	0/10	Surgical site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Tab. Colod given	Sona
2/7/26	10 Pm	02/10	Surgical site	☐ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☒ Sharp ☐ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	Tab. Diclo	prya
3/7/26	2 Am	01/10	Surgical site	☐ Continuous ☒ Intermittent	☐ Acute ☒ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Observation	prya
3/7/26	6 Am	01/10	Surgical site	☐ Continuous ☒ Intermittent	☐ Acute ☒ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Observation	prya

Re-assessment Frequency:

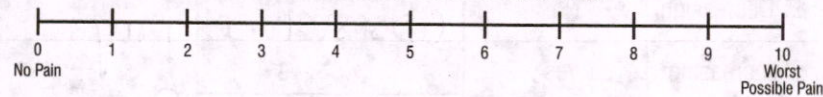
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 - 60 minutes after pain relief intervention.

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

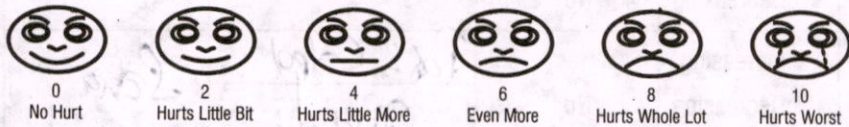
Numerical Pain Scale (Obstetric and Gynecology)



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

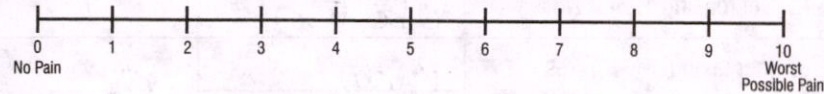
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
3/12/16	10AM	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Keep
3/12/16	2pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Keep
3/12/16	2pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Keep
3/12/16	9pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Sona
4/12/16	2AM	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Sona
4/12	6AM	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Sona
4/12	12AM	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sona
				☐ 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

Numerical Pain Scale (Obstetric and Gynecology)



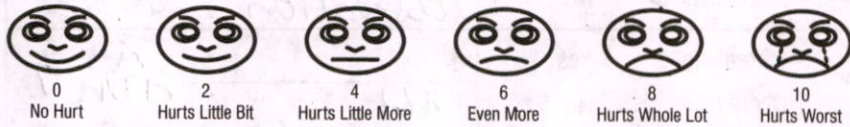
FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
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Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
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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				Fall Risk Grading		
		Score						
History of Falling (immediately or w/in 3 months)	Yes	25				Risk Level	Morse Fall Score (MFS)	Action
	No	0						
Secondary Diagnosis (more than one diagnosis)	Yes	15	15	15	15	Low Risk	0 - 24	Standard Fall Precaution
	No	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						
IV / Heparin Lock or Saline	Yes	20	20	20		High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0						
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0						
Total Morse Fall Scale Score:			35	35	35			
Signature								

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



Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time			Fall Risk Grading		
		Score					
History of Falling (immediately or w/in 3 months)	Yes	25			Risk Level	Morse Fall Score (MFS)	Action
	No	0					
Secondary Diagnosis (more than one diagnosis)	Yes	15	15	⊗	Low Risk	0 - 24	Standard Fall Precaution
	No	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					
IV / Heparin Lock or Saline	Yes	20	20	20	High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	No	0					
GAIT / Transferring	Impaired	20					
	Weak (uses touch for balance)	10					
	Normal /On Bed Rest /Immobile	0					
Mental Status	Forgets limitations	15					
	Oriented to own ability	0					
Total Morse Fall Scale Score:			35	35			
Signature			Fig	cy			

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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BAH-00525134

Mrs MEGHA AGARWAL

30-11-1993

IP5-00175850

32 Y 7 M 2 D

(F)

Dr. HIMABINDU VEERLA



BRADEN 'Q' SCALE

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date :	27-11-2023	28-11-2023	29-11-2023	30-11-2023
					Time :	2:00 PM	4:00 PM	6:00 PM	8:00 PM
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	4	4	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4	
FRICION-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	20	28	28	28
					Evaluator's Name	Arun	Sat	0	28

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

BAH-00525134 IP5-00175850
Mrs MEGHA AGARWAL
30-11-1993 32 Y 7 M 2 D (F)
Dr. HIMABINDU VEERLA



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CAESAREAN SECTION OPERATIVE NOTES

Surgeon's Name: Dr. Himabindu	Date of Delivery: 27/2/20
Assistant Surgeon: Dr. Bhargavi Reddy	Time of Delivery: 7:55 AM
Anaesthetist's Name: Dr. Amreen	Gender of Baby: Male
Type of Anaesthesia: ↓ spinal.	Weight of Baby: 3.017 kg
Neonatologist: Dr. Lakshmi Rupanjali	AGPAR Score: 8.9
Scrub Nurse: Sre Lakshmi	NICU Admission: ☐ Yes ☒ No

Pre-Operative Diagnosis: G.P.I.L. / L.T.G. / Previous L.S. / L.S.

☒ Elective

☒ Emergency

Indication: Previous L.S.

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: Elective. Knief to rectus:

CTG Description: Reach.

If there was a delay give the reasons:

Surgical Procedure: Elective L.S. ↓ spinal.

Post Operative Diagnosis: 1st P.O.D. P.I.L.

Peri-Operative Complications: Nil.

Amount of Blood Loss: 800ml

Blood Transfused (in ML): -

Name and Number of Surgical Specimen sent for examination:

Nil.

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: *Penrose drain*Uterine Incision: ☐ Lower Segment ☐ Classical☐ Inverted T ☐ J Incision *exam*Previous 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: *(2)* Cord around the neck ☐ Yes ☐ NoAppearance of placenta: *(2)* Cavity explored ☒ Yes ☐ NoUterus, tubes and ovaries: ☒ Normal ☐ Not NormalSterilization: ☒ Yes ☐ NoUterine Closure: ☐ One Layer ☒ Two Layers*viagra 101-0* SuturePeritoneal Closure: ☐ Pelvic ☐ Abdominal ☒ None

..... Suture

Sheath Closure:

viagra no. 1 SutureFat Closure: ☒ Yes ☐ No*viagra rapid 20* SutureSkin Closure: ☒ Subcuticular ☐ Mattress*11* SutureVaginal Evacuated ☒ Yes ☐ NoDrain: ☐ Yes ☒ No ☐ Remove in days ☐ Await instructionsCatheter ☒ Yes ☐ No ☐ Remove in *24 hrs* days ☐ Await instructionsSwap & Instruments count correct? ☒ Yes ☐ No ☐ Post-op Antibiotics ☒ Yes ☐ NoIntra-Operative Antibiotics Cover: ☐ Yes ☐ No ☐ Thromboprophylaxis ☐ Yes ☒ No

Post-Operative Notes:

*- NBM x 2 hours**- Input / Output**- 500 cc ceftriaxone IV**- W/H/O bleeding*Doctor Name: *Dr. Bhargava*Doctor Signature: *[Signature]* *[Signature]*Date & Time: *2/7/2016*

BAH-00525134 IP5-00175850
Mrs MEGHA AGARWAL
30-11-1993 32 Y 7 M 2 D (F)
Dr. HIMABINDU VEERLA



POST-SURGICAL CARE PLAN FORM

Procedure Done: Emergency US

Post-Surgical Diagnosis: 6' Poo

Post-Operative Monitoring Parameters /Frequency:
- when hungry.
- Int Every 15 min for 2 hrs.

Wound Care:
- Dressing for 2 weeks.

Drain /Special Lines/Catheters:
Catheter - Input /Output -

Special Patient Positioning and Requirements:
- after op's Resumed.

Nutritional Instructions:
- water after 2 hrs.

When to Start Mobilization:
after op's Resumed.

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)

Dr. Himabindu Veerla

Date: 2/7/2026 Time: 9:30 AM

Note: Plan of care will be readjusted if necessary.

BAH-00525134
Mrs MEGHA AGARWAL
30-11-1993 32 Y 7 M 2 D (F)
Dr. HIMABINDU VEERLA

Patient S

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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)		X	4
Previous VTE provoked by major surgery		X	3
Known high-risk thrombophilia		X	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; sicklecell disease; current intravenous drug user		X	3
Family history of unprovoked or estrogen-related VTE in first-degree relative		X	1
Known low-risk thrombophilia (no VTE)		X	1
Age (? 35 years)		X	1
Obesity		X	1 or 2
Parity ≥ 3		X	1
Smoker		X	1
Gross varicose veins		X	1
Obstetric Risk Factors			
Pre-eclampsia in current pregnancy		X	1
ART/IVF (antenatal only)		X	1
Multiple pregnancy		X	2
Caesarean section in labour		X	1
Elective caesarean section		X	1
Mid-cavity or rotational operative delivery		X	1
Prolonged labour (? 24 hours)		X	1
PPH (? 1 litre or transfusion)		X	1
+0 Preterm birth? 37 weeks in current pregnancy		X	1
Still birth in current pregnancy		X	1
Transient Risk Factors			
Any surgical procedure in pregnancy or puerperium except immediate repair of the perineum, e.g. appendicectomy, postpartum sterilization		X	3
Hyperemesis		X	3
OHSS (first trimester only)		X	4
Current systemic infection		X	1
Immobility, dehydration		X	1
Total			

Signature of the Doctor: _____

Action Plan: _____

Date: 2/7/2026

Time: 9:30 AM

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.

**BUNDLE CARE
SURGICAL
SECTION (SSI)**

2/1/22

2/1/22

2/1/22

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

Signature	☒ Animate patient into surgery ☒ Confirm time of surgery ☒ Animate is anaesthetized within 10 minutes of start of anaesthesia ☒ Confirm time of anaesthesia
Signature	☒ Confirm time of surgery ☒ Confirm time of anaesthesia ☒ Confirm time of surgery
Signature	☒ Confirm time of surgery ☒ Confirm time of anaesthesia ☒ Confirm time of surgery
Signature	☒ Confirm time of surgery ☒ Confirm time of anaesthesia ☒ Confirm time of surgery

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

1. Animate patient into surgery

2. Confirm time of surgery

3. Animate is anaesthetized within 10 minutes of start of anaesthesia

4. Confirm time of anaesthesia

5. Confirm time of surgery

6. Confirm time of anaesthesia

7. Confirm time of surgery

8. Confirm time of anaesthesia

9. Confirm time of surgery

10. Confirm time of anaesthesia

PATIENT TRANSFER FORM

Patient Name & UHID No.		Date & Time of Admission	Date & Time of Transfer Order
		2/12/26 @ 2:14pm	2/12/26 @
		Transfer Ordered by	Reason for Transfer
		Dr. Deepika	post op.
From Unit	To Unit	Information to Attendant	
ICU-5	ICU-5	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:	
Number of Imaging Films		Yes ☒ No ☐ If No:	
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		Name of Person Ordered Transfer	
Dr. Gayatri		Dr. Deepika	
Patient & Clinical Records Received by : Dr. Ganga			
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

Caesarean Section Audit Format (To be filled by doctor conducting C-Section)

Name of the Facility:

Encircle type of facility: MCH/DH and equivalent/SDH and equivalent/AH and equivalent/FRU-CHC and equivalent

Mention unit _____ (Applicable for medical college/tertiary setting/district hospital)

Date:

I	Patient Information	Response
1	Name of the woman undergone C-section	
2	Age of woman	
3	Hospital No./Patient identification no.	
4	G/P/L/A	
5	Booking status	Booked/Booked elsewhere/Un-booked
6	Maternal height and weight	Ht: _____ cm Wt: _____ Kg
7	Date of Admission	
8	Date and time of delivery by CS	Date: _____ Time: ☐ 9am - 6pm ☐ 6pm - 9pm ☐ 9pm - 12am ☐ 12am - 6am ☐ 6am - 9am

II	Obstetric History	Response
1	Estimated gestation, in completed weeks	
1a	Encircle the appropriate basis of estimated gestational	
2.	Number of previous stillbirths >24weeks, if any	
3	Was the mother referred to this hospital from another facility	
3a	Gestational age at the time of referral	
3b	If preterm, was AN corticosteroid given prior to referral	
4	Tick the appropriate group in which pregnant woman belongs to	☐ Group 1: Nulliparous, with a single cephalic pregnancy, ≥37 weeks gestation in spontaneous labour ☐ Group 2: Nulliparous, with a single cephalic pregnancy, ≥37 weeks gestation who had labour induced or were delivered by CS before labour ☐ Group 3: Multiparous, without a previous CS, with a single cephalic pregnancy, ≥37 weeks gestation in spontaneous labour

	☐ Group 4: Multiparous, without a previous CS, with a single cephalic pregnancy, ≥ 37 weeks gestation who had labour induced or were delivered by CS before labour ☐ Group 5: All multiparous, with at least one previous CS, with a single cephalic pregnancy, ≥ 37 weeks gestation ☐ Group 6: All multiparous, with a single breech pregnancy ☐ Group 7: All multi parous, with a single breech pregnancy including women with previous CS(s) ☐ Group 8: All women with multiple pregnancies including women with previous CS(s) ☐ Group 9: All women with a single pregnancy with a transverse or oblique lie, including women with previous CS(s) ☐ Group 10: All women with a single cephalic pregnancy < 37 weeks gestation, including women with previous CS(s)
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III	Details of Caesarean Section	Response
1	Name the senior most obstetrician involved in the decision to perform the caesarean section?	Unit chief/ Duty assistant/HOD/Assoc. Professor/Assistant professor/Others
2	Decision - delivery interval	
3	Which of the following best describes the indication for CS?	☐ Singleton breech ☐ Malpresentation / Unstable ☐ Multiple pregnancy ☐ Presumed fetal distress/IUGR/Abnormal CTG ☐ Cord prolapse ☐ Sepsis/Chorioamnionitis ☐ Placenta previa, actively bleeding ☐ Placenta previs, not actively bleeding ☐ Postdatism ☐ Oligohydramnios ☐ Previous Caesarean section ☐ Placental abruption ☐ Intrapartum haemorrhage ☐ Pre-eclampsia/eclampsia/HELLP ☐ Failure to progress (induction/in labour) ☐ Maternal medical disease (see key) ☐ Uterine rupture/scar dehiscence ☐ Previous poor obstetric outcome (BOH) ☐ Long period of infertility ☐ Others (Specify) _____
4	Was partograph used prior to decision for CS (if Yes, attach a copy of filled photograph)	
5	Were the membranes ruptured (ROM) prior to the caesarean section?	Spontaneous ROM / ARM
6	Duration of first stage of labour	Hr: _____ Mins: _____
7	Duration of second stage of labour	Hr: _____ Mins: _____

8	What cervical dilatation was reached prior to the caesarean section?	
9	Were prophylactic antibiotics given?	
10	What was the estimated blood loss?	
11	Blood / component transfusion	If so, mention no of units
IV	In case of previous caesarean delivery	Response
1	Mention the indication and gestation of previous LSCS (start from most recent LSCS)	LSCS 1 _____ Gestation _____ LSCS 2 _____ Gestation _____ N/A _____
2	Was the mother offered a trial of vaginal delivery during the pregnancy?	
3	Post OP complications, if any	
V	Current Status	Response
1	Does this mother require 'special' care post-caesarean section in addition to routine post-op care?	Yes / No
1a	If YES, where is she being managed currently?	Obs HDU / ICU General HDU / ICU Referred to another hospital
2	Whether fetal heart monitoring - Manual / Electronic was done (tick appropriately)	A) Normal B) Abnormal C) Severely abnormal D) Not done
3	Whether Meconium-stained liquor present (tick appropriately)	A) Yes B) No C) Not known
4	Other methods of delivery attempted (tick appropriately)	A) None B) Forceps C) Ventouse
5	Delivery outcome (tick appropriately)	A) Livebirth B) Stillbirth
6	Sex of the baby (tick appropriately)	A) Male B) Female C) Unknown
7	Birth weight	
8	Apgar score (tick appropriately)	A) Score at 1 minute _____ B) Score at 5 minutes _____ C) Not done
9	Transferred to SNCU/NICU (tick appropriately)	A) Yes _____, where _____ B) No
10	Maternal outcome (tick appropriately)	A) Stable and in satisfactory condition B) Shifted to Obstetric HDU/ICU due to any complications or for close monitoring C) Maternal near miss D) Maternal death. Mention cause of death _____

11	Newborn outcome (tick appropriately)	A) Stable and in satisfactory condition B) Admitted in SNCU due to complications or for close monitoring C) Still birth D) Born alive and died (Mention cause of death)
12	Tick appropriately on the need of C Section	A) Absolutely essential at that time B) More time could have been given before deciding for CS

Name and Designation of doctor

Signature with Seal

Date

*** Key for Medical Disorders:**

1. Heart disease complicating pregnancy
2. Past history of cardiac surgery like valve replacement
3. Jaundice complicating pregnancy
4. Bronchial asthma / COPD
5. Tuberculosis - pulmonary / extra pulmonary
6. Known seizure disorder - on treatment / not on treatment / treatment discontinued
7. Known hypertensive - on treatment / not on treatment / treatment discontinued
8. Known diabetic - on treatment / not on treatment / treatment discontinued
9. Chronic renal disease
10. Anemia other than iron deficiency anemia

Glossary

- Gravida denotes a pregnant state both present and past, irrespective of the period of gestation
- Parity denotes a state of previous pregnancy beyond the period of viability
- Nullipara: A nullipara is one who has never completed a pregnancy to the stage of viability. She may or may not have aborted previously
- Multipara: Multipara is one who has completed two or more pregnancies to the stage of viability or more

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Himabindu Veerla
 Asst. Surgeon : Dr. Bhargava Reddy
 Anaesthetist : Dr. Aditya
 Scrub Nurse : Dr. Sripathy

BAH-00525134 IP5-00175850
 Mrs MEGHA AGARWAL
 30-11-1993 32 Y 7 M 2 D (F)
 Dr. HIMABINDU VEERLA

Patient
 UHIL



Age : Gender : Female

Date : 2/7/16 In-time : 7:00 AM Out-time : 9 AM



Before Induction of Anaesthesia >>

Before Skin Incision >>

Before Patient Leaves Operating Room

SIGN IN		Time: <u>7:35 PM</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>[Signature]</u>		
Name : <u>Dr. Bhargava Reddy</u>		

TIME OUT		Time: <u>7:40 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>[Signature]</u>		
Name : <u>[Signature]</u>		

SIGN OUT		Time: <u>9 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>[Signature]</u>		
Name : <u>Dr. Himabindu Veerla</u>		



Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Mrs Megha Agarwal Age: Sex: F UHID.No:

Date: 2/2/26 Time: 2:30 Proposed Operation: Elective Cesarean Section

Diagnosis: G2 P L1, 38+4 WLS 1 prev

B.P / CRT: 109/72 (80) H.R: 89/min Weight: 76 kg ASA Physical Status: 1 2 3 4 5

Laboratory Data:

Hgb: 12.5.1 Glucose: Protein: HIV: X-Ray:
PCV: 33.1 Urea: Alb: HBS Ag: ECG:
WBC: 11.8 Creat: Total Bil: HCV: 2D Echo:
Plate: 315 Na: Dir. Bil: Blood group: Stress/Angio:
PT: K: LDH: T3 Other:
PTT: Ca++: Alk phos: T4
INR: Mg++: Amylase: TSH
Cl-: SGOT/SGPT:

Allergies:

Medical History: CVS: —

RESP: — Diabetes: —

CNS: —

Renal: — NAD

Hepatic / GE: — Physical Activity: Active

Others: —

Past Anaesthetic History: 1 prev LSS 2023 → uneventful

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: 2.5 cm Mentohyoid Distance: 20 Neck: 20 Teeth: 20

Lungs: AETBE

Heart: S1 S2

CNS: NAD

Pregnant: ☒ Yes ☐ No ☐ NA Venous Access Site: LVL 16G Spine Exam for regional:

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

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

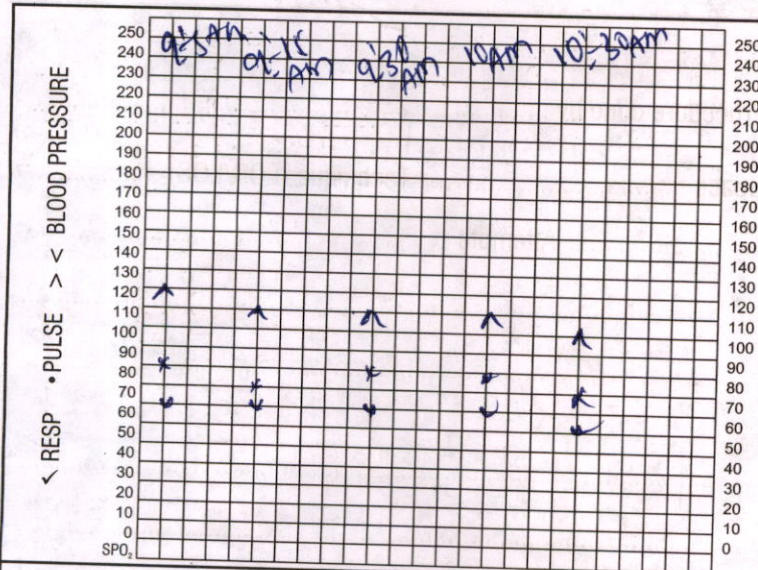
Signature: Dr. Aditi Name: Dr. Aditi

☐ Awake	☐ IV:	Signature of the Doctor:
--------------------------------	------------------------------------	--------------------------------



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: Dr. Sona Time Received: 9 AM Time Discharged:



IV Cannula Site: left
☐ O₂ 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: Pl

Oral Feeds: SBM

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	2	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		2	2	2	2		
Able to move 0 extremities voluntary or on command	= 0		2	2	2	2		
Able to deep breathe & cough freely	= 2	RESPIRATION	2	2	2	2		
Dyspnea or limited breathing	= 1		2	2	2	2		
Apneic	= 0		2	2	2	2		
BP $\pm$ 20 of Pre Anaesthetic leve	= 2	CIRCULATION	2	2	2	2		
BP $\pm$ 20-50 of Pre Anaesthetic leve	= 1		2	2	2	2		
BP $\pm$ 50 of Pre Anaesthetic leve	= 0		2	2	2	2		
Fully awake	= 2	CONSCIOUSNESS	2	2	2	2		
Arousable on calling	= 1		2	2	2	2		
Not responding	= 0		2	2	2	2		
Pink	= 2	COLOR	2	2	2	2		
Pale, dusky, blotchy, jaundiced, other	= 1		2	2	2	2		
Cyanotic	= 0		2	2	2	2		
TOTAL			9	10	10	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
2/2/26	9 AM	0/10	NA	Dr. Sona
2/2/26	12 PM	02/10	Paracetamol	Dr. Sona

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

Anaesthesiologist Name: Dr. SHINY

Anaesthesiologist Signature: [Signature]

Date & Time: 04/02/26, 8:24 AM

PACU Nurse Name: Sona

PACU Nurse Signature: [Signature]

Date & Time: 2/2/26 @ 3 PM

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):

Date & Time:



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



EPIDURAL ANALGESIA RECORD

b)

[illegible]

Date and Time :

BAH-00525134 IP5-00175850
Mrs MEGHA AGARWAL
30-11-1993 32 Y 7 M 2 D (F)
Dr. HIMABINDU VEERLA

CONSENT FOR ANAESTHESIA

Authorization By: ☒ Patient ☐ Patient Attendant

Operative Procedure: Elective Cesarean Section

Anaesthesiologist: DR. ADITYA Surgeon: Dr. HIMABINDU

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, TACHYCARDIA, BRADYCARDIA, LARYNGOSPASM, SHIVERING, PDPH

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: _____

Name: Mrs MEGHA AGARWAL

Relationship with patient: SELF

Date & Time: 11/7/21 7:01 AM

Witness:

Signature: [Signature]

Name: YASH AGARWAL

Date & Time: 11/7/21 7:01 AM

Doctor (who is taking consent):

Signature: [Signature] Name: Dr. Aditya N

Date: 11/7/21 Time: 7:01 AM

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 అవస్థాపక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్థావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు.

రిజనల్ 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 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 ☐ పొక్ ☐ ఊబకాయం ☐ దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)

☐ ఇతరవి:

రోగి / రోగి అటెండెంట్

- అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
☐ రిజనల్ 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 నర్వ్ బ్లాకులు, రిజనల్ 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:

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

Patient Name : MEGHNA AGARWAL Gender: ☐ Male ☒ Female Age : 32
UHID No : 525134 Date : 2/7/20

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)

FLECTIVE LOWER SEGMENT CESAREAN SECTION
upon
(Name of the Patient) MEGHNA AGARWAL

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.

Bleeding Blood Transfusion Infection Injury to Bowel Loops and Bladder

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. Himabindu / 4nd

Consentee :

Signature : Meghna Agarwal

Name : _____

Date & Time : _____

Patient Attendant :

Signature : Yash Agarwal

Name : Yash Agarwal

Relationship with Patient: _____

Date & Time : _____

Witness :

Signature : [Signature]

Name : Singh

Date & Time : 2/7/20 @ 6:30 AM

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

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Anshu

Date & Time : 2/7/20, 6 AM