

Patient Sticker

AH-00391557 IP5-00174011
Mrs BOCHKAR VIJAYA
01-1975 51 Y 3 M 29 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA

Rainbow
Mrs BOCHKAR VIJAYA (51 Y 3 M 29 D / F)
FLUID
BAH-00391557
BA26050966077

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

SURGERY DETAILS

Date : 19/5/20

Patient Name: Mrs. Vijaya Date of Birth: Age: 51y

Gender: Female Ward: OBG OT-1 UHID No.:

Date of Surgery: 19/5/20 OT-1 OT-2 OT-3 OT-4 OBG OT-1 OBG OT-2

Name of the Surgery : Laparoscopic ~~left~~ Ovarian cystectomy +
hysteroscopic endometrial Biopsy

Time in : 11:40 AM

Time Out : 1:15 PM

	NAME	AMOUNT
1. Surgeon	Dr. Shukti Reddy	
2. Anaesthetist		
3. Assistant Surgeon	Dr. Sanku	
4. OT Technician	Ramesh	
5. Circulating Nurse	Bobi	
6. Assistant Nurse	Prarabhati	

Special Equipment: Laparoscopy Broncoscope Harmonic Morcelator
 C-ARM Cystoscopy Versa Point Liver Cusa
 Neuro Cusa Others: neelsillar → 9615934
Hystoscopy Suits → 9615934

Signature of the Surgeon: Dr. Shukti Reddy

Signature of Circulating Nurse: [Signature]

Order No: 9615924/924

Order by: [Signature]



*Lap. Ovarian cystectomy
 + hysteroscopy polypectomy*
CONSUMABLES OF OT



Circulating staff : Technician : Date : 19/5/20 Time : 11 Am

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube <u>7-7.5</u>	1	1	Major Pack	1	1	Inj Vit.K		
LMA <u>3</u>	0	—	Sutures <u>2407, 2346</u>	2	—	Cord Clamp		
ECG leads <u>A/P/N</u>	5	3				Suction Catheter		
HME filter <u>A/P/N</u>	0	1				Feeding Tube		
Syringes : 10 cc	10	7				Vaccum Suction Set		
05 cc	10	6	Gloves <u>6.5, 7.5 24242</u>	1	—	Surgical Gloves		
02 cc	10	4	<u>6.5, 7.5 24242</u>	—	—	Gauze Pack		
01 cc	—	—				Syringe 1ml / 2ml		
Cautery plate <u>A/P/N</u>	0	—	Surgical blade <u>11#</u>	2	1	Surgical Blade # 20		
IV set	0	—	NG tube			Koochies (S) <u>20cc</u>	2	—
RL	0	1	Cautery pencil			Nes 500ml	2	1
NS : 10ml / 100ml / 500ml / 1000ml	1	1	Koochies			100	2	2
<u>Valium</u>	0	1	Ointments			Anaesth ors	1	1
<u>Dali Spine</u>	0	1	Suction Catheter			TURP set	1	1
Fentanyl	0	1	Cap, Mask	48	8+5	leggies	1	1
Morphine	1	1	Gauze Pack <u>NR</u>	3+3	4	Telly	1	—
Ketamine			Mop Pack	1	—	Gondol bag	1	—
Propofol	0	2	Bleeding pad	4	3	medulin Blue	1	—
Rocuronium	0	2	Underpad	1	1			
Glycopyrolate	0	1	Draw sheet	1	1	midax	0	1
Myopyrolate	0	1	Abgel			Nobel Aracy		
Ondansetron	0	1	Foleys catheter <u>14</u>	1	1	<u>25ml</u>	1	0
Pencan 25g Spinal Needle 22	0	—	Urobag	1	1	oral Aracy		
Bupivacaine 0.25%	0	—	Chest Drainage Catheter			2.5	1	1
Bupivacaine 0.25% (Heavy)	0	—	Romodrain bag			or mask (M)	0	1
Antibiotics			Bandage			medulin		
			Tegaderm			2018	2	—
Suppositories			loban			lop gelly	1	1
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg	0	1	Vaccum Suction set	1	1	look card	1	1
Justin 12.5 mg / 25mg / 100mg	0	1	Plastic Bed Sheet	2	—	Aspirin + Adrenal	1	1
Tab. Misoprost : 200mg			Betadine Solution	2	1	Ephedrin	1	1
O ₂ mask (A)	0	1	Microshield	1	1			
Doxa + Dexamide	1	—	Cotton Balls	1	1			
Fraxaxa (p/m)	2	1	Latex Gloves	10	10			
Gloves telan	5	—	Ramdione Scrub					
men two con zey	1	—	Saral	1	1			

Surgeon : Anaesthesiologist : 9615998 Nurse : OT Technician :
 Order No. : Ordered by :
 Doc. No. : RCH / FRM / GENERAL / 125

ADMISSION SHEET

Registration Details :



Admission No : IP5-00174011

Admit Date : 19-May-2026

Admit Time : 09:55 AM UHID : BAH-00391557

Patient Details :

Patient Name : Mrs BOCHKAR VIJAYA

Age : 51 Y 3 M 29 D

Guardian : Mr MAHESHWAR DHONDI

DOB : 20-01-1975

Gender : Female

Religion :

Occupation :

Marital Status : Married

Address (H) : 1-1-304/18,SAIKRUPA NAGAR VINAYAK
NAGAR Nizamabad R S Nizamabad
Telangana INDIA 503003

Phone No : 9494161940

E-mail : VIJAYABOCHKAR@GMAIL.COM

Admission Details :

Bed Type : DAY CARE

Bed No : RC 406

Ward Name : 4F-GYN RECOVERY

Room No : RC 406

Admission Type : First Visit

Contact Details :

Name : Mr MAHESHWAR DHONDI

Relationship : Husband

Contact Address : 1-1-304/18,SAIKRUPA NAGAR VINAYAK
NAGAR Nizamabad R S Nizamabad Telangana
INDIA 503003

Phone No : / 9494161940


Signature

Doctor Details :

Doctor Name : Dr. SHRUTHI REDDY/Dr.LAVANYA
JANAGAMA

Specialisation : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant :


Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : CARE HEALTH INSURANCE LIMITED

ACTIVITY RECORD FOR BILLING

Name : BAH-00391557 IP5-00174011 -----
Mrs BOCHKAR VIJAYA
 UHID No. : 20-01-1975 51 Y 3 M 29 D (F) Consultant: ----- Dept : -----
Dr. SHRUTHI REDDY/Dr.LAVANYA
 Date of Ac  Date of Discharge : ----- Time: -----

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
19/1/20	6:30pm	4 th floor	3 rd floor (B15)	<i>[Signature]</i>

Cross Consultation Visit

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



I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 19/5/26 Time of Admission :

Allergies: NUPA Not know any drug allergies

PRESENTING COMPLAINTS :

P2L2 has NO AUB sym been - Mirena placed →
 & came for removal in Sep-2025, had a scan.
 done → showed Incidental finding of
 Uterine-fibroids, ↑ ET-thickness

TVS - 7/3/26: Ut - AV, 11.4 X 8.3 X 9.8cm, few post. intramural fibroids (IM)
 largest - 3.8 X 2.4cm, Rt. Lat wall IM fibroid - 2.6 X 2.8cm, Rt. Lat.
 wall subserosal fibroid - 4.4 X 4.0cm, Ant. IM fibroid 3.0 X 2.0cm noted.
 Ant. IM fibroid 3.0 X 2.0cm, myometrium Bulky with heterogenous echo.
 Endometrium - 14mm, RO-⊙, LO-simple cyst - 7.8 X 6 X 7.7cm.

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : ML - 1996, NCM	Parity : P2L2
Previous Periods : regular	Mode of Delivery : NVD'S
LMP : 14/26, 4-5 days,	Last Child Birth : 2001, NVD, AGH
Contraception : Mirena ⊙ flow, clots ⊙	♂, 3.75 kg,

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
→ Mirena inserted : 2019 - removed Nil. (By Dr. Shruithi) in 26/2/26.	
→ Hypothyroid : logeans.	NLL
→ Migraine : 2019.	
→ Hemorrhoids +	



Nil

MEDICATION HISTORY:

T. Thyroxine → 125 mcg

INITIAL ASSESSMENT :

Date <u>19/5/26</u>	Breasts	Local/Speculum Examination
Ht. _____ Wt. _____	(N)	
BMI _____		
B.P. <u>110/70 mmHg</u>		
Pallor <u>absent</u>		Bimanual Pelvic Examination
CVR <u>S1S2 (+)</u>	Abdominal Examination	
Respiratory System <u>BAE (+)</u>		
Thyroid <u>(N)</u>		

PROVISIONAL DIAGNOSIS :

P2L2 ⊂ AOB^{A1} P, L for Lap. Ovary ^{2 hypothyroidism} + Hysteroplastic
 Sopic

INVESTIGATIONS ORDERED

BAT - O positive
 16/5/26 Cbp - Hb-12.2 / WBC-3960 / PLT-2.14 L.
 Viral - NR.
 16/5/26 TSM - 2.14.
 25/5/26 { Na/K/Cl → 145/4.7/104,
 Creat:- 0.9, Urea → 27, RBS-85
 LFT-(N), TNa: 1.12

PLAN OF MANAGEMENT

- admission
- consent - Lap. Ovary cystectomy + hysteroplastic
- Monitor vitals
- NBM
- Flw fluids - local hrs
- Preop pain
- PAC
- shift to OT over

noted by Sr. Tunna
 Dr. Lavanya
 19/5/26

Name of the Doctor :

Dr. Shruthi

Date & Time :

19/5/26, 10.12

Signature of Doctor
 DR. SHRUTHI REDDY, Doctor
 Registration No: 46320

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. S. Sri Reddy
 Asst. Surgeon :
 Anaesthetist : Dr. Mohan
 Scrub Nurse : Pravathi

BAH-00391557 IP5-00174011
 Mrs BOCHKAR VIJAYA
 20-01-1975 51 Y 3 M (F)
 Dr. SHRUTHI REDDY/Dr. LAVANYA

Patient Name :
 UHID No. :
 Date : 19/5/2026 In-time : 11:30 AM Out-time : 12:15 PM

Gender : F
LAP Operation
Subtotal



Before Induction of Anaesthesia >>

Before Skin Incision >>

Before Patient Leaves Operating Room

SIGN IN Time: 11:25 AM

Patient Has Confirmed

Identity Yes No
 Site Yes No
 Procedure Yes No
 Consent Yes No

Site Marked Yes No NA

Anaesthesia Safety Check Completed Yes No

Pulse Oximeter on Patient & Functioning Yes No

Does Patient have a:

Known Allergy? Yes No

Difficult Airway / Aspiration Risk?

Yes, & Equipment / Assistance Available Yes No

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

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

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

Signature :
 Name : Dr. S. Mohan

TIME OUT Time: 12:15 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

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

Signature :
 Name : Dr. Sri

SIGN OUT Time: 12:10 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 :
 Name : Dr. Pravathi

LH-00391557 IP5-00174011
 s BOCHKAR VIJAYA
 -01-1975 51 Y 3 M 29 D (F)

Patient Sticker . SHRUTHI REDDY/Dr.LAVANYA



BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date : 19/5/26

To Be Filled In By Assigned Nurse :

Department : P-OT Duration of Procedure :

Name of Surgeon : Dr. Shruthi Reddy Date of Admission : 19/5/26

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

		Staff Signature
1.	Antibiotic given prior to surgery ? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Single Dose Antibiotic or <input checked="" type="checkbox"/> Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Name of the Antibiotic : Inj cefotaxim 1gm	Sandhya
2.	Hair Removal <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No if Yes : Surgical Clipper Department where Hair Removed : <input type="checkbox"/> Ward <input type="checkbox"/> Operating Room <input type="checkbox"/> Other : Skin preparation done (cleanse surgical area with antiseptic agent)? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Sandhya
3.	Patient's body temperature immediately post operation (Recovery Room) 36.1°C <input type="checkbox"/> Oral Or <input checked="" type="checkbox"/> Axilla (Goal : 36-37 °C)	Sandhya
4.	Name of doctor or staff administering the antibiotic : Tuna sis Date & Time of antibiotic administration : @ 10:30 AM, 19/5/26 Date & Time procedure started : @ 12:15 PM, 19/5/26	Sandhya

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

Uterus
Cervix

Patient placed in Lithotomy position, ^{diaped} hysteroscopy introduced → Endometrial is thick
2 ostia is seen, Endometrial curettage done → very minimal curettrgs obtained - sent for HPE.

Amount of Blood Loss: ~ 5 ml.

Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

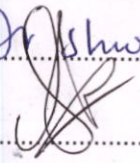
→ Left ovarian cyst wall for HPE
Endometrial curettage → HPE

Left ovarian
Cystic fluid - cytology

Peri-Operative Complications:

- NBM for 4-6hr
- IIV fluids - 1000ml/hr
- Monitor vitals - 1/4 hr x 2hr
- w/o IIV Bleeding
- Drug as charted
- Infusions

Name of the Surgeon: Dr. Shweta Reddy

Signature of the Surgeon: 

Date & Time: 19/5/20 7:45pm

AH-00391557 IP5-00174011
Mrs BOCHKAR VIJAYA
D-01-1975 51 Y 3 M 29 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA

Patient Sticker



POST-SURGICAL CARE PLAN FORM

Procedure Done: <i>Laparoscopic Left Ovarian cystectomy + hysterectomy</i>	<i>Endo met Bier</i>
Post-Surgical Diagnosis: <i>POD-0</i>	
Post-Operative Monitoring Parameters /Frequency: <i>→ monitor vitals 1hr x 2hr</i>	
Wound Care: <i>→ w/h Plw Bleeding</i>	
Drain /Special Lines/Catheters: <i>→ NIL</i>	
Special Patient Positioning and Requirements: <i>→ Can move side to side in bed</i>	
Nutritional Instructions: <i>NBM for 4-6hr</i>	
When to Start Mobilization: <i>after becoming off anesthesia</i>	
Special Referrals: <i>—</i>	
The new order for all required medications documented in the doctor order/medication sheet: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>—</i>	
Any Other Post-Operative Care Needed including Required Follow Up <i>—</i>	
<i>Dr. Shruthi Reddy</i> Treating Surgeon (Signature & Stamp)	Date: <i>19/10/20</i> Time: <i>7pm</i>
Note: Plan of care will be readjusted if necessary.	

BAH-00391557 IP5-00174011
 Mrs BOCHALAR VIJAYA
 20-01-1975 51 Y 3 M 29 D (F)
 Dr. SHRUTHI REDDY/Dr.LAVANYA



EFFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1+1			
3	Nursing Initial assessment				
4	Patient Transfer form	2			
5	In-patient Medical record	1			
6	Doctors progress sheets	2			
7	Nursing plan of care and handover sheets				
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	1			
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaesthesia notes (Pre Anaesthesia& post)	1			
22	Neonatal Admission/Delivery/Physical Exam	1			
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				
30	Intake and Out take chart (fluid chart)				
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				
39	Bed side check list				
40	PICU bed formula Dilution feeds	1			
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart	10			
44	RBS monitoring chart				
		33			
	Total No. of Pages				

Signature and Date:
 20/5/26

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



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/5/26 10:00 AM	US of Abdomen & pelvis.	
21/5/26	<p>→ Simple Hepatic cyst. (Fl - 27 x 20mm)</p> <p>→ (R) simple Renal cortical cyst. (32 x 24mm.)</p> <p>⇒ Bulky uterus with multiple fibroids & adenomyosis. 126 x 57 x 95mm AV, increased in size, altered echotexture with bulky posterior myometrium than ant. myometrium.</p> <p>Fl - multiple well defined oval hypoechoic lesion in ant & post myometrium ant - 34 x 32mm in post. myometrium. & 39 x 29mm right lat-wall.</p> <p><u>Ovary</u> Ro - (N) LO - 85 x 52 x 66mm size large well defined oval anechoic cystic lesion with minimal adjacent free fluid & minimal vascularity within the wall noted. 2. Impending torsion.</p>	<p style="text-align: right;">Dr. D. D. D. Dr. D. D. D.</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/5/2026 1pm	<p>hypotensive POD-01 Laproscopic Left ovarian cystectomy hysteroscopic endometrial Biopsy</p>	
U/O: 300ml	<p>GC: /ger B.P - 118/82 P.R - 75 SPO₂ - 100% on RA P/A: soft P/V: NAB</p>	<p>R 1) NBM for 4-6hrs 2) IV fluids - 100ml/hr 3) Drug as charted 4) Monitor vitals - q 4hr 5) Wt + HR bleedng 6) Ambulation in Bed 7) Flo charting 8) Tolerate diet</p>
Shift	<p>Cepit wall, endometrial HPT Cystic fluid → cytology.</p>	
19/5/2026 6pm	<p>POD Clo-Nil C.cefepim P-50ml/hr BP - 120/75 P/A - soft R + (shifting)</p>	<p>- Dr. Suresh Add - watch for Pulse - Ct to fluids at 100ml/hr - Input/output - Keep Bowel sounds at 8pm. - vitals 2x/4hr - Allow liquids from 8pm</p>
Shift to room.	<p>U-O - 300ml</p>	<p>Dr. Suresh</p>
	<p>Today's Renal at GAM - 20/5/2026.</p>	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/5/26 7:00pm	POD-0/ Laproscopic (L) Ovarian cystectomy + Hysteroscopic Endometrial Biopsy.	
UV -> 500ml Clear (since 2:00pm)	O/F Cc-fair BPR 61BPM BP- 117/72mmHg SpO2- 98% RA PIA- soft BS (+) No active bleeding	Adv 1UF @ 100ml/hr. till 12:00pm 1) Liquid Diet 2) Soft Diet from 9:00pm 3) No charting 4) Remove Foley vs 6AM - 20/5/26. 5) Monitor vitals Inform if PR < 45 BPM 6) Inform vs
		DRD Dr-Druye.
20/5/26 8:00pm	POD-1/ Laproscopic (L) Ovarian cystectomy, + Hysteroscopic Endometrial Biopsy.	
CV ✓ F ✓ S X refund overdox.	do: Headache O/F Cc-fair Bp- 103/80mmHg PR- 74BPM SpO2- 99% RA PIA- soft BS (+)	Adv 1) Soft Diet 2) Monitor vitals 3) Drugs as charted 4) Ambulation & Hydration
Plan Discharge STE-Due		DRD Dr-Druye Note by Shweta 20/5/26

Mrs BODHKAR VIJAYA
 20-01-1975 51 Y 3 M 29 D (F)
 Dr. SHRUTHI REDDY/Dr.LAVANYA



MEDICATION RECONCILIATION FORM

Drug Allergies: None Not known any Drug Allergies

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

Shifting From: NA Shifted to: NA

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T-Hepran	125 mg	PO	O.D	19/5	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
2						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Shri, Dr. Sruthi

Date & Time: 19/5/26, 10:40 AM

Nurse Name & Signature: Bhargava

Date & Time: 19/5/26 @ 10:40 AM

DRUG CHART

Date of Admission: 19/5/20 Drug Allergies: None Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

Signature
VERIFIED BY : Name



REGULAR PRESCRIPTIONS

Weight. Ward.

DRUG : TAB. PARACETAMOL				Date Time	2015
Dose	Route	Frequency	Start Date		
1gm	PO	QID	19/5/26	12AM	12:00
Name & Signature of the Doctor Starting the Drugs:					
Dr. S. Mohan				8AM	8:00
Additional Instructions:				12AM	12:00
				6PM	6:00
Daily Doctor's Endorsement by a Sign					
DRUG : TAB. DICLOFENAC				Date Time	2015
Dose	Route	Frequency	Start Date		
50mg	PO	TID	19/5/26	7AM	7:00
Name & Signature of the Doctor Starting the Drugs:					
Dr. S. Mohan				3PM	3:00
Additional Instructions:				11AM	11:00
				12:00	12:00
Daily Doctor's Endorsement by a Sign					
DRUG : TAB. TRAMADOL				Date Time	2015
Dose	Route	Frequency	Start Date		
100MG	PO	TID	19/5/26	10AM	10:00
Name & Signature of the Doctor Starting the Drugs:					
Dr. S. Mohan				9AM	9:00
Additional Instructions:				5PM	5:00
Daily Doctor's Endorsement by a Sign					
DRUG : Tab CEFOTAXIME				Date Time	19/5 2015
Dose	Route	Frequency	Start Date		
1gm	IV	BD	19/5	10AM	10:00
Name & Signature of the Doctor Starting the Drugs:					
Dr. Brant					
Additional Instructions:				10AM	10:00
				12:00	12:00
Daily Doctor's Endorsement by a Sign					

IAH-00391557 IP5-00174011

Mrs BOCHKAR VIJAYA

10-01-1975 51 Y 3 M 29 D (F)

Dr. SHRUTHI REDDY/Dr.LAVANYA



Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG : T-PANTOPRAZOLE				Date Time	19/1	2015														
Dose	Route	Frequency	Start Dt.																	
40mg	PO	BD	19/1	6am to 10pm Sathy																
Name & Signature of the Doctor Starting the Drugs:				Dr Sruthu																
Additional Instructions:				BP 120/70 Sathy																
Daily Doctor's Endorsement by a Sign																				

DRUG : T. Thyroxine.				Date Time		2015														
Dose	Route	Frequency	Start Dt.																	
25mg	PO	OD	19/1	6am to 10pm Sathy																
Name & Signature of the Doctor Starting the Drugs:				Dr Sruthu																
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																				

Signature
VERIFIED BY : Name



Date Time	Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.	
DRUG :	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
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	Dose		Dose		Dose		Dose		
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.		
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
19/5	10:30 AM	INJ-CEFTAKIME	1gm	IV	[Signature]	Tinna Sumanth
19/5	10:05 AM	Eq PANTOPRAZOL	40mg	PO	[Signature]	Tinna Sumanth
19/5	10:02 AM	Eq PERINORM	10 mg	PO	[Signature]	Tinna Sumanth
19/5	12:00pm	Eq- PARACETAMOL	4g	iv	[Signature]	[Signature] Sobi
19/5	12:30pm	Eq- MORPHINE	4-5mg	iv	[Signature]	[Signature] Sobi
19/5	1:15pm	Diclofenac Suppository	1:15pm	per rectal	[Signature]	[Signature] Sobi
19/5	1:15pm	TRAMADOL Suppository	1:15pm	per rectal	[Signature]	[Signature] Sobi
19/5	8:15pm	Enj. Ondansetron 4mg	4mg	IV	[Signature]	Sathy Lovely

Signature
VERIFIED BY: Name



I.V. FLUIDS CHART

Weight: Ward: OPD

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
19/5	9:45 AM	RINGER LACTATE	IV	100ml/hr	D.	Tanya Sandeep	19/5	R	Blas Blas
19/5		Ringer lactate	IV	100ml/hr	R.	Blas	19/5	R	Blas
19/5	12:00pm	RINGER LACTATE	iv	200ml/hr	R	Ram Blas	19/5	R	Sandeep Keena
19/5	3pm	Ringer lactate	IV	100ml/hr	R	Sandeep Keena	19/5		Sandeep Keena
19/5	6:30 pm	RINGER LACTATE	IV	100ml/hr		Sandeep Keena	STOP to 20/5/20		Keena

Signature

VERIFIED BY: Name

BAH-00391557 IP5-00174011
 Mrs BOCHKAR VIJAYA
 20-01-1975 51 Y 3 M 29 D (F)
 Dr. SHRUTHI REDDY/Dr.LAVANYA



RESULT SHEET

Date	16/5/26				
Time					
Hb	12.2				
PCV					
RBC					
WBC	3960				
N/L					
Platelets	2.14				
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						
Vitals - NR.						

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.) :

BAH-00391557 IP5-00174011
 Mrs BOCHKAR VIJAYA 51 Y 3 M 29 D (F)
 20-01-1975
 Dr. SHRUTHI REDDY/Dr. LAVANYA



OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 19/5/26

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: Lap ovarian cystectomy Doctor Notified on Admission: Yes No

Name of the Doctor: Dr. Saavardh

Time Notified: 9:40 A

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>Hypothyroid</u>	<u>Nil</u>	-

<p>Gynecology Assessment: <input type="checkbox"/> Not Applicable</p> <p>Menstrual History: <u>Regular</u></p> <p>Onset of Menarche:</p> <p>Menstrual Cycle: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular</p> <p>Last Menstrual Period: <u>11/4/26</u></p>	<p>Gynecology Surgical History:</p> <p>Caesarean Section: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Cervical Cerclage: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Ectopic Pregnancy: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Myomectomy: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Others:</p>	<p>Gynecological History:</p> <p>Contraceptives: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Vaginal Discharge: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Post-Coital Bleeding: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Infertility: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If Yes Type: <input type="checkbox"/> Primary <input type="checkbox"/> Secondary</p>
---	--	--

Obstetric History: G 1 P 2 L 2 A 1

Previous LSCS: Nil

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

Family History: No Abnormalities Detected

Heart Disease Hypertension Diabetes Stroke Seizures Kidney disease

Liver disease Other

Vital Signs / Measurements: Temp: 98°F HR: 80b/m RR: 20

BP: 124/84(97) Weight: Height: BMI:

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



PHYSICAL ASSESSMENT

General Appearance: Healthy ill looking Anxious Agitated Others:

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

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

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

- Mobility problem Walking Problem No Abnormality Detected
 Developmental Delay Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: No Abnormality Detected

- Overweight Poor Appetite > 3 Days Needs Therapeutic Diet.
 Under Weight Diabetes Mellitus Hyperemesis Gravidarum

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

- Calm & Cooperative Restless Depressed Agitated Confused
 Others

Inform consultant for positive criteria

Cultural & Spiritual Needs: Yes No if Yes specify Inform consultant for positive criteria.

SOCIAL SCREENING:

1. **Marital Status:** Single Married Divorced Widow

2. **Special Habits:** **Smoker:** Yes No **Alcohol Abuse:** Yes No **Drug Abuse:** Yes No

Social History: Lives With family

Orientation has been given regarding the following aspects:

- Call Bell in Reach : Yes No Waste Disposal Explained: Yes No
Infusion Pump : Yes No Hand Hygiene Explained: Yes No Others

Above information given to Patient

Name of Person Orientation was given to: Patient

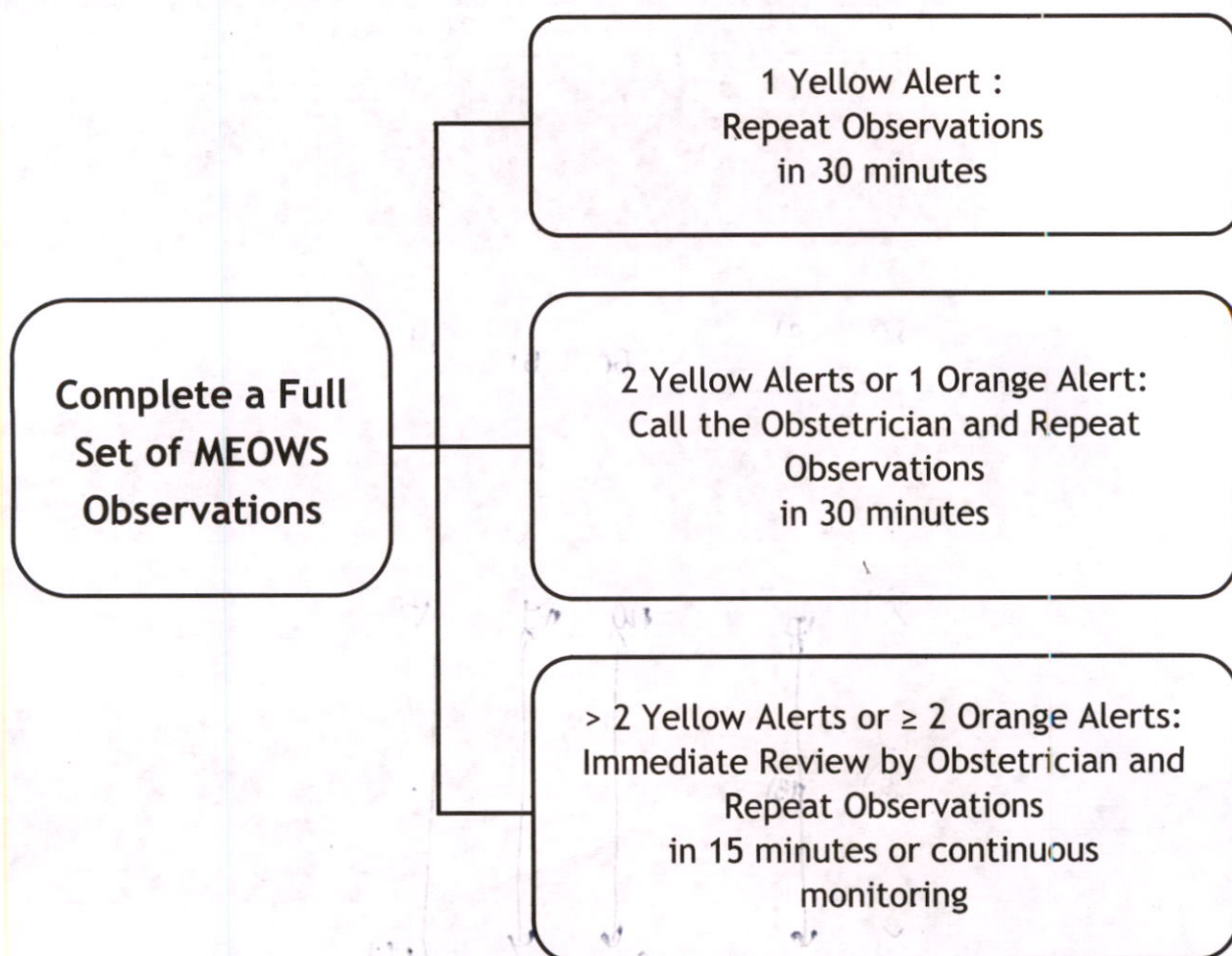
Orientation not given Reason: NA

Nurse Signature: JM

Nurse Name: Purni

Date & Time: 19/5/26 @ 9:45 Am.

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)



FLUID CHART

Sheet No. : 1

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

Date	Time	Nature of Fluid	Intake			NG	Diarrhoea	Vomit	Output		IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G				Drainage	Urine		
	08:00 am											
	09:00 am	PI	NBM	100ml/w					✓	0		Tunny
	10:00 am	PI	NBM	100ml/w			n/a		✓	0		Tunny
	11:00 am	PI	NBM	100ml/w						0		Tunny
	12:00 pm	PC		100ml						0		
	01:00 pm	PC		100ml						800ml	0	

19/5/26

Total Intake :

Total Output : U - 2M -

02:00 pm	RL			100ml							0	
03:00 pm	RL			100ml							0	
04:00 pm	PC			100ml						800ml	0	
05:00 pm	PC		H2O	100ml			n/a				0	
06:00 pm	PC		H2O	100ml						300	0	
07:00 pm	PC		H2O	100ml							0	

Total Intake : (taken)

Total Output : 500ml

08:00 pm	RL		H2O	100ml							0	
09:00 pm	RL		soup	100ml							0	
10:00 pm	RL		idly	100ml						200ml	0	shinsho
11:00 pm	RL			100ml			n/a				0	
12:00 am	RL			100ml							0	
01:00 am	RL			100ml						100ml	0	

Total Intake :

Total Output : M - 300ml - 300ml

02:00 am			H2O	100ml							0	
03:00 am				100ml							0	
04:00 am	RL		H2O	100ml						200ml	0	shinsho
05:00 am				100ml			n/a				0	
06:00 am			H2O	100ml						600ml	0	
07:00 am				100ml							0	

Total Intake :

Total Output : M - 0U - 700ml

Total 24 hrs. Intake IVF: 2300ml

Total 24 hrs. Output M - 0U - 1700ml

BAH-00391557 IP5-00174011
 Mrs BOCHKAR VIJAYA
 20-01-1975 51 Y 3 M 29 D (F)
 Dr. SHRUTHI REDDY/Dr.LAVANYA



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

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

BAH-00391557 IP5-00174011
Mrs BOCHKAR VIJAYA
20-01-1975 51 Y 3 M 29 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA




Patient Name : Mrs..... BOCHKAR VIJAYA Age : 51 Y Gender : Male Female

UHID NO: Surgeon Name: DR SHRUTHI REDDY

Anaesthesiologist : DR. SHENY

Operative procedure planned : LAPAROSCOPIC OVARIAN CYSTECTOMY

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 anaesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

Specific High Risk (s) : The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

- Heart disease Hypertension Diabetes mellitus Renal failure
- Hepatic disorders Shock Multiple organ failure Polytrauma / Renal Tubular Acidosis
- Incapacitating Chronic Obstructive Pulmonary Disease
- Others : HYPOTENSION, BRADYCARDIA, BRONCHOSPASM, LARYNGOSPASM,

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 the above mentioned operation / Diagnostic / Therapeutic procedures LAPAROSCOPIC OVARIAN CYSTECTOMY

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 : [Signature]

Name : Dr. D. Sathwik

Relationship with Patient: son

Date & Time : 19/5/26 10:45AM

Witness :

Signature : [Signature]

Name : Dr. R. Priyanka

Date & Time : 19/5/26 10:45am

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. S.H. Sanyal

Date & Time : 11/04/26

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE



It takes a lot to treat the little.



Patient Name : B. VIJAYA Gender: Male Female Age : 51 yrs
UHID No : BAH-00391557 Date : 19/5/26

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)

HYSTERO SCOPIC POLYPECTOMY + LAPROSCOPIC OVARIAN CYSTECTOMY

upon B. VIJAYA
(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.

CHANCE OF BLEEDING, BLOOD AND BLOOD PRODUCTS TRANSFUSION, CHANCE OF INFECTION, INJURY TO ADJACENT ORGANS, PERFORATION

My signature on this form indicates that

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

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

Consentee :
Signature : [Signature]
Name : B. Vijaya
Date & Time : 19/5/26, 10 Am

Patient Attendant :
Signature : [Signature]
Name : Dr. Priyanka
Relationship with Patient : Daughter in law
Date & Time : 19/5/26, 10 Am

Witness :
Signature : [Signature]
Name : Tunny
Date & Time : 19/5/26 @ 10 Am

Doctor (who is taking the consent) :
Signature : [Signature]
Name : Dr. sravanti
Date & Time : 19/5/26, 10 Am