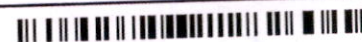


ADMISSION SHEET



Registration Details :

Admission No : IP5-00176590

Admit Date : 18-Jul-2026

Admit Time : 10:02 PM UHID : HNH-00016676

Patient Details :

Patient Name : Mrs IQRA FATIMA

Age : 21 Y 9 M 18 D

Guardian : Mr ZAID AHMED SIDDIQI

DOB : 30-09-2004

Gender : Female

Religion :

Occupation :

Marital Status : Married

Address (H) : 20-3-1/4, doodh bowli, hyd Doodh Bowli
Hyderabad Telangana INDIA 500064

Phone No : 8121548297/ 8121272212

E-mail : iqzzftm@gmail.com

Admission Details :

Bed Type : SHARED WARD

Bed No : SW 414

Ward Name : 4F-BIRTHING CENTRE

Room No : SW 414

Admission Type : First Visit

Contact Details :

Name : Mr ZAID AHMED SIDDIQI

Relationship : Husband

Contact Address : 20-3-1/4, doodh bowli, hyd Doodh Bowli
Hyderabad Telangana INDIA 500064

Phone No : 8121548297 / 8121272212



Signature

Doctor Details :

Doctor Name : Dr. ANNIE PRANUTHA P

Specialisation : OBSTETRICS AND GYNECOLOGY

Referral Doctor : SELF

Phone No :

Co-Consultant :

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : MEDI ASSIST INSURANCE TPA PVT LTD

INVESTIGATIONS

Date	Investigations	Order No.	Signature
18/7	NST ①	265-035965	Qini
19/7	NST ②		Q
19/7	GPBS. ^{post break fast} 200mg/dl	2607242	Suand
19/7	AFI doppler.	265035985	Reb
19/7	GPBS ^{pre lunch.} 136mg/dl	26072483	Suand
19/7	CBP, LFT, LDH, electrolytes	26072463	Kannig Kama
	Creatine. PT/PTT		
19/7	ECG ①	265-036000	Song
	NST ③	265-036020	
19/7	post dinner- 145mg/dl	26072543	Song
20/7	CBP, LFT, LDH, & creatine	26072551	Song
	& electrolytes.		Song
20/7	ECG - ②	265036014	Song
20/7	pre-breakfast - 155mg/dl	26072875	Song
20/7	Post breakfast - 98mg/dl 9am	26072876	Yanning
20/7	NST - ④	265-036063	Yanning
20/7	ultrasound chest	265-036069	Yany
20/7	2D echo	265-036100	Yany
20/7	AFI Doppler	265-036344	Yany
20/7	CBP, LDH, LFT	26072919	Song
	electrolytes		
21/7	CBP, & electrolytes	26072981	Song
21/7	GPBS 67mg/dl	26073012	Song

770930 08

[illegible]

Date	Procedure	Quantity	Order No.	Signature
18/7	TU placement	1	P9710653	[Signature]
18/7	Catheterization	1		[Signature]
20/7	PAC	1		Ganley

ANY OTHER INFORMATION

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Date :
Time :
Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
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Date :

Time :

Prepared By :

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor



ACTIVITY RECORD FOR BILLING

Name : _____

HNH-00016676 IP5-00176590
Mrs IQRA FATIMA
30-09-2004 21 Y 9 M 21 D (F)
Dr. ANNIE PRANUTHA P

UHID No. : _____ IP No : _____

Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

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Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00016676
Mrs IQRA FATIMA
30-09-2004 21 Y 9 M 18 D (F)
Dr. ANNIE PRANUTHA P

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IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

Referred → Severe Pre-eclampsia
FGR - AGDF.

Obstetric Formula:

Obstetric History:

Primigravida

Present Pregnancy Record:

Sp. Conception.

RISK FACTORS:

✓ High BP recordings + Headache - 1 day
✓ Pedal edema - 1 month
✓ Urine Albumin - 3+
✓ 18/7 Scan done: 25+2
Cephalic APH - 3.4cm
EFW - 596 (2.1), AC - 20%
AGDF, DV Doppler Resistance

Height: cm

Weight: 80 kg

Allergies: NCPA

Breast: ☒ Normal ☐ Abnormal

General Examination:

Consciousness: conscious

Pallor: Absent

Icterus: absent

Edema: grade 2 pedal edema

Temp: afebrile

PR: 82bpm

BP: 120/80

DTR: NAD

CVS: NAD

RS 98% on RA

Liver/Spleen: Not palpable

Urine Output: Adequate, clear

DIAGNOSIS

Primigravida / 25+2 / Severe PE / FGR / Oligohydramnios /
AGDF / DV Doppler Resistance observation /
delivery

LMP: 22.01.2026

EDD: 29.10.2026

Corrected EDD: 29.10.2026

GA: 25+2

Menstrual History: Regular: ☒ Yes ☐ No

Obstetric Examination

Fundal Height: 24 wks

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

Draining: ☐ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination

Cervix: ☐ Long ☐ Partially effaced ☐ Effaced

Not indicated

Membranes: ☐ Present ☐ Absent

Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Presenting Part: ☐ Vertex ☐ Breech ☐ Others

Sutton: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Pelvis: ☐ Adequate ☐ Doubtful

Family History:

Mother - Hypothyroid
 Maternal side w/o HTN

Surgical History:

Nil

Medical History:

Nil

Medication History:

T Iron
 T Calcium (PO x OD)
 T Ecosprin 75mg

Plan of Care:

Op/w Dr. Annie

- ✓ Admission
- ✓ Admission NST
- ✓ prepare parts
- ✓ Trace PG profile
- ✓ NNC → Informed
- ✓ MgSO₄ loading dose 4/b
 maintenance dose

Investigations:

B₄ - A positive

HIV
 VDRL (NR)
 HBsAg

18/7/26

(Himayatnagar)

V/A - 3+
 19CT - 114.

Hb - 11.4
 Plt - 3.26
 WBC - 12.31

CVE - Pvs cells - 20-22
 Epi cells - 14-16.
 Protein - 2+
 WBCs (++)

NT% 13⁺ NT 1.7mm

No Anuploidy screening
 Dr Annie

Doctor Name: Dr. Dupike

Consultant Name: Dr. Annie

Signature: [Signature]

Signature: [Signature]

Date & Time: 18/7/26, 10:30 PM

Date & Time: 18/7/26, 10:30 PM

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SECTION OPERATIVE NOTES

Surgeon's Name: Dr. Annie	Date of Delivery: 20/07/2026
Assistant Surgeon: Dr. Kiran / Dr. Smith	Time of Delivery: 3.22 PM
Anaesthetist's Name: Dr. Sunil Chandra	Gender of Baby: male
Type of Anaesthesia: Spinal	Weight of Baby: 580 grams
Neonatologist: Dr. Prathyesha, Dr. Aishwarya	AGPAR Score: 5/7
Scrub Nurse: Laxmi	NICU Admission: ☒ Yes ☐ No

Pre-Operative Diagnosis: Bmi | 25+4wks | severe PE | FHR = Absent end diastolic flow

- Urgency
- ☐ Elective ☒ Emergency Indication: Severe PE & FHR = absent end diastolic flow
- ☒ 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: Knife to rectus:

CTG Description: reactive

If there was a delay give the reasons:

Surgical Procedure: Preterm, Emergency lower segment cesarean section

Post Operative Diagnosis: POD-0, P/L

Peri-Operative Complications: Nil

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

Name and Number of Surgical Specimen sent for examination:

Placenta sent for HPE.

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 ☐ OtherUterine Incision: ☒ Lower Segment ☐ Classical ☐ Inverted T ☐ J IncisionPrevious Scar: ☐ Intact ☐ Thinned out ☐ Ruptured ☒ No ScarIncision Through Placenta: ☐ Yes ☒ NoDelivery of head: ☒ Manual ☐ ForcepsLiquor: ☒ Clear ☐ Meconium: ☐ I ☐ II ☐ III ☐ Blood ☐ Offensive ☐ Not OffensiveDelivery of Placenta: ☐ Manual ☒ CCT ☐ Complete ☐ Incomplete ☐ PiecemealCord Appearance: *Normal* Cord around the neck ☐ Yes ☒ NoAppearance of placenta: *normal* Cavity explored ☒ Yes ☐ NoUterus, tubes and ovaries: ☒ Normal ☐ Not Normal Sterilization: ☐ Yes ☒ NoUterine Closure: ☐ One Layer ☒ Two Layers *No 1-0 vicryl* SuturePeritoneal Closure: ☐ Pelvic ☐ Abdominal ☒ None SutureSheath Closure: *No 1 vicryl* SutureFat Closure: ☒ Yes ☐ No *No 2-0 rapid vicryl* SutureSkin Closure: ☒ Subcuticular ☐ Mattress *No 2-0 rapid vicryl* SutureVaginal Evacuated ☒ Yes ☐ NoDrain: ☐ Yes ☒ No ☐ Remove in days ☐ Await instructionsCatheter *(120ml)* ☒ 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 ☐ NoPost-Operative Notes: *① NG tube 24 hrs* *② Drugs as charted* *③ vitals, SpO₂, RR & T₁₀ 15 min for 2 hrs Hb* *1 hr* *④ w/p signs of Pre-eclampsia, heavy bleeding* *T₁₀* *⑤ Send CBP, LFT, UFT, Electrolytes @ 9pm* *⑥ Insulin 50 units*

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Doctor Name: *Dr. Annie*Doctor Signature: *Sutlo for Dr. Annie*Date & Time: *20/7/26; 3:52pm*

RISK ASSESSMENT TOOL FOR DEEP VEIN THROMBOSIS

(Postnatal Assessment and Management (to be assessed on delivery suite))

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

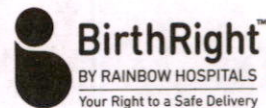
Signature of the Doctor: S. S. S. S. Date: 20/7/26 Time: 4 pm

Action Plan: Thromboprophylaxis for 10 days

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.

HNH-00016676 IP5-00176590
Mrs IQRA FATIMA
30-09-2004 21 Y 9 M 20 D (F)
Dr. ANNIE PRANUTHA P



POST-SURGICAL CARE PLAN FORM

Procedure Done: Emergency lower segment cesarean section

Post-Surgical Diagnosis: P.O.D., P/B

Post-Operative Monitoring Parameters /Frequency:

BP/PR/SpO₂/temp/RR/T₁₀ - 15 min for 1hr / P/B 1hrly.

Wound Care:

Dressing x 4 hrs.

Drain /Special Lines/Catheters:

Catheter x 24hrs
Gamola x 24hrs

Special Patient Positioning and Requirements:

Nutritional Instructions:

NBM 6hrs.

When to Start Mobilization:

after catheter removal

Special Referrals:

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

☒ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

Smita
Treating Surgeon
(Signature & Stamp)

Date: 20/7/26 Time: 4p.m.

Note: Plan of care will be readjusted if necessary.

BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse

Date : 20/12/26

Department : OBG-D

HNH-00016676 IP5-00176590
Mrs IQRA FATIMA
30-09-2004 21 Y 9 M 20 D (F)
Dr. ANNIE PRANUTHA P



Duration of Procedure : 1 hr

Name of Surgeon : Date of Admission : 20/12/26

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

		Staff Signature
1.	Antibiotic given prior to surgery ? ☒ Yes ☐ No ☒ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☒ Yes ☐ No Name of the Antibiotic : <u>Qi-magnum 1gm</u>	<u>[Signature]</u>
2.	Hair Removal ☒ Yes ☐ No if Yes : <u>Surgical Clipper</u> Department where Hair Removed : ☒ Ward ☐ Operating Room ☐ Other : Skin preparation done (cleanse surgical area with antiseptic agent) ? ☒ Yes ☐ No	<u>[Signature]</u>
3.	Patient's body temperature immediately post operation (Recovery Room) <u>36.2°C</u> ☐ Oral Or ☒ Axilla (Goal : 36-37 °C)	<u>[Signature]</u>
4.	Name of doctor or staff administering the antibiotic : <u>Dr. Sultan</u> Date & Time of antibiotic administration : <u>20/12/26 @ 2.30 PM</u> Date & Time procedure started : <u>20/12/26 @ 3 PM</u>	<u>[Signature]</u>

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



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>18/7/26</u>	Comfortable NST-Reactive	<u>Advice</u>
<u>11:30 PM</u>	Vitals - BP - 121/86 (91) PR - 78 bpm SpO ₂ - 97% on RA	✓ Monitor vitals x 2nd hourly
<u>V/O - 100ml, clear</u>	PA - VT Relaxed NST - Reactive	✓ PR x 2nd hourly
<u>NGT 25ml/hr outflow</u>		✓ V/O Monitoring x hourly
		✓ Oral hydration
		✓ AP1 + Dopplers (19/7/26)
		✓ Early breakfast - NBM
		✓ NST x BD
		✓ Drugs as charted
		✓ Inform SAs by Mr. Deepika
<u>19/7/26</u>	BP - 113/86 (96) PR - 82 bpm SpO ₂ - 97% on RA	
<u>1 AM</u>	PA ⊕ R on Doppler	
<u>V/O - 200ml, clear</u>		by Mr. Deepika

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/7/26	Outside Reports: V/A - 3+ CVE: Pvs Cms - 35-40. Bacteria present UyCT: 114 Hb - 9.8 / WBC - 14,500 Platelets - 3.30 Vrea - 25 mg/dl creatinine - 1.1 SGOT - 40 SGPT - 37 Uric Acid - 6.9 LDH - 420. PBS - 180. PT - 15 / INR - 1 APTT - 34	
18/7/26	Urine Spot PCR - 3.14 LDH - 276 SGOT - 22 SGPT - 21 creatinine - 0.5 CVE - Protein - 2+ Hb - 11.5 / Pt - 3.26 / WBC - 12.31 Spot PCR - 3.14	Aptt - 32 INR - 1 PT - 14. Pvs Cms - 20-22 Epi Cms - 14-16.
3PM	PBS: 93 mg/dl	
	by Mr. Rupika	

2

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/7/2026 3AM	BP - 123/85 (97) PR - 85 SpO ₂ - 94% on RA FHR on Doppler (+) NMC ✓	By Mr. Dupika
19/7/2026 6AM	Primis / 25 ⁺ 3 / FGR / AGDF / Pre-eclampsia	Dr Doppler Ped resistance Advice
NMC ✓ steroid ✓ MgSO ₄ on flow 25ml/hr	comfortable Vitals - BP - 122/85 (95) PR - 120bpm SpO ₂ - 96% on RA P/A - uterus Relaxed FHR on scan	~ AFI + Dopplers - today monitor vitals & 2nd hrly P/R x 3rd hrly NST x BD
v/o - 150 ml, clear Total v/o - 1350 ml	Trace Urine/s	~ Oral hydration NBM after early breakfast ~ Drugs as charted ~ Inform SDC ~ PRBC Inform
	By Mr. Dupika	

HNH-00016676 IP5-00176590
 Mrs IQRA FATIMA
 30-09-2004 21 Y 9 M 19 D (F)
 Dr. ANNIE PRANUTHA P



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/1/26 9 AM	~ Up/w Dr Niveditha PBS - 200mg/L ↓ No intervention as NBM ~ Do PBS and Inform by Dr Rupika	
		MB Swanda
Scan Fibroid	25⁺ wks, C40, 148 bpm Cephalic Placenta P/A AFI: 12.8cm Doppler ↑ resistance in Umbilical artery TEDF and cerebral resistances venous Doppler ⊕	
		MB Swanda

HNH-00016676 IP5-00176590
Mrs IQRA FATIMA
30-09-2004 21 Y 9 M 19 D (F)
Dr. ANNIE PRANUTHA P



(3)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/7/2026 4pm	Primi. 25 ⁺ wks	FGR / Doppler check
	GC: fair	
	B.P - 130/89 (101)	1) NST - BD
	P.R - 92	2) Monitor inks - 4ty
NAC ✓	SPR: 98% on RA	3) FHR - 3rdly
steroid -	PLA: Ut - Relaxed	4) Drug as charted
	24-26 wks	5) DFR < 10 (Contract)
Mg sulfate flow	FHR 120	6) Fetal ser
19/7/2026 2:30pm	History reviewed Primi 25 ⁺ wks / Severe PWS. Early onset FGR. AWD.	Dr. Subir
	Plus Mild frontal headache. No blurring of vision, No SOB. V-O = 2 stone last hour.	
	GC - fair.	
	PR - 81/min.	BP - 111/76 (MAP - 87)
	Wpo - 99% Ronda	
	RR - 19 bpm.	Knee jerks normal
	ABD - ut. Relaxed.	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>Labs</u>	<u>Ads</u>
	5:23 pm (18/12/26)	1) CRP, LDH
Wb - 11.4		LFT, S-creatin
PCV - 33.6		S. Electrolytes Na ⁺
plt - 4.92		PT/INR, APTT
LDH - 276		2) KCG, 2D Echo
LFT - Normal		3) Monitor BP / RR
S. Creatinine - S. creati		V-O hourly
PT/INR - 14/1.0		4) Daily dopplers
APTT - 32		5) Monitor RR 2nd half
Spon - Urin PCR = 3 gm		5) Monitor pre & post - mear bleed
	Steroids ✓	Sugar
	Mgso ₄ a flow	
	Adm - Physician opinion	
19/12/26	Counselled family	DR. ANNIE PRANUTHA P Registration No: 51353
3pm	<u>Problems</u>	
	- High Blood pressures with proteinuria	
	- on BP medications	
	- Severe Growth Restriction in Baby	
	- Doppler changes	
	- Spd- PCR 8.14	
	- All these are suggestive of severe preeclampsia	
	- Need of Inpatient mear & fetal	
	monitoring	
	- Need of daily dopplers	



(4)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	→ Need of renal labs for mother to consider delay in case of worsening labs for maternal imminent symptoms. Or worsen fetal dopplers → Discussed the course of the disease, possible worsening explained. → Possible need for ICU care explained. → neonatal outcomes will be discussed by neonatology team.	Dr. Anne P.
19/09/2016	Primi / 25th w / FGR / Dopplers, Severe. PE	
5:30pm	QC: / per B-P - 111/66 (87) w/kg P-R - 84 bpm SpO2 - 100% on RA P/A: UF - rehydrated FHR - 136 Act - 0.5 Na/K/Cl - 129/4.4/105 LFT - (2) LDA - 239; Hb - 9.9 Plt - 3.29 WBC: 14.01	1) NST-BD 2) Monitor vitals q2h 3) Inform if BP > 140/90 4) w/f S/S of IE 5) Drug as charted 6) Dflec SLO 7) Tissue PT / INR, APTT
		Dr. Sankar



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/2/26 10 PM	<u>Counselled family</u> - Patient and her attendants have been Counselled regarding the present condition. - The diagnosis associated maternal and fetal risks, need for close maternal and fetal monitoring, treatment plan, and possible need for early delivery depending on maternal and fetal conditions have been explained. - They have understood the information provided and all their queries have been addressed.	lv (Dr. Lavanya)
19/2/26 10:30 PM	Primigravida 25+3 wks / Severe PE / Early onset FGR <u>Abnormal dopplers</u> Pt - comfortable No S/O headache, blurring of vision. G-r-fair Afebrile PR - 72/min BP - 115/83 (au) SpO2 - 96% @ RA. P/A - not relaxed FHS (+)	<u>Advise</u> ① CBP, LFT, LDH, creatinine Co-electrolytes 2D Echo tomorrow at 6 AM. ② FHR 2nd half ③ Monitor BPLRP 10:00 half ④ Daily Dopplers. ⑤ Monitor ppe and postnatal blood sugars



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/2020	Primi 25 th wks severe PE FGR absent Doppler	
2 Am		Re
U/ 10:200	Gc: fair B.P - 119/84 (96) P.L: 72 SpO ₂ : 94% on RA Temp: 96.7°F P/A: UT 24-26 wks relaxed FHR ⊕	1) 2 lit O ₂ inhalation given 2) Monitor vitals → B.P, P.L Temp, SpO ₂ - 4 hrs 3) Temp if BP > 140/90 mmHg PR > 100, Temp > 100°F 4) w/f S/S of I.E 5) Dmg as checked 6) NST & D.
	Send 4 Traces → CBP, LPH, LFT S. electrolytes, S. creat	- Dr. Sankar
4 Am	Gc: fair B.P: 123/97 (87) P.R: 61 SpO ₂ : 98% on 2 lit O ₂ Temp: 96.5°F P/A: UT - 24-26 wks relaxed, FHR ⊕	Re 1) monitor vitals - 1 hr 2) Temp if BP > 140/90 mmHg, PR > 100, Temp > 100°F 3) w/f S/S of I.E 4) NST & D 5) Temp S/S.
ECG - 2D Echo - NGT 04 -	Traces → Lab	- Dr. Sankar



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/2/26 8 AM	Primigravida 35+4 wks / Severe PE / Early onset FGR Oligohydramnios / Abnormal Dopplers	
	Pt - comfortable No H/o headache, blurring of vision. Gr - fair Afebrile PR - 72/min BP - 110/80 (95) SpO2 - 95% @ RA RR - 22/min PIA - ut Relaxed FHR 140	Adv:- ① NBM ② AFI + Dopplers - today ③ Monitor vitals hourly and inform > 100/90 mmHg ④ Monitor vitals hourly ⑤ Monitor FHR 2nd by ⑥ NST - TID ⑦ Do pre- and post meal blood sugars and inform Physician. ⑧ Physician Consultation. ⑨ 2D Echo - Inform to Dr. Srinivas.
26/2/26 6:08 AM	Hb - 9.2 WBC - 14000 PLT - 284 Na ⁺ - 135 K ⁺ - 4.2 Cl ⁻ - 110 Sr Cr - 0.5 LFT - (N) LDH - 253	Plan:- AFI + Dopplers - Today 2D Echo - Today
	Care referred to Dr. Niveditha → advised: Ultrasound chest.	(Dr. Jayanagar)



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/2026 11:30 AM	Pain 25⁺4 wks Severe P.W. Severe FGR. A&D R Husky reseried w/o Shortness of breath on & off Saturation at 2AM body recorded 99% Room air. Received. Supplemental O₂ 2L5/min trusa SpO₂ on 2L5 O₂ 99% • SpO₂ taken → physician → adv. V89 Chst. done Suction at plend effort. Bk Basal atelectasis. • Cardiology- 2D echo done reported normal. • No neurological symptoms / signs. Vital New PR - 90/w New volume RD - 129/92 mm Chest - clinically clear SpO₂ - 97% on room air P/A - Uterus Rulerd Pur - 150 bpm Scen body → AF1 - 10 cm ↓ Umb. A. doppler → A&D R mCA CPR PI < 1% Dr - Normal.	
		⇒

HNH-00016676 IP5-00176590

Mrs IQRA FATIMA

30-09-2004

21 Y 9 M 19 D

(F)

Patient Dr. ANNIE PRANUTHAP



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Labs (6:08 AM) - 20/7/26	
US	- 9.29mi	- Neonatal counselling
PCr	- 29.8	done by Dr. Soumya
WBC	- 14.04	- Husband expressed
Plt	- 2.84	specific concerns about
lyts	- 135/4.2/116	neonatal outcome.
C-Reactive	- 0.5	- Hence, referred
CRP	- Normal (1.41 - 0.2)	Dr. Dinesh.
Syot	- 26	
SyPT	- 27	
Sids	- 2.4	
LDH	- 253	
	Counselled couple. Overall picture	
	of severe pre-eclampsia with massive proteinuria	
	(Spot UPCR 3.14).	
	- FETAL GROWTH RESTRICTION - Severe 21	
	with AWD.	
	→ New development → Shortness of breath while	
	was evaluated by Cardiology & physio. Needs	
	supplemental oxygen.	
	→ Labs - No evidence of WBC or DLE.	
	→ Cause of the disease unpredictable.	
	Can worsen suddenly.	
	→ Cancelled the need for delivery by cesarean	
	section in the interest of mother and baby.	
		Dr. Annie

HNH-00016676
Mrs IQRA FATIMA
30-09-2004 21 Y 9 M 19 D (F)
Dr. ANNIE PRANUTHA P




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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/26 11:30 AM	→ <u>Scan</u> - AFI = 10, Cephalic PI - posterior high. Doppler - UA PI - Absent CDFI & Cerebral redistribution ⇒ ECG Normal (N); GT - 62%. ⇒ USG chest - Basal atelectasis in b/l lower lobe. No c/o effusion noted b/l. ⇒ Pt is stable. BP - 129/92 [104] PR - 90 bpm SpO₂ - 97% on RA RR - 18 bpm.	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/2026 12:00pm	<u>OLE</u> pt stable BP- 118/72 (99) mmHg PR- 85 BPM SpO₂- 98% RA RR- 18 per min	Adv 1) NBM 2) IVF @ 75ml/hr 3) Drugs checked 4) Inform SB
VO- 200ml		Dr. Diugs
20/7/2026 12:30pm	<u>OLE</u> pt stable BP- 130/90 (98) mmHg PR- 82 BPM SpO₂- 97% RA RR- 25 per min	Adv ① NBM ② IVF @ 75ml/hr ③ Inform SB
VO- 50ml		Dr. Diugs
20/7/2026 1:00pm	<u>OLE</u> pt stable BP- 121/95 (100) mmHg PR- 85 BPM SpO₂- 98% RA RR- 19 BPM	Adv CST Dr. Diugs
20/7/26 1:30pm	<u>OLE</u> pt stable BP- 137/91 (106) mmHg PR- 88 BPM SpO₂- 98% RA RR- 19 per min	Adv ① T. labetalol 100mg @ 2:00pm before check BPs and Inform
noted by Sr. Manoj (18268)		Dr. Diugs



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/26 4:05 PM	→ POD - 0 / Severe PE. → Immediate post op → Patient is stable No imminent signs. C/E: GC - grade 2 pedal edema (+) BP - 139/90 [106] PR - 72 bpm SpO₂ - 98% on RA. RR - 19 cpm Temp - 97°F P/A - UA well retracted decreasing deep & intact C/E - BUNAL ✓ U/O - 200ml output C 4pm; Clear.	<u>Advice</u> ① NBM x 6hrs ② Drugs as charted ③ IVF @ 50ml/hr ④ Trij Magesack 1-5g IV B ⑤ Strict vitals & I/O monitoring every 15 min for 2hr A/b hourly ⑥ w/p signs of pre-eclampsia, breathlessness, bleeding plv. ⑦ Send V CBP, LDH, LFT, Sr. electrolytes @ 9pm on 20/7/26. <u>Sudha</u>

Date & Time	Progress Notes	Doctor's Order
7/26 4:55pm	Pt is stable; no imminent signs. BP - 140/104 PR - 56bpm SpO₂ - 98% on RA Temp - 97.4 F RR - 20bpm P/A - vt well retracted C/O - 120ml	
	<u>C/I/T (Axon)</u> <u>Admin T. Nicardipine long Stat</u> ↓ P/B	
7/2026 5:50pm	<u>T. Nicardipine long TID</u> <u>O/E A. C. 10/17</u> BP - 150/103 (117) mmHg PR - 83 bpm SpO₂ - 96% RA PLA - vt @ well RR - 27 bpm TCM - afib/br.	<u>Adv</u> ① T. Nicardipine long p/s stat. ② Monitor BP/PR/SpO₂ every 15 mins ③ I/O charting ④ Intraosseous
130ml clue		
		Dr. Diver

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/2026 7:15 PM	POD-0 Em. uses / Severe PE	
	PR: 82 bpm	
	BP: 130/90 (102) mmHg	① NBM - 10 PM
	SpO ₂ : 99% on 2L O ₂	② IVF @ 50 ml/hr
	RR: 27/min	③ Strict I/O
	U/O: 6-7 PM: 250 ml, clear.	④ Hourly vitals
	emptied.	⑤ Temp 4 hrly
✓	CASIX 20mg @ 6:40 PM	⑥ w/ Bleeding Pr
✓	NR @ 5 PM 10mg	2mm S & S.
	6 PM 10 mg	⑦ CBP, LDH, LFT, Electrolytes
✓	IV PCM 1gm 7 PM	q PM
	on IV Magnetonite 1.5mg	⑧ propped up position
	T. Pantop 40 mg	⑨ Spirometry
	T. NR 10 TID	
	T. Lab 100 TID	
	Inj dexane 40 11 PM SL	
	T. PCM/Tramadol/ IV SOS.	
	Chest: clear	
	Temp: 97.9°F	
	P/A: URW	
	BS (+)	
	P/V: BwNL.	

Dr. Y. Suresh

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/2026 7:20 PM	C/O/w Dr. Niveditha.	
	✓ T. Labetalol 200 mg TID ✓ T. Nicardia R 10 mg BD (After informing BP) ✓ overnight O₂, close monitoring ✓ Spirometry / chest physio tomorrow	
		Dr. Y. Snelus
20/7/2026 9:40 PM	S/B Dr. Annie	
	9PM: Temp: 99.2°F (Tepid sponging (+)) PCM IV @ 7PM IV Tramadol flow:	- Allow oral sips - liquid diet > 12AM - IVF @ 50 ml/hr RL - CBP 6AM 21/7/26 - Soft diet > 4 AM - To start Aggrenox.
	now: PR: 65/min. BP: 125/83 (95) mm Hg Temp: 96°F U/O: 150ml. RR: 20/min. SpO ₂ : 98% on O ₂ NP	Maintenance done. Dr. Y. Snelus

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7/2026 6AM	POD -1 fm uses /severe PE.	
	C/o Breathlessness ↓↓ o/e: Pt conscious Coherent PR: 73 bpm BP: 131/96 (110) SpO₂: 99.1 on 2 L O₂ RR: 19/min Temp: 96.5°F P/A: URW, BS (+) P/V: BWNL ⑩ _____ O: 4025 ml	<u>Adu</u> ① soft diet ② plenty of oral fluids ③ stop IVF ④ MgSO₄ on flow ⑤ Ambulate ⑥ drugs as chart ⑦ Spirometry ⑧ chest physio? ⑨ wlt 3mm S&S ⑩ propped up position ⑪ vitals, temp hourly ⑫ plan O₂ ↓↓ ⑬ physician R/w
	Trace C&P, electrolytes. FW	
		duy or 4-metre

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S/B Anon Anaesthesia Department	
	POP-I EMUS	
	AP = pmix 25 + uday swer preclampsia GER - oligohydramnios	
	ole - pt Conscious & Alert	
	Pedal Edema (+)	
	Vitals → PR 62	
	BP - 118/84 mmHg	
	SpO2 100% on 2L O2 Nasal prongs	
	U/O. 4 out	
	I/P = 1 in 5	
	ole - RS - RA + Delus	
	CUS - seen (+)	
	2/17/2026 GAM	
	Hb - 10.9	
	Plat - 290.	
	Na ⁺ 128	
	K ⁺ 5.2 → Gynic department	
	d = 29	
	started salbutamol	
	Nebulization	
		Adv
		1) Ambulation
		2) monitor urine output
		3) chest physiotherapy
		4) Monitor vitals
		5) Continuous nuchal checks
		6) Repeat electrolytes
		Dr. K Sri Ramya



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/7/26		
4:30 PM	A conscious oriented	Adv - disp aspir chilled
	O/G	- vitals 2nd h
	Gr. fair	- I/O charting
	PR - 88 bpm	- soft diet
	BP - 112/80 mmHg (95)	plenty of oral fluids
	SpH - 98% m ₁₀₀ /a	- Ambulate
	RA - 16 bpm	- Sprometry
	P/A uterine	- naproxen
	retracted	
	O/G - lochia	
	healthy	
	- Send Si electrolytes @ 6pm today	
		Dr. [Signature] or same
		NB Dr. [Signature] 2/7/26 4:30 PM

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30-09-2004 21 Y 9 M 21 D (F)
Dr. ANNIE PRANATHA P



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7/20 5:45PM	POD-1 / Em / Sec & Severe PE. Pt is stable No imminent signs o/c AC-Fair BP- 106/76 [85] PR- 86bpm SpO₂- 97% on 2L O₂ on nasal prongs RR- 24cpm Chest clear Temp- 97.1°F P/A-Ut well retracted drinking dry & intact L/E- lochia ⊕ U/O- 75ml, clear ⇒ Currently on: T/abeta 200mg TD T/civod 10mg BD Ty Mgncx Forte IV bol Ty Clexane ⇒ Send electrolytes @ 6pm.	Adm: ① w/o signs of PE ② Vitals & f/o hrly ③ w/o heavy bleeding plv ④ Dnsp as charted ⑤ Spirometry ⑥ Ambulate ⑦ Reoped up position Smith



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7/26 10:00pm.	POD-1 Pt is stable No imminent signs BP- 101/73 [84] PR- 74bpm SPO₂- Temp= 97.7°F SPO₂- 96% on 5L O₂ RR- 22cpm A/A- Ut well retracted L/a- lochia ⊕ U/O- 200ml; clear	<u>Advice</u> ① Watch signs of PC ② 2L O₂ ③ vitals 2 T/O hrly. ④ w/ heavy bloody plv. ⑤ Drugs as charted ⑥ Ambulate ⑦ Spirometry ⑧ Propped up position.
21/7/26 2am	POD-2 / PE- LSC Pt is stable sleeping comfortably BP- 99/70 [79] PR- 68bpm SPO₂- 96% on 2L O₂ Temp= 97.7°F SPO₂- 96% RR- 18cpm U/O- 80ml/hr; clear	<u>Adv</u> ① w/ signs of PC ② 2L O₂ ③ vitals 1 T/O hrly ④ w/ heavy bloody plv ⑤ Spirometry ⑥ Drugs as charted ⑦ Propped up position

Smth
NB: [Signature]



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7/26 6:50 AM	POD-2 / Severe PE + LSCS Pt is stable. No imminent signs. BP - 106/82 [90] PR - 78 bpm SpO₂ - 97% on 2L O₂ Temp - 97.9°F RR - 19 cpm PIA - ut well retracted. Dressing dry & intact 4th lochia ⊕ W/O - 75ml clear.	<u>Advice:</u> ① Soft diet ② W/O signs of PE ③ Vitals q 4hly ④ W/O heavy bleeding ⑤ Drops as charted ⑥ Intermittent auscultation ⑦ Propped up position Smother
22/7/26 9:45 AM	<u>POD-2</u> Subjectively stable No shaking of head ambulate. on 2L O₂ hypotension RT cerebral done PR - 76b SpO₂ - 97% on 2L O₂ RR - 19 cpm BP - 100/66 mmHg PA - sq ut 100ml	Lochia heavy POD



16

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		Ad
		Review f/day
		Oral ab supp. 2 P/n
		stat
		centri medicals
		as charted
	plan → ship to room 10dp	
	af. physice Rein	
		DR. ANNIE PRANUTHA P Registration No: 51356
		stat
	clby Dr. Niveditha	
22/7/20		
	gatac.	ad. SKT on 23/7/20 at
	akbule	6Am.
	PR - 87/mu	If BP > 120/80 → give
	BP - 107/80 (2)	lobet 20mg (10/1)
	spg - 28% @ RA	If BP < 90/60 - give lobet
UL	P/A - ut @ well	10mg. - vitals & temp
SL	P/v - NAB.	- Drup as charted.
		- n/p actue bleed.
		- Infombr > 100/90 mm
		- n/p 8/1 of Immune
		relamp.
		- Informer.
	shift to room.	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7/26 7:00pm B-Nileu	POD 2 / Pili / seven up F / Em. lcy Counsel on T. Labelal 20mg TID T. Cirod 1mg TID	
Voided flatus SV inf. clearing.	O/F C/fair BP - 110 / 77 (88) mm PR - 94 BPM SpO2 - 98% LM P/A ut @ uel P/A - soft BS (+)	Adv ① Bp monitoring ^{2nd} hourly ② Drugs as charted ③ Soft diet ④ Hydration ⑤ Inform S/S
	DR. Divya	
23/7/26 9:30 AM	C/D/w / Dr. Nivedita POD 3 / Pili / seven up F / Em. lcy	
B-Nileu	C/fair Vitals stable P/A ut @ uel Soft BS (+)	1) Continue same anti-HTN medication 4 R/w after lunch Dr. Nivedita 3) Monitor vitals 4) Drug as charted 5) W/t P/W Bleeding 6) Analgesia 7) F/H S/S
CBP LDH LFT Creatinine p. culture	after S due Potassium - There plan. change. Thru	



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CROSS CONSULTATION FORM

Doctor Name : Dr. C. Minedithe Date : 22/7/26 Time : 12:10pm

Diagnosis : Sev PE

Hospital : State Hosp

Type of Referral :

- ☐ Emergency
☐ Urgent
☐ Non Urgent

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

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

Sev. PE

Signature: _____

Findings and Recommendations :

2/p in KCS - 2nd pos

pt - reviewed

doing ok

o/E - SpO₂ - 94-95% on RA

PR - 82/min

BP - 120/80 mm Hg

skt -

CVS - S+S

RS - B+Tst, clear

Repeat
Ser. Potassium
tomorrow

Consultant :

Name : Dr. C. Minedithe Signature : 22/7/26 Date & Time : 12:15 pm

OK

- Continue T. Cimed

- to check BP before labet
if $>120/80$ - give 200
 $<120/80$ - 100 mg

W



CROSS CONSULTATION FORM

Doctor Name : Khushid. Shaik (PT) Date : 21/7/26 Time : 3:30/pm

Diagnosis : emles

Hospital : RCH; Bangalore

Type of Referral :

- ☐ Emergency
☐ Urgent
☐ Non Urgent

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

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

chest physiotherapy

Signature: _____

Findings and Recommendations :

AB physiotherapist

cl:- emles

o/o:- Patient is on low flow O₂ (0.5L/min)
BP- 113/85

b:- chest expansion Ex:-

- Incentive spirometry

- Frequent change of position

Consultant :

Name : Dr. Khushid. Shaik Signature : Khushid (PT) Date & Time : 21/7/26



CROSS CONSULTATION FORM

Doctor Name : Dr. C. Minedike Date : 21/7/26 Time : 1:10pm

Diagnosis : Sev PE

Hospital : STAR Hosp

Type of Referral :

☐ Emergency

☐ Urgent

☒ Non Urgent

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

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

Sev PE

Signature: [Signature]

Findings and Recommendations :

Sp em LCS - 1st POD

AD - reviewed
no headache
no giddiness
no SOB
pedal edema +

SpO₂ - 96% on 1-2 Ltr O₂
90-91 on RA
PR - 76/min
BP - 125/96 mmHg

SpO₂ -

UR - 4 St

NS - RA

occ free crepts
RT - 11

Consultant :

Name : Dr. C. Minedike Signature : [Signature] Date & Time : 21/7/26, 1:10pm

Adv
S.K. - tomorrow

Ref
✓ as per drug chart

- Chest physio

- Spirometry 2nd - 4th July

W



CROSS CONSULTATION FORM

Doctor Name : Dr. C. Riveditha Date : 20/1/26 Time : 1 pm

Diagnosis : Sev PE

Hospital : STAR HOSP

Type of Referral :

☐ Emergency

☒ Urgent

☐ Non Urgent

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

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

Sev PE

Signature U

Findings and Recommendations : Ptnt @ 25th weeks GA

Severe PE on T. lobet / TID
requiring T. HR / 80s
having sev. proteinuria
do breathlessness :: yesterday

v/o - ~ 2000 ml/hr

USG chest
↓
sl. basal
atelectasis

HR -

PR - 85/min

SP - 120/100 mm Hg

stet -

Rs: BAET, clear

Consultant :

Name : Dr. C. Riveditha Signature : U Date & Time : 20/1/26 1:15 pm

Patient Sticker

CROSS CONSULTATION FORM

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Mrs IQRA FATIMA
30-09-2004 21 Y 9 M 19 D (F)
Dr. ANNIE PRANUTHA P

Doctor Name

Date : Time :

Diagnosis :

Hospital :

Type of Referral :

☐ Emergency

☐ Urgent

☐ Non Urgent

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

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

Signature:

Findings and Recommendations :

sch *2 study*
Tul TR

Perinatal 25 weeks / FGR - approach
Sev. PE
du Mild Ser.
offered patient
Ech S.R. by the
No ST-Tols
BD 120/80
HR 80
Sp 80
No Cardiac issue
& on the up Pouching
needed

Consultant :

Name

Signature :

Date & Time : 20/7/20

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RESULT SHEET

Date	18/7/15	19/7/15	20/7/15	20/7/15	21/7	21/7
Time		3pm.	6:08 Am	8:40 Am	6 Am.	6pm
Hb	11.4	9.9	9.2	10.4	10.9	
PCV	33.6		29.8	33.7	35.8	
RBC	4.92	4.49	4.15	4.67	4.93	
WBC	12.31	14.01	14.04	14.32	16.51	
N/L						
Platelets	326	329	284	306	290	
CRP						
ESR						
PCT						
RBC Spot Ratio	3.14					
Na		129	135	132	128	127
K		4.4	4.2	5.0	5.2	4.7
Cl		105	110	105	99	99
Ca/Mg						
Phosphate						
Urea						
Creatinine	0.5	0.5	0.5			
ALP	193	167	162	164		
SGPT	22	22	27	47		
SGOT	21	18	26	46		
T.Bill/Conj	0.2 < 0.1	0.2 < 0.1	0.2 < 0.1	0.2 < 0.1		
T.Protein	6.5	5.6	5.2	5.4		
S.Albumin	3.1	2.7	2.4	2.6		
S.Globulin	3.4	2.9	2.8	2.8		
A/G Ratio	0.9	0.9	0.8	0.9		
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR	14/1.0	14/1.0				
APTT	32	38				
CSF Protein / Sugar						
Cells						
WBC	LAH	276	239	253	334	

MEDICATION RECONCILIATION FORM

Drug Allergies: NEKA ☒ Not known any Drug Allergies

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

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

Shifting From: NA Shifted to: NA

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
	T. IRON	1 tab	PO	OD		☒ C ☐ DC
2	T. CALCIUM	1 tab	PO	OD		☒ C ☐ DC
3	T. ECOSPRIN	75mg	PO	OD		☒ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Dupikas

Date & Time: 18/7/2026, 10:30pm

Nurse Name & Signature: Shweta

Date & Time: 18/7/2026, 11pm

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Mrs IQRA FATIMA
30-09-2004 21 Y 9 M 18 D (F)
Dr. ANNIE PRANUTHA P



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Sheet No:

REGULAR PRESCRIPTIONS

Weight .. 80 kgsu Ward B/C

DRUG : TAB. IPON

Date 18/7/26
Time 07

Dose 1 tab Route PO Frequency OD Start Dt. 18/7/26

Name & Signature of the Doctor Starting the Drugs:
by Dr. Deepika

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : ALY-9 Sachets

Date 19/7
Time 09

Dose 1 packet Route PO Frequency BD Start Dt. 18/7/26

Name & Signature of the Doctor Starting the Drugs:
by Dr. Deepika

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : 4; CLEXANG

Date 19/7
Time 09

Dose 400 Route s/c Frequency OD Start Dt. 19/7

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : - 2AS R coopr in

Date 19/7
Time 09

Dose 1500 Route Pls Frequency OD Start Dt. 19/7

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign



Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

VERIFIED

VERIFIED

VERIFIED BY : Name

DRUG : P.PARACETAMOL

Date
Time 21/7 22/7 23/7

Dose 1gm Route oral Frequency QID 6mly Start Dt. 20/7

Name & Signature of the Doctor
Starting the Drugs:

Dr. Akhila-K @mny

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : T-TRAMADOL

Date
Time 21/7 22/7 23/7

Dose 100mg Route oral Frequency TID 8mly Start Dt. 20/7

Name & Signature of the Doctor
Starting the Drugs:

Dr. Akhila-K @mny

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : ~~TR-TRAMADOL~~

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 : INS MAGNEX FORTE

Date
Time

Dose 1.5gm IV Route IV Frequency DD Start Dt. 20/7/24

Name & Signature of the Doctor
Starting the Drugs:

Dr. Suthi S

Additional Instructions:

Daily Doctor's Endorsement by a Sign

HNH-00016676
 Mrs IQRA FATIMA
 30-09-2004 21 Y 9 M 20 D (F)
 Dr. ANNIE PRANUTHA P



Sheet No: REGULAR PRESCRIPTIONS Weight Ward

DRUG: Tab MAGNEX FORTE Date/Time: 21/7 22/7 23/7

Dose: 1.5g Route: W Frequency: BD Start Dt.: 20/7/26

Name & Signature of the Doctor Starting the Drugs: Dr Suthi Suthi

Additional Instructions: pm 11pm 12pm

Daily Doctor's Endorsement by a Sign: Dr. Suthi Suthi

DRUG: T. PANTOPRAZOLE Date/Time: 21/7 22/7 23/7

Dose: 40mg Route: PO Frequency: BD Start Dt.: 22/7/26

Name & Signature of the Doctor Starting the Drugs: Dr Suthi Suthi

Additional Instructions: pm 11pm 12pm

Daily Doctor's Endorsement by a Sign: Dr. Suthi Suthi

DRUG: Tab CLEXANE Date/Time: 20/7 21/7 22/7

Dose: 40mg Route: sk Frequency: OD Start Dt.: 20/7/26

Name & Signature of the Doctor Starting the Drugs: Dr Suthi Suthi

Additional Instructions: @ 11pm after checking blood platelets

Daily Doctor's Endorsement by a Sign: Dr. Suthi Suthi

DRUG: T. NICARDIA Date/Time: 20/7 21/7 22/7

Dose: 10 Route: PO Frequency: TID Start Dt.: 20/7/26

Name & Signature of the Doctor Starting the Drugs: Dr Suthi Suthi

Additional Instructions: stop

Daily Doctor's Endorsement by a Sign: Dr. Y. Suthi 20/7/26 7:30PM

HNH-00016676
 Mrs IQRA FATIMA
 30-09-2004 21 Y 9 M 20 D (F)

VERIFIED

VERIFIED

VERIFIED

VERIFIED

P.T.O)

HNH-00016676
Mrs IQRA FATIMA
30-09-2004 21 Y 9 M 20 D (F)
Dr. ANNIE PRANUTHA P

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Sheet No:

REGULAR PRESCRIPTIONS

Weight 8.2 kg Ward B/L

DRUG :	Dose	Route	Frequency	Start Dt.	Date Time
T. LABETALOL	200mg	PO	TID	20/7/26	20/7 21/7 22/7 23/7
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Y. Seneha</u>					20/7 8am 21/7 8am 22/7 8am 23/7 8am
Additional Instructions:					20/7 10pm 21/7 10pm 22/7 10pm 23/7 10pm
Daily Doctor's Endorsement by a Sign					
T. NICARDIA R	10mg	PO	BD	20/7/26	21/7
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Y. Seneha</u>					21/7 8am 21/7 10pm
Additional Instructions: <u>2 form & give</u>					21/7 8am 21/7 10pm
Daily Doctor's Endorsement by a Sign					
Asthalin Neb	1 resp	neb	6thly	21/7/26	21/7 22/7 23/7
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Y. Seneha</u>					21/7 8am 21/7 10am 21/7 12pm 21/7 2pm 21/7 4pm 21/7 6pm 21/7 8pm 21/7 10pm
Additional Instructions:					21/7 8am 21/7 10am 21/7 12pm 21/7 2pm 21/7 4pm 21/7 6pm 21/7 8pm 21/7 10pm
Daily Doctor's Endorsement by a Sign					
T. CINOD	10mg	PO	BD	21/7	21/7 22/7 23/7
Name & Signature of the Doctor Starting the Drugs: <u>N</u>					21/7 8am 21/7 10am 21/7 12pm 21/7 2pm 21/7 4pm 21/7 6pm 21/7 8pm 21/7 10pm
Additional Instructions: <u>9am - 9pm</u>					21/7 8am 21/7 10am 21/7 12pm 21/7 2pm 21/7 4pm 21/7 6pm 21/7 8pm 21/7 10pm
Daily Doctor's Endorsement by a Sign					

VERIFIED

Signature

VERIFIED BY: Name

VERIFIED

VERIFIED

Dr. ANNIE PRANUTHA P



DRUG CHART

Date of Admission: 18/7/2026 Drug Allergies: NEKA ☒ 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
Additional Instructions:				

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

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

VERIFIED BY : Name

Weight. 80kg Ward. B

Page: 2/4



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
18/7	10:30 pm	TAB. CALPOL	1 gram	PO	Lp	Rashmi
19/7/20	6:30 AM	INS BETNASEOL	12mg	Im	Lp	Rashmi
19/7/20	9:00 pm	INS MYSOY	4 gram	IV	Lp	Rashmi
19/7	1:30 pm	Ty NOVARAPID	4 tabs	SLC	Q	Sunanda
20/7	2:30 am	Ty. NICARDIA	10mg	P/O	Q	Song
20/7	12 pm	Ty CEFOTAXIM	1g	IV	Sndh.	Yammy
20/7	12:30 pm	Ty PAR TOLEMOLE	40mg	IV	Sndh.	Shoba
20/7	12:32 pm	Ty. REGINORM	10mg	IV	Sndh.	Shoba
20/7	1:20 pm	INS. AVIL	3ml	IV	W	Yammy



I.V. FLUIDS CHART

Weight. 80kg Ward. DL

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
18/7	10:30 PM	INS MgSO ₄ 25mg/ml in 40ml NS	IV	25ml/hr	[Signature]	[Signature]	19/7	[Signature]	Song
20/7	2 PM	RINGER LACTATE	IV	100ml/hr	[Signature]	[Signature]	20/7	[Signature]	prya
20/7	3:20 PM	RINGER LACTATE	IV	100ml/hr	[Signature]	[Signature]	20/7	[Signature]	Leena
20/7	10:15 PM	RINGER LACTATE	IV	50ml/hr	[Signature]	[Signature]	20/7	[Signature]	Sona
		RINGER LACTATE	IV	50ml/hr	[Signature]	[Signature]			
20/7	10:15 PM	50% MgSO ₄ + (20amp) + 400ml Normal saline	IV	25ml/hr	[Signature]	[Signature]	22/7/2	[Signature]	Shweta



STAT / ONCE ONLY DRUGS

Name:

Weight: 80.95 kgs

Sheet No: 10

DATE	TIME	MEDICATION	DOSAGE & OTHER INSTRUCTIONS	ROUTE	SIGNATURE		
					Doctor	Nurse-1	Nurse-2
20/12/26	1:00pm	MAUNEX FORTE	1.5cm	IV	Dr. Manna	Shoban	
20/12/26	3:15pm	inj-ONDANSETRON	4mg	IV	Dr. Manna	Shoban	
20/12/26	3:15pm	inj-TRANEXAMIC ACID	1gm	IV	Dr. Manna	Shoban	
20/12/26	4:00pm	SUP-TRAMADOL	100mg	PR	Dr. Manna	Shoban	
20/12/26	5:00pm	T. NICARDIA	10mg	PO	Dr. Manna	Shoban	
20/12/26	5:30pm	T. Nicardia	10mg	PO	Dr. Manna	Shoban	
		INT LABETALOL	20mg	IV	Dr. Manna	Not given	
20/12/26	6:00pm	INT LASIA	20mg	IV	Dr. Manna	Shoban	
20/12/26	7pm	inj-PCM	1gm	IV	Dr. Manna	Shoban	
20/12/26	8:45pm	2mg Tramadol	100mg in	IV	Dr. Manna	Shoban	
21/12/26	1AM	2mg PCM	1gm	IV	Dr. Manna	Shoban	
21/12/26	2AM	T. Nicardia R	20mg	PO	Dr. Manna	Shoban	
21/12/26	12:30pm	Tab Nicardia R	10mg	PO	Dr. Manna	Shoban	
21/12/26	9:50pm	INT PARACETAMOL	1g	IV	Dr. Manna	Shoban	

STAT A ONCE ONLY DRUGS

DATE	TIME	DRUG	DOSE	ROUTE	REMARKS
11/15/12	10:00	Acetaminophen	100mg	PO	
11/15/12	11:00	Acetaminophen	100mg	PO	
11/15/12	12:00	Acetaminophen	100mg	PO	
11/15/12	13:00	Acetaminophen	100mg	PO	
11/15/12	14:00	Acetaminophen	100mg	PO	
11/15/12	15:00	Acetaminophen	100mg	PO	
11/15/12	16:00	Acetaminophen	100mg	PO	
11/15/12	17:00	Acetaminophen	100mg	PO	
11/15/12	18:00	Acetaminophen	100mg	PO	
11/15/12	19:00	Acetaminophen	100mg	PO	
11/15/12	20:00	Acetaminophen	100mg	PO	
11/15/12	21:00	Acetaminophen	100mg	PO	
11/15/12	22:00	Acetaminophen	100mg	PO	
11/15/12	23:00	Acetaminophen	100mg	PO	
11/15/12	00:00	Acetaminophen	100mg	PO	
11/15/12	01:00	Acetaminophen	100mg	PO	
11/15/12	02:00	Acetaminophen	100mg	PO	
11/15/12	03:00	Acetaminophen	100mg	PO	
11/15/12	04:00	Acetaminophen	100mg	PO	
11/15/12	05:00	Acetaminophen	100mg	PO	
11/15/12	06:00	Acetaminophen	100mg	PO	
11/15/12	07:00	Acetaminophen	100mg	PO	
11/15/12	08:00	Acetaminophen	100mg	PO	
11/15/12	09:00	Acetaminophen	100mg	PO	

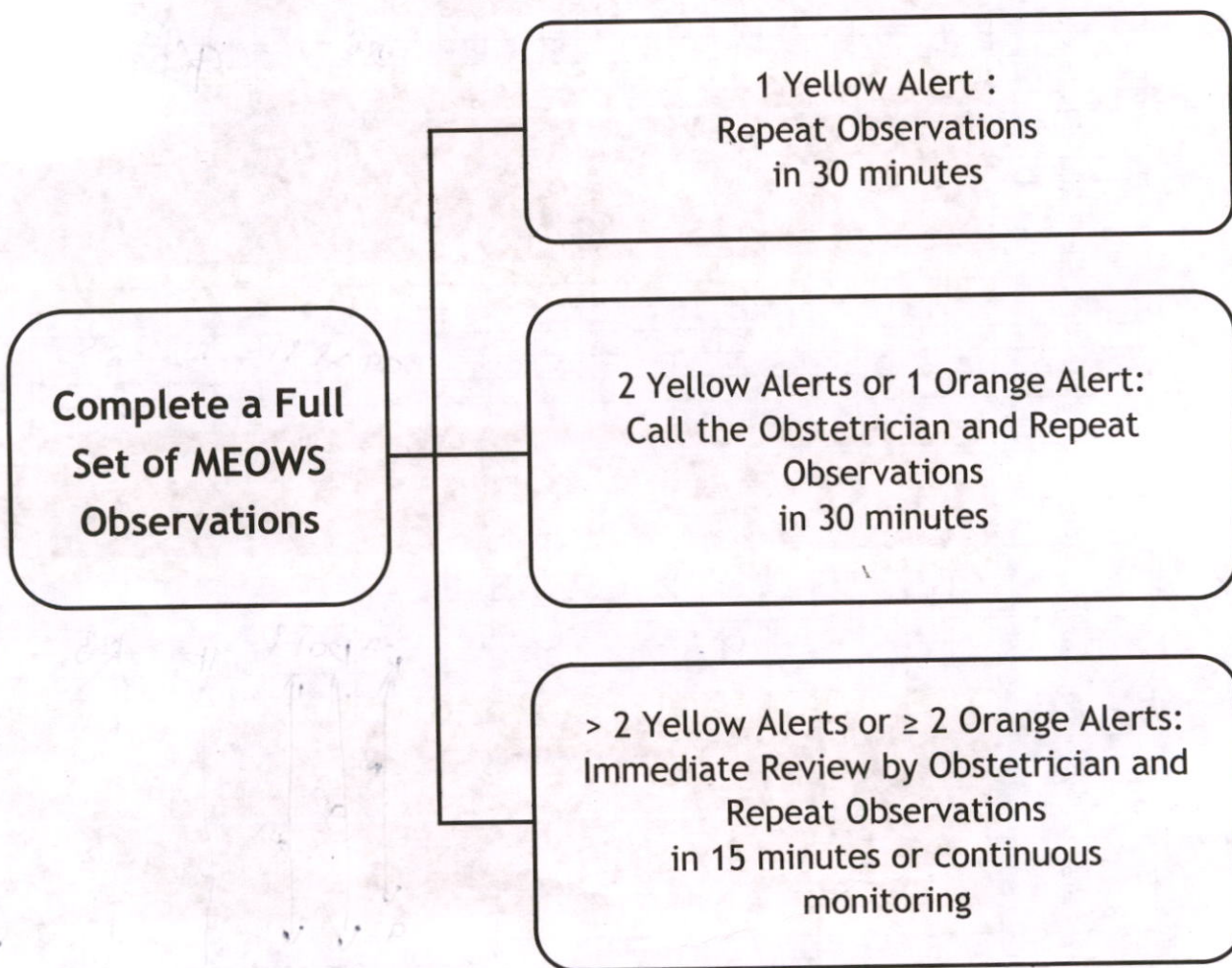


CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

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																									
< 35																										
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
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40																										
Systolic Blood Pressure	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	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																										
TOTAL ORANGE SCORES																										
Nurse Initial																										

FHR - 131 ^{5pm}
FHR - 144 ^{7pm}

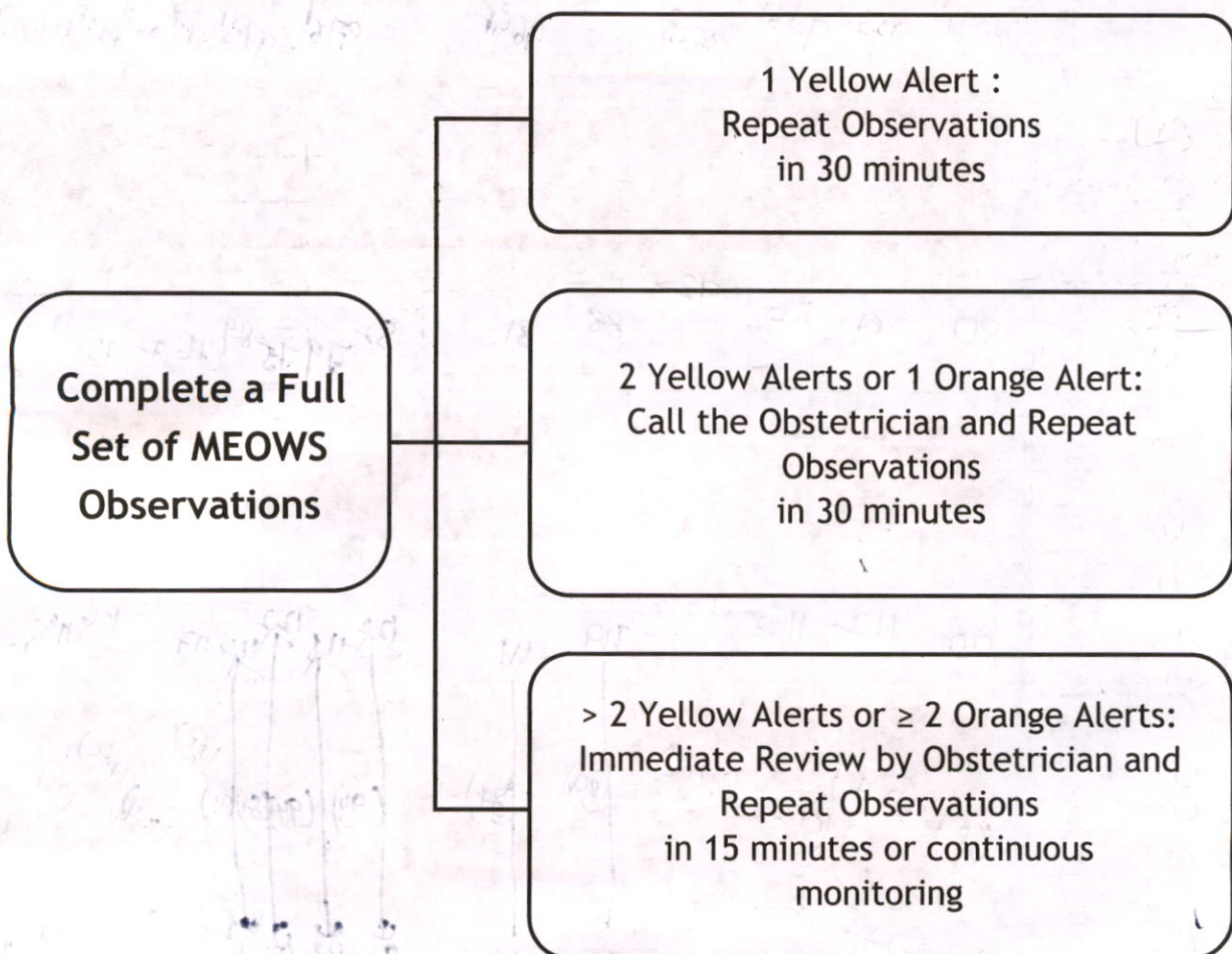
Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

Date		Time																								
		8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20	19	19	19	19	19	20	19	23	21	23	24	24	22	20	29										
	0 - 10																									
Saturations	94 - 100 %	99	98	98	98	98	99	97	96	95	95	94	93	92	91	90										
	< 94 %																									
Administered O ₂ (L/min.)																										
Temp °C	40																									
	39																									
	38																									
	37	36.8	36.8	36.8	36.8	36.8	36.8	36.8	36.8	36.8	36.8	36.8	36.8	36.8	36.8	36.8										
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90	80	79	86	92	88	81	82	79	75	89	76	72	73	89	65	79	89								
	80																									
	70																									
	60																									
	50																									
40																										
Systolic Blood Pressure	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130	110	112	113	130	119	111	122	115	122	114	117	131	126	118	125	124									
	120																									
	110																									
	100																									
	90																									
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Diastolic Blood Pressure	130																									
	120																									
	110																									
	100																									
	90	68	74	92	101	80	84	94	97	88	95	104	105	92	86	102	98									
	80																									
	70	70	77	82	89	77	78	83	83	88	92	84	91	95	81	77	86									
	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

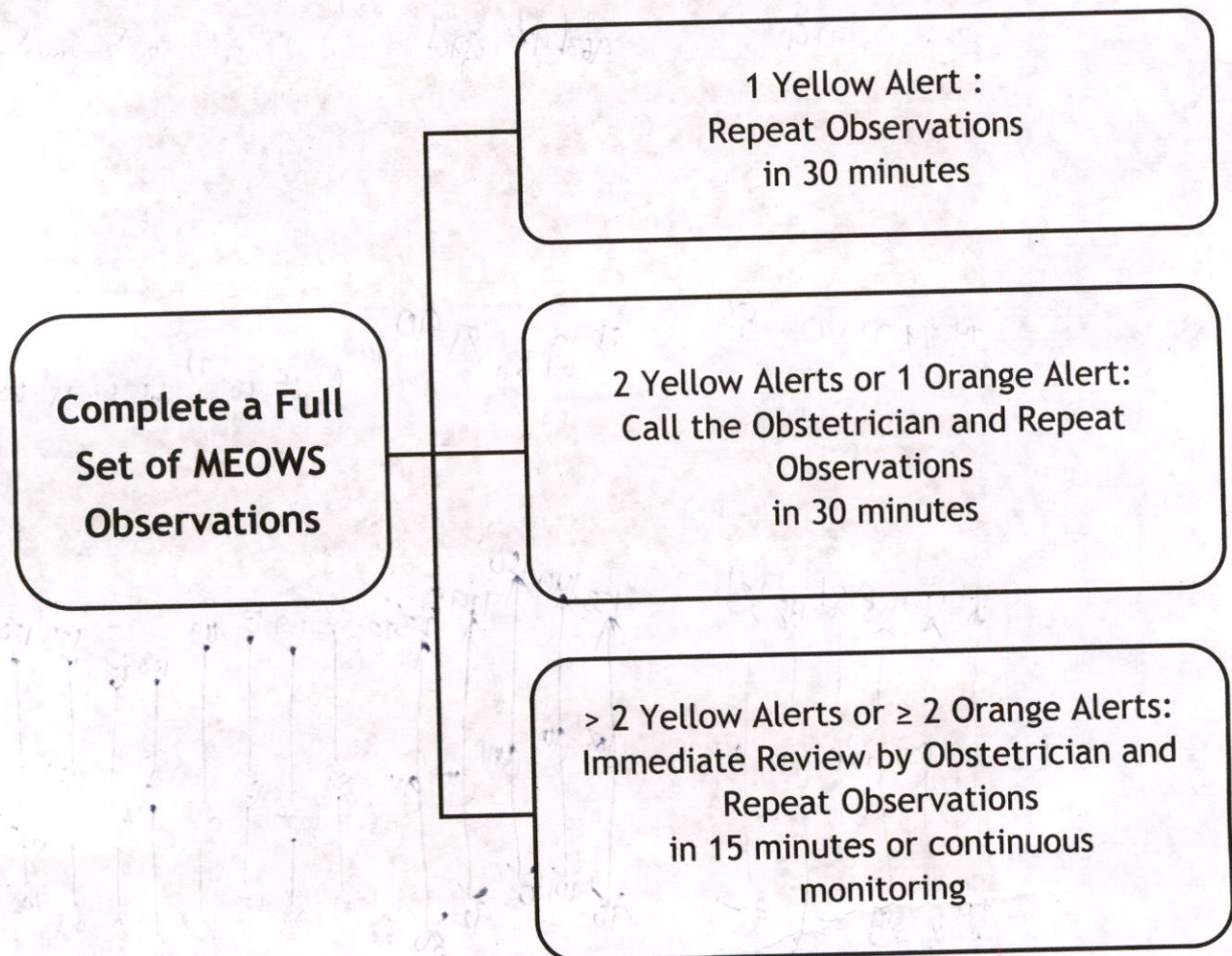


* The Modified Early Warning Score (MEOWS)

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)

HNH-00016676 IP5-00176590
Mrs IQRA FATIMA
30-09-2004 21 Y 9 M 20 D (F)
Dr. ANNIE PRANUTHA P



Early Warning Observation Score Chart - Obstetrics

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

22/7

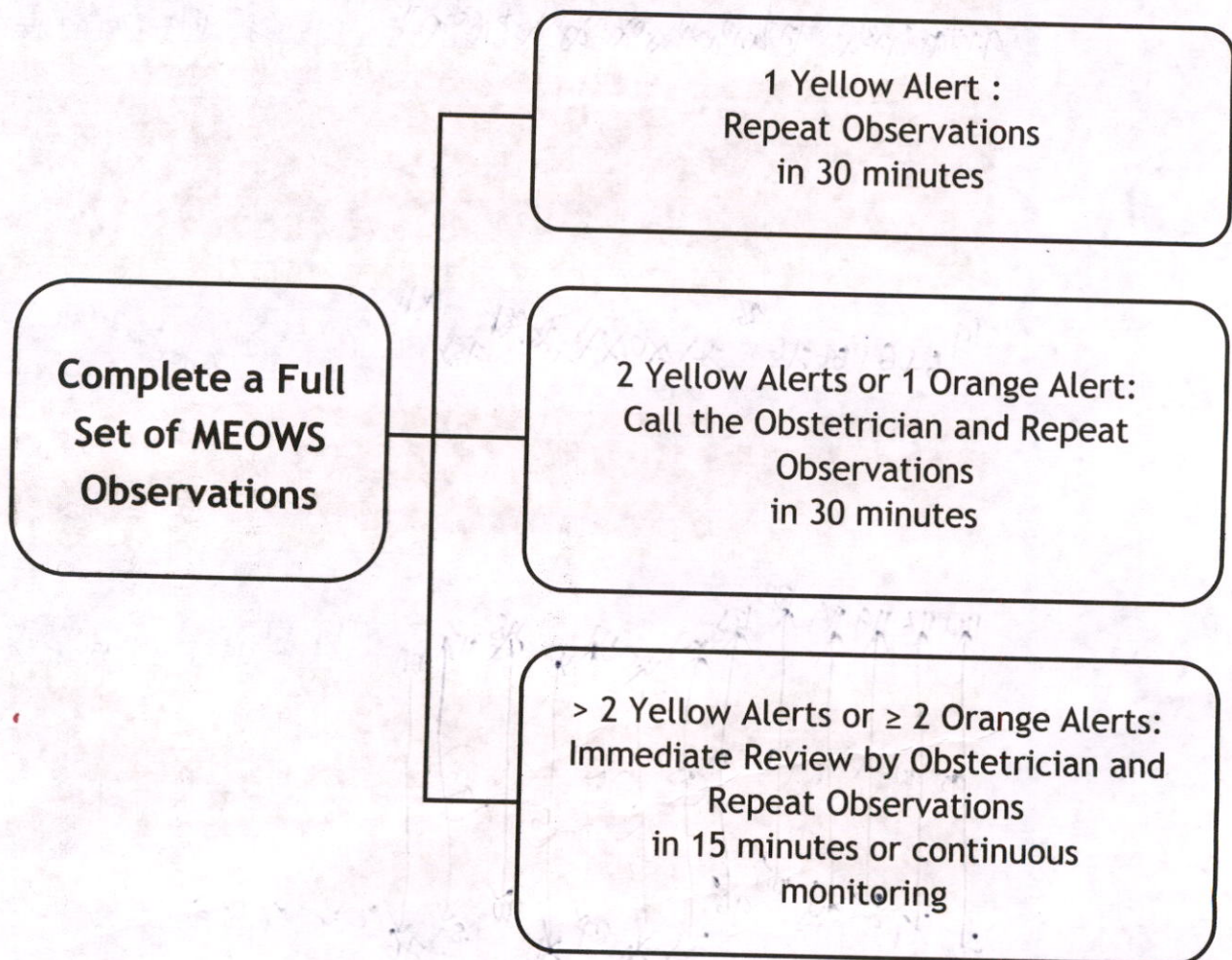
29/7/26		Date																													
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7					
RESP (write rate in corresp. box)	> 30																														
	21 - 30																														
	11 - 20	20	19	16	18	18	21	21	18	16	20	18	19	19	22	18	17	18	18	17	19	19									
	0 - 10																														
Saturations	94 - 100 %	99	98	100	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98		
	< 94 %																														
Administered O ₂ (L/min.)																															
Temp °C	40																														
	39																														
	38																														
	37																														
	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36		
	35																														
	< 35																														
Heart Rate	170																														
	160																														
	150																														
	140																														
	130																														
	120																														
	110																														
	100																														
	90	79	64	64	66	76	71	76	76	76	76	76	76	76	76	76	76	76	76	76	76	76	76	76	76	76	76	76	76		
	80																														
	70																														
	60																														
	50																														
	40																														
↑ Systolic Blood Pressure	190																														
	180																														
	170																														
	160																														
	150																														
	140																														
	130																														
	120	114	118	119	119	123	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125		
	110																														
	100																														
	90																														
	80																														
	70																														
	60																														
50																															
↓ Diastolic Blood Pressure	130																														
	120																														
	110																														
	100																														
	90																														
	80	78	81	81	81	81	81	81	81	81	81	81	81	81	81	81	81	81	81	81	81	81	81	81	81	81	81	81	81		
	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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
TOTAL ORANGE SCORES		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Nurse Initial																															

3:30pm

BP

113/96(103)

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

HNH-00016676
Mrs IQRA FATIMA
30-09-2004 21 Y 9 M 21 D (F)
Dr. ANNIE PRANUTHA P

IP5-00176590

22/7/26

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

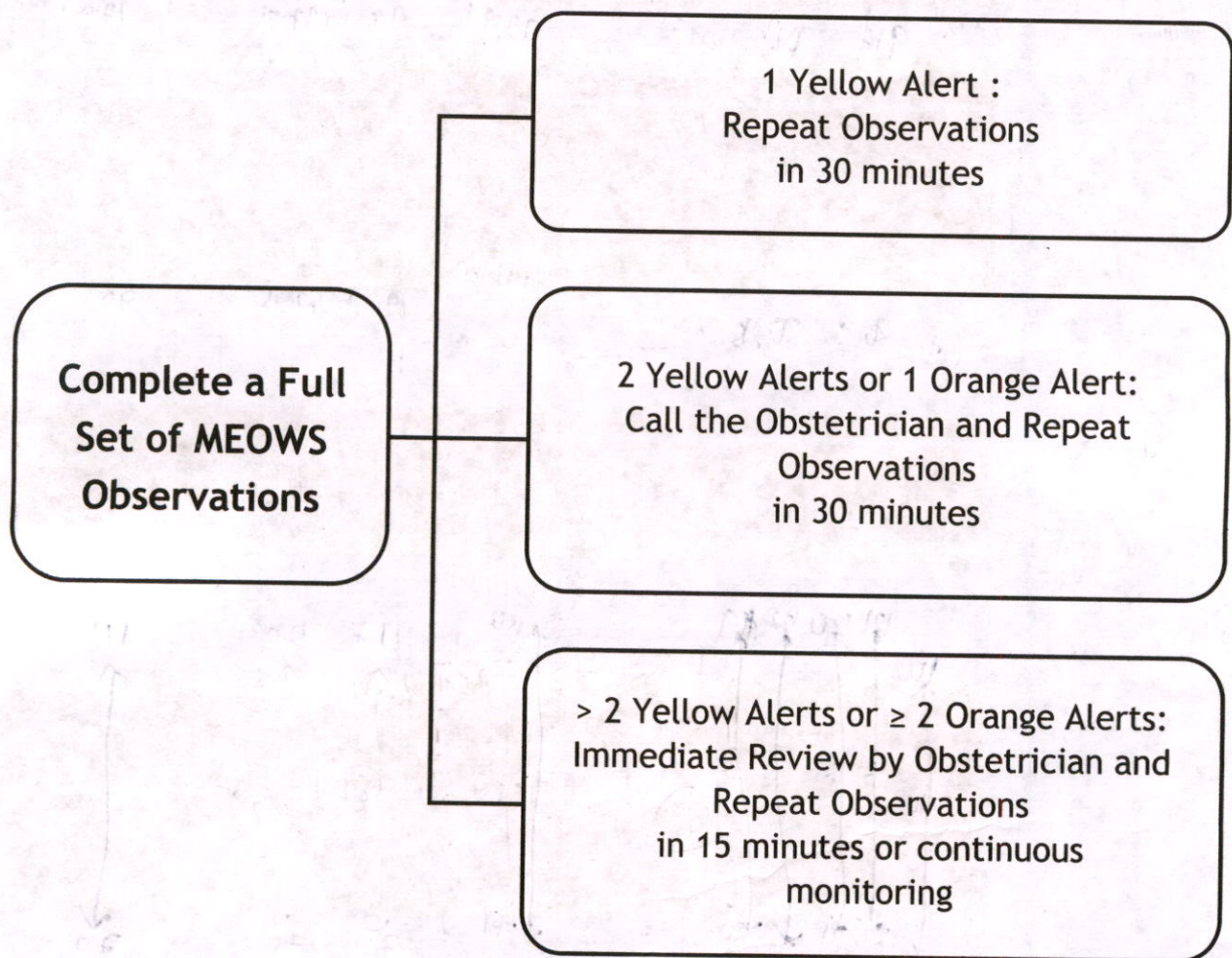
BirthRight™
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Your Right to a Safe Delivery

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	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	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20	20	19	17	18	17	17	18					1ablm		1ablm		1ablm							19		19
	0 - 10																									
Saturations	94 - 100 %		97	97	96	97	97	96	98				97	97	99	99	99							99		99
	< 94 %																									
Administered O ₂ (L/min.)																										
Temp °C	40																									
	39																									
	38																									
	37	37.2	37.1	37.0	37.1	37.0	37.1	37.0					37.0	37.1	37.0	37.1	37.0							37.0		37.1
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100												90	90	90	90	90							90		90
	90																									
	80	81	86	80	82	80	85	89																		
	70																									
	60																									
	50																									
	40																									
	Systolic Blood Pressure	190																								
180																										
170																										
160																										
150																										
140																										
130																										
120																										
110																										
100		99	100	121	120	122	119	106					110		117		120						111		112	
90																										
80																										
70																										
60																										
50																										
Diastolic Blood Pressure	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
60																										
50																										
40																										
NEURO RESPONSE [✓]	Alert	A	A	A	A	A	A						✓		✓		✓					✓		✓		✓
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30	✓	✓	✓	✓	✓	✓						✓		✓		✓					✓		✓		✓
	< 30																									
Proteinuria	Protein ++																									
	Protein > ++												✓				✓					✓		✓		✓
Lochia	Normal	✓	✓	✓	✓	✓	✓	✓																		
	Heavy / Foul																									
Liquor	Clear / Pink	✓										✓														
	Green																									
TOTAL YELLOW SCORES			0	0	0	0	0	0	0				0		0		0					0		0		0
TOTAL ORANGE SCORES			0	0	0	0	0	0	0				0		0		0					0		0		0
Nurse Initial			A	✓	✓	✓	✓	✓	✓				A		✓		✓					✓		✓		✓

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

23/12/6

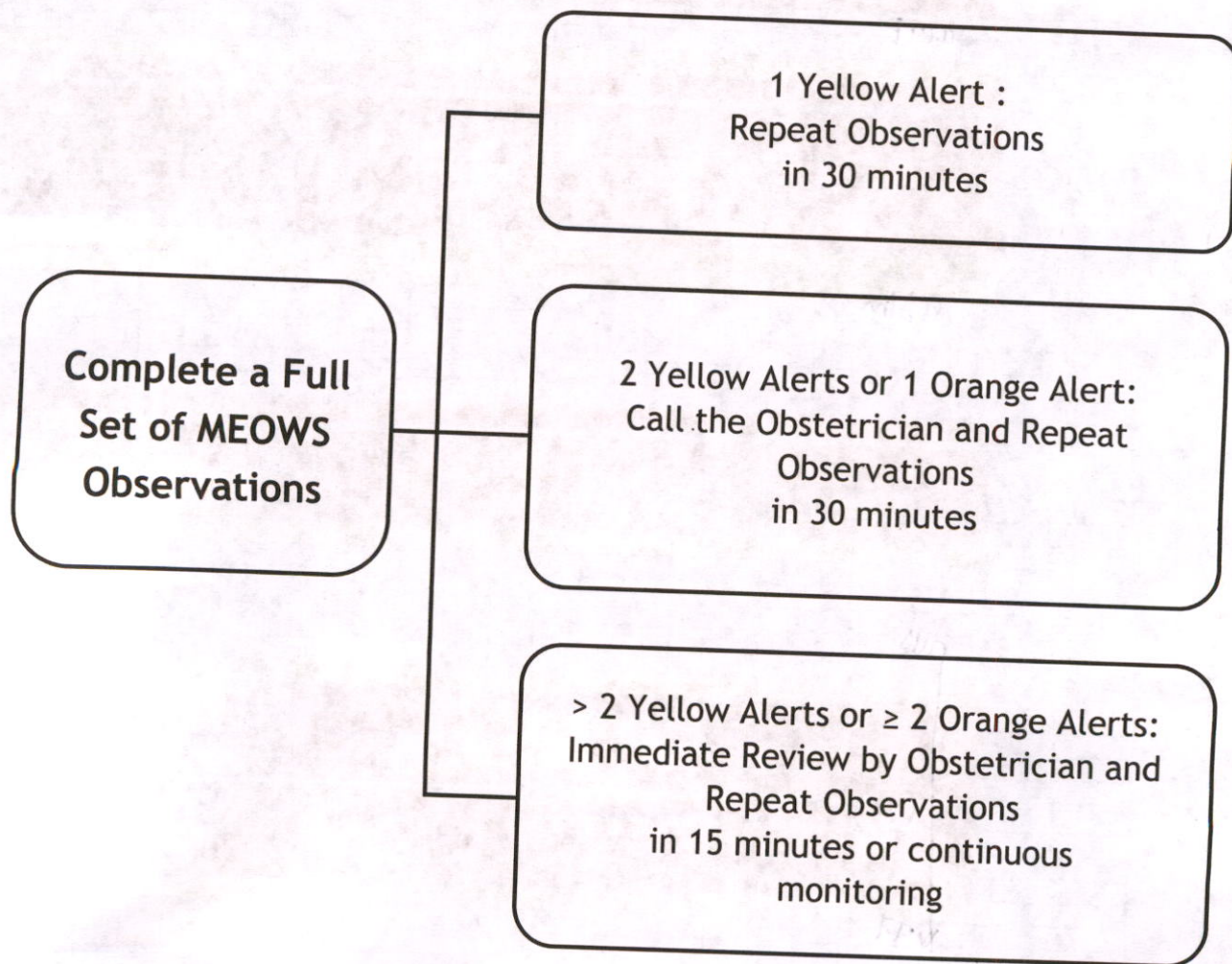


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CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

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

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)



FLUID CHART

Sheet No. : 2

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

		Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G						
	08:00 am										
	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	nglax	1720	25ul							
	11:00 pm	nglax		25ul							
	12:00 am	nglax	11	25ul					200ul	0	leash
	01:00 am	nglax		25ul					250ml	0	leash
Total Intake : 100ul					Total Output : 0 - 450ml - MD						
	02:00 am	nglax		25ul					250ml	0	leash
	03:00 am	nglax		25ul					200ml	0	leash
	04:00 am	nglax		25ul					150ml	0	leash
	05:00 am	nglax		25ul					150ml	0	leash
	06:00 am	nglax		25ul					150ml	0	leash
	07:00 am	nglax		25ul						0	leash
Total Intake : 150ul					Total Output : 0 - 1050ml - 0						
Total 24 hrs. Intake			Total 24 hrs. Output								
Taken			1350 ml								



FLUID CHART

Sheet No. : 2

19/1/26

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

		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							
19/1	08:00 am	MgSO4		25ML						250ml	0	Sundar
	09:00 am	MgSO4 B		25ML						150ml	0	
	10:00 am	MgSO4 M		25ML						250ml	0	
	11:00 am	MgSO4 NBM		25ML						180ml	0	
	12:00 pm	MgSO4 NBM		25ML						150ml	0	
	01:00 pm	MgSO4 real		25ML						200ml	0	
Total Intake :					Total Output : U = 1000 ml							
19/1	02:00 pm	MgSO4 H2O		25ml						250ml	0	Sundar
	03:00 pm	MgSO4		25ml						100ml	0	Sundar
	04:00 pm	MgSO4 H2O		25ml						100ml	0	Sundar
	05:00 pm	MgSO4		25ml						120ml	0	Sundar
	06:00 pm	MgSO4 H2O		25ml						200ml	0	Sundar
	07:00 pm	MgSO4 H2O		25ml						150ml	0	Sundar
Total Intake :					Total Output : U = 800 ml							
19/1	08:00 pm	MgSO4 H2O		25ml						150ml	0	Sundar
	09:00 pm	MgSO4		25ml						100ml	0	Sundar
	10:00 pm	MgSO4 H2O		25ml						250ml	0	Sundar
	11:00 pm									250ml	0	Sundar
	12:00 am	H2O								100ml	0	Sundar
	01:00 am									100ml	0	Sundar
Total Intake : taken					Total Output : U = 1000 ml							
20/1	02:00 am									200ml	0	Sundar
	03:00 am	H2O								200ml	0	Sundar
	04:00 am									200ml	0	Sundar
	05:00 am									100ml	0	Sundar
	06:00 am	H2O								100ml	0	Sundar
	07:00 am	NBM								70ml	0	Sundar
Total Intake : taken					Total Output : passed U = 770 ml							

Total 24 hrs. Intake **375ml**

Total 24 hrs. Output **3,925ml**

HNH-00016676 IP5-00176590
Mrs IQRA FATIMA
30-09-2004 21 Y 9 M 18 D (F)
Dr. ANNIE PRANUTHA P



FLUID CHART

Sheet No. : 3

- All measurements in ml.
- 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							
20/8/2004	08:00 am									200ml	0	Yancy
	09:00 am									250ml	0	
	10:00 am	RL		100ml						200ml	0	
	11:00 am	RL		100ml						200ml	0	
	12:00 pm	RL		100ml						180ml	0	
	01:00 pm	RL		100ml							0	
	Total Intake : Taken 400ml						Total Output : 1230ml					
20/8	02:00 pm										0	Kann
	03:00 pm										0	
	04:00 pm	RL NBm		50ml						200ml	0	
	05:00 pm	RL		50ml						150ml	0	
	06:00 pm	RL NBm		50ml						150ml	0	
	07:00 pm	RL		50ml						200ml	0	
	Total Intake : 200ml						Total Output : 720ml					
20/8	08:00 pm	RL		50ml						150ml	0	Kann
	09:00 pm									150ml	0	
	10:00 pm	RLP mgsoy	tho	50ml						100ml	0	
	11:00 pm	RLP mgsoy		50ml						75ml	0	
	12:00 am	RL + mgsoy	tho	50ml						100ml	0	
	01:00 am	RL + mgsoy		50ml						150ml	0	
	Total Intake : Taken 250ml						Total Output : 725ml					
20/8	02:00 am	RL + mgsoy		50ml						250ml	0	Sang
	03:00 am	RL + mgsoy	tho	50ml						250ml	0	
	04:00 am	RL + mgsoy		50ml						250ml	0	
	05:00 am	RL + mgsoy	tho	50ml						200ml	0	
	06:00 am	RL + mgsoy		50ml						200ml	0	
	07:00 am	RL + mgsoy		50ml							0	
	Total Intake : 300ml						Total Output : 1350ml					
Total Intake : 1150ml						Total 24 hrs. Output			4,025ml			



FLUID CHART

Sheet No. : (4)

21/2/26

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
2/2	08:00 am	mgsc		25ml						200ml	20ml	Kamy
	09:00 am	mgsc	420	100ml	25ml					150ml	02	Kamy
	10:00 am	mgsc	420	20ml	25ml					100ml	0	Kamy
	11:00 am	mgsc	420	20ml	25ml					200ml	0	Kamy
	12:00 pm	mgsc	420	20ml	25ml					200ml	0	Kamy
	01:00 pm	mgsc		25ml						200ml	0	Kamy
Total Intake :			450 ml			Total Output :					1100 ml	
2/2	02:00 pm			25ml						200ml	0	Shahid
	03:00 pm		420	25ml						100ml	0	Shahid
	04:00 pm		420	25ml						100ml	0	Shahid
	05:00 pm		420	25ml						75ml	0	Shahid
	06:00 pm			25ml						75ml	0	Shahid
	07:00 pm		420	25ml						25ml	0	Shahid
Total Intake :			Taken			Total Output :					Passed	
2/2	08:00 pm	mgsc	420	25ml						25ml	0	Ashraf
	09:00 pm	mgsc		20ml						25ml	0	Ashraf
	10:00 pm	mgsc	420	20ml						200ml	0	Ashraf
	11:00 pm		420	50ml						100ml	0	Ashraf
	12:00 am		420	50ml						300ml	0	Ashraf
	01:00 am			50ml						100ml	0	Ashraf
Total Intake :			Taken			Total Output :					Passed	
2/2	02:00 am		420	50ml						100ml	0	Ashraf
	03:00 am									80ml	0	Ashraf
	04:00 am		420	50ml						90ml	0	Ashraf
	05:00 am									100ml	0	Ashraf
	06:00 am		420	50ml						75ml	0	Ashraf
	07:00 am									80ml	0	Ashraf
Total Intake :			Taken			Total Output :					Passed	
			375ml								3700ml	

Total 24 hrs. Output

3700 ml

Total 24 hrs. Intake

Taken

CLINICAL/092

HNH-00016676 IP5-00176590
Mrs IQRA FATIMA
30-08-2004 21 Y 9 M 21 D (F)
Dr. ANNIE PRANUTHA P



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FLUID CHART

Sheet No. : 5

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
22/7	08:00 am	H ₂ O								80	0	Asheer	
	09:00 am									150ml	0	Kanng	
	10:00 am	H ₂ O								100ml	0	Kanng	
	11:00 am									✓	0	Kanng	
	12:00 pm	H ₂ O								✓	0	Kanng	
	01:00 pm									✓	0	Kanng	
Total Intake :						Total Output :							
29/7	02:00 pm										0	Poulavi	
	03:00 pm	H ₂ O								✓	0	Poulavi	
	04:00 pm										0		
	05:00 pm	H ₂ O									0		
	06:00 pm									✓	0	Poulavi	
	07:00 pm										0		
Total Intake :						Total Output :						U=2 M=20	
30/7	08:00 pm	Food									0		
	09:00 pm									✓	0		
	10:00 pm	H ₂ O									0	Satyam	
	11:00 pm										0		
	12:00 am	H ₂ O									0		
	01:00 am									✓	0		
Total Intake :						Total Output :						U=2 M=2	
31/7	02:00 am										0		
	03:00 am	H ₂ O									0		
	04:00 am									✓	0	Satyam	
	05:00 am										0		
	06:00 am	H ₂ O									0		
	07:00 am									✓	0		
Total Intake :						Total Output :						U=0 M=0	

Total 24 hrs. Intake

Total 24 hrs. Output

M=0 U=8

FLUID CHART

Sheet No. :

23/7/21

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
23	08:00 am												
	09:00 am												
	10:00 am	H ₂ O fruit								✓			
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 18/12/20

Assessment: Patient showing fear and anxiety about PE

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
10pm	Assessed The patient general condition	10:10 pm	Assessed The patient general condition	Patient is stable.
12AM	vital check.	12:15 AM	vital checked and documented	
3AM	Relieve pain & Discomfort	2:20 AM	Administer medication as per drug chart	
3AM	IL to claud monitor	3:10 AM	IL to claud monitoring in hourly	
5AM	HR monitor	5:38 AM	HR monitoring	
6AM	prevent Infection	6:10 AM	maintaining hand hygiene	
7A	apex AFI Dopple	7:15 AM	AFI Dopple T/m	
8A	ensure safety	8AM	ensure safety measure	

Re-Assessment:

Patient is comfortable, BP also normal

Special Notes:

mgau mgauing, wometer.

Nurse Signature:

[Signature]

Nurse Name:

[Signature]

Date & Time:

18/12/20 11A

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Mrs IQRA FATIMA
30-09-2004 21 Y 9 M 18 D (F)
Dr. ANNIE PRANUTHA P



NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 19/12/26

Assessment:

patient c/o 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
8AM	* Assess to pt condition.	8:30 AM	* Assessed to pt condition.	* pt is comfortable
9AM	* DIO check	9:30 AM	* DIO check maintaining - done	
10AM	* NLT	10:30 AM	* NLT - done	
11AM	* medications	11:30 AM	* medication on's	
12PM	* MgSO4	12:30 PM	* MgSO4 25mL/hr IV - provided.	
4PM	* safety	2:30 PM	* side rails provided	

Re-Assessment:

Re-assessment done PHP 3rd hourly

Special Notes:

MgSO4 fill doctor's orders / PPS's today per stand

Nurse Name:

Suanda (60679)

Date & Time:

19/12/26 2PM

HNH-00016676 IP5-00176590
 Mrs IQRA FATIMA
 30-09-2004 21 Y 9 M 18 D (F)
 Dr. ANNIE PRANUTHA P

NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 19/7/2026

Assessment:

patient is fear and Anxiety

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess the patient General Condition	2:5 pm	Assessed the patient General Condition	patient is Stable
4pm	provide monitor vitals	4:10 pm	provided monitor vitals	
	provide I/O measurement		provided I/O measurement	
6pm	provide comfortable position	6:15 pm	provided comfortable position	
7pm	provide medication	7:10 pm	provided medication	
8pm	provide psychological support	8:5pm	provided psychological support.	

Re-Assessment: Re-Assessment is done patient vital is good

Special Notes: Mgson in doctor orders

Nurse Signature:

Nurse Name:

Date & Time:

19/7/2026 @ 8pm

HNH-00016676
Mrs IQRA FATIMA
30-09-2004 21 Y 9 M 18 D (F)
Dr. ANNIE PRANUTHA P

IP5-00176590

NURSING CARE RECORD

Rainbow Children's Hospital
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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 19/7/20

Assessment: patient is having low 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
8pm	- Assess the patient general condition	8:50 pm	- Assessed the patient general condition	- patient is stable & comfortable.
10pm	- monitor vitals	10:30 pm	- monitoring vitals, BP, PR, RR, SpO2, checked & recorded	
12Am	- mgso4 Continue.	12:30 Am	- mgso4 continue till 12pm	
3Am	- maintain ELO chart	3:30Am	- ELO chart maintaining	
6Am	- NST Bn	6:30Am	- NST done.	
8Am	- Ensure safety	8Am	- Ensure safety	

Re-Assessment:

Special Notes:

pre-post sugar's

Nurse Name: Sona

Date & Time: 19/7/20 @ 8am

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 20/4/16

Assessment: pt complain for 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 pt general condition	8:10 AM	Assess pt general condition	pt is
10 AM	monitor vital	10:10 AM	Bp SpO2 pulse checked and recorded	Stable.
11 AM	Administration medication	11:40 AM	medication given as per doctor	
12 PM	Ensure safety provide	12:10 PM	ensure safety provided	
1 PM	Prevent infection.	1:20 PM	TO prevent infection	

Re-Assessment:

Special Notes: Re Assessment done pre post GIBBS, NBM.

Nurse Signature: [Signature]

Nurse Name: Shobha

Date & Time: 20/4/16 @ 2 PM

HNH-00016676

IP5-00176590

Mrs IQRA FATIMA

30-09-2004

21 Y 9 M 20 D

(F)

Dr. ANNIE PRANUTHA P



NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 20/7/26

Assessment:

Patient complains 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
2pm	* Assess the pt general condition	3pm	* Assessed the pt general condition	* Patient is Stable.
	* Monitor vitals hourly.		* Monitored vitals hourly.	
3pm	* Administer medications	4pm	* Administered Medications	
4pm	* Provide IV fluids as per order	5pm	* Provided IV fluids as per order	
5pm	* Monitor AB chart	6pm	* Maintaining AB chart hourly	
	* Provide Psychological support	7pm	* Provided Psychological support	
7pm	* Ensure patient safety	8pm	* Ensured patient safety	

Re-Assessment:

Re-assessment was done.

Special Notes:

CBP, LFT, WtH, electrolyte @ 9pm 20/7/26

Kul

Nurse Name:

Kanna (08/01)

Date & Time:

20/7/26 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 20/7/20

Assessment: patient complaint mild pain at surgical site

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the patient general condition	8:30 pm	Assessed the patient general condition	patient is stable & comfortable
10pm	monitor vitals	10:30 pm	monitoring vitals, BP, PR, RR, SpO2 checked & recorded	
12AM	maintain I/O chart			
3AM	Administer medication	12:30 AM	I/O chart maintaining	
6AM	Dr fluids,	3:30 AM	medication given as per doctor order	
8AM	ngso &	6:30AM	Dr fluid RL 25ml/hr	
		8AM	ngsoy continue.	

Re-Assessment: medication given

Special Notes: clear liquids, CBP 21/7/20 @ 6AM

Nurse Signature: [Signature] Nurse Name: Song Date & Time: 20/7/20 @ 8AM

HNH-00016676 IP5-00176590
 Mrs IQRA FATIMA
 30-09-2004 21 Y 9 M 20 D (F)
 Dr. ANNIE PRANUTHA P



NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 21/7/26

Assessment: Patient complains Pain of suture 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 pt general condition	9am	* Assessed the pt general condition	* Patient is Stable.
	* Monitor vitals hourly.		* Monitored vitals	
10am	* Administerate medication	11am	* Administerated medications	
6pm	* provide soft diet		* Provided soft diet	
	* provide Nebulizer saline	12pm	* Nebulization done	
1pm	* Ensure Patient Safety	2pm	* Provided Patient Safety	

Re-Assessment:

Re-assessment was done.

Special Notes:

Monitor vitals, Sr. electrolyte 6pm 21/7/26

Nurse Signature:

[Signature]

Nurse Name:

Kanung (017181)

Date & Time:

21/7/2026

HNH-00016676
Mrs IQRA FATIMA
30-09-2004 21 Y 9 M 21 D (F)
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NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 21/7/26

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
2pm	Assess the general Condition of the Patient.	2pm	Assessed the general Condition of the Patient.	pt is stable.
3pm	Spirometry.	3pm	Spirometry done.	
4pm	Administer the Medication	4pm	Administered the Medication as per doctor's order.	
5pm	No chat.	5pm	Hourly Maintained No chat.	
6pm	Prevent Infection.	7pm	Preventing Infection by using hand rub.	

Re-Assessment: Patient is comfortable.

Special Notes: Hourly No chat, vitals, Spirometry.

Nurse Signature: [Signature] Nurse Name: Sunkha Date & Time: 21/7/26 @ 9pm

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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 21/7/26

Assessment: patient Complaints of 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
8:00am	Assess the general condition	8:00am	Assessed the general condition	Pt is stable
10:00am	monitor vitals	10:00am	Vitals checked BP, Pulse, SpO2	
12:00am	Administer medications	12:10am	medication given as per drug chart	
2:00am	Spirometry	2:10am	Spirometry done	
4:00am	Ambulation	4:10am	Ambulation done	
6:00am	monitor Ilo chart	6:00am	Ilo chart monitored	
8:00am	Provide soft diet	8:10am	Provided soft diet	

Re-Assessment:

Special Notes: It is sleeping
 vitals hourly, spirometry, nebulisation.

Nurse Signature:

Nurse Name: Ashwita

Date & Time: 22/7/26 @ 8am



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 22/7/20

Assessment: Patient complains fear & Anxiety

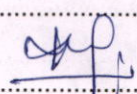
Goals

- | | | | | | |
|---|--|---|---|---|---|
| ☐ 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
8am	* Assess the pt general condition	9am	* Assessed the pt general condition	
10am	* Monitor vitals		* Monitored vitals	
	* Administerate medication	11am	* Administerated medication	
11am	* provide soft diet		* Provided soft diet	* Patient is comfortable
	* Ambulation	12m	* Ambulation was done	
1pm	* Ensure patient safety	2pm	* Provided soft diet	

Re-Assessment: Re-assessment was done.

Special Notes: 1st BP monitoring

Nurse Signature:  Nurse Name: Nursing Officer Date & Time: 22/7/20

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NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 22/7/26

Assessment: Patient complient About Iv cannula Pain

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2Pm	* Assess the general condition	2:05 pm	* Assessed general condition	
	* Check Iv cannula.		* Ass changed Iv cannula	* Reduced the Iv cannula Pain
3P 2:05 pm	* Administer the medication	2:30 pm	* Administered the medication	
3:1Pm	* Increased oral hydration	3:05 pm	* Increased oral hydration	* Now comfortable
3:10 pm	* Shift to room	3:15 pm	* Shifted to room	

Re-Assessment: After changed Iv cannulae patient relieved Pain & Comfortable

Special Notes: Vital 4th hourly

Nurse Signature:

Nurse Name: paulabi

Date & Time: 22/7/26



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 22/7/26

Assessment: patient having mild pain & discomfort at surgical site

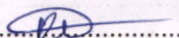
Goals

- | | | | | | |
|---|---|---|---|---|--|
| ☒ 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
3pm	→ Assess the patient general condition	3:30 pm	→ Assessed the patient general condition on the Bed	→ patient was stable now & well ambulated
4pm	→ To monitor vitals	4:30 pm	→ monitored vitals	
5pm	→ To maintain I/O chart	5:30 pm	→ maintained I/O chart	
6pm	→ To give nebulization	6:30 pm	→ nebulization has done	
7pm	→ To administer the medications	7:30 pm	→ Administered the medications as per chart	

Re-Assessment: Re-assessment has done after 1 hour the pt was stable now.

Special Notes: Serum potassium mg 6am 2.3/7/26

Nurse Signature: 

Nurse Name: Lavitha

Date & Time: 22/7/26 @ 8pm

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Mrs IQRA FATIMA
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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 22/7/24

Assessment: patient having hypertension

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 general condition	8.10pm	→ patient is stable and comfortable	pt stable
9pm	→ TO monitor vitals	9.10pm	→ checked monitored documented	
10pm	→ TO monitor I/O chart	10.10pm	→ monitored I/O chart documented	
11pm	→ TO administer medication	11.10pm	→ oral intake good	
6am	→ TO encourage stally	6.10am	→ well ambulatory	
7am	→ TO encourage ambulatory	7.10am	→ send sample for	
8am	→ TO collect sputa	8.10am		

Re-Assessment: Re-assessed after 2 hrs pt stable

Special Notes: S. potassium 6am

Nurse Signature: Satya

Nurse Name: Satya

Date & Time: 23/7/24 @ 8am

HNH-00016676 IP5-00176590
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NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 23/07/21

Assessment: patient having mild pain & discomfort 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
8:10 AM	Assess pt' condition	8:30 AM	Assess pt' general condition	pt' feel comfortable
9:10 AM	provide comfortable position to the pt'	9:30 AM	provided comfortable position to the pt'	
10:00 AM	Monitor vitals	10:30 AM	Monitor vitals and recorded.	
10:30 AM	cinidid tablet	11 AM	cinidid tablet given at 10:00 AM.	

Re-Assessment: Reassessment has been done.

Special Notes: nil

Nurse Signature: Perathi Nurse Name: Perathi Date & Time: 23/07/21 10:00 AM

NURSING CARE RECORD



Date:

Assessment:

☐ 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: _____

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30-09-2004 21 Y 9 M 18 D (F)
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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Annie Department: B/C Date of Admission: 19/7/26

SITUATION		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:						
BACKGROUND	Area							
	Shift Time	OBS 7pm-10pm	OBS 8pm-11pm	OBS 2pm-5pm	OBS 5pm-8pm	OBS 8pm-11pm	OBS 11pm-2pm	
ASSESSMENT	Medical Condition (Any special condition to be noted):	Severe pre-eclampsia	JA	JA	NA	NA	NA	
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
ASSESSMENT	Tubes/Drains/Catheter:	☒ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	97.9F	98.6F	97.8F	97.6F	98.5C	98.1F
		Res:	14b/m	14b/m	14b/m	14b/m	15b/m	14b/m
		SpO ₂ :	99	100	99	100	97	98
		Pulse:	82b/m	86	88	86	85b/m	88b/m
		BP:	122/89	120/72	114/70	115/83	125/95	100/60
	Fall Risk Score:	35	35	35	35	35	35	
	Pain Score:	0/10	0/10	0/10	0/10	0/10	0	
Recommendations	Safety Needs:	yes	yes	yes	yes	yes	yes	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	NA	NA	NA	NA	NA	NA	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	NA	NA	NA	NA	NA	NA	
Post Operative Procedure Special Orders:		NA	NA	NA	NA	NA	NA	
Handed Over By Name :		Wanli	Sundud	Sundud	Song	Nammy	Xammy	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		19/7	19/7/26	19/7/26	20/7/26	20/7/26	20/7/26	
Time:		8am	2pm	8pm	8am	2pm	8pm	
Taken Over By Name :		Sundud	Sundud	Song	Nammy	Xammy	Song	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		19/7/26	19/7/26	19/7/26	20/7/26	20/7/26	20/7/26	
Time:		8am	2pm	8pm	8am	2pm	8pm	

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Annie Department: MCU Date of Admission: 28/7/26

SITUATION		Diagnosis: <u>pinnigravida 25+2 wks</u> <u>Sever pt</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:		
BACKGROUND	Area	Shift Time	<u>MCU 8pm-8am</u>	<u>MCU 8am-2pm</u>	<u>MCU 2pm-8pm</u>	
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	
	Vital Signs:	Temp:	<u>96.5°F</u>	<u>97.8°F</u>	<u>98.2°F</u>	<u>98.4°F</u>
		Res:	<u>20</u>	<u>20</u>	<u>18</u>	<u>20</u>
		SpO ₂ :	<u>99%</u>	<u>100%</u>	<u>98%</u>	<u>98%</u>
		Pulse:	<u>64</u>	<u>72</u>	<u>75</u>	<u>80</u>
		BP:	<u>120/88</u>	<u>119/84</u>	<u>113/77</u>	<u>102/74</u>
	Fall Risk Score:	<u>35</u>	<u>35</u>	<u>35</u>	<u>35</u>	
Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0</u>		
Recommendations	Safety Needs:	<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	
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	<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>	
Handed Over By Name :		<u>Sona</u>	<u>Kanng</u>	<u>Ashwika</u>	<u>Kanng</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>21/7/26</u>	<u>21/7/26</u>	<u>21/7/26</u>	<u>22/7/26</u>	
Time:		<u>8am</u>	<u>2pm</u>	<u>8am</u>	<u>2pm</u>	
Taken Over By Name :		<u>Kanng</u>	<u>Ashwika</u>	<u>Kanng</u>	<u>Poulabi</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>21/7/26</u>	<u>21/7/26</u>	<u>22/7/26</u>	<u>22/7/26</u>	
Time:		<u>2pm</u>	<u>8am</u>	<u>2pm</u>	<u>2:30pm</u>	

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Annie pranutha Department: 3rd Floor Date of Admission: 19/7/20

SITUATION	Diagnosis: <u>LSCS</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:				
	Area	Shift Time					
BACKGROUND	Medical Condition (Any special condition to be noted):	<u>3rd floor 20m 8pm</u> <u>LSCS</u>	<u>3rd floor 8am</u> <u>LSCS</u>				
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp:	<u>97.9</u>	<u>98.1</u>			
	Res:	<u>12b/m</u>	<u>14</u>				
	SpO ₂ :	<u>98+</u>	<u>99+</u>				
	Pulse:	<u>89b/m</u>	<u>90</u>				
	BP:	<u>119/70</u>	<u>112/74</u>				
	Fall Risk Score:	<u>3/5</u>	<u>3/5</u>				
Pain Score:	<u>0/10</u>	<u>0/10</u>					
Recommendations	Safety Needs:	<u>side rail</u>	<u>yes</u>				
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	<u>NA</u>	<u>NA</u>				
	Special Diet:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>				
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>				
Handed Over By Name :		<u>Kwath</u>	<u>Saty9</u>				
Signature :		<u>[Signature]</u>	<u>[Signature]</u>				
Date:		<u>22/7/20</u>	<u>23/7/20</u>				
Time:		<u>8pm</u>	<u>8am</u>				
Taken Over By Name :		<u>Saty9</u>	<u>Kwath</u>				
Signature :		<u>[Signature]</u>	<u>[Signature]</u>				
Date:		<u>22/7/20</u>	<u>25/7/20</u>				
Time:		<u>8pm</u>	<u>8am</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	3rd / 10th				
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:		☐ 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	
Others Specify:							
Special Diet:		☐ 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	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			-	-	-	-	-	-	-	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			-	-	-	-	-	-	-	
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			-	-	-	-	-	-	-	
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			-	-	-	-	-	-	-	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			-	-	-	-	-	-	-	
Signature of the Nurse													

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

Signature of Shift In Charge :

Signature : Name :

Signature of Ward In Charge :

Signature : Name :



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					
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	-	-	-	-	1	-				Slight Pain
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	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	-	-	-	-	-	-				
	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness and Site Swelling palpable cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-	-	-	-	-	-				
Signature of the Nurse				Kam Gul			Kam Gul			Kam Gul			

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 Ward In Charge :

Signature : Shavath Name : Neeraj



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
18/7	10PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Amey
19/7	12PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Merle
19/7	4AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Merle
19/7	8AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Merle
19/7	12PM	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Suande
19/7	12PM	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Suande
19/7	2PM	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Suande
19/7	4PM	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Smith
19/7	6PM	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Smith
19/7	7PM	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Smith

Re-assessment Frequency:

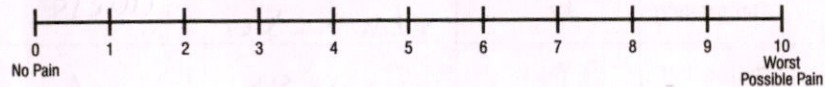
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 - 60 minutes after pain relief intervention.

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 brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
19/7	9pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	sf
19/7	11pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	sf
20/7	2AM	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	sf
20/7	5AM	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	sf
20/7	2AM	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	sf
20/7	10AM	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Yammy
20/7	12pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Yammy
20/7	2pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Yammy
20/7	4pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Yammy
20/7	6pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Yammy

Re-assessment Frequency:

1. Every eight hours for all hospitalized patients.

2. For post-surgical patients, patients with chronic pain, patient with severe pain:

a) At least every 2 hours for the first 24 hours

b) Then every 4 hours.

c) Prior to pain relieving intervention.

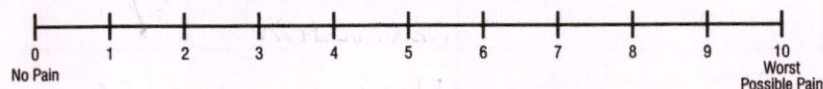
d) Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

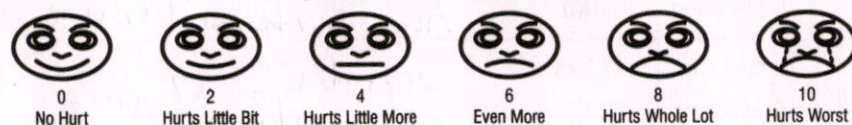
Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
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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
20/7	10 pm	0/10	Surgical site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	2ml fentanyl given	Asst
20/7	12 AM	0/10	NO pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Asst
21/7	1 AM	0/10	Surgical site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	2ml fentanyl given	Sona
21/7	3 AM	0/10	NO pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sona
21/7	6 AM	0/10	Surgical site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	2ml fentanyl given	Sona
21/7	8 AM	0/10	NO pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Kam
21/7	10 AM	1/10	Left side	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	1. Diamorphine 2ml	Kam
21/7	1 PM	0/10	NO pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Kam
21/7	4 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Smilee
21/7	6 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Smilee

Re-assessment Frequency:

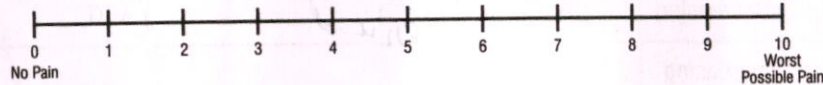
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

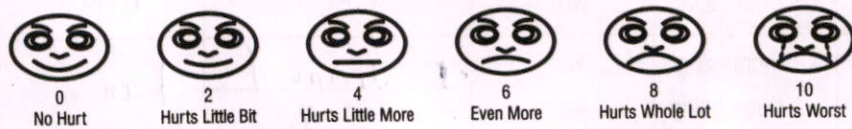
Numerical Pain Scale (Obstetric and Gynecology)



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
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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
22/7/26	8am	0	Neo m	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Kannu
22/7/26	11am	0	Neo m	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Kannu
22/7/26	1pm	0	Neo m	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Kannu
22/7/26	2pm	0	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Poulabi
22/7/26	5pm	0/10	SL	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☒ Aching ☐ Burning	☒ Increasing ☒ Decreasing	☒ Yes ☐ No	T. Tranadol given under observation	poulabi
22/7/26	4pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	observation	poulabi
23/7/26	12am	02/10	SL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	T. cal pol	Saty
23/7	10am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Saty
23/7	6am	2/10	SL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	T. cal pol	Saty
23/7	2am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Saty

Re-assessment Frequency:

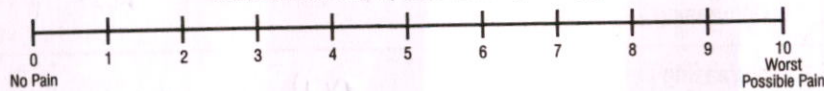
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



HNH-00016676 IP5-00176590
 Mrs IQRA FATIMA
 30-09-2004 21 Y 9 M 18 D (F)
 Dr. ANNIE PRANUTHA P

Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	12/2/26	10/2/26	19/7/26	Fall Risk Grading		
		Score	8pm	8am	8pm	Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25						
	No	0		0	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						
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0		0	0			
IV / Heparin Lock or Saline	Yes	20	20	20	20	Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20						
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0		0	0			
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0						
Total Morse Fall Scale Score:			35	35	35			
		Signature	[Signature]	[Signature]	[Signature]			

(✓) 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			Risk Level	Morse Fall Score (MFS)	Action
		Score						
History of Falling (immediately or w/in 3 months)	Yes	25				Low Risk	0 - 24	Standard Fall Precaution
	No	0	0	0	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15	15	15	15	Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0	0	0	0			
Ambulatory Aid	Furniture	30				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0	0	0			
IV / Heparin Lock or Saline	Yes	20	20	20	20	Moderate Risk	25 - 50	Implement Moderate 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	0	0	0			
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0	0	0	0			
Total Morse Fall Scale Score:			35	35	30			
		Signature	Al	Yous	Kanar			

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
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- ☒ Hourly safety check
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- ☐ 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			
	No	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15	15	15	15
	No	0	0	0	0
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0	0		
IV / Heparin Lock or Saline	Yes	20	20	20	20
	No	0	0		
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0	0	0	0
Mental Status	Forgets limitations	15			
	Oriented to own ability	0	0	0	0
Total Morse Fall Scale Score:			25	35	25
Signature			but	Kannu	Smuly

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

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- ☐ 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	21/9/20	22/9/20	22/7/20	Fall Risk Grading		
		Score	8am-8pm	8pm-2pm	2pm-8pm			
History of Falling (immediately or w/in 3 months)	Yes	25				Risk Level	Morse Fall Score (MFS)	Action
	No	0	0	0	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	0					
IV / Heparin Lock or Saline	Yes	20	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	0	0	0			
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0	0	0	0			
Total Morse Fall Scale Score:			35	35	35			
Signature			Ashwini	Kanng	Poulaby			

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

HNH-00016676
Mrs IQRA FATIMA
30-09-2004
Dr. ANNIE PRANUTHA P
21 Y 9 M 22 D
IP5-00176590
(F)

Morse Fall Risk Assessment Form

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Choose Highest Applicable Score from each Category		Date / Time	23/7/21	Fall Risk Grading		
		Score				
History of Falling (immediately or w/in 3 months)	Yes	25		Risk Level	Morse Fall Score (MFS)	Action
	No	0	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15	15	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	0			
IV / Heparin Lock or Saline	Yes	20		High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	No	0	0			
GAIT / Transferring	Impaired	20		Total Morse Fall Scale Score:	15	
	Weak (uses touch for balance)	10				
	Normal /On Bed Rest /Immobile	0	0			
Mental Status	Forgets limitations	15		Signature	Safy	
	Oriented to own ability	0	0			

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

HNH-00016676

IP5-00176590

Mrs IQRA FATIMA

30-09-2004

21 Y 9 M 18 D

(F)

Dr. ANNIE PRANUTHA P



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 :	8/7	10/7	9/7	1/7
					Time :	8:20	8:30	8:40	8:50
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	9	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4	
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	9	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28	28	28	28
Docu. No. : RCHBH / FRM / CLINICAL / 119					Evaluator's Name	Dr. Annie Pranutha P	Sunil	Sunil	Sunil

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

BRADEN 'Q' SCALE

					Date: 20/2/2024	20/2/24	21/2
					Time: 8:00 AM	8 PM	8:00 AM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:treimity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	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
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
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
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	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
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28	28
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	Yasir Khan	Yasir Khan

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
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HNH-00016676
Mrs IQRA FATIMA
30-09-2004 21 Y 9 M 21 D (F)
Dr. ANNIE PRANUTHA P

IP5-00176590



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: 21/7	21/7	20/7	22/7
					Time: 2 PM	8:00 AM	8:00 AM	2:00 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:treimity 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
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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					28	28	28	28
Evaluator's Name					Annie Pranutha P			

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay



BRADEN 'Q' SCALE

				Date : 23/7/14			
				Time : 8am			
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		
"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		
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.	9		
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		
FRICITION-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."	9		
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.	9		
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.	9		
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28	
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	Saty	

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
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HNH-00016676 IP5-00176590
Mrs IQRA FATIMA
30-09-2004 21 Y 9 M 18 D (F)
Dr. ANNIE PRANUTHA P

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient's / Learner Language: English 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		
18/1/26	10:30pm	1,2	Diagnosis/Treatment & care plan	PT, S	1	0	1	1	-	By
18/1	11pm	7	Infection control measures	PT	1	0	1	1	-	By
22/1/26	3:30 pm	9	Lactation diet	PT	0	0	1	1	-	Saima
21/1	3:30pm	5	chest physiotherapy	PT	1	0	1	1	-	Ahmed

Part - III: CODES

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



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis:

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
12/1/26 12:30PM	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Primi 1st 2nd / severe PAP / oligo / AGDF	conservative management / delivery	- NMC - myson - steroid cover - Anti-Hypertensives	hyp	☐ Nursing ☐ Others:
1/1/26	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	FHR monitor	STP / ST	plan for HCT	Qui	☐ Medical ☐ Others:
22/3/26 3:30 pm	☐ Medical ☐ Nursing ☒ Others: dietitian	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	POP-2 LSCS	soft diet	soft high protein diet	Saima	☐ Medical ☐ Nursing ☒ Others:
21/7 3:30pm	☐ Medical ☐ Nursing ☒ Others: physiotherapy	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	emces	Improve lung function	chest physiotherapy	Khushid	☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

PATIENT TRANSFER FORM

HNH-00016676 IP5-00176590 Mrs IQRA FATIMA 30-09-2004 21 Y 9 M 22 D (F) Dr. ANNIE PRANUTHA P 		Date & Time of Admission 18-7-27 @ 10:2 pm	Date & Time of Transfer Order 22-7-26 3:15 pm
		Transfer Ordered by Dr. Abshija	Reason for Transfer observation
From Unit OR MICU	To Unit Room (330)	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 33	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If Yes, what?	Patient shifted with ID band: Yes ☒ No ☐ If No:	
Number of Imaging Films NS 7-4			
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Sis-Poulabi		Name of Person Ordered Transfer Dr. Abshija	
Patient & Clinical Records Received by : Devathi			
Time of Patient Received : 22/7/26 3:50 pm			

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

☐ Nurse not Available

☐ Available Bed not ready

POST – PARTUM ASSESSMENT FORM – IN-PATIENT

Date: 22/9/26

Chief Complaint: pain in suture site, low BP

Obstetric/ Birthing History: prim, 1st EL-LSCS, POD 2

Previous Surgical/Medical History: severe DM

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

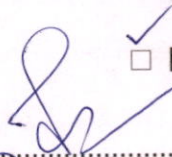
☒ Active Motion for Limbs

☒ Transfer Training & Mobility

☒ Sit to Stand

☐ Monitored Walk

☒ Posture & Ergonomic Education

Signature : 

Name : Dr. Phaneendra Prasad (PT)

Date & Time: 22/9, 5 PM



OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 18/2/26 Time of Arrival: 10:02 pm Time Seen by Nurse: 10:00 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: Severe PE

3) **Vital Signs:** Temperature: 99.5 F Pulse: 82 RR: 19 SpO₂: BP: 120/88 Weight: 80

4) **Gestational Criteria:**

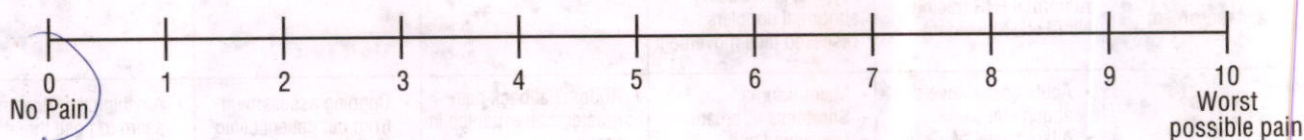
Gravida:	G <u>1</u>	P	L	A
----------	------------	---	---	---

LMP: 22/01/26 EDD: 29/10/26 Gestational Age: 25+2

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

6) **Past History:**

- a) Surgeries: Nil
- b) Medical: Iron, Calcium



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

Time seen by Doctor:11:20 pm.....

Nurse Name :S. Mounika..... Nurse Signature:[Signature].....

Date: 18/12/26 Time: 11 pm



OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 18/2/26

Baseline Information:

Admission From: ☐ ER ☐ OPD ☒ Admission Desk ☐ Others, specify
Primary Language: ☐ Telugu ☐ English ☒ Hindi ☐ Others, specify
Do you require an interpreter? ☐ Yes ☒ No if Yes specify
Source of Information: ☒ Patient ☒ Family ☐ Others, specify

Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other:
If yes, identify

Chief Complaints: Severe PE Doctor Notified on Admission: ☒ Yes ☐ No
Name of the Doctor: Dr. Deepika
Time Notified: 11:20 AM

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Nil	Nil	Nil

Gynecology Assessment: ☐ Not Applicable	Gynecology Surgical History:	Gynecological History:
Menstrual History: Regular Onset of Menarche: Menstrual Cycle: ☒ Regular ☐ Irregular Last Menstrual Period: 22/1/26	Caesarean Section: ☐ No ☐ Yes Cervical Cerclage: ☐ No ☐ Yes Ectopic Pregnancy: ☐ No ☐ Yes Myomectomy: ☐ No ☐ Yes Others:	Contraceptives: ☐ No ☐ Yes Vaginal Discharge: ☐ No ☐ Yes Post-Coital Bleeding: ☐ No ☐ Yes Infertility: ☐ No ☐ Yes If Yes Type: ☐ Primary ☐ Secondary

Obstetric History: G 1 P L A

Previous LSCS: NA

Current Medication: ~~Nil~~ None ☒ Yes, If Yes, Fill the reconciliation form

Family History: ☐ No Abnormalities Detected

☐ Heart Disease ☐ Hypertension ☒ Diabetes ☐ Stroke ☐ Seizures ☐ Kidney disease
☐ Liver disease ☐ Other: mother

Vital Signs / Measurements: Temp: 97.6°F HR: 28b RR: 19
BP: 121/86(9) Weight: 80 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 24 (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 and family

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: Patience

Orientation not given Reason: NA

Nurse Signature: [Signature]

Nurse Name: Heather

Date & Time: 18/7/20 e apr

PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00016676 IP5-00176590 Mrs IQRA FATIMA 30-09-2004 21 Y 9 M 20 D (F) Dr. ANNIE PRANUTHA P 		Date & Time of Admission 19/12/26	Date & Time of Transfer Order 20/12/26 2.4 PM
		Transfer Ordered by Dr. Smita	Reason for Transfer post op
From Unit OBG-05	To Unit mfw	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 40.	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If Yes, what?	Patient shifted with ID band: Yes ☒ No ☐ If No:	
Number of Imaging Films			
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 Smita		Name of Person Ordered Transfer Dr. Smita	
Patient & Clinical Records Received by : Sr. Kanny			
Date & Time of Patient Received : 20/12/26 4 PM			

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

HNH-00016676 IP5-00176590
Mrs IQRA FATIMA 21 Y 9 M 20 D (F)
30-09-2004 Dr. ANNIE PRANATHA P

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: Iqra Fatima Age: 21y 9m Sex: F UHID.No: HNH-00016676

Date: 20/7/26 Time: 12:10pm Proposed Operation: Em-UCS

Diagnosis: termi 25+4days - Severe PE, PGR, oligohydr, AEDT, ↑ Resistance in Dopplers

B.P / CRT: 129/92 H.R: 87/min Weight: 80kgs ASA Physical Status: ☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:
Hgb: 9.2 Glucose: 135 Protein: WNL HIV: NR X-Ray: JO
PCV: 100 Urea: 4.2 Alb: WNL HBS Ag: NR ECG: JO
WBC: 284 Creat: 1.0 Total Bill: WNL HCV: NR 2D Echo: JO
Plate: 14 Na: 135 Dir. Bill: WNL Blood group: A+ve Stress/Angio: WNL
PT: 14 K: 4.2 LDH: WNL T3: WNL Other: WNL
PTT: 35 Ca++: 1.0 Alk phos: WNL T4: WNL
INR: 1.0 Mg++: 1.0 Amylase: WNL TSH: WNL
Cl-: 110 SGOT/SGPT: WNL

Allergies:

Medical History: CVS: HPO PE - 1 day before Admission - Ue Alb 3 (+)

RESP: No Breathlessness - 2 episodes Diabetes: No Pedal Oedema: (+) Smith's

CNS: ECG, 2D Echo normal Was on labetalol tid, D. Retard

Renal: No orthopnea, PND, palpitations 100mg 10mg to

Hepatic / GE: No Physical Activity: Active

Others: No Reviewed Mgson Steroid covered

Past Anaesthetic History: No V/O adeq.

Physical Exam: No

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

Lungs: Clear. No added sounds

Heart: S1S2

CNS: NAD

Pregnant: ☒ Yes ☐ No ☐ NA Venous Access Site: (+) Spine Exam for regional: Sp Nrt felt wcl

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

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

CURRENT MEDICATIONS	DOSAGE
<u>labetalol 100 mg tid</u>	
<u>Stopped D. Retard</u>	
<u>Clexane → last 6 pm</u>	

Pre-Operative Instructions:

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

Signature: [Signature] Name: Dr. Sunitha



ANAESTHESIA CHART



Pre Induction Assessment: 3pm.

Change in Patient Condition: ☒ Yes ☐ No

Fasting Status: > 6 hrs

Physical Status:

☒ Patient Identified

☒ Consent Present

☒ Chart Reviewed

H.R:

74/nt

B.P / CRT:

142/102

SpO₂:

97%

R.R:

26/nt

Last Feed:

> 6 hrs

Pre-OP Diagnosis: Placenta previa

Operation: Caesarean section Date: 20/12/26

Surgeon: Dr. Annie Dr. Kirti

Anaesthesiologist: Dr. Sunidhara Dr. Anu

Technician: Kulsum

TIME 300 330 400

N₂O / AIR / O₂ LPM

HALO / SO / SEVO

Drugs:

INJ. ORNANETRON 1mg

INJ. TRANEXAMIC ACID 1gm

INJ. OXYTOCIN 6IU + 6IU

INJ. CARBETOCLIN 100mcg

Antibiotic

Suppository

SUP. TRAMADOL 100mg PR

Blood Loss

~200ml

NOTES

FiO₂ (SaO₂)

96 97 96

ETCO₂

SR SR

ECG

Temperature

Urine Output

Fluids

Blood

B.P

V Systolic

A Diastolic

X Mean

Heart Rate

Tourniquet on Time

Tourniquet off Time

Throat Pack In

Throat Pack Out

LAB Values

ABG

GRBS

Others

☒ Equipment Checked and Functional

☒ BP

☒ Cuff Site: RU

☐ Art Site:

☒ EKG Lead

☐ Temp Site

☐ FiO₂ Monitor

☐ Agent Monitor

☒ Pulse Oximeter

☐ Capnograph

☐ Ventilator

☐ Nerve Stimulator

Position: Supine

☐ Pressure Points Checked

Eye Care:

☐ Oint

☐ Tape

☐ Padding

☒ Awake

Temp:

☐ HME

☐ Cling Film

☐ Hugger's

☐ Other

☐ Fluid Warmer

☐ OH Warmer

☒ Cotton Wool

Times:

Anaes Start: 3:00pm

OP Start: 4:00pm

OP End: 4:00pm

Leave OR: 4:00pm

Anaesthesia:

☐ GA

☐ Monitored Anaesthesia Care

☒ Regional

Line (Size & Location)

☐ CVP:

☐ ART:

☒ IV: RU 18g

☐ IV:

☐ IV:

Induction

☐ IV

☐ Pre O₂

☐ Others

☐ Inhal

☐ RSI

☐ Mask

☐ Airway

☐ ETT #

☐ Oral

☐ Tracheostomy

☐ Drug:

☐ SGA

☐ Oral

☐ Nasal

☐ Cuff

☐ Topical

☐ Awake

☐ Video Laryngoscopy

☐ Fiberoptic

Blade #

Attempts:

Difficulty Why?

☐ Direct Vision

☐ Stylette / Bougie

☐ Bilat = BS

☐ Semi-Closed Circle

☐ Closed Circle

☐ Other

Regional:

Extremity

☒ Spinal

Others:

Position: Sitting

Site: L3/4

Needle Size: 25 white

Depth: 7.5cm

Parasthesia ☐ Yes ☒ No

Catheter at skin 0.5 cm

Drug Name & Conc: 0.5% Bupivacaine heavy

Bolus: 10mg + 25mg Fentanyl

Infusion:

Block Level: T6

Comments: comfortable

Transportation to

☒ PACU ☐ ICU ☐ Other

Relaxant Reversed ☐ Yes ☐ No ☒ NA

Name of the Doctor: Dr. Achilak

Signature of the Doctor: (Signature)

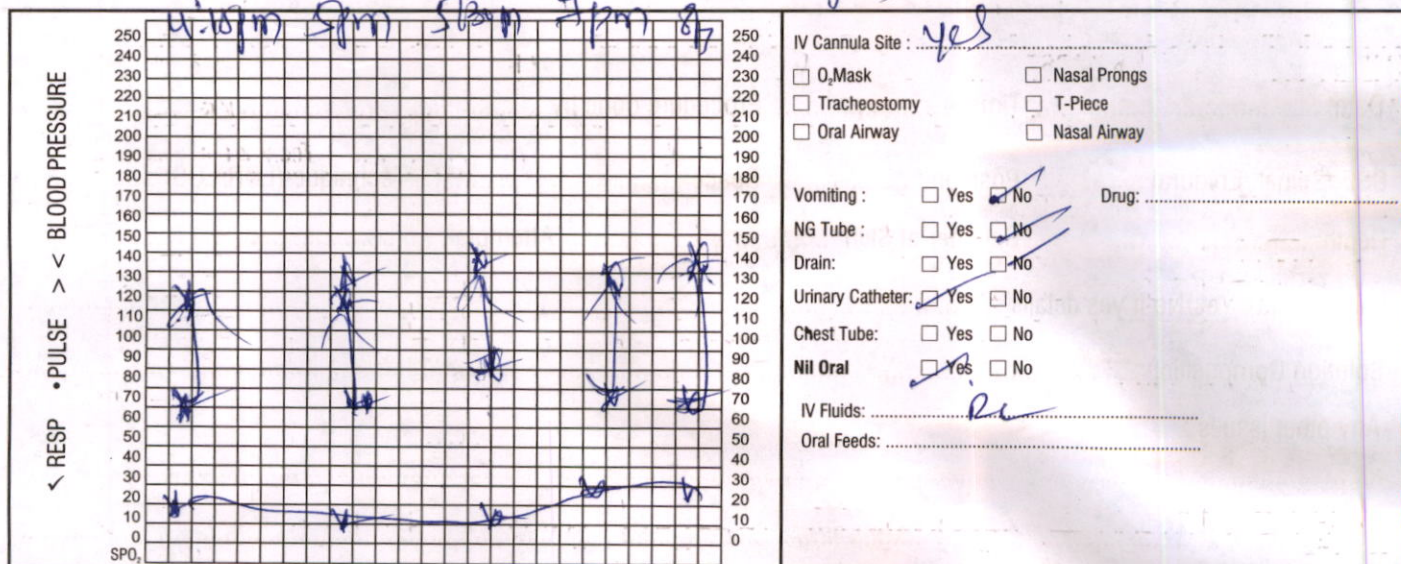


POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: Dr. Kanungo

Time Received: 4pm

Time Discharged: 22/7/20 3:10 PM



IV Cannula Site: yes

☐ 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: 2L

Oral Feeds:

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	A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:	
Able to move 2 extremities voluntary or on command	= 1							
Able to move 0 extremities voluntary or on command	= 0							
Able to deep breathe & cough freely	= 2	RESPIRATION		2	2	2		
Dyspnea or limited breathing	= 1							
Apneic	= 0							
BP $\pm$ 20 of Pre Anaesthetic leve	= 2	CIRCULATION		2	2	2		
BP $\pm$ 20-50 of Pre Anaesthetic leve	= 1							
BP $\pm$ 50 of Pre Anaesthetic leve	= 0							
Fully awake	= 2	CONSCIOUSNESS		2	2	2		
Arousable on calling	= 1							
Not responding	= 0							
Pink	= 2	COLOR		2	2	2		
Pale, dusky, blotchy, jaundiced, other	= 1							
Cyanotic	= 0							
TOTAL				9	10	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
20/7	4pm	0	NA	Kanungo
20/7	6pm	0	NA	Kanungo

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

Anaesthesiologist Name: Dr. K. S. Sanyal

Anaesthesiologist Signature: [Signature]

Date & Time: 22/7/20 3:10 PM

PACU Nurse Name: Kanungo

PACU Nurse Signature: [Signature]

Date & Time: 20/7/20 4pm

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): Dr. OT

Date & Time: 20/7/20 4pm

Patient Sticker

Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: Time: Procedure done by

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

Depth: Catheter at Skin: Attempts :

Parasthesia : Yes/No if yes details :

Solution Composition :

Any other issues :

a)

b)

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

Delivery Details : Time : APGAR: SVD / Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected :

Patient Satisfaction :

Discharge /Shifting ordered by

Doctor Signature:

Doctor Name:

Date and Time :



CONSENT FOR ANAESTHESIA

Authorization By: ☒ Patient ☐ Patient Attendant

Operative Procedure: Emergency Caesarean Section
Anaesthesiologist: Dr. Sundhara Surgeon: Dr. Annie

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, 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: [Signature]
Name: IQRA FATIMA
Relationship with patient: Self
Date & Time: 20/7/26, 12pm → 2³⁰pm

Witness:

Signature: [Signature]
Name: Farid Ahmed Siddiqui
Date & Time: 20/7/26, 12pm → 2³⁰pm

Doctor (who is taking consent):

Signature: [Signature] Name: Dr. Sundhara Date: 20/7/26 Time: 12pm

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స:

అనస్థీషియా వైద్యుడు: శస్త్రచికిత్స నిపుణుడు:

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

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

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

స్పెసిఫిక్ హై రిస్క్:

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

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

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

☐ ఇతరవి:

రోగి / రోగి అటెండెంట్

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

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్:

సంతకం: పేరు: తేదీ & సమయం:

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

Patient Name : Mrs. IGRA FATIMA Gender: ☐ Male ☒ Female Age : 21 y.o.
UHID No : RAM-HAH-0016676 Date : 20/7/26

Instruction:

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

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

EMERGENCY CESARIAN SECTION

upon

(Name of the Patient) IGRA FATIMA

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, INFECTION, MULTIPLE BLOOD TRANSFUSION, DAMAGE TO BOWEL & BLADDER & URETER & REPAIR, NEED FOR NICU STAY

My signature on this form indicates that

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

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

Consentee:

Signature : [Signature]

Name : Igra Fatima

Date & Time : 20/7/26, 3:00pm

Witness:

Signature : [Signature]

Name : Kamr

Date & Time : 20/7/26, 3:00pm

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

Patient Attendant:

Signature : [Signature]

Name : Zaid Ahmed Siddiqui

Relationship with Patient : Husband

Date & Time : 20/7/26, 3:00pm

Doctor (who is taking the consent):

Signature : [Signature]

Name : Dr. Smita

Date & Time : 20/7/26, 11:40 AM

HNH-00016676 IP5-00176590
Mrs IQRA FATIMA
30-09-2004 21 Y 9 M 21 D (F)
Dr. ANNIE PRANUTHA P



339

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 22/7/26

Time: 3:30pm

Origin: Indian

Height: 155cm

Weight: 80kg's

BMI: 31 kg/m²

Food Allergies: No

Diagnosis: POD-2 / LSCS (Lower Segment Cesarean Section)

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

Diet Advised:

soft High protein diet
include plenty of oral liquids
avoid spicy, chilled & outside foods

Patient's / Attendant's

Dietician's

Signature:

Signature: Saima

Name: Iqra fatima

Name: Saima

Date & Time: 22/7/26
3:30 pm

Date & Time: 22/7/26
3:30 pm

DIETARY NOTES[illegible]

ADMISSION SHEET



Registration Details :

Admission No : IP5-00176590 Admit Date : 18-Jul-2026 Admit Time : 10:02 PM UHID : HNH-00016676

Patient Details :

Patient Name	: Mrs IQRA FATIMA	Age	: 21 Y 9 M 18 D
Guardian	: Mr ZAID AHMED SIDDIQI	DOB	: 30-09-2004
Gender	: Female	Religion	:
Occupation	:	Marital Status	: Married
Address (H)	: 20-3-1/4, doodh bowli, hyd Doodh Bowli Hyderabad Telangana INDIA 500064	Phone No	: 8121548297 / 8121272212
		E-mail	: iqzzftm@gmail.com

Admission Details :

Bed Type : SHARED WARD Bed No : SW 414 Ward Name : 4F-BIRTHING CENTRE
Room No : SW 414 Admission Type : First Visit

Contact Details :

Name : Mr ZAID AHMED SIDDIQI Relationship : Husband
Contact Address : 20-3-1/4, doodh bowli, hyd Doodh Bowli
Hyderabad Telangana INDIA 500064 Phone No : 8121548297 / 8121272212


Signature

Doctor Details :

Doctor Name : Dr. ANNIE PRANUTHA P Specialisation : OBSTETRICS AND GYNECOLOGY
Referral Doctor : SELF Phone No :
Co-Consultant :

Payment Details :

Deposit Amount : 0.00
Payment Mode : Cash Payor Name : MEDI ASSIST INSURANCE TPA PVT LTD

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ Consultant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
22/7/26	3:50 pm	BC	339	poulabi

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Prathmesh	19/7/26		
2	Dr. Prathmesh kumar (NNC)	20/7/26	9712979	Yannu
3	Dr. Niveditha	20/7/26	9712981	Yannu
4	Dr. Srinivas	20/7/26	9712989	Yannu
5	Dr. Khushik	21/7/26	09714553	Lanka
6	Dr. Niveditha	21/7/26	9716367	Lanka
7	Dr. Niveditha	22/7/26	9716487	Lanka
8	Dr. Pheena Sharma	22/7/26	9716851	Perathi
9	Dr. Niveditha (TC)	23/7/26	9717802	Perathi
10				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
18/7	NST ①	265-035965	Pui
19/7	NST ②		21
19/7	GPBS. ^{post break fast} 200 mg/dl	26072442	Suand
19/7	AFE doppler.	265035985	Deb
19/7	GPBS ^{post lunch} 136 mg/dl	26072483	Suand
19/7	CBP, LFT, LDH, s-electrolytes	26072463	Kamng
	Creatinine. PT/PTT		
19/7	ECG ①	265-036000	Kama
	NST ③	265-036020	
19/7	Post dinner- 145 mg/dl	26072593	Song
20/7	CBP, LFT, LDH, Sr creatine	26072551	Song
	Sr electrolytes.		Song
20/7	ECG - ②	265036019	Song
20/7	pre-breakfast - 155 mg/dl	26072875	Song
20/7	Post breakfast - 98 mg/dl 9am	26072876	Yanning
20/7	NST - ④	265-036063	Yanney
20/7	ultrasound chest	265-036069	Yany
20/7	2D Echo	265-036100	Yany
20/7	AFE Doppler	265-036344	Yany
20/7	CBP, LDH, LFT	26072919	Song
	electrolytes		
21/7	CBP, Sr electrolytes	26072981	Song
21/7	GPBS 67 mg/dl	26073012	Song