Name	Mrs R POOJA	**UHID**	HNH-00001066
Father/Guardian	Mr G SAIDEEP	**Age/Gender**	30 Y 8 M 25 D/ Female
Address	Malakpet, Hyderabad, Telangana, INDIA, 500036		
IP No	IP26-00006938	**Admission Date**	24-07-2026
Ref Doctor	Self.		
Discharge Date	25.07.2026		

DISCHARGE SUMMARY

Consultant:
Dr. PADMAJA YELISETTY
MBBS, MD, MRCOG, FRCOG
52427

Diagnosis: PRIMI AT 14^{+2} WEEKS WITH SHORT CERVIX FOR PROPHYLACTIC CERVICAL CERCLAGE

CERVICAL CERCLAGE (MC DONALD'S TECHNIQUE) DONE ON 24.07.2026

History: She was booked to Rainbow Hospitals with Primigravida at 14^{+2} weeks POG with short cervix for prophylactic cerclage. IVF conception USG scan done on 24.07.2026 with SLIUF at 14^{+2} weeks with cephalic placenta-post low reaching os AFI: DVP-3.9cms cervix length-23mm, funnelling absent. She was admitted for prophylactic cerclage in view of short cervix

Name	Mrs R POOJA	UHID	HNH-00001066
IP No	IP26-00006938	Admission Date	24-07-2026

Menstrual History:- LMP- 16.04.2026
Previous cycles: Regular

Obstetric History: Primigravida

Medical History: Nil
Surgical History: Nil
Allergies: Nil
Family History: Mother-DM, Father-HTN

Investigations: Enclosed.
Blood group: "O" Positive

Surgery Notes:
Operation performed:
CERVICAL CERCLAGE (MC DONALD'S TECHNIQUE) UNDER SPINAL ANAESTHESIA

Indication: Short cervix

Operative findings:
Intra OP findings:
- copious amount of curdy white discharge present.
- HVS taken and sent for culture and sensitivity.
- Anterior and posterior vaginal wall retracted.
- Vagina cleaned with betadine.
- Short cervix length noted.
- Mc Donald's stitch applied knot tied anteriorly with trusilk no-1.
- Hemostasis achieved.
- Pre and post procedure. FHR confirmed with USG.

Name	Mrs R POOJA	**UHID**	HNH-00001066
IP No	IP26-00006938	**Admission Date**	24-07-2026

- Patient withstood procedure well.

Post-Operative Notes: She was closely monitored in the postoperative period. Her vital signs remained stable. She was encouraged to ambulate and void spontaneously. 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 200mg (Cefixime 200mg) twice daily till 28.07.2026 (9am - 9pm) after food.
2. Tab. Calpol 500mg (Paracetamol 500mg) twice daily till 25.07.2026 (10am-10pm) after food.
3. Tab. Pantodac 40 mg (Pantoprazole 40mg) once daily (7am) before food till 28.07.2026
4. Candid V6 vaginal pessary at bedtime for 6 days.
5. Cap SUSTEN-SR 300 MG oral once daily for 10 days.
6. Tab FOLVITE 5MG once daily till 16 weeks.
7. Tab Duphastone 10 mg once daily for 10 days.
8. Continue Inj Proluton Depot 250mg weekly (Friday) till further order.
9. Continue Tab Ecosprin 75 mg once daily till further order.
10. Cervical length scan on 30.07.2026.

Review consultation with Dr. Padmaja Yelisetty after 1 weeks on 30.07.2026 with cervical length scan at Rainbow children's Hospital in Gynec OPD (**Review consultation will be charged**).

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

Name	Mrs R POOJA	**UHID**	HNH-00001066
IP No	IP26-00006938	**Admission Date**	24-07-2026

language that I can understand and I acknowledge.

Patient/ Attender

In case of emergency like bleeding, fever 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. Padmaja Yelisetty,
MBBS, MD, MRCOG,FRCOG
52427

HNH-00001066 IP26-00006938
Mrs R POOJA
29-10-1995 30 Y 8 M 25 D (F)
Dr. PADMAJA YELISETTY

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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	3			
7	Nursing plan of care and handover sheets	1			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery				
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)	1			
22	Neonatal Admission/Delivery/Physical Exam	1			
23	Medication Reconciliation				
24	Emergency Triage record				
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart	2			
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				
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale				
38	Braden Q Scale				
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 others	1 6			
	Total No. of Pages	25			

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

Signature and Date : 29/5/2021

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

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 : IP26-00006938 **Admit Date** : 24-Jul-2026 **Admit Time** : 01:27 PM **UHID** : HNH-00001066

Patient Details :

Patient Name	: Mrs R POOJA	**Age**	: 30 Y 8 M 25 D
Guardian	: Mr G SAIDEEP	**DOB**	: 29-10-1995
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: Malakpet Hyderabad Telangana INDIA 500036	**Phone No**	: 9032120103/ 9000911160
		E-mail	: NA@GMAIL.COM

Admission Details :

Bed Type : TWIN SHARING **Bed No** : PDA-413 **Ward Name** : 4F -OT

Room No : PDA-413 **Admission Type** : First Visit

Contact Details :

Name : Mr G SAIDEEP **Relationship** : Husband

Contact Address : Malakpet Hyderabad Telangana INDIA 500036 **Phone No** : 9000911160

Signature

Doctor Details :

Doctor Name : Dr. PADMAJA YELISETTY **Specialisation** : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self. **Phone No** :

Co-Consultant :

Payment Details :

Deposit Amount : 30000.00

Payment Mode : DC/CC Card **Payor Name** : SELFPAY

PATIENT TRANSFER FORM

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Patient Name & UHID No	Date & Time of Admission	Date & Time of Transfer Order
HNH-00001066 IP26-00006938 Mrs R POOJA 29-10-1995 30 Y 8 M 25 D (F) Dr. PADMAJA YELISETTY	24/7/26 @	24/7/26 @ 2:10 PM
	Transfer Ordered by DR. naveena	Reason for Transfer cerculage
From Unit pre - post	To Unit OT	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 25	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 - 500 ml	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. naveena

Patient & Clinical Records Received by : Susheela

Date & Time of Patient Received : 24/7/26 @ 2:10pm.

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

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ACTIVITY RECORD FOR BILLING

Name: ---------- HNH-00001066 Mrs R POOJA 29-10-1995 Dr. PADMAJA YELISETTY 30 Y 8 M 25 D (F) IP26-00006938 ----------

UHID No : ---------- IP No : ---------- Dept : ----------

Date of Admission : ---------- of Discharge : ---------- Time: ----------

Room / Bed No : ---------- Ward : ---------- Requested Billable bed type : ----------

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
24/7	2:10pm	Pre-post	OT	Sujatha / Sushela
24/7/26	5:35pm	OT	prepost	Puja. / Akula.
24/7/26	10:00pm	Pre post	Room	Nurse / [illegible]

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
24/7	CBP	12485	
	anti HIV, Anti HCV,	12485	Sujatha
	HBSAG VDRL		
	vaginal Swab for c/s	12494	
		(x)VS check done by Akila	
	Cross checked	by Sunanda	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
24/7	cardiac monitor	3:35Pm	6:30pm	16582	Akula
24/7	Infusion pump	3:35Pm	6:30pm		
					cross checkdonesy Akula.
		Cross checked by Sunanda			

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
24/7	IV placement	(1)	✓ 16583	Sri
24/7/26	~~catheterisation~~ PAC	(1)	✓ 16584	Q
	Cross checked by Sunanda			

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00001066 IP26-00006938
Mrs R POOJA
29-10-1995 30 Y 8 M 25 D (F)
Dr. PADMAJA YELISETTY

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I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 24/7/2026 Time of Admission : .....

Allergies: No. ☐ Not know any drug allergies

PRESENTING COMPLAINTS :

Primigravida with 14^{+2} wks POG with short cervix for Prophylactic Circlage.

- ivf Conception

USG (24/7/26): SCIUF, 14^{+2} wks, cephalic, Placenta - Post. low reaching Os.
AFI - DVP - 3.9cms
Cx length - 23mm, funnelling absent.

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : 2022.	Parity : Primigravida.
Previous Periods : Regular.	Mode of Delivery : —
LMP : 16/4/2026	Last Child Birth : —
Contraception : —	

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
Nil.	Nil.

HNH-00001066 IP26-00006938
Mrs R POOJA
29-10-1995 30 Y 8 M 25 D (F)
Dr. PADMAJA YELISETTY

Mother – DM
father – HTN.

MEDICATION HISTORY:

T. Folvite
Cap. Susten 300mg
T. Ecospirin 75mg.
T. Doxinato

INITIAL ASSESSMENT :

Date 24/7/2026
Ht. _____ Wt. 75
BMI _____
B.P _____
Pallor _____
CVR S1S2(+), no murmur
Respiratory System B/L NVBS(+)
Thyroid normal

Breasts: Normal

Abdominal Examination: 12-14 wks ut Relaxed FHR(+)

Local/Speculum Examination: not done

Bimanual Pelvic Examination: not done.

PROVISIONAL DIAGNOSIS : Primi | 14+2 wk | Short cervix.

INVESTIGATIONS ORDERED

BGT – 'O' Positive

CBP (24/7/2026)

Hb – 11.1
plt – 4.54
TLC – 8.55
PCV – 29.1

HIV, HbsAg, HCV, VDRL } NR

TSH –

PLAN OF MANAGEMENT

Admission
NBM, Parts preparation
PAC.
drugs as chalted.
shift to OT for Circlage on call

Name of the Doctor : D. Padmaja. Y.
Signature of Doctor _____
Date & Time : 24/7/2026

Dr. Padmaja Yellisetty
Consultant Obstetrics and Gynecology
Reg. No: 52427

HNH-00001066 IP26-00006938
Mrs R POOJA
29-10-1995 30 Y 8 M 25 D (F)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/7/2026	Cl/o Dr Manisha	
3pm	POD-0	
		Adv
	Ce - Fair Afebrile.	
	BP 116/70	- NBM x 2-4 h
	PR 75	- Drugs as charted
	PA Ut ~ 12-14 wks	- W/F vitals
	FHS (+)ve	- Encourage to Pass urine
	UE NAD	- Post Epid Elevations
		- Modified Bed rest
24/7/2026	Cl/o Dr Manisha	
6pm	POD-0	
		Adv
	GC Fair Afebrile	- NBM ↔ Allow sips > 6'30 pm
	Vitals Stable	- Drugs as charted
	PA Ut ~ 12-14 wks	- Encourage to Pass urine
	FHS (+)ve	- Foot Sup Elevation
		- Can be discharged

HNH-00001066 IP26-00006938
Mrs R POOJA
29-10-1995 30 Y 8 M 25 D (F)
Dr. PADMAJA YELISETTY

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/7/2026	C/s/b Dr Manisha	
10:30pm	POD-0	
		Adv
	GC Fair Afebrile	Soft Diet / Adeq hydration
	Vitals stable	Drugs as charted
	P/A FHS ⊕R	Foot End Elevation
	(Confirmed by Scan)	W/f vitals & FHS
	Soft	Inform Sos
		Shift to Room
		[signature]
		[signature]
25/7/2026	C/s/b Dr Manisha	
7Am	POD 0	
		Adv
	GC-Fair Afebrile	✓ Soft Diet / Adeq Hydration
	Vitals stable	✓ Foot End elevation
	P/A wt ~12-14wk	✓ W/F vitals & BPV (if any)
	relaxed	✓ W/F FHS
W✓	FHS ⊕ (Confirmed on Scan)	✓ modified Bed Rest
	L/E- NAD	✓ Drugs as charted
		✓ Inform SOS
	No complaints	[signature]
		[signature]
		NB Sunanda

HNH-00001066 IP26-00006938
Mrs R POOJA
29-10-1995 30 Y 8 M 25 D (F)
Dr. PADMAJA YELISETTY

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/7/2026 10:45am	c/s/by	Dr. Naveena
	POD1	
	O/E GC - fair	Adv:
	Afebrile	- Soft diet
	Vitals - stable	- Adequate hydration
	PA: ut. 12-14wks	- drugs as charted
	Relaxed	- M/C & P/scs
	FHR(+)	Noted by sandhya
	L/E - NAD	
	patient	can be discharged
		Dr Naveena.

HNH-00001086 IP26-00006938
Mrs R POOJA
29-10-1995 30 Y 8 M 25 D (F)
Dr. PADMAJA YELISETTY

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00001066 IP26-00006938
Mrs R POOJA
29-10-1995 30 Y 8 M 25 D (F)
Dr. PADMAJA YELISETTY

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MEDICATION RECONCILIATION FORM

Drug Allergies: Nil ☑ Not known any Drug Allergies

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

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

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T. FOLVITE	5MG	PO	OD		☐ C ☐ DC
2	TAP. SUSTEN-SR	200mg	PO	OD		☐ C ☐ DC
3	T. ECOSPRIN	75mg.	PO	OD		☐ C ☐ DC
4	T. Doxinate	1TAB	PO	OD		☐ 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 Naveena @.

Date & Time : 24/7/2026 @ 2:00pm.

Nurse Name & Signature: Madhumita @ Madhu

Date & Time : 24/7/26 @ 2Pm

Docu. No. : RCH / FRM / GENERAL / 090

HNH-00001066 IP26-00006938
Mrs R POOJA
29-10-1995 30 Y 8 M 25 D (F)
Dr. PADMAJA YELISETTY

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DRUG CHART

Date of Admission: .... 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 .... nature ....

HNH-00001066 IP26-00006938
Mrs R POOJA
29-10-1995 30 Y 8 M 25 D (F)
Dr. PADMAJA YELISETTY

REGULAR PRESCRIPTIONS Weight. .... Ward. ....

DRUG : T. PARACETAMOL				Date / Time	Stop M/D
Dose	Route	Frequency	Start Date		
1GM	P/O	QID	24/7		
Name & Signature of the Doctor Starting the Drugs: Dr. Dr. Dnep Sharmi					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

DRUG : T-TAXIMO				Date / Time	24/7	25/7
Dose	Route	Frequency	Start Date	9am		(sign)
200mg	PO	BD	24/7			
Name & Signature of the Doctor Starting the Drugs: Dr. Naveena.						
Additional Instructions:				9pm	(sign)	
Daily Doctor's Endorsement by a Sign						

DRUG : T.PANTOPRAZOLE				Date / Time	Stop M/D
Dose	Route	Frequency	Start Date		
40MG	PO	BD	24/7		
Name & Signature of the Doctor Starting the Drugs: Dr. Naveena.					
Additional Instructions: ~~CEFIXIME~~					
Daily Doctor's Endorsement by a Sign					

DRUG : CANDID V6 PESSARY				Date / Time	24/7
Dose	Route	Frequency	Start Date	3:30pm (sign)	
1 PESSARY	PV	OD	24/7		
Name & Signature of the Doctor Starting the Drugs: Dr. Naveena.					
Additional Instructions: (@ Bedtime)					
Daily Doctor's Endorsement by a Sign					

HNH-00001066 IP26-00006938
Mrs R POOJA
29-10-1995 30 Y 8 M 25 D (F)
Dr. PADMAJA YELISETTY

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Sheet No: .....

REGULAR PRESCRIPTIONS

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

DRUG : TPARACETAMOL

Dose	Route	Frequency	Start Dt.
1g	P/O	BD	24/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	24/7	25/7/17
Time	10am	10pm

DRUG : T. PANTOPRAZOLE

Dose	Route	Frequency	Start Dt.
40mg	P/O	OD	24/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	24/7	25/7
Time	10am	

DRUG : CAP SUSTEN SR

Dose	Route	Frequency	Start Dt.
300mg	P/O	OD	24/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	24/7
Time	10pm

DRUG : T. POLVITE

Dose	Route	Frequency	Start Dt.
5mg	P/O	OD	25/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	25/7
Time	10pm

(P.T.O.)

HNH-00001066 IP26-00006938
Mrs R POOJA
29-10-1995 30 Y 8 M 25 D (F)
Dr. PADMAJA YELISETTY

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Sheet No: .....

REGULAR PRESCRIPTIONS

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

DRUG : T. DUPHASTONE

Dose	Route	Frequency	Start Dt.
10mg	PO	OD	25/7

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time 25/7

10am

DRUG : T. ECOSPRIN

Dose	Route	Frequency	Start Dt.
75mg	PO	OD	25/7

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time 25/7

10pm

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

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

HNH-00001066 IP26-00006938
Mrs R POOJA
29-10-1995 30 Y 8 M 25 D (F)
Dr. PADMAJA YELISETTY

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
24/7	1:30pm	INJ. CEFOTAXIME	1GM	IV		Maddy
24/7	1:35pm	INJ. METOCLOPRAMIDE	10MG	IV		Maddy
24/7	1:35pm	INJ. PANTOPRAZOLE	40MG	IV		Maddy
24/7	3:30pm	TRAMADOL suppository	100MG	PR		
24/7	3:20pm	CAP. SUSTEN	400mg	PV		
24/7	3:30pm	CANDID V6 VAGINAL PESSARY	1 PESSARY	PV		
25/7/24	5pm	PARACETAMOL	1g	IV		AKW/S

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

HNH-00001066 IP26-00006938
Mrs R POOJA
29-10-1995 30 Y 8 M 25 D (F)
Dr. PADMAJA YELISETTY

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
24/7	1pm	RINGER LACTATE	IV	500			24/7		
24/7	9:30pm	RINGER LACTATE	IV	500			24/7		

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

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RESULT SHEET

Date						
Time						
Hb						
PCV						
RBC						
WBC						
N/L						
Platelets						
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 group: O+ve						
HIV, HbsAg, HCV } NR.						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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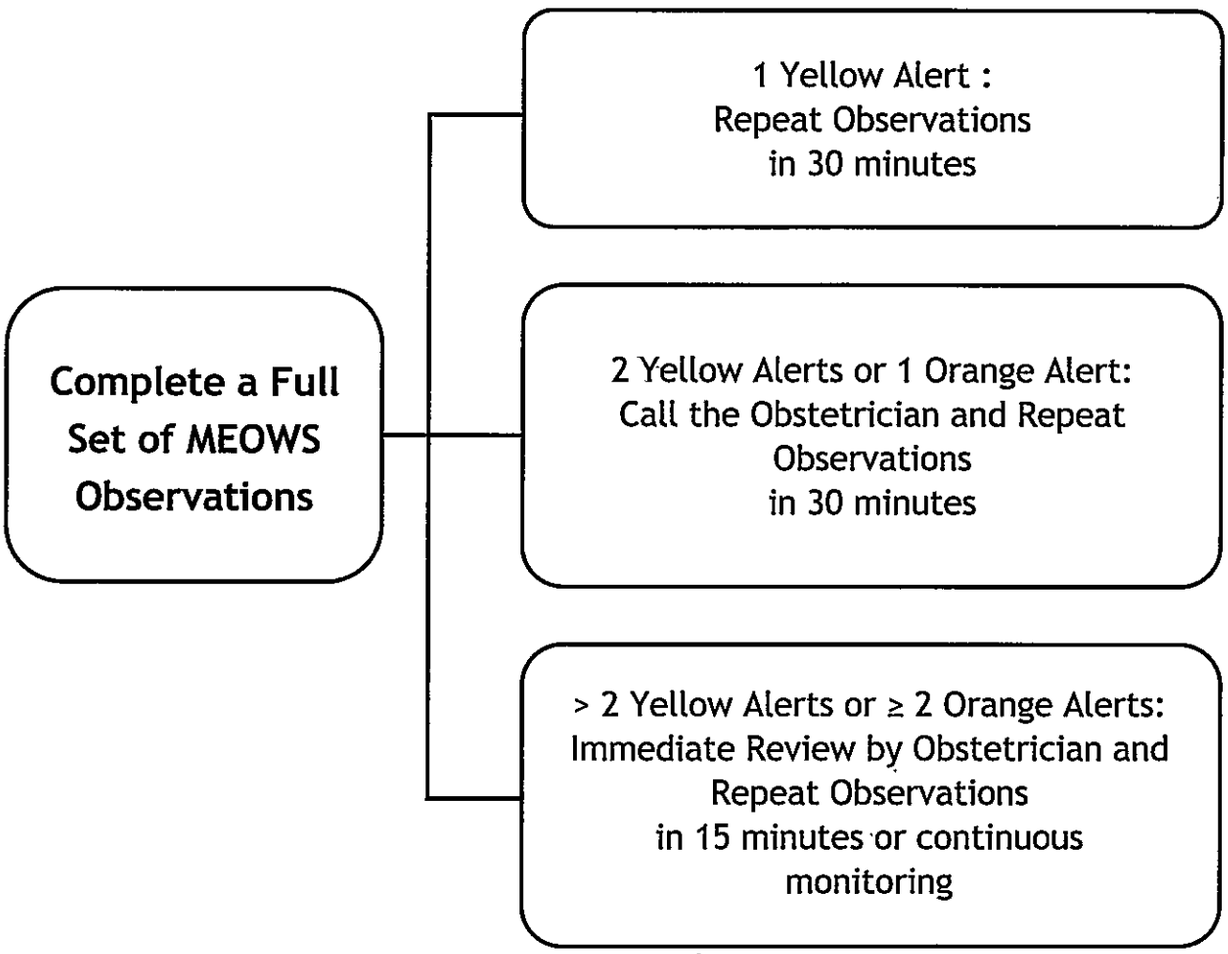
Early Warning Observation Score Chart - Obstetrics

24/8/26

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

		Date																						
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20									20	20						20				20				20	
	0 - 10																									
Saturations	94 - 100 %									99							99				99				99	
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37									-	-						-									
	36																				36°				36°	
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80									75	77						72								75	
	70																				70					
	60																									
	50																									
	40																									
↑ Systolic Blood Pressue	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130									116	115						142									
	120																				110					
	110																									
	100																								106	
	90																									
	80																									
	70																									
	60																									
	50																									
↓ Diastolic Blood Pressure	130																									
	120																									
	110																									
	100																									
	90																									
	80									50							75								60	
	70										75										72					
	60																									
	50																									
	40																									
NEURO RESPONSE [✓]	Alert									-	-						✓				-				-	
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30																✓				-				-	
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal																✓				-				-	
	Heavy / Foul																									
Liquor	Clear / Pink																✓				-				-	
	Green																									
TOTAL YELLOW SCORES										0	0						0				0				0	
TOTAL ORANGE SCORES										0	0						0				0				0	
Nurse Initial										A	N						SH				SH				SH	

Obstetrics and Gynaecology Early Warning Signs



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

HNH-00001086
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FLUID CHART

Sheet No. : (1)

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm	RL	ORS	100ml								
Total Intake :						**Total Output :**						
2/12	02:00 pm	RL	ORS	100ml								
	03:00 pm	RL		100ml				—				
	04:00 pm	RL	ORS	100ml								
	05:00 pm	RL		100ml			NA				0	@
	06:00 pm	RL		100ml								
	07:00 pm	RL		100ml.								
Total Intake :						**Total Output :**						
2/12	08:00 pm											
	09:00 pm							—				
	10:00 pm	0	Idly									
	11:00 pm		ORS				NA			✓	0	@
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**				U-1	M-0	
25/12	02:00 am											
	03:00 am											
	04:00 am	0	ORS							✓	0	@
	05:00 am				NA			NA				
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**				U-1	M-0	

Total 24 hrs. Intake		Total 24 hrs. Output	

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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	

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NURSING CARE RECORD

Date: 24/7/26

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							
Afternoon	2Pm – 8Pm	→ Assess the Pt condition → monitor the vitals → Administration of medication → maintained I/O chart	2Pm – 8Pm	→ Assessed the Pt condition → monitor the vitals & recorded → Administered medication → maintained I/O chart	Pt is stable	Maintain I/O chart & record	Akhila
Night	8PM to 8am	– Assess the pt condition – 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	[signature]

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NURSING CARE RECORD

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Date: .....

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							
Afternoon							
Night							

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PAIN ASSESSMENT FORM

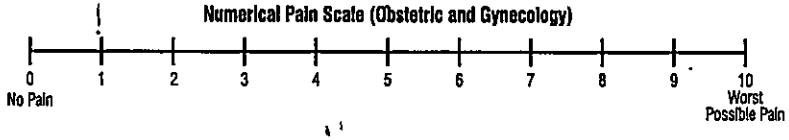
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
24/7/26	2PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
24/7/26	6PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
24/7/26	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
25/7/26	2am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
25/7/26	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

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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BRADEN 'Q' SCALE

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					Date : 24/2	25/2		
					Time : E	N		
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		
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		
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		
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		
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				

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

Docu. No. : RCH /FRM / CLINICAL / 119

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

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	24/7/26	24/7/26	
		Score	6	M	
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	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	
		Signature	N	[illegible]	

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

HNH-00001066
Mrs R POOJA
29-10-1995
Dr. PADMAJA YELISETTY
IP26-00006938
30 Y 8 M 25 D
(F)

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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		0	0							
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1		–	–							
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2		–	–							
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3		–	–							
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4		–	–							
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5		–	–							
		Signature of the Nurse			A	A							

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 : Akila

Signature of Ward In Charge :

Signature : ..... Name : Kavitha

Patient Sticker

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CHECKLIST FOR THROMBOPHLEBITIS

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		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 : .....

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Padmaja Department: C.D.T Date of Admission: 24/7/26

SITUATION	Diagnosis:				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
BACKGROUND	Area / Shift Time	24/7 E2	25/7 N1				
	Medical Condition (Any special condition to be noted):	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:	98.1°F	98.3°F				
	Res:	20b/mt	20b/m				
	SpO_2:	99%.	99%.				
	Pulse:	84b/mt	82b/m				
	BP:	110/70	110/72				
	Fall Risk Score:	—	—				
	Pain Score:	0/10	0/10				
Recommendations	Safety Needs:	Yes	Yes				
	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:	NA	NA				
Post Operative Procedure Special Orders:		NA	NA				
Handed Over By Name :		Akhila	Sunanda				
Signature :							
Date:		24/7/26	25/7/26				
Time:		8pm	8am				
Taken Over By Name :		Sunanda					
Signature :							
Date:		24/7					
Time:		8pm					

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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OBSTETRICS / GYNECOLOGY
NURSING INITIAL ASSESSMENT FORM

Date of Admission: 24/2/26

Baseline Information:

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

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

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

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

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

If yes, identify .....

Chief Complaints: came for surgery,

Doctor Notified on Admission: ☑ Yes ☐ No

Name of the Doctor: Dr. Nazeena

Time Notified: 1 Pm

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 1 ..... L ..... A .....

Previous LSCS: ND

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

Family History: ☐ No Abnormalities Detected

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

☐ Liver disease ☐ Other .....

Vital Signs / Measurements: Temp: 97.1°F HR: 75bpm RR: 20bpm

BP: 111/70 Weight: ..... Height: ..... BMI: .....

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

HNH-00001066 IP26-00006938
Mrs R POOJA
29-10-1995 30 Y 8 M 25 D (F)
Dr. PADMAJA YELISETTY

PHYSICAL ASSESSMENT

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

Fall Assessment: ☐ Yes ☑ No Score ..0.. (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore: ☐ Yes ☑ No Score ..0.. (complete the Braden Q Sheet)

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

☐ Mobility problem ☐ Walking Problem ☑ No Abnormality Detected

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☑ No Abnormality Detected

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

☐ Under Weight ☐ Diabetes Mellitus ☐ Hyperemesis Gravidarum

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

☐ Others .....

Inform consultant for positive criteria

SOCIAL SCREENING:

1. **Marital Status:** ☐ Single ☑ Married ☐ Divorced ☐ Widow
2. **Special Habits:** **Smoker:** ☐ Yes ☑ No **Alcohol Abuse:** ☐ Yes ☑ No **Drug Abuse:** ☐ Yes ☑ No

Social History: Lives With ..family members..

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 ..pt..

Name of Person Orientation was given to: ..Mrs. Pooja..

Orientation not given Reason: .....

Nurse Signature: ..A..

Nurse Name: ..Akhils..

Date & Time: ..24/12/26 @ 4pm..

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OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 24/2/26 Time of Arrival: 1PM Time Seen by Nurse: 1PM

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: 97°F Pulse: 76bmt RR: 20bmt SpO_2: 99% BP: ..... Weight: .....

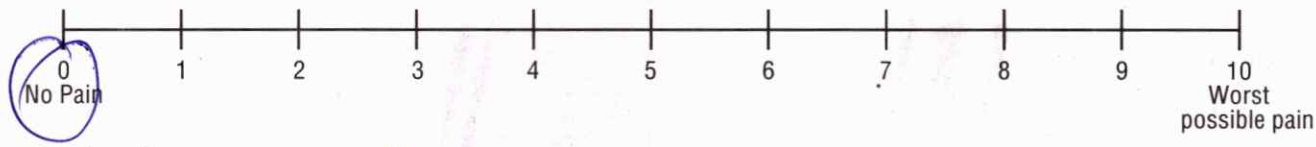
4) **Gestational Criteria:**

Gravida:	G	P 1	L	A

LMP: 16/4/26 EDD: 9/12/26 Gestational Age: 12w2weeks

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: ..... NIL
- Interventions: .....

.....

6) **Past History:**

a) Surgeries: ..... NIL

b) Medical: ..... NIL

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Mrs R POOJA
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Dr. PADMAJA YELISETTY

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: 1Pm

Nurse Name : Akhila Nurse Signature: .....

Date: 24/12/26 Time: 1PM

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : MRS. R. POOJA. Gender: ☐ Male ☒ Female Age : 30 YRS.

UHID No : HNH-0000D1066. Date : 24/7/2026

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)

PROPHYLACTIC CERVICAC CIRCLAGE

upon

MRS R Pooja. (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.

PV leak, PV bleeding, Miscarriage, Injury to adjacent organs - Ureter, Bladder.

My signature on this form indicates that

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

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

Consentee :

Signature :

Name : MRS. R. Pooja.

Date & Time : 24/7/2026 @ 1:55pm.

Witness :

Signature : Madhu

Name : Madhumita

Date & Time : 24/7/26 @ 1.55Pm

Patient Attendant :

Signature :

Name : R. Krishna Rao.

Relationship with Patient: Father.

Date & Time :

Doctor (who is taking the consent) :

Signature :

Name : Dr. Naveena.

Date & Time : 24/7/2026 @ 1:55pm.

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: Mrs. R. Pooja Age: 30yrs Sex: F UHID.No: HNHJ-00001066

Date: 24/7/26 Time: 1:30pm Proposed Operation: Cervical cerclage

Diagnosis: G1 IVF conception 14+2 weeks

B.P / CRT: .... H.R: .... Weight: 75kgs 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: O +ve	Stress/Anglo:
PT:	K:	LDH:	T3	Other:
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH	
	Cl -:	SGOT/SGPT:		

Allergies: NK DA

Medical History: CVS: ⊖ (CVS to Others)

Placenta - posterior low lying; Cervical length 25mm; Last ecospirin taken at Night

RESP: Diabetes: ⊖

CNS:

Renal:

Hepatic / GE: Physical Activity: METS > 4

Others:

Past Anaesthetic History: H/o IVF Conception Oocyte Retrieval

Physical Exam:

Airway: MP 1 (2) 3 4 Mouth Opening: 3F ⊕ Mentohyoid Distance: N Neck: N Teeth: No loose teeth, Tooth Filling ⊕

Lungs: BLAE ⊕, Clear

Heart: S1S2 ⊕

CNS: C/C/C, Oriented

Pregnant: ☑ Yes ☐ No ☐ NA Venous Access Site: ⊕ Spine Exam for regional: Spine palpable

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

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

CURRENT MEDICATIONS	DOSAGE
Ecospirin 75mg	

Pre-Operative Instructions: NBM : 12AM solids

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: CBP

Signature: [signature] Name: Dr. Durga Bhavani

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

HNH-00001066 IP26-00006938
Mrs R POOJA
29-10-1995 30 Y 8 M 25 D (F)
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ANAESTHESIA CHART

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Pre Induction Assessment

Change in Patient Condition: ☐ Yes ☑ No		Fasting Status Confirmed
Physical Status:	☑ Patient Identified	☑ Consent Present ☑ Chart Reviewed

H.R: 70	B.P / CRT: 103/72	SpO_2: 99%	R.R: 17/min	Last Feed: 7hr

Pre-OP Diagnosis: VSD 14 weeks Operation: Cardiac Date 24/7/25

Surgeon: DR. Padmaja Yelisetty Anaesthesiologist: DR. Durga Bhavani & Ayesha Technician: Pallavi

TIME 2:30pm

N_2O /AIR /O_2 LPM
HALO /SO /SEVO
Drugs:

Antibiotic

Suppository PR TAB PANADOL 100MG.

Blood Loss

FIO_2 / SaO_2 99/99%
$ETCO_2$
ECG NVR NVR
Temperature
Urine Output

NOTES

Fluids Blood

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

240 220 200 180 160 140 120 100 80 60 40 20 10 0

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

LAB Values

ABG
GRBS
Others

☑ Equipment Checked and Functional
☑ BP
☑ Cuff Site: RUL
☑ Art Site:
☑ EKG Lead Blue
☐ Temp Site
☐ FIO_2 Monitor
☐ Agent Monitor
☑ Pulse Oximeter
☐ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position: Lithotomy
☑ Pressure Points Checked

Eye Care:
☐ Oint
☐ Tape
☐ Padding
☑ Awake

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

Times:
Anaes Start: 2:30pm
OP Start: 2:40pm
OP End:
Leave OR: 3:30pm

Anaesthesia:
☐ GA
☐ Monitored Anaesthesia Care
☑ Regional

Line (Size & Location)
☐ CVP:
☐ ART:
☑ IV: LUL
☐ IV:
☐ IV:

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

☐ Mask ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
ETT# ..... at ..... cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug:

☐ Awake ☐ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# ..... Attempts: .....
Difficulty Why? .....

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

Regional:
Extremity Specify: .....
☑ Spinal ☐ Epidural ☐ Caudal
Others: Saddle Block
Position: Sitting
Site: L3-L4 midline
Needle Size: 25G whitacre Depth: .....
Parasthesia ☐ Yes ☐ No
Catheter at skin ..... cm
Drug Name & Conc: 0.5% (1) BUPIVACAINE
Bolus: 2.5ml
Infusion: .....
Block Level: T10
Comments: Saddle Block

Transportation to
☑ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☑ NA
Name of the Doctor: DR Durga Bhavani
Signature of the Doctor: [signature]

HNH-00001066
Mrs R POOJA
29-10-1995 30 Y 8 M 25 D (F)
Dr. PADMAJA YELISETTY
IP26-00006938

Patie

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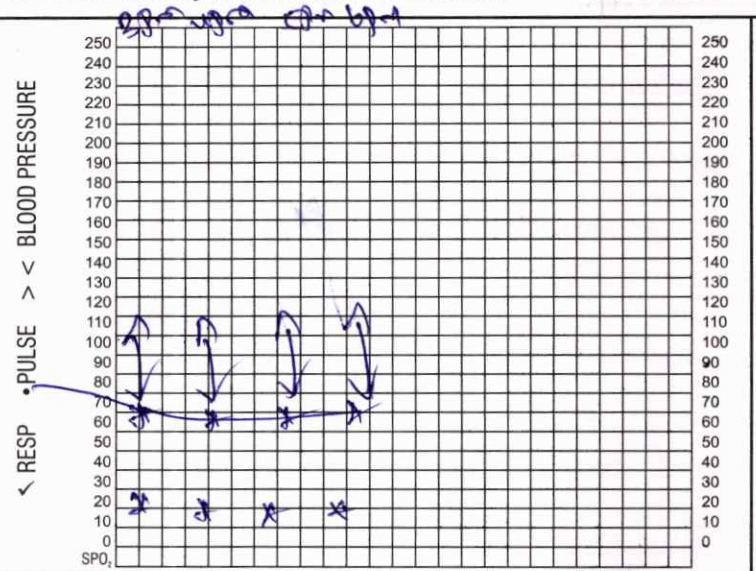
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Sis. Akhila Time Received : 8:30Pm Time Discharged : 6Pm



IV Cannula Site : left side

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

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

IV Fluids: RL
Oral Feeds: N.B.M

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		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		
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		
Fully awake Arousable on calling Not responding	= 2 = 1 = 0	CONSCIOUSNESS		2	2	2		
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0	COLOR		2	2	2		
		TOTAL		9	10	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
24/17	2Pm	0/10	NA	
24/17	4Pm	0/10	NA	
24/17	5Pm	0/10	NA	
24/17	6Pm	0/10	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. Ayesha
Anaesthesiologist Signature:
Date & Time:

PACU Nurse Name : Akhila
PACU Nurse Signature:
Date & Time: 24/7/17

Transferred to Unit by (PACU):
Date & Time: 24/7/17

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		FHR	Comments
				BP	Pulse		

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

Catheter Removed by and Tip Inspected : .....

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

HNH-00001066 IP26-00006938
Mrs R POOJA
29-10-1995 30 Y 8 M 25 D (F)
Dr. PADMAJA YELISETTY

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OPERATION NOTES

Surgeon : Dr. Padmaja Yelisetty	Asst. Surgeon : Dr. Priyadarshini

Pre-Operative Diagnosis: Primigravida with 14+2 weeks POG with short cervix for Prophylactic Encirclage.

Surgical Procedure :
- Jr. Saddle block. Prophylactic Encirclage.

Indications for Surgery : Short Cervix.

Date : 24/07/2026	Start Time :	End Time :

Post Operative Diagnosis: POD0 following Prophylactic Encirclage.
Primigravida with 14+2 weeks.

Peri-Operative Complications: —

Amount of Blood Loss: 50ml	Blood Transfused (in ML) —

Name and Number of Surgical Specimen sent for examination:
—

Operation Notes: Intra OP findings;
- ~~bot copious amount of white~~
- Copious amount of Curdy white discharge present
- HVS taken & sent for Cul. & Sensitivity.
- Anterior and Posterior Vaginal wall retracted

- Vagina cleaned with Betadine.
- McDonald's stitch applied, knot applied Anteriorly

Short- Cervical length of - noted
- Haemostasis achieved
- Pre and Post procedure FHR noted by Bed USG.
- Cap. Susten 400mg kept PV
- Candid V6 Vaginal pessary kept
- Patient withstood procedure well.

→ Operative findings were explained to Parents by Dr. Padmaja Yelisetty

Post OP Orders

- NBM for 2-4hrs.
- T. Taxim O 200mg PO 1-0-1 x5days
- T. CALPOL 500mg PO 1-0-1 x 2days
- T. Pan 40mg. PO 1-0-1 x 5days
- Candid V6 Vaginal Pessaries PV. x6days.
- Cap. Susten 300mg PO xOD till further orders
- RTV after 1week for Cervical length Scan
-

Name of the Surgeon: Y. Padmaja

Signature of the Surgeon: P Yelisetty 5202

Date & Time: 24/7/2026 @. 3:30 pm

SURGICAL SAFETY CHECKLIST

Surgeon : Dr Padmaja
Asst. Surgeon : Dr. Priyadarshini
Anaesthetist : Dr. Durga Bhavani
Scrub Nurse : Sr. Sangeetha

HNH-00001066 IP26-00006938
Mrs R POOJA
29-10-1995 30 Y 8 M 25 D (F)
Dr. PADMAJA YELISETTY

Patient Name : ... UHID : ... Age : ... Gender : ...
Date : 24/7/26 ... Procedure Name : Cervical cerclage
... Out-time : ...

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Before Induction of Anaesthesia ➢ ➢

SIGN IN Time: 2:25 p.m.

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 : Dr. SK. Ayesha

Before Skin Incision ➢ ➢

TIME OUT Time: 2:41 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 — minimal Bleeding. 15 minutes.

Anaesthesia Team Reviews:
- Are There Any Patient-specific Concerns? ☐ Yes ☐ No ☐ NA — fasting inadequate

Nursing Team Reviews:
- Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☑ Yes ☐ No ☐ NA — Inj: Cefotaxime 1gm @ 1:30 Pm — O-ve

Is Essential Imaging Displayed? ☐ Yes ☐ No ☐ NA

Signature : Sushela
Name : Sushela 24/7/26 @ 2:47 pm.

Before Patient Leaves Operating Room

SIGN OUT Time: 2:30 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]
Name : Dr. Padmaja. Yelisetty

Doc. No. : RCH / FRM / CLINICAL / 111

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : Mrs. R. Pooja Age : 30yrs Gender : Male ☐ Female ☑

UHID NO: HNH0000106G Surgeon Name: Dr. Padmaja Yelisetty

Anaesthesiologist : Dr. Durga Bhavani

Operative procedure planned : Cervical cerclage

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 : Hemodynamic changes, Bleeding, O2 support, Aspiration, PDPH, patchy block

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. R. Pooja the above mentioned operation / Diagnostic / Therapeutic procedures Cervical cerclage

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 : ..... R. POOJA

Name : .....

Relationship with Patient: ..... SELF

Date & Time : 24/7/22

Witness :

Signature : ..... R. Manjula

Name : ..... R. Manjula

Date & Time : 24/7/22

Doctor (who is taking the consent) :

Signature : .....

Name : ..... Dr. Durga Bhavani

Date & Time : 24/7/22

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00001066 IP26-00006938 Mrs R POOJA 29-10-1995 30 Y 8 M 25 D (F) Dr. PADMAJA YELISETTY	24/7/26 @ 2:30 pm	24/7/26 @ 3:35pm.
	Transfer Ordered by: Dr. Durga Bharani	Reason for Transfer: Observation
From Unit: OT	To Unit: Pre Post	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
Parvez	Dr. Durga Bharani

Patient & Clinical Records Received by : Akhila @

Date & Time of Patient Received : 24/7/26 @ 3:30 pm

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

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