

ADMISSION SHEET

Registration Details :



Admission No : IP5-00173746 Admit Date : 12-May-2026 Admit Time : 09:35 PM UHID : BAH-00476851

Patient Details :

Patient Name : Mrs MADHURI SAGI Age : 34 Y 2 M 24 D
Guardian : Mr SIVARAM G DOB : 18-02-1992
Gender : Female Religion :
Occupation : Martial Status : Married
Address (H) : FLAT NO-172,GAYATRI HILLS,ROAD NO-10 C Phone No : 9849819116/ 9666772277
Jubilee Hills Hyderabad Telangana INDIA E-mail : GSHIVA@GCON.CO.IN
500033

Admission Details :

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

Contact Details :

Name : Mr SIVARAM G Relationship : Husband
Contact Address : FLAT NO-172,GAYATRI HILLS,ROAD NO-10 Phone No : 9849819116 / 9666772277
C Jubilee Hills Hyderabad Telangana INDIA
500033

Signature

Doctor Details :

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

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00
Payor Name : SELFPAY

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ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : **3AH-00476851** IP5-00173746
Mrs MADHURI SAGI
Dr. SASIKALA KOLA 34 Y 2 M 24. D (F) Consultant: _____ Dept : _____

Date of Adm : _____ 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	NHA	14/5/26		Anita
2	(Dietician) Dr. Sundarani	14/5/26	9609466	Anita
3	(Lactation) Dr. Nalini	14/5/26		Anita
4	Dr. Tubeena	16/5/26	9611071	Anita
5				
6				
7				
8				
9				
10				

BAH-00476851 IP5-00173746
M's MADHURI SAGI
11-02-1992 34 Y 2 M 25 D (F)
D: SASIKALA KOLA



Suite-5



NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 14/5/26 Time: 10:30am

Origin: Indian Height: 165cms Weight: 76-7kgs BMI: 28-19kg/m²

Food Allergies: ~~egg~~ Yeast

Diagnosis: PND-1 (Post Normal delivery)

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

Diet Advised:
Normal high protein diet
plenty of oral liquids
- Avoid spicy, Chilled, outside foods

Patient's / Attendant's
Signature: Madhuri

Name: Madhuri

Date & Time: 14/5/26, 10:30am

Dietician's
Signature: Nikitha

Name: Nikitha

Date & Time: 14/5/26, 10:30am



IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

For 90L

LMP: 7/8/2025

EDD:

Corrected EDD: 14/5/2026

GA: 39⁺⁵

Obstetric Formula:

GSPILIA3

Menstrual History: Regular: Yes No

Obstetric Examination

Obstetric History:

- 1-1/2022, 2moA, sp. misc, SERPC
- 2-5/2022, IVF, 7wks, miss mis, MCRPC
- 3-12/2022, sp. concep, 7wks, miss misc SERPC

Present Pregnancy Record:

↓
 Triploidy xx4.

- 4-sp. conception, ♀, NVD, 3.1kg
 8/2024 GDM OHA
 Hypothyrod.

RISK FACTORS:

5-PP- sp. conception
 MC: 2016, NCM

Fundal Height: Term

Ut. Activity: Relaxed Mild Mod Severe

Liquor: Adequate Oligo Poly

PP: Cephalic Breech Others _____

Head Fifths Palpable: _____

FHS: Normal Tachy Brady Absent

Per Speculum Examination NA

Draining: Present Absent Bleeding

Colour of Liquor: Clear Meconium Blood Stained

Vaginal Examination

Cervix: Long/P Partially effaced Effaced

Os: Closed _____ Dilated 1 finger

Membranes: Present Absent

Liquor: Clear Meconium Blood Stained

Presenting Part: Vertex Breech Others

Sutton: -3 -2 -1 0 +1 +2

Pelvis: Adequate Doubtful

Height: 165 cm

Weight: 76.7 kg

Allergies: NKDA

Breast: Normal Abnormal

General Examination:

Consciousness: + Pallor: -

Icterus: - Edema: -

Temp 97.6° F PR: 90

BP: 100/60 DTR: NAD

CVS: RS

Liver/Spleen: NAD Urine Output: Adequate

DIAGNOSIS

GSPILIA3 39⁺⁵ - 90L



<p>Family History:</p> <p>Mother - HTN</p> <p>Father - Pat GM + Pat GF</p>	<p>Surgical History:</p> <p>SER PC - Jan 22 / Dec 22</p> <p>Lap ov drilling - 7/2021</p> <p>Hysteroscopy + Metroplasty 9/6/23</p>
<p>Medical History:</p> <p>NIU</p>	<p>Medication History:</p> <p>See reconciliation</p>
<p>Plan of Care:</p> <p>consent < VD</p> <p>parts prep JOL</p> <p>CBP</p> <p>NSI 3 hrs</p> <p>epidural siting</p> <p>Vitals FHR hrs</p> <p>w/ PO</p> <p>inform sbs</p>	<p>Investigations:</p> <p>4/5/26 : Hb 10.5g/l</p> <p>TC 9270</p> <p>PT 2.14</p> <p>O positive</p> <p>HIV</p> <p>HBsAg / Neg</p> <p>VDRL</p> <p>10/2/26</p> <p>27/4/26 : SLUG 36⁺</p> <p>10.2cm</p> <p>AC 33/</p> <p>2728(38/)</p> <p>Doppler (N)</p>

Doctor Name: Dr. Y. Sneha

Signature: [Handwritten Signature]

Date & Time: 12/5/26; 10PM

Consultant Name: Dr. Sasikala

Signature: [Handwritten Signature]

Date & Time: 12/5/26 10PM

3AH-00476851 IP5-00173746
 Mrs MADHURI SAGI
 B-02-1992 34 Y 2 M 24 D (F)
 Dr. SASIKALA KOLA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/5/2026 2AM	Pt comfortable Sleeping Vitals stable NST Reactive	O ₁ miso 25mg po stat Dr Y Snelke
13/5/2026 6AM	Pt comfortable sleeping P/A: Irritable NST Reactive PR: 78/45 BP: 104/72 SpO ₂ : 98%	C/O/w Dr. Sasikala ✓ T. miso 25mg po stat ✓ Reassess @ 8AM
	Noted by Dr.	Dr Y Snelke

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/5/2026		
8:15 AM		
	P/A: Mild Action	
	P/V: 1/2" / 2cm	<u>NST now</u>
	clear leak	
	SR0M	
	FHR good	
	noted by Bullym	dry
		dry green
13/5/26	S/B Dr Sanikala	Adv
9:20 AM	O/E ac-fair	w/ progression of labour
	Vitals stable	NST 3rd hly
	P/A - ut moderate	FHR monitoring continuously
	FHR ⊕	- vitals 2nd hly
	V/E - Cr 2hly	- 2nd hly
	Vinch hly	
	Clear leak ⊕	
	Vp 2 hly	
		Dr Sanikala

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 Mrs MADHURI SAGI
 18-02-1992 34 Y 2 M 25 D (F)
 Dr. SASIKALA KOLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/05/2026 2:50pm	<p>ABDO B/LA₂/SVD</p> <p>O/E Gc fair, Temp</p> <p>PR - 87</p> <p>BP - 124/72 (83)</p> <p>SpO₂ 100</p> <p>P/A - ut @ well</p> <p>V/E Bleeding</p>	<p><u>Adv</u></p> <ul style="list-style-type: none"> - soft diet, plenty of oral fluids - drugs as per charting - vitals every 4hr - I/O charting - w/f active <p>Bleeding pt</p> <ul style="list-style-type: none"> - Inform SRS
Early m		
up		
	<p>- Remove Foley's @ 6pm on 13/5/26</p>	<p>Noted by SRS <u>Manu (R. MATHAN)</u></p>
13/05/2026 9pm	<p>PND - 0/1w₂ A₃/SVD</p> <p>Comfortable</p> <p>Gc Fair/Alphile</p> <p>Vitals - Stable</p> <p>P/A - views retracted</p> <p>Soft</p> <p>V/E - Minimal Bleeding</p>	<p><u>Advice:</u></p> <ul style="list-style-type: none"> ✓ oral hydration ✓ soft diet ✓ monitor vitals ✓ Ambulation ✓ w/f excessive bleeding ✓ Inform SRS <p><u>By Dr Deepika</u></p>
Babywell		
Voided ✓		



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>11/5/2026</u>	<u>PND-1 SVD</u>	<u>Advice</u>
<u>8AM</u>	Comfortable 46 F/A	<ul style="list-style-type: none"> ✓ oral hydration ✓ Regular diet
<u>Babywell</u>	Vitals - stable	<ul style="list-style-type: none"> ✓ Monitor vitals
V _v	P/A - uterus retracting well	<ul style="list-style-type: none"> ✓ Drugs as charted
S _v	soft VVE minimal Bleeding ⊕	<ul style="list-style-type: none"> ✓ Ambulation ✓ Inform SES
	Remove cannula	By Chiranjeevi
Noted by Sis. Anita		
<u>12/5/2026</u>	Pt comfortable	<u>Adv ⊕</u>
<u>2:00pm</u>	OB - C/G - fair	<ul style="list-style-type: none"> - soft diet, plenty of oral fluids
	Vitals stable	<ul style="list-style-type: none"> - drugs as per charted
	P/A - ut ⊕ well	<ul style="list-style-type: none"> - vitals continue
	V/E - lochia healthy	<ul style="list-style-type: none"> - Ambulate
C _v		<ul style="list-style-type: none"> - W/F active
S _v		Bleeding ⊕
<u>Baby m</u>		- soft diet

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 Mrs MADHURI SAGI
 18-02-1992 34 Y 2 M 25 D (F)
 Dr. SASIKALA KOLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<p>11/02/26 6:20pm W N S Baby - no</p>	<p>PE comfortable Gc = fair vitals - stable P/A - well U/B - normal healthy</p>	<p>Adv - Reg diet, plenty of fluids - drug as per chart - vitals 6 hourly - Ambulate - Hygiene</p>
<p>Noted by S.S. Anita</p>	<p>PRO-2</p>	<p>Adv</p>
<p>13/5/26 8am</p>	<p>Gc = fair Vitals: stable P/A: uterus retracted well S/E: NAB</p>	<p>Adv - regular diet - follow drug chart - Monitor vitals 6hrly - Ambulation</p> <p>C. Sankar Dr. Sankar</p>

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 Mrs MADHURI SAGI
 18-02-1992 34 Y 2 M 25 D (F)
 Dr. SASIKALA KOLA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/5/26 2pm	<p style="text-align: center;"><u>PND-2</u></p> <p>Vitals: stable</p> <p>P/A: uterus retracted well</p> <p>of E: NAB</p>	<p style="text-align: center;"><u>Ado</u></p> <p>Continue same treatment</p> <p style="text-align: right;">C. Sonika Dr G. Sonika</p>
15/5/26 9pm	<p style="text-align: center;"><u>PND-2</u></p> <p>pt vitally stable</p>	<p style="text-align: center;"><u>Ado</u></p> <p>Continue same treatment</p> <p style="text-align: right;">C. Sonika Dr G. Sonika</p>

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Mrs MADHURI SAGI

18-02-1992 34 Y 2 M 25 D (F)

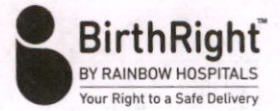
Dr. ASIKALA KOLA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/5/2026	PND-3	c/o cramps while feeding
8:30 AM	comfortable	
subnormal	G.C - faintly afebrile	<u>Advice</u>
voided ✓	vitals - stable	✓ oral hydration
stools ✓	P/A - vitals rechecked well	✓ Regular diet
	soft	✓ Bkx as charted
15/5 (PVE)	VRE - lochia ⊕ healthy	✓ monitor vitals
		✓ Ambulation
		✓ w/f oxycodone Bedding
		✓ Inform SCS
		by Dr. Deepika
	Noted by	
	Sis Anita	

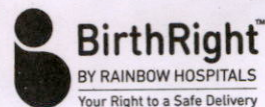
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 Mrs MADHURI SAGI
 18-02-1992 34 Y 2 M 24 D (F)
 Dr SASIKALA KOLA



RESULT SHEET

Date	12/5/26				
Time	10:53pm				
Hb	10.9				
PCV	33.7				
RBC	3.79				
WBC	9.88				
W/L	74.5 / 16.8				
Platelets	2.12 Lakhs				
CRP					
ESR					
PCT					
FBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bil/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

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 Mrs MADHURI SAGI
 18-02-1992 34 Y 2 M 24 D (F)
 Dr. S. SIKALA KOLA



MEDICATION RECONCILIATION FORM

Drug Allergies: Not known any Drug Allergies

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

Shifting From: ICU Shifted to: Ward

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Oral clexane	20mg	slc	OD	11/5/26	<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
2	T. Iron	1tab	PO	OD	11/5/26	<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
3	T. calcium	1tab	PO	OD	11/5/26	<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
4	T. vit D	1tab	PO	OD	11/5/26	<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Y. Srinivas

Date & Time: 12/5/26 8PM

Nurse Name & Signature: Prasanna S

Date & Time: 12/5/26 8pm

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Mrs MADHURI SAGI
18-02-1992 34 Y 2 M 25 D (F)
Dr. SASIKALA KOLA



Sheet No: 50 **REGULAR PRESCRIPTIONS** Weight Ward BC

DRUG : <u>LONOPIN</u>				Date						
Dose	Route	Frequency	Start Dt.	Time						
<u>4mg</u>	<u>SLC</u>	<u>OD</u>	<u>14/5</u>	<u>6AM</u>	<u>14/5</u>	<u>15/5</u>	<u>16/5</u>			
Name & Signature of the Doctor Starting the Drugs: <u>M(2) MATHA</u>										
Additional Instructions: <u>(after churki chudiy)</u>										
Daily Doctor's Endorsement by a Sign										

DRUG : <u>TAB. PARACETAMOL</u>				Date						
Dose	Route	Frequency	Start Dt.	Time						
<u>500mg</u>	<u>PO</u>	<u>TID</u>	<u>14/5/26</u>	<u>12am</u>	<u>14/5</u>	<u>15/5</u>	<u>16/5</u>			
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Deepika</u>										
Additional Instructions:										
Daily Doctor's Endorsement by a Sign										

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

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

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 Mrs M. DHURI SAGI
 18-02-1992 34 Y 2 M 24 D (F)
 Dr. SA SIKALA KOLA



DRUG CHART

Date of Admission: 12/5/26 Drug Allergies: Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name Signature

REGULAR PRESCRIPTIONS

Weight Ward. BPR



DRUG : AS CERAMINE				Date Time	13/5	14/5	15/5	16/5												
Dose	Route	Frequency	Start Date																	
20mg	P/O	BD	13/5	10 AM	11 AM	12 PM	1 PM	2 PM												
Name & Signature of the Doctor Starting the Drugs:				M. (D. MATHAN)																
Additional Instructions:				10 AM 11 AM 12 PM 1 PM 2 PM																
Daily Doctor's Endorsement by a Sign				h h h																
DRUG : PARACETAMOL				Date Time	13/5	14/5	15/5	16/5												
Dose	Route	Frequency	Start Date																	
100mg	P/O	TID	13/5	12 AM	1 PM	2 PM	3 PM													
Name & Signature of the Doctor Starting the Drugs:				M. (D. MATHAN)																
Additional Instructions:				4 PM 8 PM STOP by Dr. Deepika																
Daily Doctor's Endorsement by a Sign				h h h																
DRUG : PANTAP				Date Time	13/5	14/5	15/5	16/5												
Dose	Route	Frequency	Start Date																	
40mg	P/O	OD	13/5	7 AM	8 AM	9 AM	10 AM													
Name & Signature of the Doctor Starting the Drugs:				M. (D. MATHAN)																
Additional Instructions:				7 AM 8 AM 9 AM 10 AM 11 AM 12 PM																
Daily Doctor's Endorsement by a Sign				h h h																
DRUG : DUPHALAC				Date Time	13/5	14/5	15/5	16/5												
Dose	Route	Frequency	Start Date																	
15ml	P/O	OD	13/5	10 AM	11 AM	12 PM	1 PM													
Name & Signature of the Doctor Starting the Drugs:				M. (D. MATHAN)																
Additional Instructions:				bedtime																
Daily Doctor's Endorsement by a Sign				h h h																

Patient Sticker

Weight. Ward. BAP

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
13/5/26	2AM	T-MISOPROSTOL	25mcg	PO	[Signature]	Preen
13/5/26	6AM	T-MISOPROSTOL	25mcg	PO	[Signature]	Preen
13/5/26	9:30AM	Inj CEFOTAXIME	1gm	IV	[Signature]	Pushpa, Nikitha
13/5/26	12:45 PM	TRANEXA	1gm	IV	[Signature]	Pushpa
13/5/26	12:0 PM	Tab MISOPROSTOL	600mcg	Pla	[Signature]	Pushpa, Shaba
13/5	2:28 PM	DICLOFENAC SUP	100mg	Pla	[Signature]	Nikita, Shaba
13/5	1:57 PM	Lj OXYTOCIN	10IU	m	[Signature]	Nikita, Shaba
13/5	1:58 PM	Inj CALCIUM GLUCONATE	1amp	IV	[Signature]	Nikita, Shaba

Signature

VERIFIED BY : Name

BAH-00476851 IP5-00173746
 Mrs MADHURI SAGI
 18-02-1992 34 Y 2 M 25 D (F)
 Dr. SASIKALA KOLA



Rainbow Children's Hospital

BirthRight™
 W HOSPITALS
 a Safe Delivery

BAH-00476851 IP5-00173746
 Mrs MADHURI SAGI
 18-02-1992 34 Y 2 M 25 D (F)
 Dr. SASIKALA KOLA



FLUID CHART

13/05/21

Sheet No. :

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

Date	Time	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		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	Local 200ml	PL	PL						0		Saba
	03:00 pm	thro 100ml	PL	PL					400ml	0		Saba
	04:00 pm	thro 200ml	PL	PL						0		Saba
	05:00 pm	thro 100ml	PL	PL						0		Saba
	06:00 pm	thro 100ml	PL	PL					500ml	0		Saba
	07:00 pm	thro 200ml	PL	PL					300ml	0		Saba
Total Intake : Taken					Total Output : Passed							
	08:00 pm	thro								0		
	09:00 pm	thro								0		Reddy
	10:00 pm	thro								0		Reddy
	11:00 pm	thro								0		Reddy
	12:00 am	milk								0		Reddy
	01:00 am									0		
Total Intake : Taken					Total Output : Passed							
	02:00 am									0		Reddy
	03:00 am	thro								0		Reddy
	04:00 am									0		
	05:00 am									0		
	06:00 am									0		Reddy
	07:00 am	thro								0		
Total Intake : Taken					Total Output : Passed							
Total 24 hrs. Intake					Total 24 hrs. Output							

BAH-00476851 IP5-00173746
 Mrs MADHURI SAGI
 18-02-1992 34 Y 2 M 25 D (F)
 Dr. SASIKALA KOLA

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.
- 24 hrs. total to be entered in the kardex in RED.

Date	Time	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
14/5/26	08:00 am	H2O							✓		No IV Anita	Anita
	09:00 am											
	10:00 am	H2O				✓						
	11:00 am	H2O				✓						
	12:00 pm								✓			
	01:00 pm	H2O							✓			
Total Intake :		Taken			Total Output : 0-3 m-0							
	02:00 pm								✓			Sub
	03:00 pm	lunch 200ml										Sub
	04:00 pm	bro 100ml										Sub
	05:00 pm	soup 200ml							✓			Sub
	06:00 pm	bro 100ml							✓			Sub
	07:00 pm	bro 100ml										Sub
Total Intake :		Taken			Total Output : m-3e8							
	08:00 pm											
	09:00 pm	milk							✓			Sub
	10:00 pm	H2O										Sub
	11:00 pm								✓			Sub
	12:00 am								✓			Sub
	01:00 am	Idian										Sub
Total Intake :		Taken			Total Output :							
	02:00 am											
	03:00 am	H2O							✓			Sub
	04:00 am	H2O										Sub
	05:00 am											Sub
	06:00 am											Sub
	07:00 am	milk							✓			Sub
Total Intake :		Taken			Total Output : m-3e8							
Total 24 hrs. Intake					Total 24 hrs. Output							

3AH 00476851 IP5-00173746
 Mrs MADHURI SAGI
 18-02-1992 34 Y 2 M 27 D (F)
 Dr. SASIKALA KOLA



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.

Date	Time	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse		
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine				
			Mouth	I.V	N.G								
15/5/16	08:00 am	H ₂ O							✓		No IV Aunt		
	09:00 am												
	10:00 am	H ₂ O											
	11:00 am								✓				
	12:00 pm	H ₂ O											
	01:00 pm								✓				
Total Intake :		Taken			Total Output : 0-2 m-0								
15/5/16	02:00 pm										No IV Aunt		
	03:00 pm	H ₂ O							✓				
	04:00 pm												
	05:00 pm	H ₂ O											
	06:00 pm												
	07:00 pm	H ₂ O							✓				
Total Intake :		Taken			Total Output :								
15/5/16	08:00 pm										No IV Aunt		
	09:00 pm	H ₂ O							✓				
	10:00 pm												
	11:00 pm												
	12:00 am	H ₂ O							✓				
	01:00 am												
Total Intake :		Taken			Total Output :								
15/5/16	02:00 am										No IV Aunt		
	03:00 am	H ₂ O							✓				
	04:00 am												
	05:00 am								✓				
	06:00 am	H ₂ O											
	07:00 am												
Total Intake :		Taken			Total Output :								
Total 24 hrs. Intake												Total 24 hrs. Output	



FLUID CHART



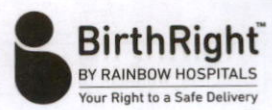
Sheet No. : 4

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
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		
16/5/06	08:00 am	H ₂ O								✓	No IV FV	S. Sube
	09:00 am											
	10:00 am	H ₂ O								✓		
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :			Taken			Total Output :					Part Jcd	
	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



Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Mrs. madhuri Sagi Age: 34y Sex: Female UHID.No: BAH-00476851
 Date: 12/5/26 Time: 8:00 pm Proposed Operation: Epidural Analgesia
 Diagnosis: G5P1L1A3 38^w weeks
 B.P / CRT: H.R: Weight: 77kg ASA Physical Status: 1 2 3 4 5

Laboratory Data:

Hgb: 10.5 Glucose: Protein: HIV: X-Ray:
 PCV: 33.5 Urea: Alb: HBS Ag: ECG:
 WBC: 9.270 Creat: Total Bill: HCV: 2D Echo:
 Plate: 2.74 Na: Dir. Bill: Blood group: O+ve Stress/Angio:
 PT: K: LDH: T3 Other:
 PTT: Ca++: Alk phos: T4
 INR: Mg++: Amylase: TSH
 Cl-: SGOT/SGPT:
HbA1c = 5.4 Allergies: NEPA

Medical History: CVS:
 RESP: Diabetes:
 CNS: Not significant
 Renal:
 Hepatic / GE: Physical Activity: Active
 Others: H/O 3 Miscarriages
 Past Anaesthetic History: H/O AXSERPC H/O
 Physical Exam: (N) H/O
 Airway: MP 1 2 3 4 Mouth Opening: Adequate Mentohyoid Distance: 2FB Neck: (N) Teeth: intact
 Lungs: BAE (+) clear
 Heart: SI (+)
 CNS: ADTFF (+)
 Pregnant: Yes No NA Venous Access Site: (R) Spine Exam for regional:
 Anaesthetic Plan: MAC REGIONAL GA-ETT LMA
 Peri-Operative Plan Explained to the Patient: Yes No

CURRENT MEDICATIONS	DOSAGE
<u>LMWH</u>	<u>20mg OD</u>

- Pre-Operative Instructions:**
- DVT Prophylaxis:
 - NIL ORAL $\left\{ \begin{array}{l} \text{Water / ORS 2 Hours} \\ \text{Others 6 Hours} \end{array} \right.$
 - Informed Consent: Standard High Risk
 - Post Operative Pain Management: Discussed with Patient
 - Other Instructions:

Signature: [Signature] Name: Dr. Sunanda

Patient Sticker

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Time Received : Time Discharged :

< RESP • PULSE > < BLOOD PRESSURE >	250		250	IV Cannula Site :
	240		240	<input type="checkbox"/> O ₂ Mask <input type="checkbox"/> Nasal Prongs
230		230	<input type="checkbox"/> Tracheostomy <input type="checkbox"/> T-Piece	<input type="checkbox"/> Oral Airway <input type="checkbox"/> Nasal Airway
220		220	Vomiting : <input type="checkbox"/> Yes <input type="checkbox"/> No	Drug:
210		210	NG Tube : <input type="checkbox"/> Yes <input type="checkbox"/> No	
200		200	Drain: <input type="checkbox"/> Yes <input type="checkbox"/> No	
190		190	Urinary Catheter: <input type="checkbox"/> Yes <input type="checkbox"/> No	
180		180	Chest Tube: <input type="checkbox"/> Yes <input type="checkbox"/> No	
170		170	Nil Oral <input type="checkbox"/> Yes <input type="checkbox"/> No	
160		160	IV Fluids:	
150		150	Oral Feeds:	
140		140		
130		130		
120		120		
110		110		
100		100		
90		90		
80		80		
70		70		
60		60		
50		50		
40		40		
30		30		
20		20		
10		10		
0		0		
SPO ₂				

POST ANAESTHESIA SCORE (Modified Aldrete Score)	IN	MINUTES			OUT	SCORING INTERPRETATION
		30	60	90		
Able to move 4 extremities voluntary or on command = 2 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 0						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:
ACTIVITY						
Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0						
RESPIRATION						
BP ± 20 of Pre Anaesthetic level = 2 BP ± 20-50 of Pre Anaesthetic level = 1 BP ± 50 of Pre Anaesthetic level = 0						
CIRCULATION						
Fully awake = 2 Arousable on calling = 1 Not responding = 0						
CONSCIOUSNESS						
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0						
COLOR						
TOTAL						

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature

Pain Tool Used: N PASS FLACC Wong Baker NPS

Reassessment Frequency:

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

Anaesthesiologist Name :

Anaesthesiologist Signature:

Date & Time:

PACU Nurse Name :

PACU Nurse Signature:

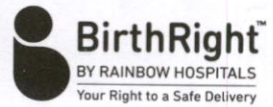
Date & Time:

Transferred to Unit by (PACU):

Date & Time:

3AH-00476851 IP5-00173746

Mrs MADHURI SAGI 34 Y 2 M 24 D (F)
Dr. SASIKALA KOLA



Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: 12/05/20 Time: 8²⁰ pm Procedure done by Dr. Sundhara

CSE / Spinal (Epidural) Position: Sitting Space: L4/5 Technique (LOF/LOS)

Depth: 5.5 cm Catheter at Skin: 10.5 cm Attempts: 1

Parasthesia: Yes/No (No) if yes details:

Solution Composition: Sited Epidural. Test-dose 3cc 2% lig e Adeginen

- Any other issues:
- a)
- b)

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level		Maternal		FHR	Comments
			Left	Right	BP	Pulse		
9:50	4	0.8% LOX	T ₁₀	T ₁₀	122/72	89	100	Comfortable

Delivery Details: Time: 1:56 pm APGAR: 9,10 SVD / Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected: Dr. Aditi, 10:00 pm, Tip intact

Patient Satisfaction:

Discharge / Shifting ordered by
 Doctor Signature: *[Signature]*
 Doctor Name: Dr. Sr. Ayeshu
 Date and Time: 11/5