Rainbow Children's Hospital - Banjara Hills

8-2-120/103/1,2,3,4 and 5,Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad ,Telangana, India ,500034.
TEL NO :+91-40-4466 5555
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176697 **Admit Date** : 21-Jul-2026 **Admit Time** : 10:30 AM **UHID** : BAH-00406134

Patient Details :

Patient Name	: Mrs SHABANA FATIMA	**Age**	: 41 Y 0 M 8 D
Guardian	: Mr MAHMOOD BAIG ,	**DOB**	: 13-07-1985
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: H NO - 8-4-379/J/400, NRR PURAM COLONY SITE - 1 , Borabanda Hyderabad Telangana INDIA 500018	**Phone No**	: 9533436191
		E-mail	: NOMAIL@GMAIL.COM

Admission Details :

Bed Type : DAY CARE **Bed No** : RC 408 **Ward Name** : 4F-GYN RECOVERY

Room No : RC 408 **Admission Type** : First Visit

Contact Details :

Name : Mr MAHMOOD BAIG , **Relationship** : Husband

Contact Address : H NO - 8-4-379/J/400, NRR PURAM COLONY SITE - 1 , Borabanda Hyderabad Telangana INDIA 500018 **Phone No** : 9533436191

Signature

Doctor Details :

Doctor Name	: Dr. SHRUTHI REDDY/Dr.LAVANYA JANAGAMA	**Specialisation**	: OBSTETRICS AND GYNECOLOGY
Referral Doctor	: Self	**Phone No**	:
Co-Consultant	:		

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash **Payor Name** : SELFPAY

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ACTIVITY RECORD FOR BILLING

Name :_____

UHID No. : _____ IP No : __ BAH-00406134 IP5-00176697 Mrs SHABANA FATIMA 13-07-1985 41 Y 0 M 8 D (F) Dr. SHRUTHI REDDY/Dr.LAVANYA _____ Dept : _____

Date of Admission: _____ Time _____ e : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
21/7/26	12PM	GYN	OT	Reey
21/7/26	5PM	OT	OBG	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
21/7	Cardiac monitor	4:00pm	10:00pm	97/16796	[signature]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
20/7	PAC	op borne		Sravani
28/7	2v plount		9714438	Sravani
21/7	Catheterization			Sravani

ANY OTHER INFORMATION

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....

....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

BAH-00406134 IP5-00176697
Mrs SHABANA FATIMA
13-07-1985 41 Y 0 M 8 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA

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OBSTETRICS / GYNECOLOGY
NURSING INITIAL ASSESSMENT FORM

Date of Admission: 21/7/26

Baseline Information:

Admission From: ☐ ER ☐ OPD ☑ Admission Desk ☐ Others, specify .....

Primary Language: ☑ Telugu ☑ English ☐ Hindi ☐ Others, specify .....

Do you require an interpreter? ☐ Yes ☑ No if Yes specify .....

Source of Information: ☑ Patient ☐ Family ☐ Others, specify .....

Allergies: ☐ Yes ☑ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: .....

If yes, identify .....

Chief Complaints: G2 L2 A1 c/o Heavy Menstrual bleeding

Doctor Notified on Admission: ☑ Yes ☐ No

Name of the Doctor: Dr. Dilly

Time Notified: 11 AM.

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

Past Medical History	Past Surgical History	Previous Hospital Admission
DM HTN Urine infection	2 LSCS	Nil

Gynecology Assessment: ☐ Not Applicable

Menstrual History: .....

.....

Onset of Menarche: .....

Menstrual Cycle: ☐ Regular ☐ Irregular

Last Menstrual Period: 20/6/26

Gynecology Surgical History:

Caesarean Section: ☐ No ☑ Yes

Cervical Cerclage: ☑ No ☐ Yes

Ectopic Pregnancy: ☑ No ☐ Yes

Myomectomy: ☑ No ☐ Yes

Others: _____

Gynecological History:

Contraceptives: ☑ No ☐ Yes

Vaginal Discharge: ☑ No ☐ Yes

Post-Coital Bleeding: ☑ No ☐ Yes

Infertility: ☑ No ☐ Yes

If Yes Type: ☐ Primary ☐ Secondary

Obstetric History: G ..... P 2 ..... L 2 ..... A 1 .....

Previous LSCS: 2 LSCS

Current Medication: ☐ None ☑ Yes, If Yes, Fill the reconciliation form

Family History: ☐ No Abnormalities Detected

☐ Heart Disease ☑ Hypertension ☐ Diabetes ☐ Stroke ☐ Seizures ☐ Kidney disease

☐ Liver disease ☐ Other .....

Vital Signs / Measurements: Temp: 98.6°F HR: 86 bt RR: 20 bt

BP: 136/74 mmHg Weight: ..... Height: ..... BMI: .....

Pain Assessment: **Pain:** ☐ Yes ☑ No (If Yes, complete the Pain Assessment / Reassessment Form)

BAH-00406134 IP5-
Mrs SHABANA FATIMA
13-07-1985 41 Y 0 M 8 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA

PHYSICAL ASSESSMENT

General Appearance: ☑ Healthy ☐ ill looking ☐ Anxious ☐ Agitated ☐ Others: .....

Fall Assessment: ☑ Yes ☐ No Score 35 (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore: ☑ Yes ☐ No Score 28 (complete the Braden Q Sheet)

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

☐ Mobility problem ☐ Walking Problem ☑ No Abnormality Detected

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☑ No Abnormality Detected

☐ Overweight ☐ Poor Appetite > 3 Days ☐ Needs Therapeutic Diet.

☐ Under Weight ☐ Diabetes Mellitus ☐ Hyperemesis Gravidarum

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

☑ Calm & Cooperative ☐ Restless ☐ Depressed ☐ Agitated ☐ Confused

☐ Others .....

Inform consultant for positive criteria

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 ..... 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: ..... MRS SHABANA .....

Orientation not given Reason: .....

Nurse Signature: .....

Nurse Name: ..... Meghri .....

Date & Time: ..... 21/7/26 at 10.30A .....

Patient Sticker

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OPERATION THEATER NOTES

Patient's Name : Mrs. Shabana. Age : 41 Gender : ☐ Male ☑ Female

UHID No.: BAH-00406134 Weight : 63kg Height :

Surgeon : Dr. Shruthi Reddy		Asst. Surgeon :
Anesthetist :	OT Nurse:	OT Technician:

Pre-Operative Diagnosis: AUB-L / P2L2A1

Surgical Procedure : Laparoscopic Myomectomy

Indications for Surgery : AUB(L)

Date : 22/7/26	Start Time :	End Time :

Pre Operative Preparations:

Post Operative Diagnosis: POD 0 Lap myomectomy

Peri-Operative Complications: ↓ aseptic precaution, abdomen & perineum cleaned & draped. Veress needle at supraumbilical area placed. 5mm supraumbilical port placed.

Operation Notes: 2 left lateral. 5mm port placed.

Operative finding: ① 5cm posterior uterine fibroid noted, ② left ovary simple cyst noted - of size 3×3cm, 3×2cm.

Surgery: ① Uterus enlarged with fibroid of size 14-16 weeks.

(2) posterior uterine wall. Fibroid noted, vertical — 5cm.
Incision given, omit, Myomectomy done. Myoma removed via posterior colpotom
(3) Fibroid is degenerated.
(4) Endometrial cavity is opened,
(8) Mirena removed through this site
(5) Myoma bed sutured in 2 layers with Barbed sutures
Hemostasis secured
(6) Fibroid removed through colpotomy.

Amount of Blood Loss: | Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:
Cyst wall, Fibroid

Peri-Operative Complications:

(7) Left ovary is Enlarged with 2 simple cyst.
3x3Cm, 3x2Cm, cyst wall removed & sent
for HPE.
(8) Clear Fluid drained
(9) Hemostasis secured
(10) procedure Uneventful.

Name of the Surgeon: Dr. Akshay For Dr. Smith.

Signature of the Surgeon:

Date & Time: 21/7/25, 7pm

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Mrs SHABANA FATIMA
13-07-1985 41 Y 0 M 8 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA

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I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 21/07/2026 Time of Admission : .....

Allergies: NKDA ☑ Not know any drug allergies

PRESENTING COMPLAINTS :

→ $P_2L_2A_1$ | c/o Heavy menstrual bleeding ∴ 5 years.
not used any ocp's
on Tranexa on & off.
→ Mirena insertion done on 28/4/2026 @ RCH. by Dr SK.

6/7/2026 USG ut- 83X63X59mm, AV, ET-30.3mm, Adenomyosis. Cx-28mm, cystic lesion-Slo-Nabothian cysts. RO-Vol-6.9cc, LO-97.1cc [cyst(s)-53X38X46mm, vol-48 Simple ① cyst. Mirena displaced towards ④ & mid uterine cavity. ? Post. Intramural fibroid & submucosal 51X42X30mm extending into uterine cavity - ca fibroid polyp.

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : 2005	Parity : $P_2L_2A_1$
Previous Periods : Regular. Dysmenorrhea ①	Mode of Delivery : 2 previous LSCS.
LMP : 20/06/2026	Last Child Birth : 2011
Contraception : Nil	

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
→ DM$_2$ since 5 years.	→ LSCS - 2008, 2011
→ HTN since 1 years.	→
→ Mirena - 28/4/26 Insertion.	
Had taken 2 IV Iron infusion.	

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Mrs SHABANA FATIMA
13-07-1985 41 Y 0 M 8 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA

FAMILY HISTORY:	MEDICATION HISTORY:
Mother - HTN	

INITIAL ASSESSMENT :

Date 21/7/26 Ht. Wt. BMI B.P Pallor absent CVR S1,2 (+) Respiratory System BAE (+) Thyroid (N)	Breasts (N) Abdominal Examination P/A soft	Local/Speculum Examination Bimanual Pelvic Examination

PROVISIONAL DIAGNOSIS :	P2L2A1 / AUB (A) (L) / Displaced Mirena in situ / for lap. (L) ovarian cyst. Myomectomy

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT
BGT - B positive Viral - NR 19/7/26 CBP - Hb - 11.7 g/dL WBC - 6100 PLT - 2.90L CUE - (N) FBS - 153 HbA1c -	- Admission - cannula - written & informed consent - shift to OT on call

Name of the Doctor : Dr. Divya

Signature of Doctor

Date & Time : 21/7/2026; 11:30AM.

BAH-00406134 IP5-00176697
Mrs SHABANA FATIMA (F)
13-07-1985 41 Y 0 M 8 D
Dr. SHRUTHI REDDY/Dr.LAVANYA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7/2026 3:00pm	POD-0/ Lap myomectomy	
	pt stable	
	O/E	
	Gc fair	Adv
	Bp-98/74(82)	1) NBM for 4hrs-6hrs
	PR-76 BPM	2) IVF @ 100ml/hr.
	SpO2-98% RA.	3) Drugs as charted
UO-500ml	P/A-soft	4) I/O charting
		5) Monitor vitals 4th hrs
		6) Inform SOS
		Dr. Divya
		NB by Ashwini
21/7/26. 7pm	-POD-0/ Lap myomectomy / Type 2 DM & HTN.	
	- Pt is stable.	
	- BP-121/81	Advice
	PR- 100bpm	
	SpO2 - 98% on RA	1) Clear liquids today
	P/A - Soft, BS ⊕.	2) IVF @ 120ml/hr
	U/O - 700ml; clear.	3) Soft diet tomorrow c Gum
		4) Vitals & I/O 4th hrly
		5) W/f bleeding p/v
		6) Inform SOS
		Sruthi

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13-07-1985 41 Y 0 M 8 D (F)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/4/26 11pm.	POD-0 / lap myomectomy + T, DM + HTN.	
	BP - 124/70 (91)	Advice.
	PR - 93bpm	(1) Clear liquids
	SpO_2 - 100% on RA.	(2) Drugs as charted
	P/A - soft, BS⊕	(3) Vitals 4th hrly
	L/C - NAD	(4) C/W hypotension,
	U/O - 200ml, clear.	tachycardia, bleeding p/v
		(5) NTF @ hourly
	=> soft diet tomorrow mrng	(6) Inform sos.
		Sruthi
22/4/26. 3AM	- POD 0	
	- Pt is stable	
	NO C/O	
	sleeping comfortably	Advice
	BP - 120/74 [90]	(1) Vitals 4th hrly
	PR - 80bpm	(2) W/f hypotension
	SpO_2 - 98% on RA.	tachycardia, bleeding p/v
	U/O - 800ml; clear.	
		Sruthi
		NB by Akanksha

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13-07-1985 41 Y 0 M 8 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7/26 7pm	POD-1 / Lap myomectomy + T_2DM + HTN Pt is stable NAD c/o BP - 106/61 [75] PR - 80 bpm SpO_2 - 98% on RA P/A - Soft, non tender. c/c - NAD. UV ⇒ Patient can be discharged.	Advice. ① Soft diet ② Hydrate & ambulate ③ Drugs as charted ④ Vitals 4th hrly ⑤ W/f heavy bleeding PPV ⑥ Tab Pcm SOS Sd/- NB by Akshitha

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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DRUG CHART

Date of Admission: 21/7/26 Drug Allergies: NKDA ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

GENERAL - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.

DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line / 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 ....

Mrs SHABANA FATIMA
13-07-1985 41 Y 0 M 8 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA

REGULAR PRESCRIPTIONS

Weight. ..... Ward. .....

DRUG : T. PARACETAMOL

Dose	Route	Frequency	Start Date
1gm	ORAL	QID	21/7/26

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	Time	22/7
	12 AM	Akhaila Sudha
	6 AM	Akhaila Sudha
	12 PM	
	6 PM	

DRUG : T. TRAMADOL

Dose	Route	Frequency	Start Date
100mg	ORAL	TID	21/7/26

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	Time	22/7
	9 AM	Akhaila Sudha
	10 AM	
	7 PM	

DRUG : T. DICLOFENAC

Dose	Route	Frequency	Start Date
50mg	ORAL	TID	21/7/26

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	Time	22/7
	1 AM	Akhaila Sudha
	9 AM	
	5 PM	

DRUG : T. Pantoprazole

Dose	Route	Frequency	Start Date
40mg	Po	OD	22/7/26

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	Time	22/7
	6 AM	Akhaila Sudha

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Mrs SHABANA FATIMA
13-07-1985 41 Y 0 M 8 D (F)
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Sheet No: .... **REGULAR PRESCRIPTIONS** Weight .... Ward ....

DRUG : INJ-cefotaxim				Date ▸ Time ▾	22/7
Dose	Route	Frequency	Start Dt.		
1gm	iv	BD	22/7/26		
Name & Signature of the Doctor Starting the Drugs: Dr Divya				12 AM	Ashwitha Sudha
Additional Instructions:				12 PM	
Daily Doctor's Endorsement by a Sign					

DRUG : T. METFORMIN				Date ▸ Time ▾	22/7
Dose	Route	Frequency	Start Dt.		
500mg	PO	TID	22/7/26		
Name & Signature of the Doctor Starting the Drugs: Dr Sruthi Sr				8AM	Ashwitha Sudha
Additional Instructions:				2pm	
Daily Doctor's Endorsement by a Sign					

DRUG : T. MET-XL				Date ▸ Time ▾	22/7
Dose	Route	Frequency	Start Dt.		
25mg	PO	OD	22/7/26		
Name & Signature of the Doctor Starting the Drugs: Dr Sruthi Sr				8AM	not taken Ashwitha
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

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

VERIFIED BY : Name .... Signature ....

Patient Sticker

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

DRUG :

Date ▸ Time ▾

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Date ▸ Time ▾

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Date ▸ Time ▾

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Date ▸ Time ▾

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

VERIFIED BY : Name .... Signature ....

BAH-00406134 IP5-00176697
Mrs SHABANA FATIMA
13-07-1985 41 Y 0 M 8 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA

Weight. ..... Ward. .....

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
21/7/24	12:15pm	INJ. CEFOTAXIM	1gm	IV		
21/7/26	12:10pm	INJ. PANTOP	40MG	IV		
21/7/26	1.15	INJ PARACETAMOL	1gm	IV		
21/7/24	1.30	INJ MORPHINE	6mg	IV		
21/7/24	2:15pm	INJ. TRANEXAMIC ACID	1gm	IV		
21/7/26	2:55pm	SUPP. TRAMADOL	100mg	P/R		
21/7/26	2:55pm	SUPP. DICLOFENAC	100mg	P/R		

BAH-00406134 IP5-00176697
Mrs SHABANA FATIMA
13-07-1985 41 Y 0 M 8 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA

I.V. FLUIDS CHART

Weight. ..... Ward. .....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
21/7/26	2pm	RINGER LACTATE	IV	100			21/7		
21/7/26	3PM	RINGER LACTATE	IV	100			21/7		
21/7/26	4pm	RINGER LACTATE	IV	100			21/7		
21/7/26	5PM	RINGER LACTATE	IV	100/hr			21/7		
21/7/26	10:30pm	RINGER LACTATE 500ml	IV	120ml/hr		Ashwitha Sudha	22/7		Ashwitha Sudha
22/7/26	12:00AM	RINGER LACTATE 500ml	IV	120ml/hr		Ashwitha Sudha			Ashwitha Sudha
		RINGER LACTATE 500ml	IV	120ml/hr					

VERIFIED BY : Name ..... Signature .....

BAH-00406134 IP5-00176697
Mrs SHABANA FATIMA
13-07-1985 41 Y 0 M 8 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA

Patient Sti

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MEDICATION RECONCILIATION FORM

Drug Allergies: NKDA ☑ Not known any Drug Allergies

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

Shifting From: ..... Shifted to: .....

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T. TAFT-XL	1 tab (25 mg)	PO	OD	21/7/26	☐ C ☑ DC
2	T. Metformin	500mg	PO	TID	21/7/26	☐ C ☑ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr Divya.

Date & Time : 21/7/2026, 11:40pm

Nurse Name & Signature: Reegnei Reey

Date & Time : 21/7/26 at 12pm.

BAH-00406134 IP5-00176697
Mrs SHABANA FATIMA
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Patien

Blood group B +VE

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RESULT SHEET

Date	19/7/26					
Time						
Hb	11.7					
PCV						
RBC						
WBC	6,100					
N/L						
Platelets	2.9					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
HIV, HBSAg HCV	-VE					

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

Others (ECG, Contrast Studies etc.,) : .....

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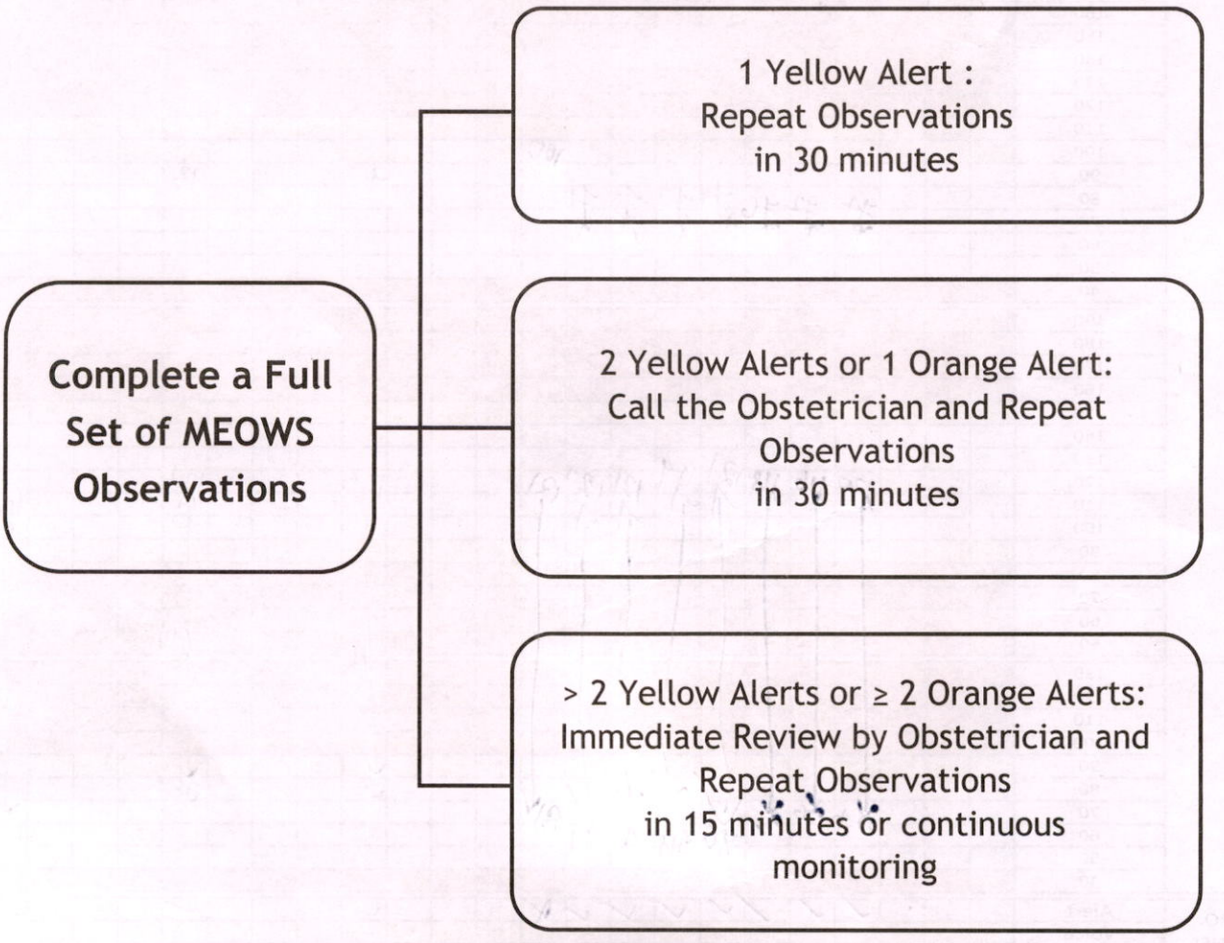
Early Warning Observation Score Chart - Obstetrics

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

21/7/26	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				18	18	18	18	18	18	18	18				20				20				20	
	0 - 10																								
Saturations	94 - 100 %				99	99	99	99	99	99	99	100				99				99				99	
	< 94 %																								
Administered O_2 (L/min.)																									
Temp°c	40																								
	39																								
	38																								
	37				*	*	*	*	*	*	*					37.8°C				37.8°C				37.8°C	
	36																								
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100											100													
	90															90				93					
	80				74	72	76	74	72	78	71													80	
	70																								
	60																								
	50																								
	40																								
Systolic Blood Pressue ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120				120	116	118	121	119	121	127	121				123				121				106	
	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
	40																								
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70				74	76	71	80	74	70	71	81				83				78				61	
	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	
TOTAL ORANGE SCORES					0	0	0	0	0	0	0	0				0				0				0	
Nurse Initial																									

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score **(MEOWS)**

BAH-00406134 IP5-00176697
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13-07-1985 41 Y 0 M 8 D (F)
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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, (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37																									
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
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	60																									
	50																									
	40																									
↑ Systolic Blood Pressue	190																									
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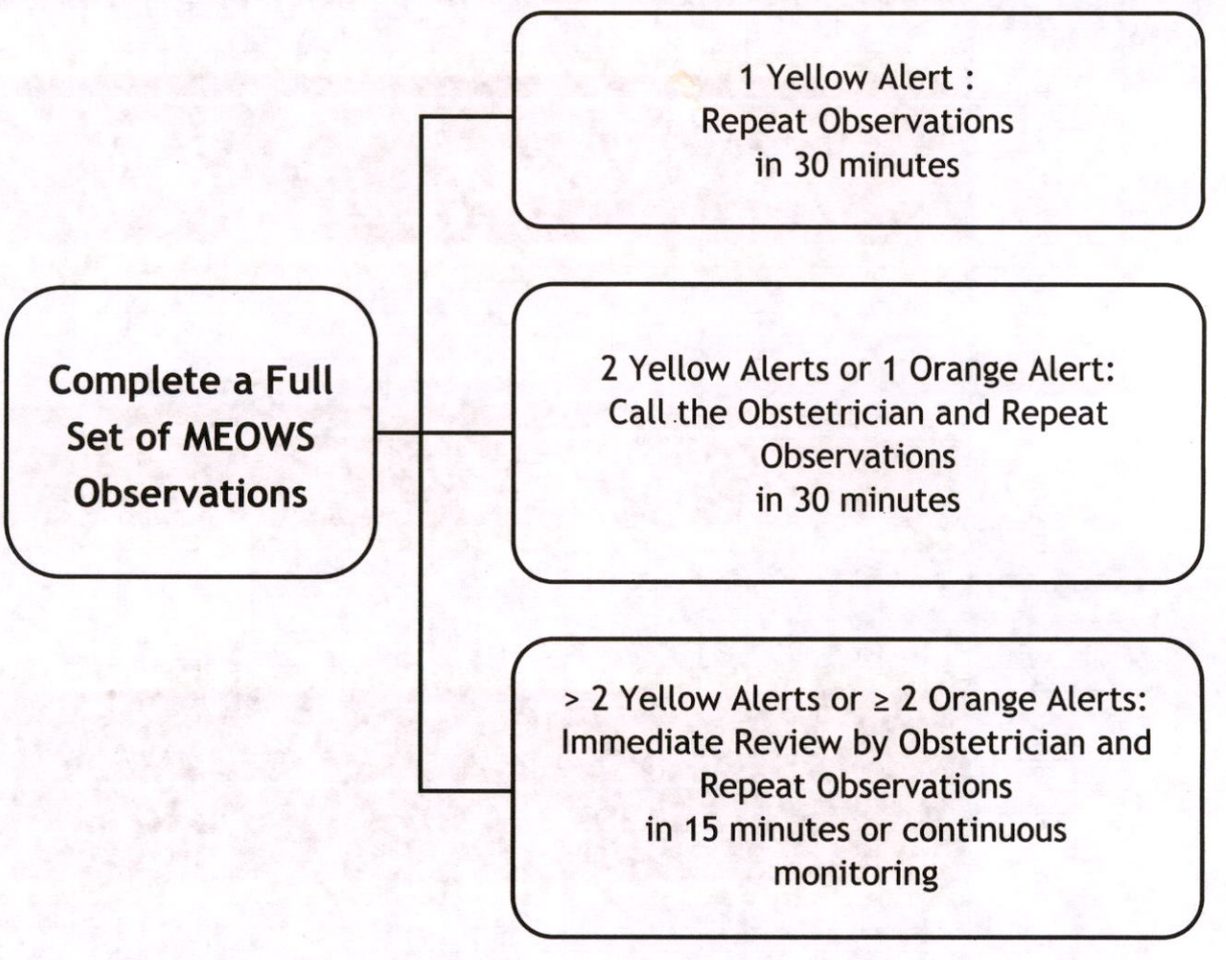
	60																									
	50																									
	40																									
NEURO RESPONSE [✓]	Alert																									
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30																									
	< 30																									
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)**

Patient Sticker

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Early Warning Observation Score Chart - Obstetrics

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		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																									
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	< 35																									
Heart Rate	170																									
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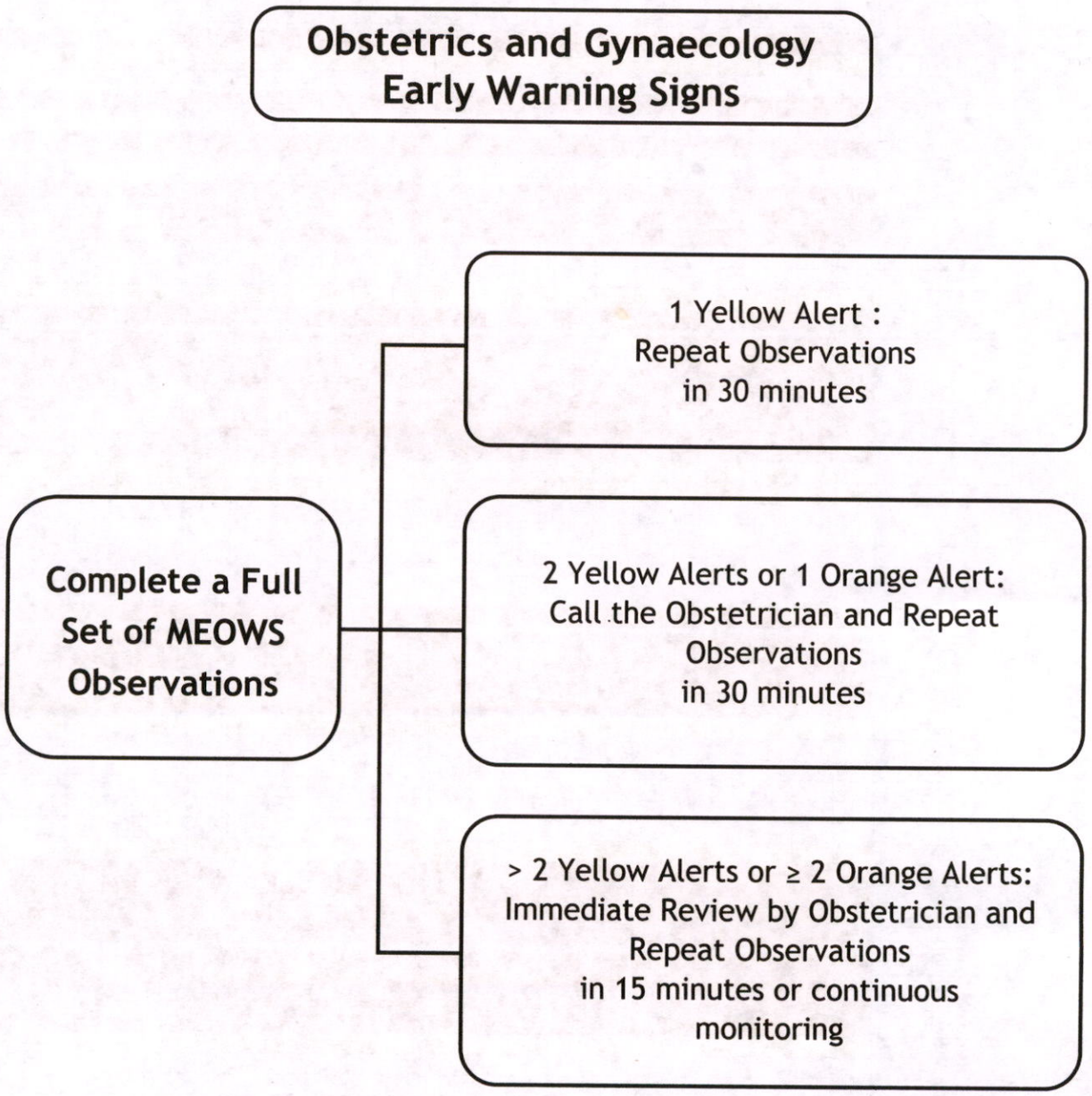
TOTAL YELLOW SCORES																										
TOTAL ORANGE SCORES																										
Nurse Initial																										



* The Modified Early Warning Score **(MEOWS)**

BAH-00406134 IP5-00176697
Mrs SHABANA FATIMA (F)
13-07-1985 41 Y 0 M 8 D
Dr. SHRUTHI REDDY/Dr.LAVANYA

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INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

...Hindi/Telugu.......... Patient / Learner Literacy: ☐ Read ☐ Write ☐ Speak Willingness to Learn: ☐ Yes ☐ No Healthcare Literacy: ☐ Yes ☐ No

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding	Comments	Designation / Signature
				Use codes from the list in part III						
21/7/26	12pm	2,5 4	Diagnosis, treatment & care plan pain management & Informed consent	pt	1	O	1	1		[signature]
21/7/26	12	2,8 6,7	patient taught regarding English about infection control measures	pt	1	O	1	1		[signature]

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
2. Physical Impairment
3. Emotional Barriers
4. Language Barrier
5. Educational Level
6. Desire / Motivate to Learn
7. Impaired Thought Process/Cognitive limitations
8. Responsibilities at Home
9. Cultural Differences
10. Financial Difficulties
11. Beliefs and Values
12. Impaired Vision/ or Hearing
13. Cultural/Religion Practice
14. Others (Specify ....

Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed

Mechanism/s to overcome barrier/s:
1. None
2. Obtain translator
3. Reassurance & Support
4. Teach Family / Others
5. Respect values & beliefs
6. Respect Cultural / Religion Preference
7. Other, Specify ....

Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review

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MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: P2L2 A1 | AUB-(A)(L) | (L) ovarian cyst | Displaced mirena | For lap. myomectomy

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
21/7/25 11:30pm	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☑ Per-Op ☐ Post Op	AUB-(A)(L) (L) ovarian cyst Displaced mirena	→ Safe surgery	Lap. myomectomy	[signature]	☐ Nursing ☐ Others:
21/7/25 12pm	☐ Medical ☑ Nursing ☐ Others:	☑ Initial ☐ Modified ☑ Per-Op ☐ Post Op	NPO Dehydration	To prevent dehydration	IV fluid RL onflow	[signature]	☐ Medical ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

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FLUID CHART

Sheet No. : 1

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am		N									
	10:00 am		P									
21/7	11:00 am	RL	O	100ml							0	
	12:00 pm			100ml							0	
	01:00 pm			10ml						~	0	
Total Intake :						**Total Output :**						
	02:00 pm		N	100 ml							0	
	03:00 pm		P	100ml						500 ml	0	
	04:00 pm		O	100 ml							0	
	05:00 pm		N	100 ml						300 ml	~	
	06:00 pm											
	07:00 pm									200ml		
Total Intake :						**Total Output :**						
	08:00 pm	RL		100ml/hr							0	Ashwitha
	09:00 pm	RL		100ml/hr							0	Ashwitha
	10:00 pm	RL	Sips of water	100ml/hr			NP				0	Ashwitha
21/7	11:00 pm	RL		100ml/hr							0	Ashwitha
	12:00 am	RL	Coconut water	100ml/hr							0	Ashwitha
	01:00 am	RL	H2O	100ml/hr							0	Ashwitha
Total Intake :	Taken					**Total Output :**	Passed					
	02:00 am	RL		100ml/hr							0	Ashwitha
	03:00 am	RL	H2O	100ml/hr							0	Ashwitha
22/7	04:00 am	RL		100ml/hr			N				0	Ashwitha
	05:00 am	RL		100ml/hr			P				0	Ashwitha
	06:00 am	RL	H2O	100ml/hr						150ml	0	Ashwitha
	07:00 am	RL		100ml/hr						~	0	Ashwitha
Total Intake :	Taken					**Total Output :**						

Total 24 hrs. Intake	2100 ml	**Total 24 hrs. Output**	2500 ml.

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FLUID CHART

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Sheet No. : .....

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

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

Total 24 hrs. Intake		**Total 24 hrs. Output**	

Patient Sticker

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FLUID CHART

Sheet No. : .....

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			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		**Total 24 hrs. Output**	

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			Mouth	I.V	N.G							
	08:00 am											
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	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
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	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**	

Patient Sticker

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Sheet No. : .....

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		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
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	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
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	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**	

Patient Sticker

FLUID CHART

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Sheet No. : .....

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

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

Total 24 hrs. Intake		**Total 24 hrs. Output**	

Patie

BAH-00406134 IP5-00176697
Mrs SHABANA FATIMA
13-07-1985 41 Y 0 M 8 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA

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POST-SURGICAL CARE PLAN FORM

Procedure Done: laparoscopic myomectomy

Post-Surgical Diagnosis: p.o.d - 0 | P1L1A1 | Lap myomectomy

Post-Operative Monitoring Parameters /Frequency:

- BP/PR/SpO2 every 15 min x 2 hrs

Wound Care:

Nil

Drain /Special Lines/Catheters:

foley's fill 60 ml - 21/7/26

Special Patient Positioning and Requirements:

supine

Nutritional Instructions:

NBM for 6 hrs

When to Start Mobilization: After foley removal

Special Referrals: NIL

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

Nil

Dr. Prashanthi

Treating Surgeon
(Signature & Stamp)

Date: 21/7/26 Time: 2:00pm

Note: Plan of care will be readjusted if necessary.

Patient Stick

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13-07-1985 41 Y 0 M 8 D (F)
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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 21/7/16

Department : P'CVT Duration of Procedure : 2hs

Name of Surgeon : Dr. Shruti Reddy Date of Admission : 21/7/16

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

		Staff Signature
1.	Antibiotic given prior to surgery ? ☑ Yes ☐ No ☐ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☑ Yes ☐ No Name of the Antibiotic : Inj. Taxim 1gm	
2.	Hair Removal ☑ Yes ☐ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☐ Operating Room ☐ Other : ..... Skin preparation done (cleanse surgical area with antiseptic agent)? ☑ Yes ☐ No	
3.	Patient's body temperature immediately post operation (Recovery Room) 34 °C ☐ Oral Or ☑ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : Nagaraj G. Date & Time of antibiotic administration : @ 12:30pm 21/7/16 Date & Time procedure started : @ 21/7/16	

- 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

…CAL …Y CHECKLIST

Surgeon : Dr. Shruthi
Asst. Surgeon :
Anaesthetist : Dr. Aditi
Scrub Nurse : Puravathi

Patient Name : Mrs. Shabana Age : 41 Y Gender : F
UHID No. : 406134 Surgery Name : Lap myomectomy
Date : 21/7/26 In-time : 12:30 pm Out-time :

BAH-00406134 IP5-00176697
Mrs SHABANA FATIMA
13-07-1985 41 Y 0 M 8 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA

Before Induction of Anaesthesia ➤➤

SIGN IN Time: 12.30

Patient Has Confirmed

- Identity ☑Yes ☐No
- Site ☑Yes ☐No
- Procedure ☑Yes ☐No
- Consent ☑Yes ☐No

Site Marked ☐Yes ☐No ☑NA

Anaesthesia Safety Check Completed ☑Yes ☐No

Pulse Oximeter on Patient & Functioning ☐Yes ☑No

Does Patient have a:

- Known Allergy? ☐Yes ☑No

Difficult Airway / Aspiration Risk?

- Yes, & Equipment / Assistance Available ☐Yes ☑No

Risk of > 500ml Blood Loss (7ml/kg In Children)?

- Yes, and Adequate Intravenous Access and Fluids Planned ☐Yes ☑No ☐NA
- Blood Units Reserved ☐Yes ☑No ☐NA

Has Antibiotic Prophylaxis been given within the last 60 minutes? ☑Yes ☐No ☐NA

Signature : Aditi

Name : Dr. Aditi N

Before Skin Incision ➤➤

TIME OUT Time: 12:52 pm

Confirm all team members have introduced themselves by Name and Role ☑Yes ☐No

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm

- Correct Patient (Check ID Band) ☑Yes ☐No
- Correct Site ☑Yes ☐No
- Correct Procedure ☑Yes ☐No

Anticipated Critical Events

Surgeon Reviews:

What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? ☐Yes ☑No ☐NA

Anaesthesia Team Reviews:

Are There Any Patient-specific Concerns? ☑Yes ☐No ☐NA Hypertensive, post procedure O_2 Reduce.

Nursing Team Reviews:

Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☑Yes ☐No ☐NA

Is Essential Imaging Displayed? ☐Yes ☑No ☐NA

Power Supply, Earthing, Power Backup and functioning of equipment checked. ☑Yes ☐No

Signature : [signature]

Name : [signature]

Before Patient Leaves Operating Room

SIGN OUT Time:

Nurse Verbally Confirms with the Team:

- The Name of the Procedure Recorded ☑Yes ☐No
- That Instrument, Sponge and Needle Counts are Correct (or Not Applicable) ☑Yes ☐No ☐NA
- The Specimen is Labelled (including patient name) ☑Yes ☐No ☐NA
- Whether there are any Equipment Problems to be addressed ☐Yes ☑No ☐NA

To Surgeon, Anaesthetist and Nurse:

What are the key concerns for recovery and management of this patient? ☐Yes ☑No

Signature : [signature]

Name :

SURGICAL SAFETY CHECKLIST

Surgeon : .....
Asst. Surgeon : .....
Anaesthetist : .....
Scrub Nurse : .....

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

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Before Induction of Anaesthesia ➤➤

SIGN IN Time:.....

Patient Has Confirmed
- Identity ☐Yes ☐No
- Site ☐Yes ☐No
- Procedure ☐Yes ☐No
- Consent ☐Yes ☐No

Site Marked ☐Yes ☐No ☐NA

Anaesthesia Safety Check Completed ☐Yes ☐No

Pulse Oximeter on Patient & Functioning ☐Yes ☐No

Does Patient have a:
- Known Allergy? ☐Yes ☐No

Difficult Airway / Aspiration Risk?
- Yes, & Equipment / Assistance Available ☐Yes ☐No

Risk of > 500ml Blood Loss (7ml/kg In Children)?
- Yes, and Adequate Intravenous Access and Fluids Planned ☐Yes ☐No ☐NA
- Blood Units Reserved ☐Yes ☐No ☐NA

Has Antibiotic Prophylaxis been given within the last 60 minutes? ☐Yes ☐No ☐NA

Signature :.....

Name :.....

Before Skin Incision ➤➤

TIME OUT Time:.....

Confirm all team members have introduced themselves by Name and Role ☐Yes ☐No

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm
- Correct Patient (Check ID Band) ☐Yes ☐No
- Correct Site ☐Yes ☐No
- Correct Procedure ☐Yes ☐No

Anticipated Critical Events

Surgeon Reviews:
- What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? ☐Yes ☐No ☐NA

Anaesthesia Team Reviews:

Are There Any Patient-specific Concerns? ☐Yes ☐No ☐NA

Nursing Team Reviews:

Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☐Yes ☐No ☐NA

Is Essential Imaging Displayed? ☐Yes ☐No ☐NA

Power Supply, Earthing, Power Backup and functioning of equipment checked. ☐Yes ☐No

Signature :.....

Name :.....

Before Patient Leaves Operating Room

SIGN OUT Time:.....

Nurse Verbally Confirms with the Team:

The Name of the Procedure Recorded ☐Yes ☐No

That Instrument, Sponge and Needle Counts are Correct (or Not Applicable) ☐Yes ☐No ☐NA

The Specimen is Labelled (including patient name) ☐Yes ☐No ☐NA

Whether there are any Equipment Problems to be addressed ☐Yes ☐No ☐NA

To Surgeon, Anaesthetist and Nurse:

What are the key concerns for recovery and management of this patient? ☐Yes ☐No

Signature :.....

Name :.....

BAH-00406134 IP5-00176697
Mrs SHABANA FATIMA
13-07-1985 41 Y 0 M 8 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

BirthRight BY RAINBOW HOSPITALS
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Patient Name : Mrs. FATIMA SHABANA Gender: ☐ Male ☑ Female Age : 21/7/26

UHID No : BAH 00406134 Date : ....

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)

LAPROSCOPIC MYOMECTOMY / HYSTERECTOMY

upon (Name of the Patient) Mrs. fatima shabana

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, injury to Bowel and Bladder

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

Name of the Doctor who is performing the Surgery / Procedure: Dr-Shruthi Reddy

Consentee :
Signature : [signature]
Name : Mrs. fatima Shabana
Date & Time : 21/7/26 ; 11:50Am

Patient Attendant :
Signature : [signature]
Name : MAHMOOD Baig
Relationship with Patient: Husband.
Date & Time : 21/7/26 ; 11:50Am

Witness :
Signature : Neeyari
Name : Naga Mani
Date & Time : 21/7/26 at 12pm

Doctor (who is taking the consent) :
Signature : [signature]
Name : Dr-Divya
Date & Time : 21/7/26 ; 11:48AM.