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FC

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DISCHARGE SUMMARY

Name	Mrs MANSI RAMCHANDANI	**UHID**	HNH-00013901
Father/Guardian	Mr HARESH RAMCHANDANI	**Age/Gender**	30 Y 5 M 12 D/ Female
Address	flat no 405 floor msk towers street number 11, Himayathnagar, Hyderabad, Telangana, INDIA, 500029		
IP No	IP26-00006881	**Admission Date**	18-07-2026
Ref Doctor	Self.		
Discharge Date	20.07.2026		

Consultant: Dr. SWATHI H V
MBBS/MS
TSMC/FMR/15501

Diagnosis: PRIMI WITH 7^{+1} WEEKS WITH RIGHT UNRUPTURED LIVE TUBAL ECTOPIC PREGNANCY.

LAPAROSCOPIC RIGHT SAPINGECTOMY DONE ON 18.07.2026

History: She presented with 2 months of amenorrhea ,pain abdomen,UPT weakly positive on 02.07.2026. Outside scan (16.07.2026) showed no evidence of Gestational sac with ET-28 mm. Beta HCG- 4351.On 18.07.2026 Scan at

Name	Mrs MANSI RAMCHANDANI	UHID	HNH-00013901
IP No	IP26-00006881	Admission Date	18-07-2026

rainbow hospital showed singleton pregnancy, Gestational sac of 9*7*7 mm with minimal peripheral vascularity noted in right adnexa, Yolk sac seen, Fetal pole noted with cardiac activity corresponding to 6 weeks, S/o Right tubal live ectopic pregnancy ,ET-20.5 mm ,thickened and echogenic, both ovaries visualised - right ovary - corpus luteal cyst , No evidence of free fluid in POD and no adnexal tenderness. She was admitted for laparoscopic right salpingectomy.

Menstrual History:- LMP- 28.05.2026
Previous cycles: Regular.

Obstetric History: PRIMI

Medical History: Nil.
Surgical History: Left elbow fracture surgery 1 year back
Family History: Nil.
Allergies: Nil.

Investigations: Enclosed.
Blood group: "B" Positive

Surgery Notes:
Operation performed: **LAPAROSCOPIC RIGHT SALPINGECTOMY UNDER GENERAL ANAESTHESIA**

Indication: Right unruptured Live Tubal Ectopic Pregnancy

Name	Mrs MANSI RAMCHANDANI	**UHID**	HNH-00013901
IP No	IP26-00006881	**Admission Date**	18-07-2026

Operative findings:

- Right unruptured tubal ectopic pregnancy m/s 2*2 cm in ampullary region noted.
- Bilateral ovary -Normal
- Left fallopian tube - Normal.
- Uterus -Bulky
- Rest of viscera -Normal.
- Proceeded with Right salpingectomy
- Hemostasis achieved
- Specimen retrieved through 10 mm port
- Procedure uneventful
- Specimen sent for HPE.

Post-Operative Notes: She was closely monitored in the postoperative period. Her vital signs remained stable. She was encouraged to ambulate and void spontaneously. She was shifted to room. Her general condition was satisfactory and she was found to be fit for discharge. Medications were explained to the patient supplemented by written information.

Advice:

1. Tab. Taxim O 200 mg twice daily till 24.07.2026 (9am - 9pm) after food.
2. Tab. Calpol 500mg (Paracetamol 500mg) (2tabs)thrice daily till 22.07.2026 (7am-3pm-10pm) after food.
3. Tab. Voveran 50 mg (Diclofenac 50mg) twice daily till 22.07.2026 (9am-9pm) after food.
4. Tab. Pantodac 40 mg (Pantoprazole 40mg) once daily (7am) before food till 24.07.2026
5. Cap Suport once daily (2pm) for 1 month after food.

Name	Mrs MANSI RAMCHANDANI	**UHID**	HNH-00013901
IP No	IP26-00006881	**Admission Date**	18-07-2026

6. Collect HPE report

Review with Dr. SWATHI H V after on 25/7/2026 with prior appointment.

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, when and how to obtain emergency care etc also have been explained by doctor ..... in a language that I can understand and I acknowledge.

Patient/ Attender

In case of emergency like bleeding, fever [please refer to postpartum book for further details - Chapter II page 6] kindly contact 9154865045 at Rainbow Children's Hospital just dial one toll free number - 18002122.
You can also take appointments at any time by going online to our website **www.rainbowhospitals.in**

Registrar/Resident/C.M.O

Consultant:
Dr. SWATHI H V
MBBS/MS
TSMC/FMR/15501

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00013901 IP26-00006881 Mrs MANSI RAMCHANDANI 08-02-1996 30 Y 5 M 13 D (F) Dr. SWATHI H V	18/7/26 @ 6:27pm	19/7/26 @ 7:40Am
	Transfer Ordered by DR. DUA	Reason for Transfer Observation
From Unit Pre-post	To Unit Room	Information to Attendant Yes ☐ No ☐
Number of Sheets in Clinical File 28	Number of Imaging Films –	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	RL 500ml	1
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sis. Sujatha	DR. DUA

Patient & Clinical Records Received by : Sunanda @ 7.40 am

Date & Time of Patient Received : 19/7/26

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

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar ,Hyderabad ,Telangana, INDIA ,500029.
TEL NO :040-48873000
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006881 **Admit Date** : 18-Jul-2026 **Admit Time** : 06:27 PM **UHID** : HNH-00013901

Patient Details :

Patient Name	: Mrs MANSI RAMCHANDANI	**Age**	: 30 Y 5 M 12 D
Guardian	: Mr HARESH RAMCHANDANI	**DOB**	: 06-02-1996
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: flat no 405 floor msk towers street number 11 Himayathnagar Hyderabad Telangana INDIA 500029	**Phone No**	: 9890623853/ 9550288048
		E-mail	: mansi06104@gmail.com

Admission Details :

Bed Type : TWIN SHARING **Bed No** : PDA-412 **Ward Name** : 4F -OT

Room No : PDA-412 **Admission Type** : First Visit

Contact Details :

Name : Mr HARESH RAMCHANDANI **Relationship** : W/O

Contact Address : flat no 405 floor msk towers street number 11 Himayathnagar Hyderabad Telangana INDIA 500029 **Phone No** : 9890623853

Signature

Doctor Details :

Doctor Name	: Dr. SWATHI H V	**Specialisation**	: OBSTETRICS AND GYNECOLOGY
Referral Doctor	: Self.	**Phone No**	:
Co-Consultant	:		

Payment Details :

Payment Mode	: DC/CC Card	**Deposit Amount**	: 20000.00
		Payor Name	: SELFPAY

HNH-00013901 IP26-00006881
Mrs MANSI RAMCHANDANI
08-02-1996 30 Y 5 M 12 D (F)
Dr. SWATHI H V

PRE - OPERATIVE CHECK LIST

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Date: 18/7/26

Patient's Name : mrs mansi Age : Gender : ☐ M ☑ F

Blood Group : UHID : HNH-00013901

Planned Surgery : Lap Ectopic Surgeon : Dr Swathi H.V.

Anesthetist : Dr Ayasha Date & Time of Operation : 18/7/26

Tick Appropriate Boxes, to be filled by Nurse Incharge / Senior Nurse :

S.No	INSTRUCTIONS	ER/Ward. Nurse			OT Nurse		
		Yes	No	NA	Yes	No	NA
1.	Weight checked and recorded?	☑	☐	☐	☐	☐	☐
2.	Is the patient fasting for over 6 hours Pre-Operatively?	☑	☐	☐	☐	☐	☐
3.	Check Pre-OP Investigations & Results (CBP, Blood Group, BT, CT, PT / APTT, Viral Screening, CXR etc) available before starting the procedure	☑	☐	☐	☐	☐	☐
4.	Enema given / Bowel Preparation	☑	☐	☐	☐	☐	☐
5.	Remove all ornaments, earrings, toe rings, nose rings etc and implants, dentures	☑	☐	☐	☐	☐	☐
6.	Sterile Gown Given	☑	☐	☐	☐	☐	☐
7.	Is Blood arranged as required?	☑	☐	☐	☐	☐	☐
8.	If Blood has been ordered - is Blood bag ready?	☑	☐	☐	☐	☐	☐
9.	IV Cannula to be placed / IV fluids if Indicated	☑	☐	☐	☐	☐	☐
10.	Pre Anesthetic consultation with anesthesiologist	☑	☐	☐	☐	☐	☐
11.	Pre Medications Given? (Sedatives / etc)	☑	☐	☐	☐	☐	☐
12.	Skin Preparation	☑	☐	☐	☐	☐	☐
13.	Site is marked	☑	☐	☐	☐	☐	☐
14.	Surgery consent / High Risk consent taken by surgeon? (Consent should be taken by the operating surgeon only)	☑	☐	☐	☐	☐	☐
15.	Implants are available	☑	☐	☐	☐	☐	☐
16.	Equipment is avaialble	☑	☐	☐	☐	☐	☐
17.	Antibiotic Prophylaxis is given within the last 60 minutes	☑	☐	☐	☐	☐	☐
18.	Other (if any)	☐	☑	☐	☐	☐	☐

NOTE: If any of above is ticked "NO" Discuss with the registrar / consultant immediately

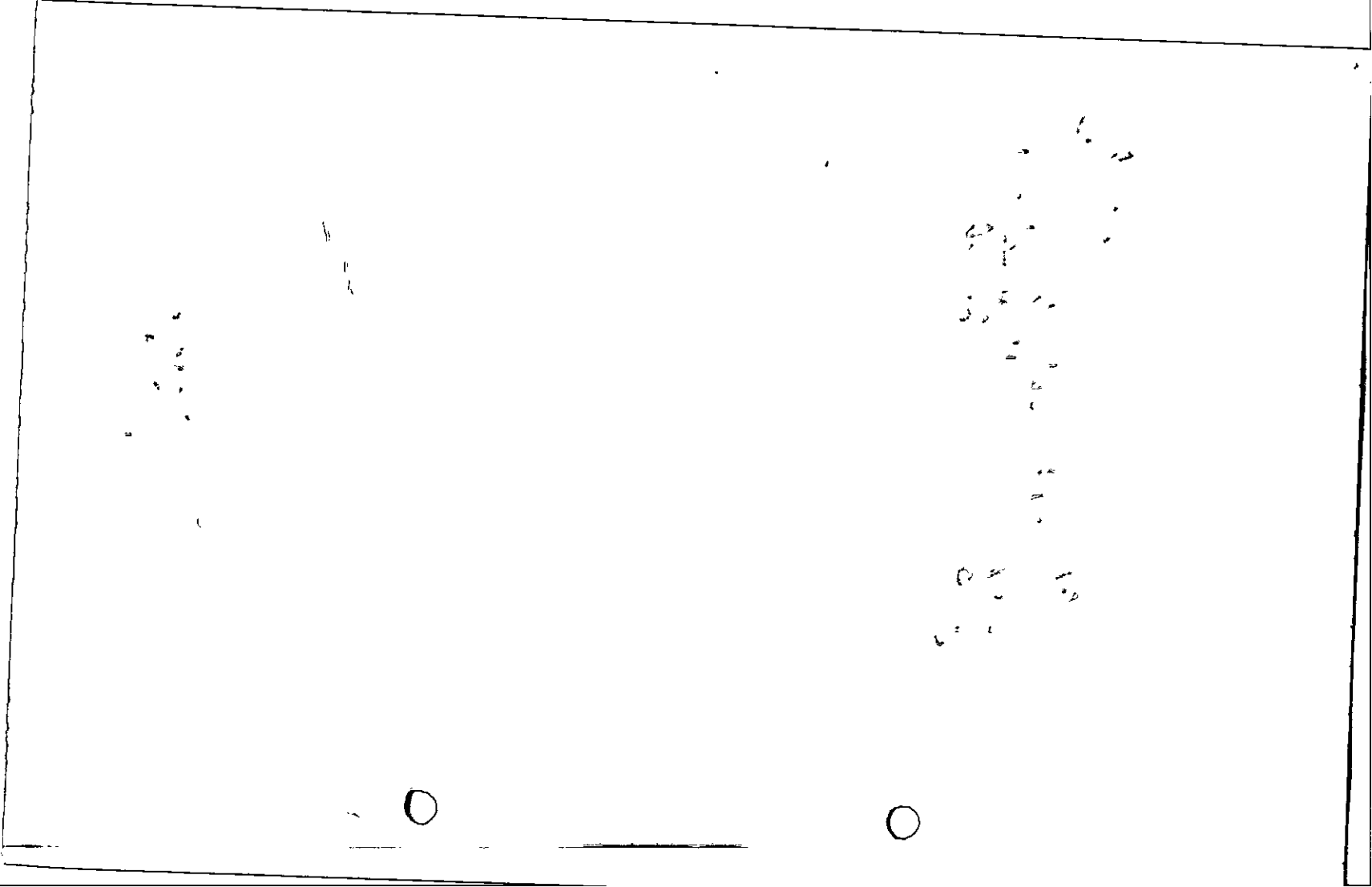
Billing Clearance Taken : ☐ Yes ☐ No

Billing Executive Name : OT Nurse Name : Madhumitha ER/Ward Nurse Name :

Billing Executive Signature : Signature of OT Nurse : Madhu Signature of ER/Ward Nurse :

Date & Time : 18/7/26 @ 7.10 Date & Time : 18/7/26 @ 7pm Date & Time :

Doc. No. : RCH / FRM / CLINICAL / 107



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Patient Name & UHID	Date & Time of Admission	Date & Time of Transfer Order
HNH-00013901 IP26-00006881 Mrs MANSI RAMCHANDANI 08-02-1996 30 Y 5 M 12 D (F) Dr. SWATHI H V	18/7/26 @6:27pm	18/7/26
	Transfer Ordered by DR-DUA	Reason for Transfer Laparoscopic Right Salpingectomy
From Unit PreSpost	To Unit (OT)	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 30	Number of Imaging Films ~~NIL~~	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	RL	1
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☑ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Madhumita @ Madhu	Dr. DUA

Patient & Clinical Records Received by : Kalung 18/7/26

Date & Time of Patient Received :

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

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
18/7	IV placement	1	15049	Asha
18/7	PAC OP		226719	Asha
18/7	catheterization	(0)	5075	Sujatha
				cross checked by sujatha
				19/7/26@ 7Am
19/7/26	NHA	(1)	5199	cross checked done 20/7/26

ANY OTHER INFORMATION

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Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

...EDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
18/7	Cardiacmonitor	10pm	19/7 7Am	215074	Sujatha
18/7	infusionpump	10pm	7Am	215074	
18/7	oxygen	10pm	18/7 11:30pm	215074	

cross checked by Sujatha 19/7/26 @ 7AM

Crosschecked done 20/7/26

INVESTIGATIONS

Date	Investigations	Order No.	Signature
18/7	CBP.	·12048	[illegible]

cross checked by Swatha 19/7/26 @ 7Am

cross checked done 20/7/26

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ACTIVITY RECORD FOR BILLING

Name :_ _ HNH-00013901 IP26-00006881
Mrs MANSI RAMCHANDANI
UHID No. : 08-02-1996 30 Y 5 M 12 D (F)
Dr. SWATHI H V

_____Consultant: _____ Dept : _____

Date of Ad

_____Date of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
18/7/26	8 PM	Pre-post	(OT)	Karuna
18/7/26	9:40 Pm	OT	Pre-Post	Karuna/Sujatha
19/7/26	7:40AM	Pre-post	Room	Sujatha

Cross Consultation Visit

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

HNH-00013901 IP26-00006881
Mrs MANSI RAMCHANDANI
08-02-1996 30 Y 5 M 12 D (F)
Dr. SWATHI H V

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I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 18/7/26. Time of Admission : .....

Allergies: ..... ☐ Not-know any drug allergies

PRESENTING COMPLAINTS :

LMP: 28/5/2026.

Primi c 2months of amenorrhea. (7 +2 wk)

came c outside scan reporting (16/7/26)

ET: 28mm., NO e/o G-sac. UPT-weakly positive 21/7/26.

c/o pain abdomen : today

18/7/26 : Singleton pregnancy

G-sac m/s 9x7x7mm c minimal peripheral vasculars noted in Rt adnexa. ET-20.5mm, thickened NO e/o free fluid in POD

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : 7months	Parity : Primi
Previous Periods :	Mode of Delivery : -
LMP : 28/5/26.	Last Child Birth : -
Contraception :	

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
-	Left Fracture Elbow - Surgery. 1 year back.

HNH-00013901 IP26-00006881
Mrs MANSI RAMCHANDANI
08-02-1996 30 Y 5 M 13 D (F)
Dr. SWATHI H V

Nil	**MEDICATION HISTORY:** Nil

INITIAL ASSESSMENT :

Date 18/7/26 Ht. ____ Wt. ____ BMI ____ B.P 119/78 mmHg. Pallor PR: 84/min CVR S1&S2 (+) Respiratory System (N) Thyroid (N)	Breasts Normal Abdominal Examination Soft	Local/Speculum Examination Not done Bimanual Pelvic Examination Not done

PROVISIONAL DIAGNOSIS : Primi G1 P0+2 L1 C Rt tubal ectopic pregnancy

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT
18/6 - 10.8 / 2.9 lakh. 16/7 BHCG - 4,351 TSH - 3.3 B positive Send - CBC - BGT - HIV, HbsAg, VDRL, HCV HIV, HbsAg, VDRL, HCV NR	Laproscopic Salpingectomy - NBM - Informed consent - parts preparation - pre op medication - Shift to OT on call. - PAC.

Dr. Swathi H V
Consultant Obstetrics and Gynecology
Reg. No: 15501

Name of the Doctor : Dr. Swathi HV

Signature of Doctor

Date & Time : 18/7/26.

HNH-00013901 IP26-00006881
Mrs MANSI RAMCHANDANI
06-02-1996 30 Y 5 M 12 D (F)
Dr. SWATHI H V

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/7/26 10pm	C/S/B Dr. Dna	
	POD-0	
	Afebrile	Adv
	BP: 118/63 mmHg	- NBM till further order.
	PR: 88/min	- IV. fluids
	P/A soft	- Drugs as charted
	C/E NAD	- Urine I/O charting
		- Monitor vitals
		- W/F PV bleed
		- Inform SOS
19/7/26 6:30AM	C/S B Dr. Dna	
	POD-0 (S/P Lap. Rt salpingectomy)	
		Adv
		- Oral sip f/b Liquid diet
	Afebrile	- IV fluids
	BP: 103/56 mmHg	- Drugs as charted
	PR: 84/min	- Urine I/O charting
U/O - Adequate	P/A soft BS (+)	- Monitor vitals
	A/E Minimal bleeding (+)	- W/F PV bleed
		- Inform SOS
Pt can be shifted to Room.		- Foleys Removal at 10am Now.

Docu. No. : RCH /FRM / CLINICAL / 088

HNH-00013901 IP26-00006881
Mrs MANSI RAMCHANDANI
08-02-1996 30 Y 5 M 12 D (F)
Dr. SWATHI H V

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/07/2026 9:02	S/B Dr SWATHI. HV	
	- POD-0 lap salpingectomy	
	- pt received. comfortable	
	- Generalised bleed	
		Advice
	O/E: vitals ©	- Ambulation
	P - 88 bpm	- soft diet
	BP 110/80.	→ NJ tpeace (term/
	nopallor	blantpv
	PA: soft	- Inform SOS
	BS (+)	
	L/E: mild bleeds	Dr SWATHI. HV.
19/7/2026 11:00am	cls by Dr Naveena	
	POD-1	
	O/E GC-fair	Adv.
	Afebrile	- Soft diet
	Vitals - stable	- Adequate hydration
U - ✓	PA: ut. retracted well	- drugs as charted
F - +	Soft, NT	- w/f PV bleeding
S - +.	Dressings: dry & clean	- Monitor Vitals
	L/E: mini. bleeding.	- Inform SOS
	Dr Naveena	

Dr. Swathi H V
Consultant Obstetrics and Gynecology
Reg. No: 15501

Docu. No. : RCH /FRM / CLINICAL / 088

(P.T.O)

HNH-00013901 IP26-00006881
Mrs MANSI RAMCHANDANI
06-02-1996 30 Y 5 M 13 D (F)
Dr. SWATHI H V

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/7/2026 3:15pm	c/s/by	Dr. Naveena
		POD7
	o/E GC- fair	Adv.
U-✓	Afebrile	- Soft diet
F-✓	Vitals - stable.	- Adequate hydration
S-✗	PA ut- retracted well.	- drugs as charted
	Soft, NT	- w/f PV bleeding.
	Dressings: dry & clean	- Monitor Vitals
	LE: min. bleeding.	- Inform SOS
		NB: Mo[illegible]
		Dr. Naveena
19/7/2026 7:30pm	c/s/by	Dr. Naveena
		POD1
	o/E GC- fair	Adv
U-✓	Afebrile	- Soft diet
F-✓	Vitals - stable	- Adequate hydration
S-✗	PA Soft, NT	- drugs as charted
	Dressings - dry & clean	- w/f PV bleeding
	LE: mini spotting	- Dulcolax suppositories 2 PR stat
		- Monitor Vitals
		- Inform SOS
		NB. Mo[illegible] @ 8PM
		Dr Naveena

HNH-00013901 IP26-00006881
Mrs MANSI RAMCHANDANI
06-02-1996 30 Y 5 M 13 D (F)
Dr. SWATHI H V

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/2026 7:00am	c/s/by Dr Naveena	
	O/E GC-fair	Adv
	Afebrile	Regular diet
V- ✓	Vitals - stable	Adequate hydration
	PA: soft, NT	drugs as charted
F- ✓	Dressing: minimal soakage	w/f PV bleeding
S- ✓		Ambulation
	L/E: mini spotting	M/V & I/SOS
	Patient can be discharged	Noted by Divya 20/7/26
	@ Dr Naveena	
	N/B Dr Swathi HV	
20/7/2026 8:00AM	- pt comfortable	Adv
		- @ vitals
	O/E: vitals @	- Ambulation
U ✓	PA: soft	- plenty of fluids
S ✓	NT	
	HB: NAD	- [illegible]
		- Man [illegible] today.

Dr. Swathi H V
Consultant Obstetrics and Gynecology
Reg. No: 15501

Dr Swathi HV

HNH-0001390
Mrs MANSI RAMCHANDANI
06-02-1996 30 Y 5 M 12 D (F)
Dr. SWATHI H V

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
18/7/26	7pm	RL	IV	100ml/hr			18/7		
18/7/26	9:15pm	RINGER LACTATE	IV	500 ml/hr			18/7		
18/7/26	8:30 pm	RINGER LACTATE	IV	1000ml/hr			18/7/26		
19/7/26	1AM	RINGER LACTATE	IV	100ml/hr			19/7		
19/7	6AM	RINGER LACTATE	IV	100ml/hr			19/7		
←		STOP D. Naveen						→	

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

HNH-00013901 IP26-00006881
Mrs MANSI RAMCHANDANI
08-02-1996 30 Y 5 M 12 D (F)
Dr. SWATHI H V

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
18/7	8.15Am	METOCLOPROMIDE	10mg	IV		Maddy
18/7	8.20Pm	PANTOPRAZOLE	40mg	IV		Maddy
18/7	9:00pm	Inj. MORPHINE	3mg	IV		Kavi
18/7	8:45pm	Inj. PARACETAMOL	1gm	IV		Kavi
18/7	9:35pm	DICLOFENAC Suppository	100mg	PR		Kavi
18/7	9:35pm	TRAMADOL Suppository	100mg	PR		Kavi
18/7	6:40Am	ONDANSETRON	4mg	IV		Sujatha
18/7	10:12Am	METACLOPRAMIDE	10mg	IV		
19/7	8:00pm	DULCOLAX SUPPOSITORIES	2	PR		

Patient Sticker

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BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

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

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				

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Mrs MANSI RAMCHANDANI
08-02-1996 30 Y 5 M 12 D (F)
Dr. SWATHI H V

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Sheet No: .....

REGULAR PRESCRIPTIONS

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

DRUG : PANTOPRAZOLE

Dose	Route	Frequency	Start Dt.
40mg	PO	BD	18/7

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time: 19/7 6AM 6PM

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Signature

VERIFIED BY : Name

(P.T.O.)

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REGULAR PRESCRIPTIONS

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

DRUG : CEFOTAXIME				Date / Time	18/7	19/7	20/7
Dose	Route	Frequency	Start Date				
1g	IV	BD	18/7	9am			
Name & Signature of the Doctor Starting the Drugs: Dr. Dr. [illegible]				9pm	8:30pm		
Additional Instructions:							
Daily Doctor's Endorsement by a Sign							

DRUG : Inj. PARACETAMOL				Date / Time	19/7	20/7/26	
Dose	Route	Frequency	Start Date				
1gm	IV	TID	18/7/26				
Name & Signature of the Doctor Starting the Drugs: Dr. Ayesha				6AM	Akhila		
				2PM			
Additional Instructions: To be converted to oral after 24 hrs				10PM			
Daily Doctor's Endorsement by a Sign							

DRUG : T. DICLOFENAC				Date / Time	19/7	20/7/26	
Dose	Route	Frequency	Start Date				
50mg	PO	BD	18/7/26				
Name & Signature of the Doctor Starting the Drugs: Dr. Ayesha				9am			
Additional Instructions:				9pm			
Daily Doctor's Endorsement by a Sign							

DRUG : T. TRAMADOL				Date / Time	19/7	20/7	
Dose	Route	Frequency	Start Date				
100mg	PO	BD	18/7/26				
Name & Signature of the Doctor Starting the Drugs: Dr. Ayesha				9am			
Additional Instructions:				9pm			
Daily Doctor's Endorsement by a Sign							

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DRUG CHART

Date of Admission: 18/7/26 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 / 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 ....

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☑ Not known any Drug Allergies

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

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

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						☐ C ☐ DC
2						☐ 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 Dna

Date & Time : 18/7/26 @ 7pm

Nurse Name & Signature: Madhumita @ Madhu

Date & Time : 18/7/26 @ 8pm

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RESULT SHEET

Date (I.P)	18/7/26					
Time	6.42Pm					
Hb	10.7					
PCV	30.9					
RBC	4.22					
WBC	8.88					
N/L	65.8/23.1					
Platelets	291					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Blood Grouping	B' positive					
HIV						
HBSAg						
HCV } NR						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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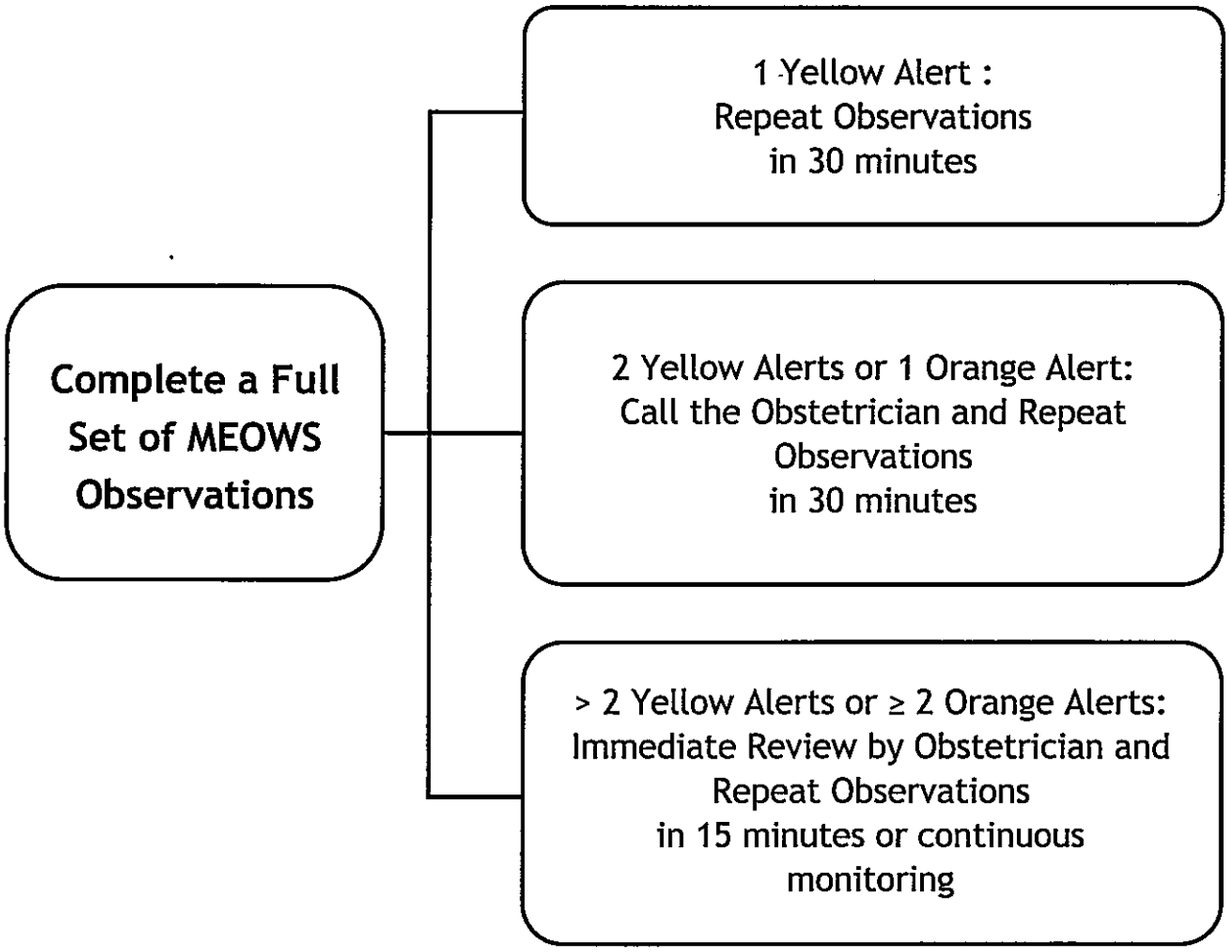
Early Warning Observation Score Chart - Obstetrics

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

18/7/26	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			20	20	20	20	20	20	20	20	20	20
	0 - 10																								
Saturations	94 - 100 %												100			99	99	99	99	99	99	99	99	99	99
	< 94 %																								
Administered O_2 (L/min.)																									
Temp°c	40																								
	39																								
	38																								
	37																								
	36															98°		97°		98°			97°		97°
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80															88	75			75		80	82		85
	70												86												
	60																								
	50																								
	40																								
Systolic Blood Pressue ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100												117			115	112			110		105		112	110
	90																								
	80																								
	70																								
	60																								
	50																								
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
	50												70			63	67			65		67		72	69
	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
TOTAL ORANGE SCORES													0			0	0		0		0			0	0
Nurse Initial																									

Obstetrics and Gynaecology Early Warning Signs



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

HNH-00013901 IP26-00006881
Mrs MANSI RAMCHANDANI
08-02-1996 30 Y 5 M 12 D (F)
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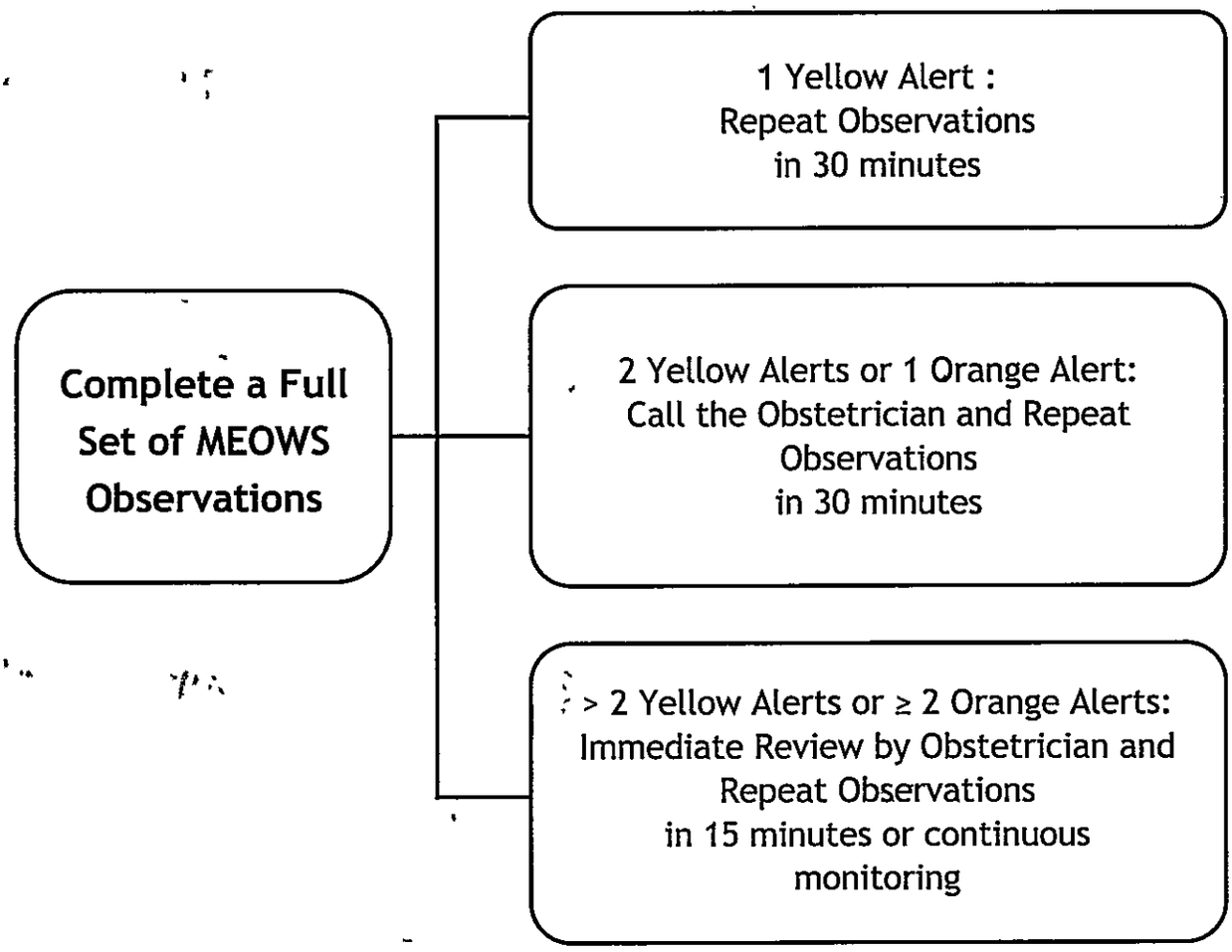
Early Warning Observation Score Chart - Obstetrics

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

19/7/26	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			23				24				20				20				20				20	
	0 - 10																								
Saturations	94 - 100 %			99%				98%				99				99				98%				99%	
	< 94 %																								
Administered O_2 (L/min.)																									
Temp°c	40																								
	39																								
	38																								
	37			36°C				37°C				36°C				98°F				98.4°F				98.6°F	
	36																								
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80			79				82				67				72				84				85	
	70																								
	60																								
	50																								
	40																								
Systolic Blood Pressure ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120			113				115				106				112				115				110	
	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70			72				75				67								63				76	
	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				2				0				0	
TOTAL ORANGE SCORES				0				0				0				0				0				0	
Nurse Initial																									

Obstetrics and Gynaecology Early Warning Signs



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

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Mrs MANSI RAMCHANDANI
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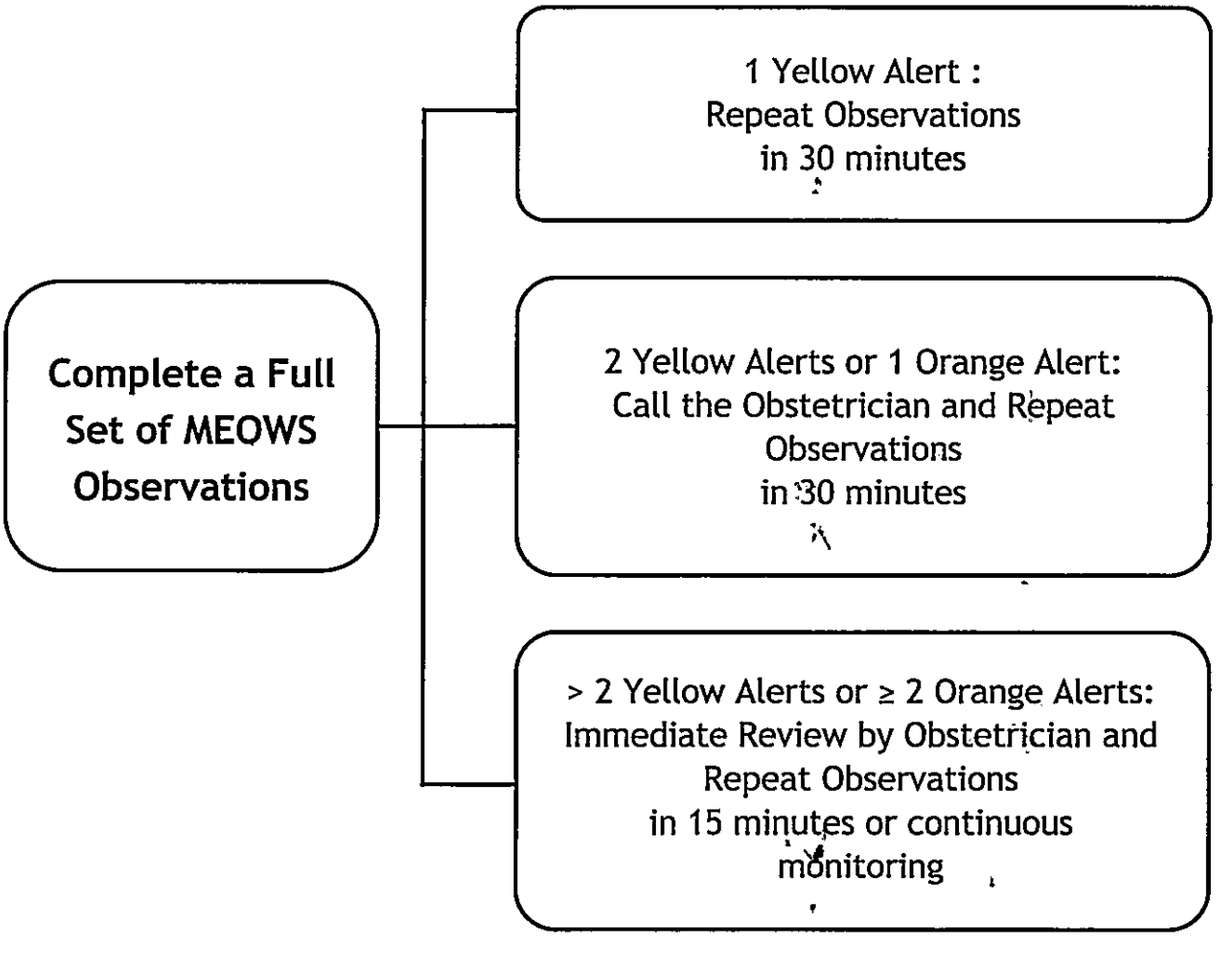
Early Warning Observation Score Chart - Obstetrics

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

30/7/20

		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																					
	0 - 10																									
Saturations	94 - 100 %				95%																					
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37				98.2																					
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90				81																					
	80																									
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110				113																					
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50				89																					
	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																					
TOTAL ORANGE SCORES					0																					
Nurse Initial					SB																					

Obstetrics and Gynaecology Early Warning Signs



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

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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.

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am				NA							
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
18/7/26	02:00 pm										0	
	03:00 pm											
	04:00 pm											
	05:00 pm									✓		CB
	06:00 pm											
	07:00 pm	RL	MBM	100ml							1	
Total Intake :						**Total Output :**						
	08:00 pm	RL	N	100ml								
	09:00 pm	RL	B	100ml							1	
	10:00 pm	RL	A	100ml						400ml	0	→ Empty
	11:00 pm	RL	N	100ml								
	12:00 am	RL	B	100ml							1	
	01:00 am	RL	M	100ml								
Total Intake : taken						**Total Output :**						
	02:00 am	RL	N	100ml						500ml		→ Empty
	03:00 am	RL		100ml							0	
	04:00 am	RL	B	100ml								
	05:00 am	RL	M	100ml								
	06:00 am	RL	H2O	100ml						400ml		→ Empty
	07:00 am	RL		100ml						100ml		→ Empty
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

Docu. No. : RCH /FRM / CLINICAL / 092

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Dr. SWATHI H V

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Your Right to a Safe Delivery

FLUID CHART

Sheet No. : .....

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

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
19/7/26												
	08:00 am	RL		100ml								
	09:00 am	RL		100ml								
	10:00 am	RL	Idly +	100ml								
	11:00 am	RL		100ml								
	12:00 pm	RL	H2O	100ml								
	01:00 pm	RL		100ml								
Total Intake :						**Total Output :**						
19/7/26	02:00 pm											
	03:00 pm		Khichdi + H2O									
	04:00 pm											
	05:00 pm	0			NA			NA			0	
	06:00 pm											
	07:00 pm											
Total Intake :		Taken				**Total Output :**	U - 2				M - 0	
19/7/26	08:00 pm		chapati									
	09:00 pm											
	10:00 pm	0	H2O									
	11:00 pm				NA			NA			0	
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
20/7/26	02:00 am											
	03:00 am											
	04:00 am	0	H2O								0	
	05:00 am				NA			NA				
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

Docu. No. : RCH /FRM / CLINICAL / 092

HNH-00013901 IP26-00006881
Mrs MANSI RAMCHANDANI
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FLUID CHART

Sheet No. : .....

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

		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							
20/7/26	08:00 am		30ml + H2O									
	09:00 am											
	10:00 am	0			NR			NA			0	M
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :** U- M-						
	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. : .....

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											
	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**	

HNH-00013901 IP26-00006881
Mrs MANSI RAMCHANDANI
06-02-1996 30 Y 5 M 12 D (F)
Dr. SWATHI H V

NURSING CARE RECORD

Rainbow® Children's Hospital
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BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: 18/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning				MA			
Afternoon	2pm to 8pm	=> Assess the patient condition => plan for vital => plan for Discharge	2pm to 8pm	=> Assessed the patient condition => maintain vital & recorded => maintain Discharge	patient is stable	vital is stable	Claude CD
Night	8pm To 8AM	→Assess the pt condition →plan for vitals →plan for I/o chart →plan for medication	8pm To 8AM	→Assessed the pt condition →vital are checked & recorded → I/o chart maintained	I/o chart maintained	patient is Stable	Sujatha Sujatha

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NURSING CARE RECORD

Date: 19/7/26

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	Re-Assessment	Nurse Name & Signature
Morning	8am to 2pm	→ Assess pt condition → monitor the vitals → maintain I/o chart → Administer medication as per drug chart	8AM to 2pm	→ Assessed pt condition → monitored the vitals → maintained I/o chart → Administer medication as per drug chart	→ Patient is stable now	→ Re-checked vitals & I/o chart	Anusha
Afternoon	2PM / 8PM	→ Assess the general Condition of pt → Monitor vitals → Maintain I/o chart → Administer medication	2PM / 8PM.	→ Assessed the general Condition of pt → Monitored vitals → Maintaing I/o chart → Administered medication	Pt is stable	Re assess vitals	Manjunath
Night	8PM to 8AM	– Assess the general condition of the pt – Monitor the v/s – Maintain the I/o – Drug as per chart	8PM to 8AM	– Assess the pt condition – Monitor the v/s – Maintain the I/o – Drug as per chart	– Now pt is stable	– Rechecked the v/s	

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NURSING CARE RECORD

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Date: 20/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am 2pm	- Assess the Pt Condition - Monitor vitals - Maintain I to O Chart - Medication Given as per drug Chart	8am 2pm	- Assessed the Pt Condition - monitored vitals - Maintain I to O Chart - Medication Given as per drug chart	Pt is Stable	Recheck vitals	
Afternoon							
Night							

Patient Sticker

NURSING CARE RECORD

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Date: .....

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							

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CHECKLIST FOR THROMBOPHLEBITIS

18/7/26 19/7/26 20/7/26

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			
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		NA	NA	NA	NA	NA	NA			
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2		NA	NA	NA	NA	NA	NA			
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		NA	NA	NA	NA	NA	NA			
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		NA	NA	NA	NA	NA	NA			
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5		NA	NA	NA	NA	NA	NA			
		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 : Chavhakade Name : Chavhakade

Signature of Ward In Charge :
Signature : Kasthuri Name : Kasthuri

Patient Sticker

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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										
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1										
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2										
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3										
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4										
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5										
		Signature of the Nurse											

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 : .....

HNH-00013901 IP26-00006881
Mrs MANSI RAMCHANDANI
08-02-1996 30 Y 5 M 12 D (F)
Dr. SWATHI H V

BRADEN 'Q' SCALE

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					Date : 18/7/20	18/7	19/7	19/7
					Time : 6a	Night	Mg	5
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 extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
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	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 mean 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
				TOTAL SCORE	28	28	28	28
				Evaluator's Name	CR	Pj	[illegible]	[illegible]

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

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

HNH-00013901 IP26-00006881
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06-02-1996 30 Y 5 M 13 D (F)
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BRADEN 'Q' SCALE

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					Date : 19/7	20/7		
					Time : 10pm	mc		
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 extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	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		
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		
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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		
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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		
				TOTAL SCORE	28	28		
				Evaluator's Name	SB	MC		

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

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
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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	18/7/26	18/7	19/7/26
		Score	52	Night	M16
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0			
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0	0	0	0
IV / Heparin Lock or Saline	Yes	20	20	20	20
	No	0			
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0			
Mental Status	Forgets limitations	15			
	Oriented to own ability	0			
Total Morse Fall Scale Score:			20	20	20
		Signature			

Fall Risk Grading

Risk Level	Morse Fall Score (MFS)	Action
Low Risk	0 - 24	Standard Fall Precaution
Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
High Risk	≥ 51	Implement High Risk Fall Prevention Intervention

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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Morse Fall Risk Assessment Form

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Choose Highest Applicable Score from each Category		Date / Time	19/7/26	19/7/26	
		Score	E2	N1	
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0			
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0			
IV / Heparin Lock or Saline	Yes	20			
	No	0	0	0	
GAIT / Transferring	Impaired	20	20	20	
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0			
Mental Status	Forgets limitations	15			
	Oriented to own ability	0			
Total Morse Fall Scale Score:					
		Signature			

Fall Risk Grading

Risk Level	Morse Fall Score (MFS)	Action
Low Risk	0 - 24	Standard Fall Precaution
Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
High Risk	≥ 51	Implement High Risk Fall Prevention Intervention

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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PAIN ASSESSMENT FORM

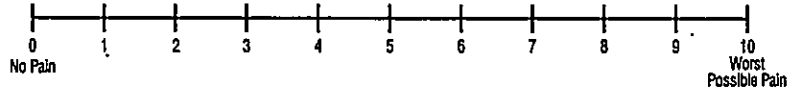
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
18/7/26	8pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	CR
18/7	8Pm	8Pm	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
19/7	12Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
19/7	4Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
19/7	10Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ ~~Yes~~ ☐ No	NA	
19/7	2pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ ~~Yes~~ ☐ No	NA	
19/7/26	6pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
19/7/26	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	~~NA~~	
20/7/26	2am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	~~NA~~	
20/7/26	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	~~NA~~	

Re-assessment Frequency:

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

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

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, SaO_2	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

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Dr. SWATHI H V

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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	18/7/26 G2	18/7 night	19/7 M6	19/7/26 E2	19/7/26 N1	20/7/26 M6
	Medical Condition (Any special condition to be noted):	—	NA	NA	NA	NA	NA
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:	97°F	98F	98.2°F	98.4°F	98.3°F	98.6°F
	Res:	20	20	23	24b/m	22b/m	20b/m
	SpO_2:	100%	99%	99%	99%	99%	99%
	Pulse:	86	85	82	86b/m	84b/m	80b/m
	BP:	110/70	115/75	112/68	112/69	112/72	113/76
	Fall Risk Score:	—	—	—	—	—	—
	Pain Score:	—	—	—	—	—	—
Recommendations	Safety Needs:	—	—	yes	yes	yes	Yes
	Physiotherapy	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☐ No ✓	☐ Yes ☑ No	☐ Yes ☑ No
	Others Specify:	—	NA	—	—	—	—
	Special Diet:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Other Special Orders / Medications:	—	NA	NA	NA	NA	NA
Post Operative Procedure Special Orders:		—	NA	NA	NA	NA	NA
Handed Over By Name :		Chudu	Srijath	Anusha	Mounika	Sunanda	Manisha
Signature :		[signature]	[signature]	[signature]	[signature]	[signature]	[signature]
Date:		18/7/26	19/7/26	19/7/26	19/7/26	20/7/26	20/7/26
Time:		8pm	8AM	2pm	8PM	8am	2pm
Taken Over By Name :		Srijath	Anusha	Mounika	Sunanda	Manisha	
Signature :		[signature]	[signature]	[signature]	[signature]	[signature]	
Date:		18/7/26	19/7/26	19/7/26	19/7/26	20/7/26	
Time:		8pm	8AM	2PM	8pm	8am	

Docu. No. : RCH/FRM/CLINICAL/097

Patient Sticker

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area / Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							

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URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 18/7 Date of Removal: 19/7/26 @ 7AM

Parameters / Date / Shift Time	18/7 8AM	19/7/26 7am					
Need for the Catheter	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Hand Hygiene	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Usage of Sterile Equipment	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Is the Collection bag below the level of bladder	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Check the Tube for Obstruction (Free of Kinking)	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Is Catheter dated as policy	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Collecting bag is been emptied regularly?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Maintenance of closed system for the catheter	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Dressing clean and dry?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Is the line removed as Policy?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Performance of Perineal Care	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Onset of New Fever	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Asses for the leakage at the site of insertion	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Name of the Nurse	Sujatha						
Signature of the Nurse	Sj						

Catheter removed at 7.30 am

removed 19/7/26 @ 7AM

Docu. No. : RCH /FRM / CLINICAL / 114

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OPERATION THEATER NOTES

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Dr. SWATHI H V

Patient's Name : .. ..Age : ....Gender : ....

UHID.: .... No. :..Weight : ....

Surgeon : Dr. Swathi HV	Asst. Surgeon : Dr. Dua
Anesthetist : Dr. Ayesha	OT Nurse :

Surgical Procedure :

Laparoscopic Right Salpingectomy.

Indications for Surgery :

Rt tubal ectopic pregnancy.

Date : 18/7/26.	Start Time :	End Time :

PRE-OPERATIVE PREPARATION :

OPERATION NOTES: - Rt unruptured tubal ectopic pregnancy geslsac m/s. 2x2cm in ampullary region (+)

- Rt ovary - (N)
- left ovary (N)
- left F.T - (N)
- Uterus - Bulky
- Rest of viscera (N).

- Proceeded with Right Salpingectomy
- Hemostasis achieved.
- Specimen retrieved through 10 mm port.
- procedure uneventful.
- Specimen sent for HPE.

POST - OPERATIVE ORDERS :

- NBM till further order
- IVF
- IV Antibiotics for 24hrs
- Analgesics as per AXON
- Urine I/O charting
- Monitor vitals
- Informed

Dr. Swathi HV

Consultant Surgeon's Name

Consultant Surgeon's Signature

Date : 18/7/26 Time : .....

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Swathi HV
Asst. Surgeon : Dr Dia
Anaesthetist : Dr. Ayesha
Scrub Nurse : Sr. Sangeetha, Archana

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Patient Name :
UHID No. :
Date : 18/7/26 Time : 8:30pm

..... Gender : .....
.....
.me : 9:40pm

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Before Induction of Anaesthesia ➤ ➤

SIGN IN Time: 8:20pm

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 : [signature]
Name : [illegible]

Before Skin Incision ➤ ➤

TIME OUT Time: 8:41 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

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

Signature : [signature]
Name : Gauri @ 8:45 PM

Before Patient Leaves Operating Room

SIGN OUT Time: 8:30 PM

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] SWATHI HV
Name : [illegible]

PATIENT TRANSFER FORM

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Dr. SWATHI H V

Treating Consultant Name Dr. Swathi HV	Date & Time of Admission 18/9/26 @ 6:27PM	Date & Time of Transfer Order 18/9/26 @ 9:40PM
	Transfer Ordered by Dr. Ayesha	Reason for Transfer Observation
From Unit OT	To Unit Pre-Port	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 28	Number of Imaging Films —	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	RL	(1)
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☑ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Karuna	Dr. Ayesha.

Patient & Clinical Records Received by : Sujatha

Date & Time of Patient Received : 18/9/26 @ 10PM

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

Ramchandani 30/SM
Patient Sticker

307

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NUTRITIONAL ASSESSMENT FOR GYNEC PATIENTS

Date: 19/7/26 Time: 11:10 Am

Origin: Indian Height: 161 cms Weight: 66 kg. BMI: 25.48 kg/m²

Food Allergies: NO

Diagnosis: POD-0 Lap> Salpingectomy.

Medical History: Nil

Surgical History: —

☐ Vegetarian ☑ Non-Vegetarian ☐ Vegan

Diet Advised: Soft Diet

Patient's / Attendant's

Signature: Manisa

Name: Ramchandani

Date & Time: 19/7/26 ; 11:10 Am

Dietician's

Signature:

Name: Sathwika-G

Date & Time: 19/7/26 ; 11:10 Am

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OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 18/1/26 Time of Arrival: 7 pm Time Seen by Nurse: 7.10 Am

1) **Level of Consciousness:** ☐ Conscious ☐ Semi-Conscious ☐ UnConscious

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

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

3) **Vital Signs:** Temperature: 98°F Pulse: 86 RR: 20 SpO_2: 100 BP: 110/70 Weight: .....

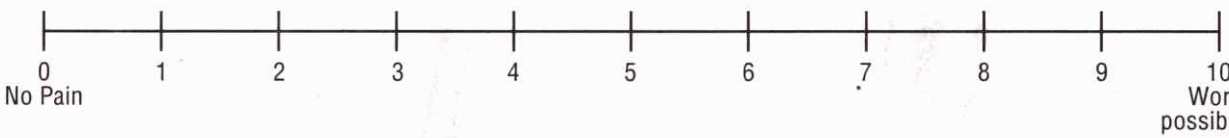
4) **Gestational Criteria:**

Gravida:	G	P	L	A

LMP: ..... EDD: ..... Gestational Age: .....

Uterine Contraction	☐ Yes	☐ No	☐ NA	Onset	Time	Frequency:
Membrane Rupture	☐ Yes	☑ No	☐ NA	Onset	Time	Fluid Color:
Vaginal bleeding	☐ Yes	☑ No	☐ NA	Onset	Time	Amount:
Pre Eclampsia Symptoms	☐ Yes	☑ No	☐ NA	If Yes specify: Headache / Visual Symptoms / Pain Abdomen / Vomiting		
Good fetal Movement	☐ Yes	☑ No	☐ NA	If No specify:		

5) **Pain Screening:** **Numerical Pain Scale (NPS)**



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

6) **Past History:**

a) Surgeries: .....

b) Medical: 3 Nil

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7) **Allergy:** ☐ Yes ☑ No, If Yes : ....

8) **Current Medications:** ☐ Prenatal Vitamin ☑ None ☐ Others: ....

9) **Prenatal Medical History:**

☑ None
☐ Chronic Hypertension
☐ Gestational Hypertension
☐ Diabetes
☐ Gestational Diabetes
☐ Low placenta
☐ Others if yes, specify ....

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

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

Time seen by Doctor: 6:00am

Nurse Name : Chandrakala Nurse Signature: ct

Date: 18/7/26 Time: 6:10pm

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OBSTETRICS / GYNECOLOGY
NURSING INITIAL ASSESSMENT FORM

Date of Admission: 18/7/26

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: .....

pain abd

.....

.....

Doctor Notified on Admission: ☐ Yes ☐ No

Name of the Doctor: Dr. DUO

Time Notified: .....

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

Past Medical History	Past Surgical History	Previous Hospital Admission
–	–	–

Gynecology Assessment: ☐ Not Applicable

Menstrual History: .....

Regular

Onset of Menarche: .....

Menstrual Cycle: ☑ Regular ☐ Irregular

Last Menstrual Period: .....

Gynecology Surgical History:

Caesarean Section: ☐ No ☐ Yes

Cervical Cerclage: ☐ No ☐ Yes

Ectopic Pregnancy: ☐ No ☐ Yes

Myomectomy: ☑ No ☐ Yes

Others: _____

Gynecological History:

Contraceptives: ☐ No ☐ Yes

Vaginal Discharge: ☐ No ☐ Yes

Post-Coital Bleeding: ☐ No ☐ Yes

Infertility: ☐ No ☐ Yes

If Yes Type: ☐ Primary ☐ Secondary

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

Previous LSCS: .....

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

Family History: ☑ No Abnormalities Detected

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

☐ Liver disease ☐ Other .....

Vital Signs / Measurements: Temp: 99°F HR: 80 RR: 20

BP: 110/70 Weight: ..... Height: ..... BMI: .....

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

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08-02-1996 30 Y 5 M 12 D (F)
Dr. SWATHI H V

PHYSICAL ASSESSMENT

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

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

Risk of Pressure Sore: ☐ Yes ☑ No Score ..... (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 .....

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: ..... Rammchandani .....

Orientation not given Reason: ..... NA .....

Nurse Signature: .....

Nurse Name: Chowhakale .....

Date & Time: 18/7/26. @ 7pm .....

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : Mrs Mansi Ramchandani Gender: ☐ Male ☑ Female Age : 30yrs

UHID No : HNH-0001390| Date : 18/7/26

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)

RIGHT LAPAROSCOPIC SALPINGECTOMY

upon Mrs Mansi Ramchandani (Name of the Patient)

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

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

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

bleeding, infection, injury to adjacent organs
Need for blood transfusion.

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. Swathi HV

Consentee :

Signature : Mansi

Name : Mansi Ramchandani

Date & Time : 18.7.2026 @ 7pm

Witness :

Signature : Madhu

Name : Madhumita

Date & Time : 18/7/26 @ 7pm

Patient Attendant :

Signature : P Ramchandani

Name : Dr Priya Ramchandani

Relationship with Patient: Sister

Date & Time : 18/7/26 @ 7pm

Doctor (who is taking the consent) :

Signature :

Name : Dr. Dina

Date & Time : 18/7/26. @ 7pm

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : Mrs. MANSI RAMCHANDANI Age : 30y Gender : Male ☐ Female ☑

UHID NO: HNH-0001890 Surgeon Name: Dr. SUNITH H.V

Anaesthesiologist : Dr AYESHA

Operative procedure planned : LAPAROSCOPIC SALPINGECTOMY · (Rt)

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 without numbness can be achieved by infusing weak solutions of local anesthetics arid 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 mellitus ☐ Renal failure

☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma / Renal Tubular Aacidosis

☐ Incapacitating Cronic Obstructive Pulmonary Disease

☑ Others : Hypotension, Desaturation, delayed Recovery, Bleeding

Comments :

- Doctor to document in medical record also if necessary (Cross-out if not applicable)

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient Mrs. MANSI RAMCHANDANI the above mentioned operation / Diagnostic / Therapeutic procedures LAPAROSCOPIC SALPINGECTOMY · (Rt)

I authorize and give consent for anaesthesia (☐ Regional / ☑ General Anesthesia / ☐ Monitored Anesthesia Care as considered appropriate by the anaesthetic team.

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, risk, benefits and alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anesthesia.

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, asthmatic reactions, headaches.

I authorize the anaesthetic team to perform any additional procedures (for example, Central Venous Pressure line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I 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 in need arises.

I understand that the above mentioned consultant anesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

- Pregnant : ☐ Yes ☐ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

I declare that I have explained the nature of General Anaesthesia / Regional Anaesthesia / Monitored Anesthesia Care to be given and discussed the risks that particularly concern this patient.

I have given the patient an opportunity to ask questions and I have answered these.

Patient / Patient Attendant :

Signature : Mansi

Name : Mansi Ramchandani

Relationship with Patient: .....

Date & Time : .....

Witness :

Signature : R Ramchandani

Name : Dr Riya Ramchandani

Date & Time : .....

Doctor (who is taking the consent) :

Signature : Ayesha

Name : Dr. SK. Ayesha

Date & Time : 18/4/26, 6:20 pm

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: Mrs. MANSI RAMCHANDANI Age: 30y Sex: F UHID.No : HNH-0001390 1

Date: 18/7/26 Time: 6:05 pm Proposed Operation: Lap: Salpingectomy

Diagnosis: Ectopic PREGNANCY (Rt), 7w1+2d

B.P / CRT: 118/66 mmHg H.R: ..... Weight: 66kg ASA Physical Status: ☐ 1 ☑ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb:	Glucose:	Protein:	HIV:	X-Ray: .....
PCV:	Urea:	Alb:	HBS Ag:	ECG: .....
WBC:	Creat:	Total Bill:	HCV:	2D Echo: .....
Plate:	Na:	Dir. Bill:	Blood group:	Stress/Anglo: .....
PT:	K:	LDH:	T3 146 ng/dl	Other: .....
PTT:	Ca++:	Alk phos:	T4 8.7 µg/dl	
INR:	Mg++:	Amylase:	TSH 3.3 µIU/ml	
	Cl -:	SGOT/SGPT:		

Allergies: NIL

Medical History: CVS : NIL SIGNIFICANT

RESP : Diabetes : -

CNS :

Renal :

Hepatic / GE : Physical Activity: METS > 4

Others :

Past Anaesthetic History: (Rt) Elbow # Repair ↓ Regional block

Physical Exam: (N)

Airway: MP 1 (2) 3 4 Mouth Opening: Adequate Mentohyoid Distance: (N) Neck: (N) Teeth: Artificial dentures fixed (+)

Lungs : BAE (+), Clear

Heart: S_1S_2 (+)

CNS: NAD

Pregnant: ☑ Yes ☐ No ☐ NA Venous Access Site : Peripheral (+) Spine Exam for regional : M

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours; Others 6 Hours
3. Informed Consent: ☐ Standard ☐ High Risk
4. Post Operative Pain Management: ☐ Discussed with Patient
5. Other Instructions:
   (1) CBP, BGT, ~~Blood~~ Viral marker

Signature: Ayesha Name: Dr. Sk. Ayesha

Docu. No. : RCH/FRM / CLINICAL / 044

HNH-00013901 IP26-00006881
Mrs MANSI RAMCHANDANI
06-02-1996 30 Y 5 M 13 D
Dr. SWATHI H V (F)

ANAESTHESIA CHART

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Pre induction

Change in Patient Condition: ☐ Yes ☑ No	Fasting Status: Adequate

Physical Status:	☑ Patient Identified	☑ Consent Present	☑ Chart Reviewed

H.R: 100/min	B.P / CRT: 122/72 mmHg	SpO_2: 99% on RA	R.R: 17/min	Last Feed: >6 hrs

Pre-OP Diagnosis: (Rt) Ectopic pregnancy Operation: Laparoscopic Salpingectomy Date: 18/7/26

Surgeon: .... Anaesthesiologist: .... Technician: ....

TIME	8:20	8:30		8:40		8:50		9:00		9:15		9:30		9:40
N_2O (AIR) (O_2) LPM 1·2/min	//////											— O_2 —		
HALO / ISO (SEVO) MAC 1	~~~~~~ →													

Drugs:
- Inj. MIDAZOLAM 2mg IV
- Inj. PROPOFOL 100+20+10 mg IV
- Inj. FENTANYL 100mcg IV
- Inj. ROCURONIUM 40mg IV
- Inj. PARACETAMOL 1gm IV
- Inj. MYOPYRROLATE 50mg IV

FIO_2 (SaO_2)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
$ETCO_2$	34	35	36	37	36	36	36	36	39	40	38	37	37	37
ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Temperature														
Urine Output														

Fluids / Blood: 1 (L) RL

Antibiotic

Suppository: DICLOFENAC 100mg, TRAMADOL 100mg

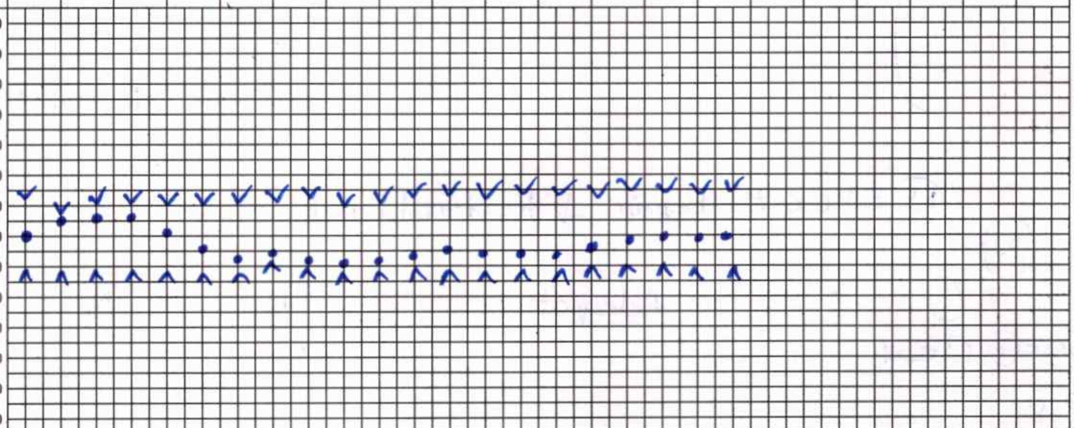
Blood Loss

NOTES

B.P
V Systolic
Λ Diastolic
X Mean
• Heart Rate

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out



LAB Values: ABG / GRBS / Others

Checklist:
- ☑ Equipment Checked and Functional
- ☑ BP
- ☑ Cuff Site: (Lt) UL
- ☐ Art Site: ....
- ☑ EKG Lead 3 lead
- ☑ Temp Site
- ☑ FIO_2 Monitor
- ☑ Agent Monitor
- ☑ Pulse Oximeter
- ☑ Capnograph
- ☑ Ventilator
- ☐ Nerve Stimulator

Position: ....
- ☑ Pressure Points Checked

Eye Care:
- ☐ Oint
- ☑ Tape
- ☐ Padding
- ☐ Awake

Temp:
- ☐ HME ☐ Fluid Warmer
- ☐ Cling Film ☐ OH Warmer
- ☑ Hugger's ☐ Cotton Wool
- ☐ Other

Times:
- Anaes Start: 8:30pm
- OP Start: 8:50pm
- OP End: 9:35pm
- Leave OR: 9:40pm

Anaesthesia:
- ☑ GA
- ☐ Monitored Anaesthesia Care
- ☐ Regional

Line (Size & Location)
- ☐ CVP: ....
- ☐ ART: ....
- ☑ IV: 18G on (Rt) UL
- ☐ IV: ....
- ☐ IV: ....

Induction
- ☐ IV ☑ Inhal
- ☐ Pre O_2 ☐ RSI
- ☐ Others

- ☐ Mask ☐ SGA
- ☐ Airway ☐ Oral ☐ Nasal
- ETT# 6.5 at 20 cm
- ☑ Oral ☐ Nasal ☐ Cuff
- ☐ Tracheostomy ☐ Topical
- ☑ Drug: ROCURONIUM
- ☐ Awake ☐ Direct Vision
- ☑ Video Laryngoscopy ☐ Stylette / Bougie
- ☐ Fiberoptic
- Blade# .... Attempts: 1
- Difficulty Why? ....

- ☑ **Bilat = BS**
- ☐ Semi-Closed Circle
- ☐ Closed Circle
- ☐ Other

Regional: /
- Extremity Specify: ....
- ☐ Spinal ☐ Epidural ☐ Caudal
- Others: ....
- Position: ....
- Site: ....
- Needle Size: .... Depth: ....
- Parasthesia ☐ Yes ☐ No
- Catheter at skin .... cm
- Drug Name & Conc: ....
- Bolus: ....
- Infusion: ....
- Block Level: ....
- Comments: ....

Transportation to ☐ PACU ☐ ICU ☐ Other

Relaxant Reversed ☐ Yes ☐ No ☐ NA

Name of the Doctor: Dr. Ayesha

Signature of the Doctor: [signature]

HNH-00013901 IP26-00006881
Mrs MANSI RAMCHANDANI
08-02-1996 30 Y 5 M 12 D (F)
Dr. SWATHI H V

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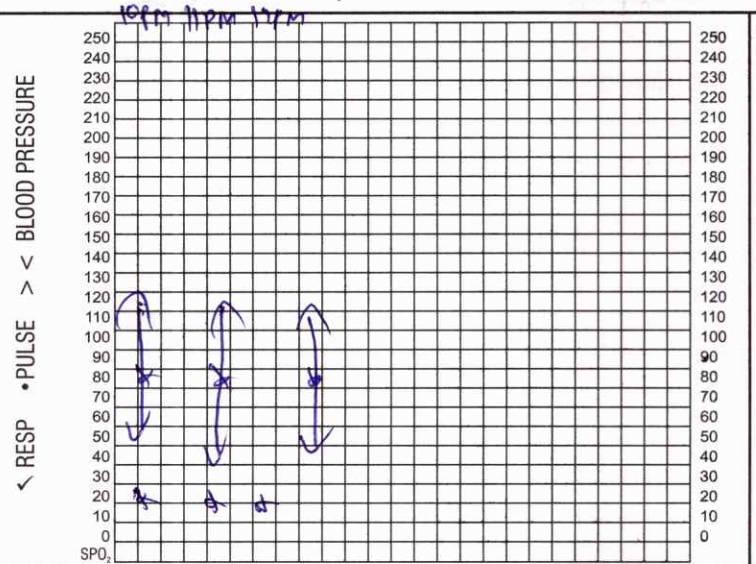
POST-ANAES... RE UNIT RECORD

Received in PACU by : Sujatha Time Received : 10 PM Time Discharged : .....



IV Cannula Site : .....

- ☐ O_2 Mask
- ☐ Nasal Prongs
- ☐ Tracheostomy
- ☐ T-Piece
- ☐ Oral Airway
- ☐ Nasal Airway

Vomiting : ☐ Yes ☑ No
NG Tube : ☐ Yes ☑ No
Drain: ☐ Yes ☑ No
Urinary Catheter: ☑ Yes ☐ No
Chest Tube: ☐ Yes ☑ No
Nil Oral ☐ Yes ☑ No

Drug: INJ Itayine 1gm

IV Fluids: RL
Oral Feeds: NBM

POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	MINUTES 30	60	90	OUT	SCORING INTERPRETATION
Able to move 4 extremities voluntary or on command Able to move 2 extremities voluntary or on command Able to move 0 extremities voluntary or on command	= 2 = 1 = 0	ACTIVITY		1	2	2	2	A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to deep breathe & cough freely Dyspnea or limited breathing Apneic	= 2 = 1 = 0	RESPIRATION		2	2	2	2	
BP ± 20 of Pre Anaesthetic leve BP ± 20-50 of Pre Anaesthetic leve BP ± 50 of Pre Anaesthetic leve	= 2 = 1 = 0	CIRCULATION		2	2	2	2	
Fully awake Arousable on calling Not responding	= 2 = 1 = 0	CONSCIOUSNESS		2	2	2	2	
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0	COLOR		2	2	2	2	
		TOTAL		9	10	10	10	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
18/7	10pm	0	NA	
18/7	11 PM	0	NA	
19/7	12AM	0	NA	
19/7	7AM	0	NA	

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 reliving intervention
   d. With in 30-60 minutes after pain relief intervention

Anaesthesiologist Name : Dr. SAIRAM V
Anaesthesiologist Signature:
Date & Time: 19/07/2026

PACU Nurse Name : Sujatha
PACU Nurse Signature:
Date & Time: 19/7/26 @ 7AM

Transferred to Unit by (PACU): 3rd floor (307)
Date & Time: 19/7/26 @ 7AM

Patient Sticker

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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 Left Right	Maternal BP	Maternal Pulse	FHR	Comments

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 : .....

26-0000 2150HH

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NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name:	MRS. MANSI RAMCHANDANI	Age:	30Y	Gender:	F
UHID No:	HNH-0001390	IP No:	IP26-00006881	Date:	18/7/26 Time: 6:56 Pm
Diagnosis:	LAP SALPINGECTOMY				WARD: OT

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	100 MCG	ONE AMP
	Morphine Sulphate Inj. 15mg/Ml		
3.	Remifentanil Hydrochloride Inj. 2MG		
4.	Remifentanil Hydrochloride inj. 1MG		

Doctor Name: Dr. SK. AYESHA

Doctor Registration No: TSMC/FMR/02725

Signature:

NARCOTIC DISPENSING FORM
APPENDIX 4 – FORM NO. 3E
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: IP26-00006881 **Date:** 18/7/26

Aadhaar No. of the Patient (Optional): .....

1.	**Name :** MRS. MANSI RAMCHANDANI	**Remarks**
2.	Complete postal address (with contact number, if any)	FLAT NO 105 FLOOR MSK TOWERS 11 HIMAYATHNAGAR HYD
3.	Brief description of the illness	LAP SALPINGECTOMY
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	NO
5.	Details of essential Narcotic drug dispensed	FENTANYL

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
18/7/26	FENTANYL	ONE AMP		

Dispensed by (Name & ID No.): Jai Chandu 02115 3 Signature: .....

Received by (Name & ID No.): ..... Signature: .....

Time: .....

26-0000 215044

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NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name:	MRS. MANSI RAMCHANDANI	Age:	30Y	Gender:	F
UHID No:	[illegible]	IP No:	IP26-00006881	Date: 15/7/26	Time: 6:56pm
Diagnosis:	LAP SALPINGECTOMY			WARD: OT	

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	100 MCG	ONE AMP
2.	Morphine Sulphate Inj. 15mg/Ml		
3.	Remifentanil Hydrochloride Inj. 2MG		
4.	Remifentanil Hydrochloride inj. 1MG		

Doctor Name: Dr. SK. AYESHA

Doctor Registration No: TSMC/FMR/03702X

Signature: [signature]

NARCOTIC DISPENSING FORM
APPENDIX 4 – FORM NO. 3E
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: IP26-00006881

Date: 15/7/26

Aadhaar No. of the Patient (Optional): ....

		Remarks
1.	**Name :** MRS. MANSI RAMCHANDANI	
2.	Complete postal address (with contact number, if any)	FLAT NO 405 FLOOR MSK TOWERS HIMAYATHNAGAR HYD
3.	Brief description of the illness	LAP SALPINGECTOMY
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	NO
5.	Details of essential Narcotic drug dispensed	FENTANYL

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
15/7/26	FENTANYL	ONE AMP	[signature]	

Dispensed by (Name & ID No.): .... Signature: ....

Received by (Name & ID No.): [signature] 021153 Signature: [signature]

Time: ....

Docu. No: RCH / FRM / CLINICAL / 133

Rainbow Children's Hospital

BirthRight

NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name:		Age:	Gender:
UHID No.:	IP No.	Date:	Time:
Diagnosis:			

PRESCRIPTION DETAILS (Use only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Pentazocine Inj. 30mg/ml		
2.	Morphine Sulphate Inj. 15mg/ml		
3.	Pentazocine Hydrochloride Inj. 2MG		
4.	Pentazocine Hydrochloride Inj. 1MG		

Doctor Name:

Signature: Doctor Registration No.:

NARCOTIC DISPENSING FORM
APPENDIX 4 – FORM NO. 3E
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No.: Date:

Address: (If any Patient (Optional))

Sl. No.	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb impression of the patient / Patient Attender	Remarks, if any
1.	Name			Remarks
2.	Complete postal address (with contact number, if any)			
3.	Brief description of the illness			
4.	Whether registered with any other registered medical practitioner / recognized medical institution (If yes, details of the records)			
5.	Details of essential Narcotic drug dispensed			
Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb impression of the patient / Patient Attender	Remarks, if any

Dispensed by (Name & ID No.): Signature:

Received by (Name & ID No.): Signature:

Time:

26-00012505?

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NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name:	MRS. MANSI RAMCHANDANI	Age:	30Y	Gender:	F.
UHID No:	ANH 000139	IP No:	IP26-00006[illegible]	Date:	18/7/26 Time: 6:56 pm
Diagnosis:	LAP SALPINGECTOMY.			ward: 07.	

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml		
2.	Morphine Sulphate Inj. 15mg/Ml	15 mG	ONE AMP
3.	Remifentanil Hydrochloride Inj. 2MG		
4.	Remifentanil Hydrochloride inj. 1MG		

Doctor Name: DR. SK. AYESHA

Doctor Registration No: TSMC | FNR | 07725

Signature:

NARCOTIC DISPENSING FORM
APPENDIX 4 – FORM NO. 3E
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: IP26-0000688 **Date:** 18/7/26

Aadhaar No. of the Patient (Optional): .....

1.	**Name :** MRS. MANSI RAMCHANDANI.	**Remarks**
2.	Complete postal address (with contact number, if any)	FLAT NO 105, HIMAYATHNAGAR.
3.	Brief description of the illness	LAP SALPINGECTOMY
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	NO
5.	Details of essential Narcotic drug dispensed	MORPHINE.

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
18/7/26	MORPHINE	ONE AMP	Mansi	

Dispensed by (Name & ID No.): ..... Signature: .....

Received by (Name & ID No.): JAI CHANDU 021153 Signature: .....

Time: .....

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26-00012505?

NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name: Mrs. Mansi Ramchandani		Age: 30Y	Gender: F
UHID No: [illegible]	IP No: IP26-00006688	Date: 15/7/26	Time: 6:56pm
Diagnosis: LAP SALPINGECTOMY			ward: 07

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml		
2.	Morphine Sulphate Inj. 15mg/Ml	15 mg	one Amp
3.	Remifentanil Hydrochloride Inj. 2MG		
4.	Remifentanil Hydrochloride inj. 1MG		

Doctor Name: Dr. SK Arora

Doctor Registration No: TSMC/TNR/07725

Signature:

NARCOTIC DISPENSING FORM
APPENDIX 4 – FORM NO. 3E
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: IP26-00006688 **Date:** 15/7/26

Aadhaar No. of the Patient (Optional): .....

1.	**Name :** Mrs. Mansi Ramchandani	**Remarks**
2.	Complete postal address (with contact number, if any)	Flat No 105, Himalaya Heights
3.	Brief description of the illness	LAP SALPINGECTOMY
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	No
5.	Details of essential Narcotic drug dispensed	Morphine

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
15/7/26	Morphine	one Amp	Mansi	

Dispensed by (Name & ID No.): ..... Signature: .....

Received by (Name & ID No.): Sai Chandu 62115 ..... Signature: .....

Time: .....

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar ,Hyderabad ,Telangana, INDIA ,500029.
TEL NO :040-48873000
WEB : https://rainbowhospitals.in

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Mrs MANSI RAMCHANDANI**	**Age :**	**30 Y 5 M 12 D**
IP No:	**IP26-00006881**	**Sex:**	**Female**
Consultant:	**Dr. SWATHI H V**	**Ward/Bed No:**	**4F -OT/PDA-412**

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science and that no guarantee have been made to me as the results of my evaluation and I or treatment.

I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal items and valuables.

"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process as per evidence based guidelines".

Note:
1 We do not allow use of medication brought from outside by the patient.
2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.
(Receivers Signature:.....)

3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.
4 Financial and billing counseling has been done to me.

Signature of Patient/Relative:

Name: Haresh Ramchandani
Relationship: father
Date: 18/07/2026 Time: 18:27
Witness Name: Yaseen ali khan
Witness Signature:

Patient Address:

flat no 405 floor msk towers street number 11 Himayathnagar Hyderabad Telangana INDIA 500029

HNH-00013901 IP26-00006881
Mrs MANSI RAMCHANDANI
06-02-1995 30 Y 5 M 12 D (F)
Dr. SWATHI H V

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BILLING POLICY

- Billing cycle: - With effective from 1st January 2020, Our billing cycle to be start from 12 PM to 12 PM, Settlement post 12 PM, room rent will be charge for half day extra & post 6 pm, it will be charge for full day. Less than 24 hours stay will be considered as one day.
- As per the GOI guidelines, we can collect Rs 1,99,999/- only in cash mode, balance patient can pay through Card tpaln the event of TPA/ Cashless denial or approval not received due to any reason then hospital tariff will be applicable and any discount or special rates given to TPA's / corporates won't be applicable.
- If the surgery / scans performed in Emergency hours (8pm - 7am), public holiday and on Sunday will be charged TPA processing charges Rs.720 for every TPA route cases.
- All charges vary as per Room category, except Pharmacy and consumables.
- We follows a "No Discounts Policy" kindly cooperate.
- No Duplicate/Second copy of OP OR IP bill is issued.
- ICU/Ward Charges DO NOT INCLUDE - Air Mattress, Monitor, Consultants/ Specialty Doctors Visit, Infusion/syringe pump, Ventilator/C pap, Oxygen, Investigations, Procedures, Consumables, Medicines or any other bedside equipment's/devices etc. (Detailed list can be taken from billing department).

Patient attendant can collect for Interim/provisional bill of the patient from the billing section on daily basis. Interim Bill shall be based on the acknowledged services in HIS. Final Bill of the patient may vary from the Interim bill based on actual update taken on the day of discharge. It is requested that patients/attendants inquire daily about the bill amount from billing section and pay the outstanding as on that day.

Patient bill outstanding should not be increase more than 10,000/-

You are requested to clear your outstanding amount on daily basis before 12 PM.

MODE OF PAYMENT & REFUNDS

- We accept payments by cash (up to Rs 1,99,999/- only), cards, online transfer and Demand Drafts.
- All refund more than Rs.2,000/- will be refund through NEFT in three Bank working days.

Name & signature of Patient/Attendant

(Signature of Admission Desk executive)

NOTE: Self - attested Govt. ID proof is mandatory whosoever is signing the undertaking.

RAINBOW CHILDREN'S MEDICARE PRIVATE LIMITED

Registered Office: Road No.2, Banjara hills, Near Hotel Park Hyatt, Hyderabad - 500 034, T: +91 40 2233 4455.
Corporate Office: 8-2-19/1/A, Daulet Arcade, Karvy Line, Road No.11, Banjara Hills, Hyderabad - 500 034.
Branches : BANJARA HILLS - T: 2233 4455 | VIKRAMPURI - T: 4246 2200 | KONDAPUR - T: 4246 2400 | MADHAPUR - T: 6464 2020 |KUKATPALLY - T: 4246 2300 | L B NAGAR - T: 7111 1333 | MARATHAHALLI, BENGALURU - T: +91 80 7111 2345 | BANNERGHATTA ROAD, BENGALURU - T: +91 80 2551 2345, HIMAYATNAGAR- T:- 40 48873000

CIN: U85110 TG1998 PTC029914 email : info@rainbowhospitals.in **www.rainbowhospitals.in**

DECLARATION BY PATIENT OR PATIENT ATTENDANT (TPA / INSURANCE / AROGYA BHADRATA / CORPORATE)

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Date: 18/07/2026

I have attended the financial counseling desk / billing desk and understood the approximate expected costs of treatment. I clearly understand and agree that the hospital would bill as per its (hospital's) existing terms and conditions or MOU with my TPA/ Insurance Company/ Corporate /Arogya Bhadrata Scheme.

In case my claim is rejected by my TPA / Insurance Company / Corporate / Arogya Bhadrata Scheme at any point of time, i.e. before admission, during admission, during discharge or post discharge when hospital bill claim is submitted, I promise to settle the claim with the hospital. I understand and agree that there are certain TPA / Insurance Company / Corporate / Arogya Bhadrata Scheme Non - Coverable billing components which have to be paid totally by me like the following.

Registration charges, Insurance Processing fee, Medical Record Charges, MLC Charges, Tax Collected at Source (TCS), Dietician Consultation, F&B charges. Luxury Tax, Pharmacy and Consumables Non Medicals like Gloves, Masks, Draw Sheets, Diapers / Koochees, Intrafix, Q-Syte, Venflon, Sterilium, Splint, Gowns, Stockings, etc, Investigations like HIV, HbsAg, Pre Anesthesia Checkup (PAC), all Genetic Investigations, Double Occupancy, Vaccination Charges etc, instruments like Laparoscope, Thoracoscope, Harmonic, N-Seal, Morcellator, Cobulator, C-Arm, Micro Debrider, Medetronic Drill, Mann Mann Drill, Neuro Microscope, Neuro Endoscope, Endoscope etc, Maternity related like, Anti D, Muhurtham, Welt Baby Charges, Epidural, Entonox, Tubectomy etc. Any other facility used / treatment / investigation done which is not related to the present ailment is not covered.

I promise to clear my medical / non-medical bill dues during admission on daily basis or as and when applicable or whenever called for.

Mandatory Documents to be submitted for cashless process (Corporate Policy)

1. Employee ID Card.
2. Employee Government ID Proof (PAN /Aadhaar Card / Passport / Voter ID).
3. Patient TPA / Insurance Health Card or E-Card.
4. Patient Government ID Proof (PAN /Aadhaar Card / Passport / Voter ID / Birth Certificate)

Mandatory Documents to be submitted for cashless process (Individual Policy)

1. Proposer's ID Proof.
2. Patient TPA / Insurance Health Card or E-Card.
3. Patient Government ID Proof (PAN / Aadhaar Card / Passport / Voter ID / Birth Certificate)

Name of the Patient: Mansi Ramchandani Date & Time of Admission: 18/07/2026 @ 16:27

Name of the Parent / Guardian: Mahesh Ramchandani Mobile Number: 9890623853

Parent Aadhaar Card Number: .....

Signature & Relation

HNH-00013901 IP26-00006881
Mrs MANSI RAMCHANDANI
06-02-1995 30 Y 5 M 12 D (F)
Dr. SWATHI H V

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UNDERTAKING OF INSURANCE PATIENT/ CREDIT PATIENT FOR ADVANCE PAYMENT

To

The Management,

Rainbow Children's Hospital, Himayat Nagar,

Hyderabad - 500029.

Sub:- **Undertaking of Insurance Patient for Advance Payment.**

I Mr./Mrs./Ms. Haresh Ramchandani (Father/ Mother/ Other _____) of Master/ Baby/ Baby of/ Mrs. / Ms. mansi Ramchandani was bought to your hospital on Emergency basis on 18/07/2026 at 18:27. approximate charges deposit details were explained by the front office executive on duty.

As I have cashless insurance so I have to pay 20k- as a caution deposit at the time of admission. If there will be any difference amount after getting the approval I'll pay that amount at the time discharge.

Thanking You

Signature

Name:- Haresh

Ph. No.:- 9550288048

H-00013901 IP26-00006881
MANSI RAMCHANDANI
02-1996 30 Y 5 M 14 D (F)
SWATHI H V

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DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	1			
6	Doctors progress sheets	2			
7	Nursing plan of care and handover sheets	3			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery	1			
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaestesia notes (Pre Anaesthesia& post)				
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list	1			
26	Surgical safety checklist	1			
27	Operation Theatre notes	1			
28	Nurses clinical Presentation				
29	TPR & BP chart	3			
30	Intake and Out take chart (fluid chart)	2			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart	1			
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale				
38	Braden Q Scale	2			
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	Billing	1			
	Others	5			
	Total No. of Pages	33			

Doc. No. : RCH/ FRM / GENERAL / 126

Signature and Date : 20/07/26

(P.T.O)

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU / 2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

HNH-00013901 IP26-00006881
Mrs MANSI RAMCHANDANI
08-02-1996 30 Y 5 M 12 D (F)
Dr. SWATHI H V

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SURGERY DETAILS

Date : 18/7/26

Patient Name: Mrs Mansi Ramchandani Date of Birth: 08-02-1996 Age: 30yrs

Gender: female Ward : OT 2 UHID No.: HNH-000 13901
IP26-000 06881

Date of Surgery: 18/7/26 ☐ OT -1 ☑ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Laproscopic Right Salpingechomy.

Time in : 8:30PM Time Out : 9:40PM

		NAME	AMOUNT
1.	Surgeon	Dr. Swathi HV	
2.	Anaesthetist	Dr. Ayesha	
3.	Assistant Surgeon	Dr. Dua.	
4.	OT Technician	Br. Sai chandu & Arvind	
5.	Circulating Nurse	Sr Karuna	
6.	Assistant Nurse	Sr. Sangeetha Sr Archana.	

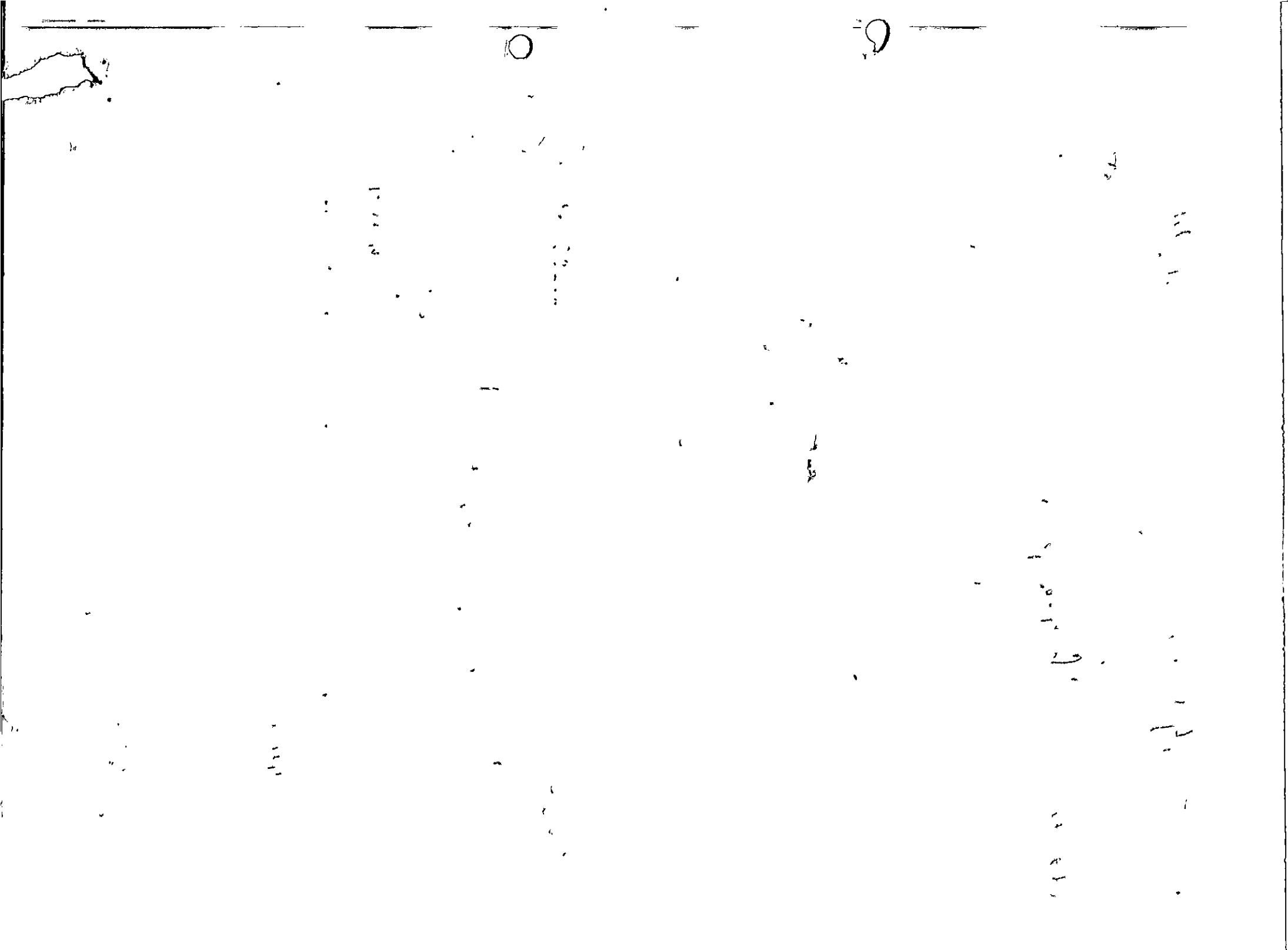
Mrs MANSI RAMCHANDANI (30 Y 5 M 12 D/ F)
TUBES
NINV04329
HN26012067TUBES

Special Equipment: ☑ Laparascopy ☐ Broncoscope ☑ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others Vessel Sealing (26-0000215070/69)

Signature of the Surgeon

Karuna
Signature of Circulating Nurse

Order No: 26-0000215068 Order by: Archana 18/7/26 @ 22:30pm



HNH-00013901 IP26-00006881
Mrs MANSI RAMCHANDANI
08-02-1996 30 Y 5 M 12 D (F)
Dr. SWATHI H V

Right Laproscopic VIL Salpangectomy

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CONSUMABLES OF OT

Circulating staff : Karuna Technician : Arvind Date : 18/7/26 Time : 8:50Am

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube 6.5		01	Major Pack General kit		01	Inj Vit.K	-	
LMA			Sutures 2346		1	Cord Clamp		
ECG leads : A / P / N		03				Suction Catheter		
HME filter : A / P / N						Feeding Tube		
Syringes : 10 cc		05				Vaccum Suction Set		
05 cc		05	Gloves SG 6.5		04	Surgical Gloves		
02 cc		04	Encore 6.5		02+2	Gauze Pack		
01 cc			SG 7.0		1	Syringe 1ml / 2ml		
Cautery plate : A / P / N		01	Surgical blade 11		1	Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL		03	Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml		02	Koochies XXL		01			
MIDa 20 lam		01	Ointments			10CC		2
O2 mask (A)		01	Suction Catheter			NS 500ml.		1
Fentanyl		01	Cap, Mask		40+10	Distell water		2
Morphine		01	Gauze Pack 10x10		01	TRP leggings big		1
~~Ketamine~~ Pmo Cline 20cm		01	Mop Pack		1			
Propofol		02	Steristrip			Tegaderm 8582		02+2
Rocuronium		01	Underpad		2			
Glycopyrolate			Draw sheet					
Myopyrolate		01	Abgel					
Ondansetron			Foleys catheter no-16		1			
Pencan 25g/ Spinal Needle 22			Urobag		1			
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
			Tegaderm					
Suppositories			~~Ieban~~ Irrigation set	1				
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg		01	Vaccum Suction set		1			
Justin : 12.5 mg / 25mg / 100mg		01	Plastic Bed Sheet Apron		03			
Tab. Misoprost : 200mg			Betadine Solution		01			
Lox Patch		01	Microshield		1			
Kaso Advocate 26		01	Cotton Balls		1			
			Latex Gloves		10			
			Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 26-0000215072/071 Ordered by : Archana 18/7/26 @ 23:03Pm.

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

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040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	: HNH-00013901	**Name**	: Mrs MANSI RAMCHANDANI
Age / Sex	: 30 Y 5 M 12 D / Female	**Doctor**	: SWATHI H V
Adm/Reg Date/Time	: 18/07/2026 18:27	**Payor**	: MEDI ASSIST INSURANCE TPA PVT LTD
Order Date	: 18/07/2026 23:02	**Ordernumber**	: 26-0000215071
Visit ID	: IP26-00006881	**Ward/Bed No**	: 4F -OT / PDA-412
Patient Address	: flat no 405 floor msk towers street number 11, Himayathnagar, Hyderabad, Telangana, INDIA, 500029		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	SUPRIDOL SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
2	SGLOVE # 7.0(SURGICARE)	SURGICAL GLOVES 7.0	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
3	LEGGINGS DISPOSABLE (PROTECTCARE) BIG		1 Nos	/ 10 AM	1 Days		1 Nos	Dispensed
4	HIGH PRESSUR EXTENTION 200 CM PRYMAX		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
5	GAUZE PACK STERILE 10X10X12 PLY 5S	GAUZE PACK STERILE 10X10X12 PLY 5 PACK	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
6	ROCUNIUM INJ 50 MG 5 ML		1 Vial	Injection / Once Daily	1 Days		1 Vial	Dispensed
7	UROBAG (ADULT) - URODYNE		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
8	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
9	RL 500 ML CLOSED SYSTEM	RINGER LACTATE 500ML CLOSED	1 Bottle	/ Once Daily	3 Days		3 Bottle	Dispensed
10	VICRYL 1-0 VP 2346	VICRYL 1-0 VP 2346	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
11	NS 500ML CLOSED BOTTLE		1 Bottle	External / Once Daily	1 Days		1 Bottle	Dispensed
12	NS 1000 ML CLOSED EUROFLEX		1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
13	DSYRINGE 5ML (NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		5 Nos	Dispensed
14	FOLEYS CATHETER 18-UROCATH		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
15	GENERAL SURGERY KIT SAFE SECURE		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
16	ET TUBE - 6.5 MM CUFFED (WELCO LIFE)		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
17	D WATER 10 ML AMPULE	DISTIL WATER10ML	1 Bottle	External / Once Daily	1 Days		2 Bottle	Dispensed
18	E.C.G ELECTRODES (ADULT)	ELECTRODES ADULT	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
19	MEZOLAM INJ 5 MG 5 ML		1 Vial	External / Once Daily	1 Days		1 Vial	Dispensed
20	OxygenMask With Tubing - Adult ROMSONS-FC		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
21	SURGICAL BLADE 11	SURGICAL BLADE 11	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
22	COTTON BALLS 2 GM 5 NOS		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
23	DISPOSABLE APRONS STERILE XL	DISPOSABLE APPRON STERILE XL	1 Nos	/ Once Daily	3 Days		3 Nos	Dispensed
24	IRRIGATTO(T.U.R SET)	IRRIGATTO(T.U.R SET)	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
25	Encore Microptic gloves-6.5		1 Nos	/ Once Daily	1 Days		4 Nos	Dispensed
26	MCT-ROF 100MG 10ML		1 Nos	Injection / Once Daily	1 Days		2 Nos	Dispensed
27	PREGELLED SURGICAL PLATES(ADULT)	PREGELLED PLATED ADULT	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
28	TEGADERM WITH PAD 5X7CMS (3582)(6582)	TEGADERM 8582	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
29	LOX-LIDOCAIN-5PER PATCH 2S		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
30	POVINANZ SOLUTION 10% 100 ML		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
31	NASOPHARYNGEAL TUBES 26	NASOPHARYNGEAL TUBE26	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
32	DSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
33	MOPS 30X30 8PLY 5S X-RAY	MOPS 30X308 PLYDATT	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
34	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		7 Nos	Dispensed
35	JUSTIN SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
36	VACCUME SUCTION SET		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed

SWATHI H V
OBSTETRICS AND GYNECOLOGY
Reg No : TSMC/FMR/15501

* This document is just for reference purpose only. Not to be considered as primary report.

Note

*** This prescription is valid only for specified duration.**

*** Do not refill medicines.**

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer,
Old MLA quarters road AP State Housing Board Himayatnagar ,
Hyderabad ,Telangana, INDIA ,500029.
040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	: HNH-00013901	**Name**	: Mrs MANSI RAMCHANDANI
Age / Sex	: 30 Y 5 M 12 D / Female	**Doctor**	: SWATHI H V
Adm/Reg Date/Time	: 18/07/2026 18:27	**Payor**	: MEDI ASSIST INSURANCE TPA PVT LTD
Order Date	: 18/07/2026 23:02	**Ordernumber**	: 26-0000215072
Visit ID	: IP26-00006881	**Ward/Bed No**	: 4F -OT / PDA-412
Patient Address	: flat no 405 floor msk towers street number 11, Himayathnagar, Hyderabad, Telangana, INDIA, 500029		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	NITRILE EXAMINATION GLOVES P F- MEDIUM		1 Nos	External / Once Daily	1 Days		10 Nos	Dispensed
2	MYOPYROLATE-INJ-5ML		1 Nos	/ Once Daily	1 Days		1 Ampule	Dispensed
3	BACTOPREP SOLUTIONS 100 ML		1 mL	/ Once Daily	1 Days		1 Nos	Dispensed
4	UNDER PAD 60X90 10's Pack - MEDICUBE		1 Nos	External / 10 AM	1 Days		2 Nos	Dispensed
5	ADULT DIAPERS-XXL		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
6	SURGEON CAP FEMALE SAFE SECURE		1 Nos	External / 10 AM	1 Days		10 Nos	Dispensed
7	FACE MASK 3 LAYER - ELASTIC	FACE MASK 3 LAYER	1 Nos	External / Once Daily	1 Days		10 Nos	Dispensed

SWATHI H V
OBSTETRICS AND GYNECOLOGY
Reg No : TSMC/FMR/15501

* This document is just for reference purpose only. Not to be considered as primary report.

Note

*** This prescription is valid only for specified duration.**

*** Do not refill medicines.**

Printed Date/Time : 18/07/2026 23:27 Printed By : SUNKARI SANGEETHA

DR. Swathi

Rainbow® Children's Hospital — It takes a lot to treat the little. | BirthRight™ BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

ESTIMATION SLIP

Date : 18/7/26 **UHID / IP No. :** HNH-00013901 **Sl No.** 1727

Name of Patient : Mrs. Mansi Ranchordani **Age:** 30yrs **Gender:** F

Father's / Husband's Name : Mr. Harish **Corporate / Occupation :**

Address : Vinayak Nagar **Phone :** 9550288046 **Email :** 9890623853

Procedure / Plan : Lap. Salpingectomy **EDD/Dos:** July - 18th

MODE OF PAYMENT : ☐ SELF ☐ TPA : New India ☐ GIPSA : ☐ OTHER

TARIFF INFORMATION : 7 M.A

Particulars	Package Amounts (Rs.)	
Room Category	Normal Delivery	LSCS
Multi Shared Ward	Lap. Salpingectomy	
Shared Ward		
Twin Shared Ward →	1.50k + Pharmacy & Investigation Ente	
Private Room →	1.70k + Pharmacy & Investigation Ente	
Super Deluxe Room		
Suite Room		
Package includes (Package starts from the time of admission)	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee and Labour Ward Charges	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee Anesthetist's Fees and OT Charges
	Length of Stay for :	Length of Stay for :
	Pharmacy up to	Pharmacy up to
	Investigations up to	Investigations up to
Others		

Neonatologist Charges : ☐ Covered ☐ Not Covered **Epidural / Entonox :** ☐ Covered ☐ Not Covered

Initial Minimum Deposit : 10,000/- Advance done at Admission

REMARKS :

1. Room eligibility is purely subject to TPA approval and the Package / Room Tariff starts from the time of admission. The estimated amount may Change according to duration of stay, medical condition, investigations, pharmacy and any other procedure.
2. Proportionate difference of bill amount is applicable in case the patient opts for a category higher than the TPA approved, which has to be paid by the patient and may not be reimbursed by the TPA at later stage.
3. **Total baby charges are extra which include admission, pharmacy, vaccinations, investigations, disposables, consumables, equipments, speciality consultations, etc.**
4. In Case the patient gets discharged earlier than the packages permitted days, no refund of any type is applicable and if the length of stay is beyond the package permitted, additional payment is applicable for which kindly contact the Financial Counselling desk between 9am to 6pm
5. **For Non-medicals, Disposables, Consumables, Taxes, Kiwi Cup charges, Implants, Tubectomy charges, HIV/HbsAg, Anti-D, Medical Records, Double Occupancy and Registration Charges, etc. credit cannot be exchanged. These items are not payable to us as per Insurance company norms.**
6. Difference if any between the final bill amount and amount permitted/approved by TPA or total bill amount in case of denial from TPA has to be paid by the patient. In case of denial, cash tariff would be applicable.
7. Two attendants are permitted with patients in SDLX, DLX and PVT rooms and only one attendant is permitted in the rest of the categories of rooms and no attendant is permitted in ICU's
8. Tariffs are subject to revision
9. Kindly check your billing status on day to day basis at IP Billing Department.
10. Additional Charges on package are applicable for Non-working hours and Non-working days (sundays and public holidays)

DECLARATION

I Harish have attended the Financial counseling desk and understood the expected costs and other conditions applicable. In case the TPA / Insurance Company rejects the claim for whatsoever reasons at any point of time I promise to settle the hospital bill with the hospital without any ambiguity.

Signature of the Client | Husband — Signatory Relationship | Signature of the financial Counselor