

BAH-00640605 IP5-00176190
Mrs VAISHNAVI SHARMA
13-12-1997 28 Y 6 M 27 D (F)
Dr. PRANATHI REDDY A



Shelshar
11/07/26

Rainbow[®]
Children's
Hospital
It takes a lot to treat the little.

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Your Right to a Safe Delivery

SURGERY DETAILS

Date : 10/9/26
Patient Name: Mr. Varshman Date of Birth: 13/12/1997 Age: 28yrs
Gender: Female Ward : UHID No.: BAH-00640605
Date of Surgery: ☐ OT-1 ☐ OT-2 ☐ OT-3 ☐ OT-4 ☒ OBG OT-1 ☐ OBG OT-2
Name of the Surgery : Emergency Lower segment cesarean section
↓ LSA

Time in : 6:00pm

Time Out : 7:00pm

	NAME	AMOUNT
1. Surgeon	Dr. Pranathi Reddy	
2. Anaesthetist	Dr. Shipa	
3. Assistant Surgeon	Dr. Deepika Reddy	
4. OT Technician	Shirisha	
5. Circulating Nurse	Sis. Rebeca	
6. Assistant Nurse	Sis. Carui	

Special Equipment: ☐ Laparoscopy ☐ Bronchoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others

Surgeon

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9897394

Order by: Sis. Rebeca

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CONSUMABLES OF OT

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Technician : *Shamale*

Date : *10/7/16*

Time : *6pm*

Anaesthesia Disposables		Qty	Surgical Disposables		Qty	Disposables (Baby Side)		Qty
Issued	Used		Issued	Used		Issued	Used	
ET tube			Major Pack	<i>1st drape</i>	<i>1</i>	Inj Vit.K		<i>2</i>
LMA			Sutures	<i>2346</i>	<i>1</i>	Cord Clamp		<i>1</i>
ECG leads : A / P / N	<i>02</i>			<i>2364</i>	<i>1</i>	Suction Catheter		
HME filter : A / P / N	<i>00</i>			<i>2762</i>	<i>1</i>	Feeding Tube		
Syringes : 10 cc	<i>02</i>					Vacuum Suction Set		<i>1</i>
05 cc	<i>02</i>		Gloves	<i>6.6 1/2 17</i>	<i>3/13</i>	Surgical Gloves	<i>1</i>	<i>13</i>
02 cc	<i>02</i>			<i>P.F 6 1/2</i>		Gauze Pack		<i>1</i>
01 cc			Surgical blade	<i>22</i>	<i>1</i>	Syringe 1ml / 2ml		<i>2</i>
Cautery plate : A / P / N	<i>00</i>		NG tube			Surgical Blade # 20		<i>1</i>
IV set	<i>02</i>		Cautery pencil		<i>2</i>	Koochies (S)	<i>1's</i>	<i>1</i>
RL	<i>01</i>		Koochies	<i>XL</i>	<i>01</i>	<i>Underp</i>		<i>1</i>
NS : 10ml / 100ml / 500ml / 1000ml	<i>01</i>		Ointments					
<i>20x 2 f.</i>	<i>01</i>		Suction Catheter					
Fentanyl	<i>01</i>		Cap, Mask		<i>10/10/10</i>			
Morphine			Gauze Pack		<i>1/12</i>			
Ketamine			Mop Pack		<i>2</i>			
Propofol			Steristrip	<i>20ne</i>	<i>1</i>			
Rocuronium			Underpad		<i>1</i>			
Glycopyrolate			Draw sheet	<i>Quick set</i>	<i>1</i>			
Myopyrolate			Abgel		<i>2</i>			
Ondansetron	<i>01</i>		Foleys catheter					
Pencan 25g/ Spinal Needle 22	<i>01</i>		Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25% (Heavy)	<i>02</i>		Romodrain bag					
Antibiotics			Bandage					
			Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg	<i>01</i>		Vacuum Suction set		<i>1</i>	<i>Thermedicine</i>		<i>1</i>
Justin : 12.5 mg / 25mg / 100mg	<i>01</i>		Plastic Bed Sheet			<i>subo</i>		<i>6</i>
Tab. Misoprost : 200mg	<i>02</i>		Betadine Solution		<i>2</i>			
<i>Tramexa</i>	<i>02</i>		Microshield					
<i>gange + gloves</i>	<i>01</i>		Cotton Balls		<i>1/1</i>			
			Latex Gloves		<i>00</i>			
<i>Adrenaline</i>	<i>1</i>		Ramdione Scrub					
<i>Atrophine</i>	<i>1</i>		Saral DA		<i>2</i>			

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. : *9697399 / 140 / 241*

Ordered by : *Bichu*

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

ADMISSION SHEET
Registration Details :


Admission No : IP5-00176190 Admit Date : 10-Jul-2026 Admit Time : 07:47 AM UHID : BAH-00640605

Patient Details :

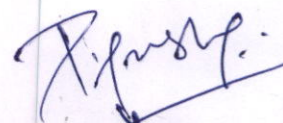
Patient Name	: Mrs VAISHNAVI SHARMA	Age	: 28 Y 6 M 27 D
Guardian	: Mr PIYUSH NAHATA	DOB	: 13-12-1997
Gender	: Female	Religion	:
Occupation	:	Martial Status	: Married
Address (H)	: 3-4-10/A 1ST FLOOR Barkatpura Hyderabad Telangana INDIA 500027	Phone No	: 9502199821/ 9030751022
		E-mail	: nomailid@gmail.com

Admission Details :

Bed Type : MICU Bed No : MICU ISO 429 Ward Name : 4F-BIRTHING CENTRE
 Room No : MICU ISO 429 Admission Type : First Visit

Contact Details :

Name : Mr PIYUSH NAHATA Relationship : Husband
 Contact Address : 3-4-10/A 1ST FLOOR Barkatpura Hyderabad Phone No : 9502199821 / 9030751022
 Telangana INDIA 500027


 Signature

Doctor Details :

Doctor Name : Dr. PRANATHI REDDY A Specialisation : OBSTETRICS AND GYNECOLOGY
 Referral Doctor : Self Phone No :
 Co-Consultant :

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00
 Payor Name : RELIANCE GENERAL INSURANCE
 COMPANY LTD

ACTIVITY RECORD FOR BILLING

Name : BAH-00640605 IP5-00176190
Mrs VAISHNAVI SHARMA
13-12-1997 28 Y 6 M 27 D (F)
 UHID No. : Dr. PRANATHI REDDY A
 Date of Admission : _____ Date of Discharge : _____ Time : _____
 Room / Bed No : _____ Ward : _____ Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
10/7	6:00 AM	ORs	OT	Radhya
10/7	7 AM	OT	ORs	Angela
10/7	11 AM	ORs	Room (3rd)	Turney

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Tuheera Sharma (PT)	11/7/26	9698286	Tuheera
2				
3				
4				
5				
6				
7				
8				
9				
10				

[illegible]

Signature



Ree Run

[Signature]

[illegible]

[illegible]

Date :

Time :

Prepared By :

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor



IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

Cl-1 early P/L - 6 AM

Obstetric Formula:

Pru

Obstetric History:

1st - PP spontaneous
conception

Present Pregnancy Record:

Booked at 8 wks.
had chorionic biopsy.

RISK FACTORS:

Height: 155 cm

Weight: 59.9 kg

Allergies: Nil

Breast: ☒ Normal ☐ Abnormal

General Examination:

Consciousness: conscious Pallor: Absent

Icterus: absent Edema: absent

Temp: 37.2 PR: 72

BP: 107/70 DTR: NAD

CVS: NAD RS: NAD

Liver/Spleen: Not palpable Urine Output: Adequate, clear

LMP: 9/10/2016

EDD:

Corrected EDD: 16/7/2017

GA:

39+1 wks

Menstrual History: Regular: ☐ Yes ☐ No

Obstetric Examination

Fundal Height: 28 cm

Ut. Activity: ☐ Relaxed ☒ Mild ☐ Mod ☐ Severe

Liquor: ☒ Adequate ☐ Oligo ☐ Poly

PP: ☒ Cephalic ☐ Breech Others: _____

Head Fifts Palpable: _____

FHS: ☒ Normal ☐ Tachy ☐ Brady ☐ Absent

NG - Reactive

Per Speculum Examination

Draining: ☒ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☒ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination

Cervix: ☒ Long ☐ Partially effaced ☐ Effaced

Os: Closed _____ Dilated 2 cm

Membranes: ☒ Present ☐ Absent

Liquor: ☒ Clear ☐ Meconium ☐ Blood Stained

Presenting Part: ☒ Vertex ☐ Breech ☐ Others

Sutton: ☐ -3 ☒ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Pelvis: ☐ Adequate ☐ Doubtful

4020 - 44.1 cm RA

DIAGNOSIS

Pru at 39+1 wks with. Shokin
Early labor

Family History: - father - A7 .	Surgical History:
Medical History: Cholelithiasis 2015 .	Medication History: ORACON .
Plan of Care: - for admission . - Preoperative - Examine . - Send csp . - PUE, - 25mg } - 7:50 . 2+25 - with Prognosis . - Next 5 x 500 hourly . - when - starting . - final Blood availability	Investigations: - B Ate . - HIV . - HBSAg } NA - HCV 25/6/2020 - SLT , 36 hr - PI - A7 . - for - 510000 . - ATI - 8.50 . - Apple - navel .

Doctor Name: Dr. Bhargava
 Signature: [Signature]
 Date & Time: 10/7/2020, 7:40 AM

Consultant Name: Dr. Pranathi
 Signature: [Signature]
 Date & Time: 10/7/2020, 7:40 AM



hnavi Sharma

PROGRESS NOTES AND DOCTOR'S ORDER

10/07/2026 Pr. Pranathi

Date & Time	Progress Notes	Doctor's Order
<u>10/07/2026</u> <u>11:40 AM</u>	no pain Vitals - BP - 120/85/16 PR - 88 bpm SpO₂ - 99% on RA P/A - uterus Aching mildly NSG - Reactive V/G - Ex 1/4th inch, 2cm, clear leak (+) RA (-2)	<u>Advice</u> ✓ Tab. PGE1 25mg PO x 12pm ✓ Monitor FHR/Vitals ✓ Upright position ✓ Epidural (cos) ✓ Inform SRS ✓ Oxycodone infusion - 2pm
		<u>By Dr. Deepika</u>
<u>10/7/2026</u> <u>3pm</u>	NSG - Reactive on Synto - 18ml/hr.	<u>Advice:</u> ✓ Ball exercises ✓ Monitor FHR/Vitals ✓ W/F PO ✓ Inform SRS
		<u>By Dr. Deepika</u>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/12/20	S/B Dr. Pranathi Reddy	
5:30pm	Pl. common, & overexposed	<u>Adv</u>
	O/S ac-fair	- post for emergency USG chlo nm.
	vitals stable	program of labour
	P/A uterus	- PAC
	mild tachy	- Brace pads
	FHR @	- Br op medication
	Dr. Or / monitoring,	- Foley's catheterization
	soft, 2cm,	- shift to on call
	challiqua,	- Infuse BT
	Vx-2 station	
		<i>Dr. Anne.</i>
	Pl and attendus have been counselled regarding the same findings. Need for emergency USG chlo Non-program risk of chromo anomalies explained	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/26. 7:15 PM	POD-0. Immediate post op. Pt is stable. NO cp. BP - 110/61 [72] mmHg. PR - 86bpm SpO₂ - 100% on RA P/A - OT well retracted Dressing dry & intact L/E - Bw RL U/O - 200ml emptied, clear.	<u>Advice:</u> ① NBM today ② Clear Liquids @ 6AM on 11/7/26 ③ Monitor vitals & I/O & check for bleeding plv every 15min for 1hr P/b 1hrly for 2 hrs ④ Drugs as charted. ⑤ W/O hypotension, tachycardia, bleeding plv ⑥ Inform SOS.
11/7/26.	⇒ Catheter removal @ 12pm on 11/7/26. ⇒ Dulcotalx @ 12pm on 11/7/26 ⇒ Clear liquids on 11/7/26 @ 6AM ⇒ CBP on 6AM / 11/7/26.	⑦ ⑧ ⑨ ⑩ ⑪ ⑫ ⑬ ⑭ ⑮ ⑯ ⑰ ⑱ ⑲ ⑳ ㉑ ㉒ ㉓ ㉔ ㉕ ㉖ ㉗ ㉘ ㉙ ㉚ ㉛ ㉜ ㉝ ㉞ ㉟ ㊱ ㊲ ㊳ ㊴ ㊵ ㊶ ㊷ ㊸ ㊹ ㊺ ㊻ ㊼ ㊽ ㊾ ㊿
		Signature



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/2026 10:00pm	POD-0 / P/L / Em. lsc. pt comfortable.	
Baby-well VO-200ml clean	O/E G.I. fair BP- 125/68 (8) mmHg PR- 74 bpm SpO ₂ - 98% RA PLA- ut @ well L/E- Bwvl BS (+)	Advice ① NBM today ② clear liquids 6am - 11/7/26 ③ I/O charting ④ monitor vitals 4th hly ⑤ wlf active bleeding plv ⑥ Drugs as charted ⑦ IUF @ 100ml/h ⑧ Foley removal @ 4pm 11/7/26
CP- 6am - 11/7/2026 Dolodax 2tab on 11/7/2026 Foley removal - 12pm @ 12pm 11/7/26 last clear liquid from 6am 11/7/26		
Shift to Room		DR. Dilys NBS Tunnel
11/7/26 7:30am	- POD-1 / P/L / Em lsc. - Pt is stable ; tolerating liquids. - BP- 112/72 (88) PR- 79bpm SpO ₂ - 99% on RA PLA- ut well retracted dressing dry & intact ; BS (+) c/c- lochia @ healthy O/L- 1200ml (x 2am) Remove Foley @ 12pm, 11/7/26 T. Dolodax 2# PR @ 12pm.	Advice ① Soft diet @ 9am ② Drugs as charted ③ Vitals 4th hly ④ Hydrate & ambulate ⑤ wlf heavy bloody plv ⑥ I/O as per ⑦ Trace CBR Srlbi: 11/7/26 11/7/26



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/12/2016	POD-1 / PIL / Embr	
1:40pm		R
B-wee	Gc: per vitals: stable P/A: HT @ wee	1) Soft diet & plenty of oral fluid
U/ +	Soft	2) Drug as charted
S ⊕	BS ⊕	3) w/t fw Bleeding
	P/V: NAB	4) Ambulation
		5) Monitor vitals - 4hr
		6) Stuck for
		Noted by Dr. Sravanti
11/12/2016	POD-1 / PIL / Embr	
7:30pm		R
B-wee	Gc: per vitals: stable	1) Soft diet & plenty of oral fluid
U/ +	P/A: HT @ wee	2) Drug as charted
S ⊕	Soft, BS ⊕	3) w/t fw Bleeding
	P/V: NAB	4) Ambulation
		5) Monitor vitals - 4hr
		6) Stuck for
		Noted by Dr. Sravanti



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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

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RESULT SHEET

Date	10/7/26	11/7/26			
Time	9:20 AM	5:57 AM			
Hb	12.5	10.4			
PCV	36.7	31.3			
RBC	4.19	3.54			
WBC	11.80	10.18			
N/L		45.3/19.2			
Platelets	267	217			
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					

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MEDICATION RECONCILIATION FORM

Drug Allergies:

☐ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ORL

Shifted to: OR

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature :

Date & Time : 10/7/2024

Nurse Name & Signature: [Signature]

Date & Time : 10/7/2024



DRUG CHART

Date of Admission: 10/7/26 Drug Allergies: Nil ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name _____ Signature _____

Weight. Ward.

Page: 2/4



Date Time		Nurse Sig.	Nurse Sig.	Nurse Sig.	Nurse Sig.
DRUG : TAB DICLOFENAC		Dose 50 mg	Dose	Dose	Dose
		Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.
Route PO	Start Date 10/7/26	Dose	Dose	Dose	Dose
		Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.
Name & Signature of the Doctor		Dose	Dose	Dose	Dose
Dr. Sri Ranga		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	Dose
		Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.
Route	Start Date	Dose	Dose	Dose	Dose	Dose
		Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.
Name & Signature of the Doctor		Dose	Dose	Dose	Dose	Dose
		Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.
Additional Instructions:		Dose	Dose	Dose	Dose	Dose
		Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
10/7/26	7:30 AM	T. Miso	50 mg	PO	Dr. Y	Suavee, Veevee
10/7/26	10:15 AM	any cetotamine	1 gm	TU	Dr. Y	Suavee, Veevee
10/7/26	12 PM	T. PGE1	25 mg	PO	Dr. Y	Suavee, Veevee
10/7/26	4:15 pm	Enema	100 ml	PR	Dr. Y	Anjali, Rebecca
10/7	5:30 pm	by METRONIDAZOLE	500 mg	IV	Dr. Y	Suavee, Veevee
10/7	6:10 pm	by PANTOP	40 mg	IV	Dr. Y	Suavee, Veevee
10/7	6:15 pm	by PERIVAM	100 mg	IV	Dr. Y	Suavee, Veevee
10/7/2026	6:30 am	FWJ TRANAXAMIC ACID	1 g	IV	Dr. Y	Suavee, Veevee
10/7/2026	6:30 pm	ENTONPAN SATRON	40 mg	IV	Dr. Y	Suavee, Veevee

11/10/26 12 pm SUPP. DULCOTEN 2 tabs P/R Page: 3/4 (P.T.O) 10/11/26



I.V. FLUIDS CHART

Weight. Ward. 013

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
10/1/26	8 AM	RINGER LACTATE	IV	100 ml	P	Swarna Veena	10/1	hy	Swarna Veena
10/1/26	11 AM	RINGER LACTATE 500ml	IV	100ml/hr	Cy	Swarna Veena	10/1	hy	Swarna Veena
10/1/26	2 PM	RINGER LACTATE 500ml	IV	100ml/hr	Cy	Anjali Rebecca	10/1	D	Anjali
10/1/26	2 PM	INS. OXYTOCIN 10U IN 500ml RL	IV	6ml/hr	Cy	Anjali Rebecca	10/1	D	Anjali Rebecca
10/1	4 PM	RINGER LACTATE 500ml	IV	RL	A	Anjali Rebecca	10/1	D	Anjali Rebecca
10/1/26	6 PM	RINGER LACTATE 500ml	IV	100ml/hr	A	Anjali Rebecca	10/1	A	Anjali Rebecca
10/1/26	8 PM	RINGER LACTATE 500ml	IV	100ml/hr	A	Anjali Rebecca	10/1	A	
10/1/26		RINGER LACTATE	IV	100ml/hr					
10/1/26		RINGER LACTATE	IV	100ml/hr					
10/1/26		RINGER LACTATE	IV	100ml/hr					

Signature

VERIFIED BY : Name



Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

DRUG : <u>T. DICLOFENAC</u>				Date Time	<u>11/7</u>
Dose	Route	Frequency	Start Dt.		
<u>50mg</u>	<u>PO</u>	<u>TID</u>	<u>10/7/26</u>		
Name & Signature of the Doctor Starting the Drugs:					
<u>Dr Smt Smt</u>					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

DRUG : <u>Inj. METRONIDAZOLE</u>				Date Time	
Dose	Route	Frequency	Start Dt.		
<u>500mg</u>	<u>IV</u>	<u>TID</u>	<u>10/7/26</u>		
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

DRUG : <u>T. PANTOPRAZOLE</u>				Date Time	<u>11/7</u>
Dose	Route	Frequency	Start Dt.		
<u>40mg</u>	<u>PO</u>	<u>BD</u>	<u>10/7/26</u>		
Name & Signature of the Doctor Starting the Drugs:					
<u>Dr Smt Smt</u>					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

DRUG : <u>T. CEFIXIME</u>				Date Time	<u>12/7</u>
Dose	Route	Frequency	Start Dt.		
<u>200mg</u>	<u>PO</u>	<u>BD</u>	<u>11/7</u>		
Name & Signature of the Doctor Starting the Drugs:					
<u>Dr Pranchi</u>					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

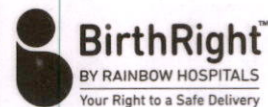
VERIFIED BY : Name Signature

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

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

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

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



Bartholomew

Bartholomew
Hospital

STAT / ONCE ONLY DRUGS

2 1/2 mg. 10/10/11

BAH-00640605
Mrs VAISHNAVI SHARMA
13-12-1997
Dr. PRANATHI REDDY A
IP5-00176190
28 Y 6 M 27 D
(F)

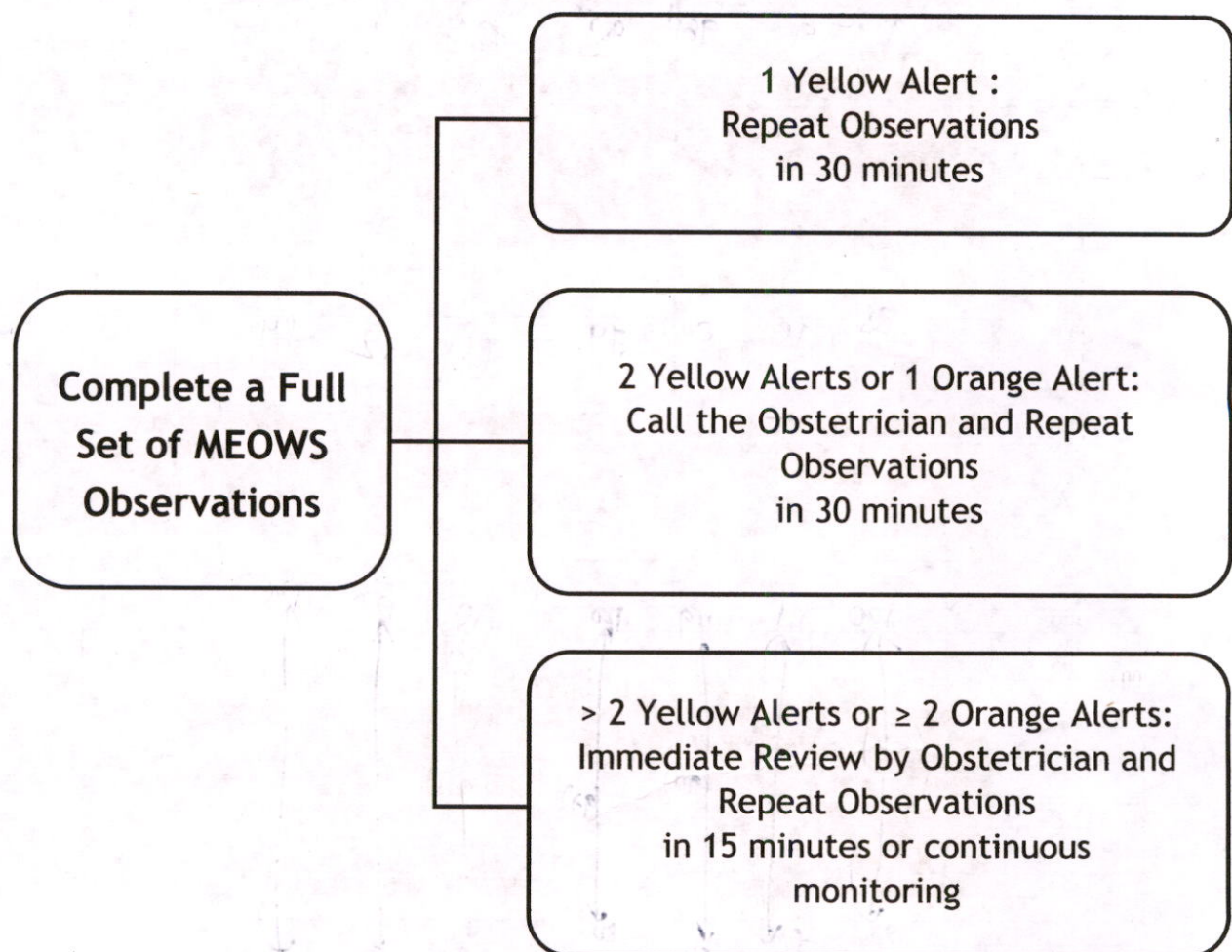


Warning Observation Score Chart - Obstetrics

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

[illegible]

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

IPS-00176190

13-12-1997

28 Y 6 M 27 D

(F)

Dr. PRANATHI REDDY A



11/7/26



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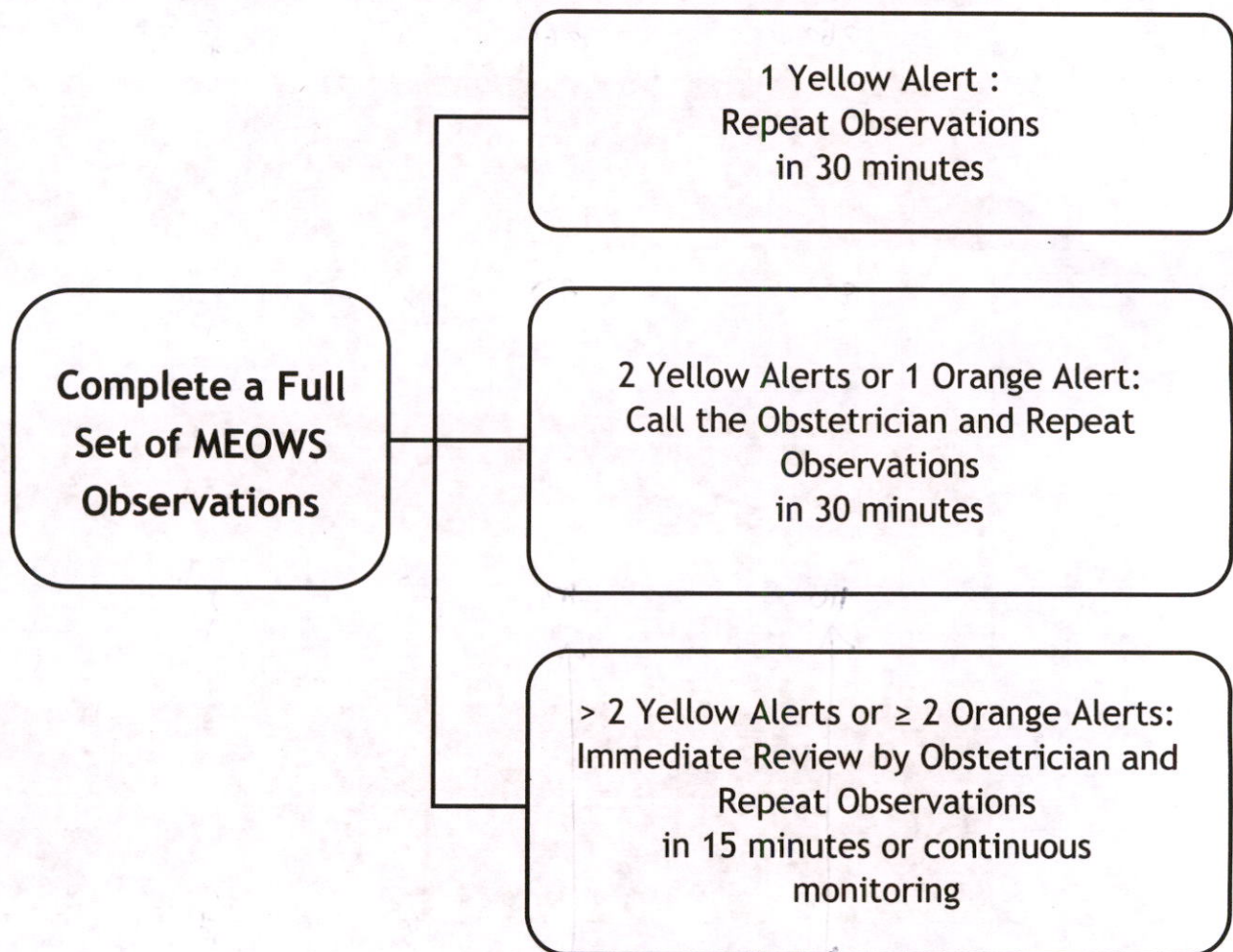
BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Early warning Observation Score Chart - Obstetrics

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

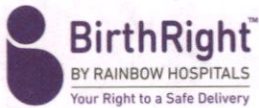
[illegible]

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

BAH-00640605 IP5-00176190
Mrs VAISHNAVI SHARMA
13-12-1997 28 Y 6 M 27 D (F)
Dr. PRANATHI REDDY A

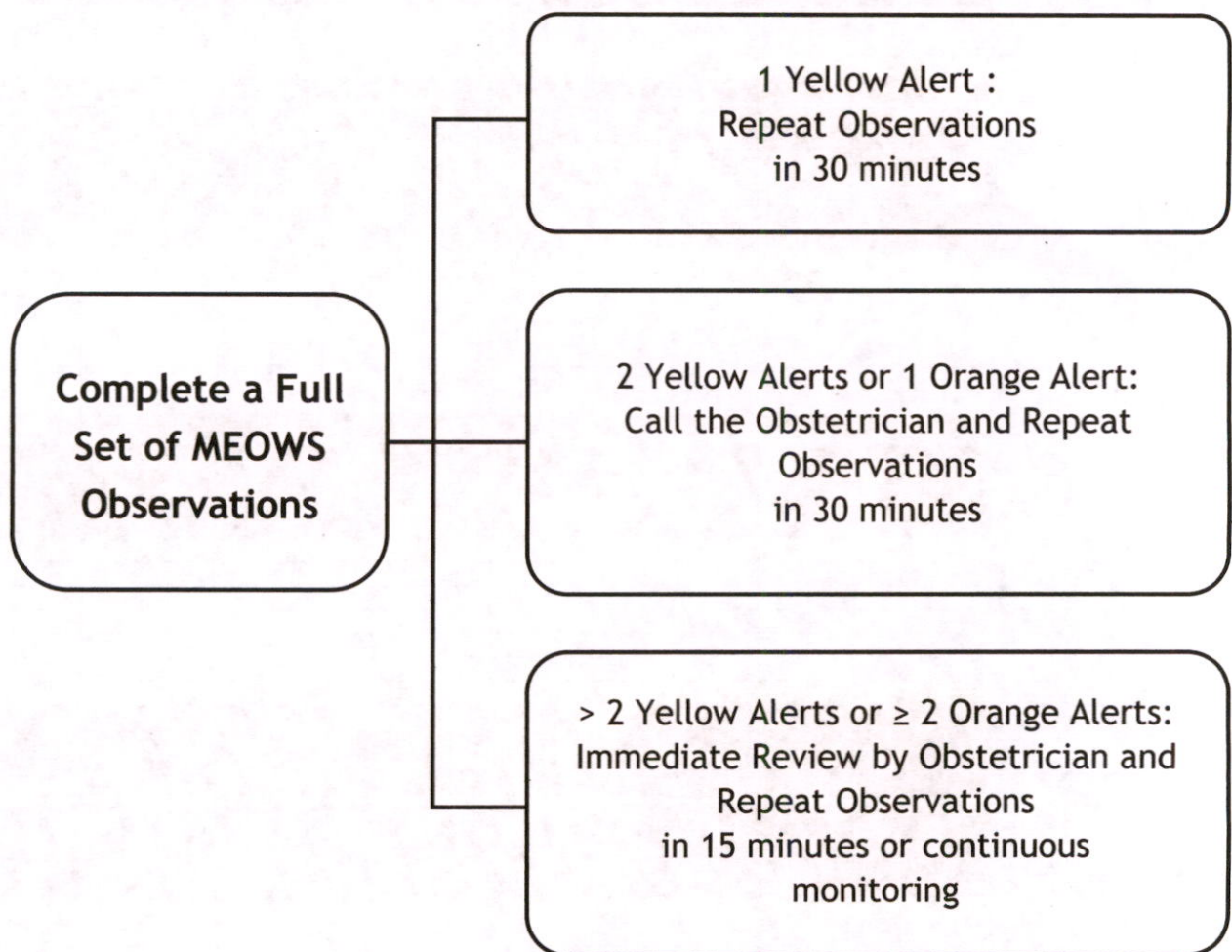


Early Warning Observation Score Chart - Obstetrics

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

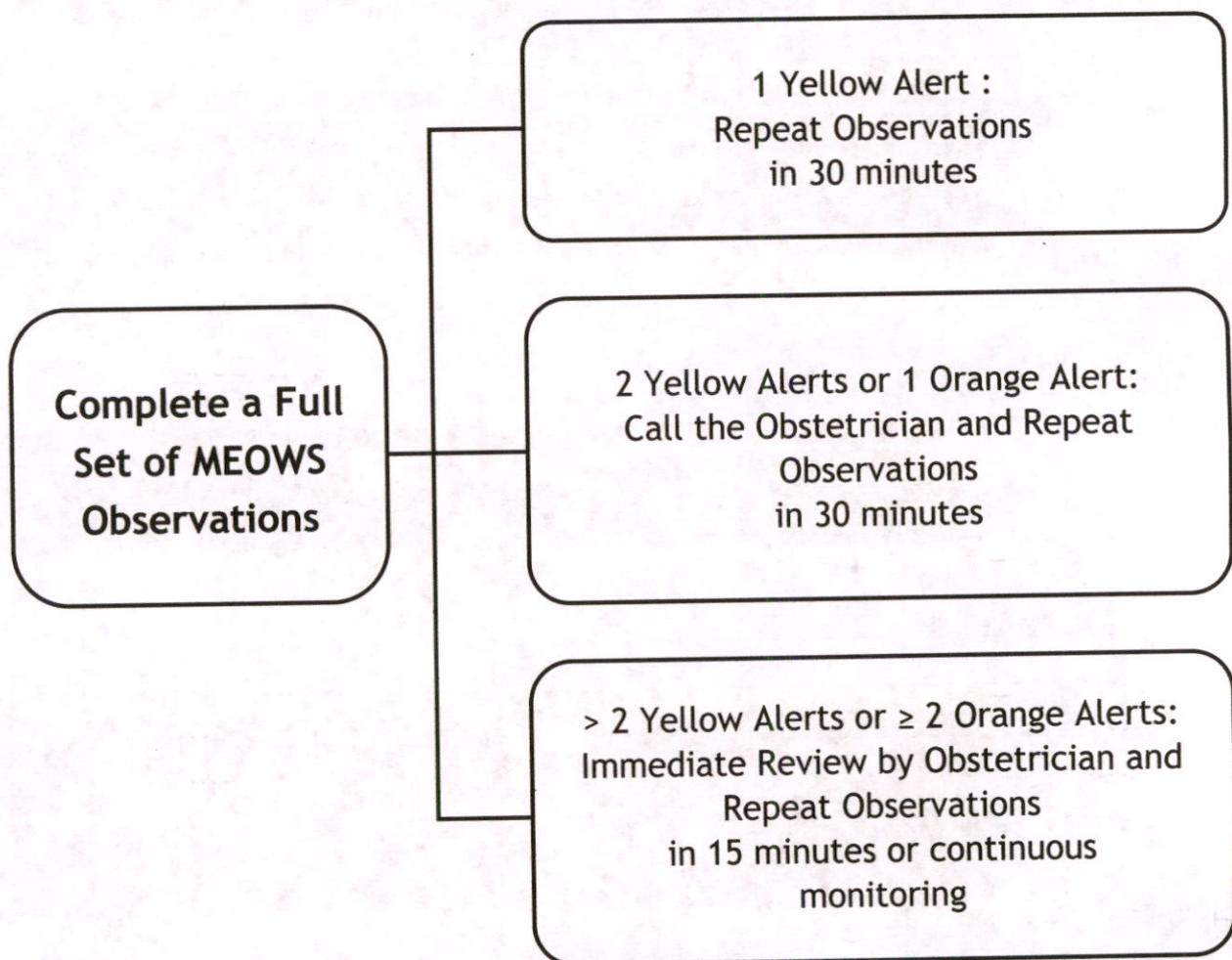
Date																														
		Time																												
		8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7					
RESP (write rate in corresp. box)	> 30																													
	21 - 30																													
	11 - 20																													
	0 - 10																		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

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

Obstetrics and Gynaecology Early Warning Signs



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

BAH-00640605
Mrs VAISHNAVI SHARMA
13-12-1997 28 Y 6 M 27 D (F)
Dr. PRANATHI REDDY A

IP5-00176190



FLUID CHART

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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.
3. 24 hrs. total to be entered in the kardex in RED.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
10/7/20	08:00 am										0	Ashika
	09:00 am		100ml							✓	0	Ashika
	10:00 am										0	Ashika
	11:00 am		100ml							✓	0	Ashika
	12:00 pm		100ml								0	Sweeny
	01:00 pm		100ml							✓	0	Sweeny
	Total Intake : 1000ml			Total Output : passed								
10/7/20	02:00 pm		100ml								0	Angeli
	03:00 pm		Juice							✓	0	Angeli
	04:00 pm		100ml								0	Angeli
	05:00 pm										0	Tony
	06:00 pm		NBM							↓	0	Tony
	07:00 pm		NBM							200ml	0	Tony
	Total Intake : 100ml			Total Output : passed								
	08:00 pm	PI	NBM	100ml						0	0	Tony
	09:00 pm	PI	NBM	100ml						0	0	Tony
	10:00 pm	PI	NBM	100ml						200	0	Tony
	11:00 pm	PI	NBM	100ml						0	0	2
	12:00 am	PI	NBM	100ml							0	0
	01:00 am		NBM	100ml						300ml	0	0
	Total Intake : NBM			Total Output : U - 500ml, m 0								
	02:00 am	PI	NBM	100ml							0	Yann
	03:00 am	PI	NBM	100ml							0	Yann
	04:00 am	PI	NBM	100ml							0	Yann
	05:00 am	PI	NBM	100ml							0	Yann
	06:00 am	PI	NBM	100ml						1200ml	0	Yann
	07:00 am		NBM	100ml							0	Yann
	Total Intake :			Total Output : 1200ml m 0								
Total 24 hrs. Intake		1000ml + 100ml										
Total 24 hrs. Output		1200ml m 0										

FLUID CHART

Sheet No. : 2

11/7/26

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
11/7/26	08:00 am	↓								200ml	0	Full
	09:00 am	RL									0	Full
	10:00 am	RL	H2O								0	Full
	11:00 am	↑									0	Full
	12:00 pm		H2O							900ml	0	Full
	01:00 pm									✓	0	Full
Total Intake :						Total Output : 6-1200ml m-o						
11/7/26	02:00 pm	↓									0	Full
	03:00 pm	NO	H2O							✓	0	Full
	04:00 pm	H2O									0	Full
	05:00 pm	FLUID								✓	0	Full
	06:00 pm		H2O							✓	0	Full
	07:00 pm										0	Full
Total Intake :						Total Output : 0-2 m-o						
11/7/26	08:00 pm	↓									0	Sub
	09:00 pm		H2O						✓	✓	0	Sub
	10:00 pm	NO FLUID									0	Sub
	11:00 pm		H2O						✓	✓	0	Sub
	12:00 am										NO FLUID	Sub
	01:00 am		H2O								0	Sub
Total Intake :						Total Output : M-0 0-2						
11/7/26	02:00 am	↓								✓		Sub
	03:00 am		H2O							✓		Sub
	04:00 am	NO FLUID								✓	NO FLUID	Sub
	05:00 am		H2O									Sub
	06:00 am											Sub
	07:00 am		H2O							✓		Sub
Total Intake :						Total Output : M-0 0-2						

Total 24 hrs. Intake

Total 24 hrs. Output

M-0 0-7



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 10/7/26

Assessment: Patient complaining with hematuria with pain

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess the patient general condition and recording vitals	8:10am	Assessed the patient General condition and recording vitals.	PT is comfortable.
10am	Maintain I/O chart	10:10am	I/O Chart Maintained	
12pm	Plan for NST	12:5pm	NST 3rd hourly	
3pm	provide IV fluids	3:15pm	Re 500ml / 100ml / hr ongoing	
5pm	Administer medication	5:20pm	Drug as per chart given	
7pm	provide Education	7:50pm	Education	

Re-Assessment: Vitals stable.

Special Notes: w/f bleeding.

Nurse Signature:

Nurse Name: Anjali

Date & Time: 10/7/26 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 10/7/26

Assessment: Patient complaints of fear & Anxiety

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	⇒ Assess the Pt Condition	10pm	⇒ Assessed the Pt Condition	patient is comfortable.
10pm	⇒ Administration medication	12pm	⇒ medication given as per drug chart	
12Am	⇒ NBM & IV fluids	2Am	⇒ Pt is on NBM & IV fluids ongoing	
2Am	⇒ Ensure safety	4Am	⇒ Side rails provided.	
4Am	⇒ prevent infection	6Am	⇒ Hand hygiene maintained	
6Am	⇒ u/o monitoring	8Am	⇒ u/o monitoring done.	

Re-Assessment: Vitals stable, u/o is good.

Special Notes: CBP @ 6am 11/7/26 done w/ excessive bleeding.

Nurse Signature: TM

Nurse Name: Punny

Date & Time: 10/7/26 @ 8Am

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Mrs VAISHNAVI SHARMA
13-12-1997 28 Y 6 M 27 D (F)
Dr. PRANATHI REDDY A



NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 11/7/26

Assessment: Patient is having pain and discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	* Assess the patient condition	9am	* Assessed the patient condition	Patient is stable.
10am	* Monitor vitals	11am	* Monitored vitals.	
12pm	* maintain personal hygiene	1pm	* maintained personal hygiene	
2pm	* Ensure safety	3pm	* provided side rails.	
4pm	* Administer medication as per doctor order	5pm	* Administered medication given as per doctor order.	
6pm	*	7pm	*	

Re-Assessment: Re-assessment done every 6th hrly.

Special Notes: ADILEOLUX supp given

Nurse Signature: Srey

Nurse Name: Jume (605725)

Date & Time: 11/7/26 @ 8pm



NURSING CARE RECORD



Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 4/7/24

Assessment: patient is having discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	* Assess the patient condition and vitals check	8:30 pm	* Assessed the patient condition and vitals checked	now patient condition is stable
10pm	* monitor the I/O chart	10:30 pm	* monitored the I/O chart	
12pm	* maintain personal hygiene	12:30 AM	* maintained personal hygiene	
3AM	* provide comfortable position to the pt	3:30 AM	* provided comfortable position to the pt	
6AM	* Administer medicine as per chart	6:30 AM	* Administered medicine as per chart	
7AM	* Ensure safety	7:30 AM	* Ensured safety	

Re-Assessment: Assess the patient condition. Now it is stable

Special Notes: null

Nurse Signature: Sneh

Nurse Name: Sneh - 607635

Date & Time: 4/7/24 @ 8pm



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Pranathi Reddy Department: BB - II Date of Admission: 10/7

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☒ No ☐ Not Known			
	<u>Poison - 39+1 wks</u>		If Yes Specify:			
BACKGROUND	Area	Shift Time	<u>0805</u> <u>8am-8pm</u>	<u>0805</u> <u>8pm-8am</u>	<u>0805</u> <u>8am-8pm</u>	<u>0805</u> <u>8pm-8am</u>
	Medical Condition (Any special condition to be noted):		<u>EVA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	<u>98.9°F</u>	<u>98.8°F</u>	<u>98.9°F</u>	<u>97.6°F</u>
	Res:	<u>19 bpm</u>	<u>19 bpm</u>	<u>18 bpm</u>	<u>22 bpm</u>	
	SpO ₂ :	<u>99%</u>	<u>100%</u>	<u>98%</u>	<u>97%</u>	
	Pulse:	<u>88 bpm</u>	<u>87 bpm</u>	<u>88 bpm</u>	<u>88 bpm</u>	
	BP:	<u>120/80</u>	<u>119/70</u>	<u>103/72</u>	<u>101/74</u>	
	Fall Risk Score:	<u>20</u>	<u>20</u>	<u>20</u>	<u>20</u>	
Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>		
Recommendations	Safety Needs:	<u>2nd yr</u>	<u>NA</u>	<u>yes</u>	<u>yes</u>	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Swarupa</u>	<u>Deepa</u>	<u>Tuneri</u>	<u>Sudhi</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>10/7/26</u>	<u>11/7</u>	<u>11/7/26</u>	<u>11/7/26</u>	
Time:		<u>8pm</u>	<u>8am</u>	<u>8pm</u>	<u>8pm</u>	
Taken Over By Name :		<u>Tuneri</u>	<u>Tuneri</u>	<u>Sudhi</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>10/7</u>	<u>11/7/26</u>	<u>11/7/26</u>		
Time:		<u>8pm</u>	<u>8am</u>	<u>8pm</u>		

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: Tubes/Drains/Catheter: Vital Signs: Temp: Res: SpO ₂ : Pulse: BP: Fall Risk Score: Pain Score:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Recommendations	Safety Needs: Physiotherapy: Others Specify: Special Diet: Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Post Operative Procedure Special Orders:						
	Handed Over By Name :						
	Signature :						
	Date:						
	Time:						
	Taken Over By Name :						
	Signature :						
	Date:						
	Time:						



Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	10/7/26	10/7	11/7	Fall Risk Grading		
		Score	8am-8pm	8pm-8am	8am-8pm	Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25						
	No	0	0	0	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15						
	No	0	0	0	0			
Ambulatory Aid	Furniture	30				Low Risk	0 - 24	Standard Fall Precaution
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0	0	0			
IV / Heparin Lock or Saline	Yes	20	20	20	20	Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0		0				
GAIT / Transferring	Impaired	20				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0	0	0	0			
Mental Status	Forgets limitations	15						
	Oriented to own ability	0		0				
Total Morse Fall Scale Score:			20	20	20			
Signature			<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>			

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

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
10/7	8 AM	2/10	abdomen pain	☐ Continuous ☒ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☒ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Under observation	
10/7	10 AM	2/10	abdomen pain	☐ Continuous ☒ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☒ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Under observation	
10/7	12 PM	2/10	abdomen pain	☐ Continuous ☒ Intermittent	☐ Acute ☐ Chronic	☒ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Under observation	
10/7	12:30 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	
10/7	2 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Ajayli
10/7	3 PM	2/10	abdomen pain	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☒ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Breathing Exercise	Ajayli
10/7	3:30 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Ajayli
10/7	5 PM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Ajayli
10/7	9 PM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Healy
10/7	11 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Healy

Re-assessment Frequency:

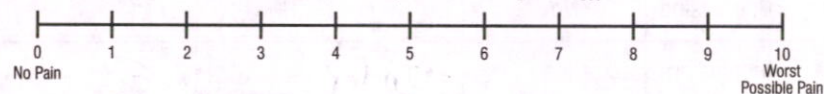
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

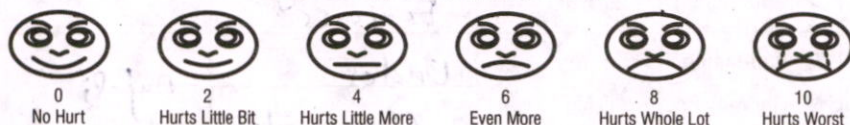
FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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 drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, 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

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years



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, SaO₂	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



PAIN ASSESSMENT FORM

Date	Time	(0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
11/7/26	5am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Tummy
11/7/26	11Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Tummy
11/7/26	5pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Tummy,
11/7/26	9pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Suckle
12/7/26	12pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Suckle
12/7/26	3pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Suckle
12/7/26	6pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Suckle
				☐ 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:

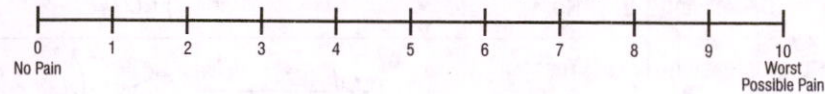
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PAIN ASSESSMENT TOOLS

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Wong - Baker (Pediatrics) Above 7 Years



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	10/4 DAY-1			11/7/26 DAY-2			12/7/26 DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0	0	0	0				
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	-	-	-	-	-	-				
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				[Signature]									

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 : [Signature] Name : [Name]

Signature of Ward In Charge :

Signature : [Signature] Name : [Name]

BAH-00640605 IP5-00176190
Mrs VAISHNAVI SHARMA
13-12-1997 28 Y 6 M 27 D (F)
Dr. PRANATHI REDDY A




**Rainbow[®]
Children's
Hospital**
It takes a lot to treat the little.


BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

POST – PARTUM ASSESSMENT FORM – IN-PATIENT

Date: 11/7/26

Chief Complaint : Pain at the suture site & lower back

Obstetric/ Birthing History : PHL, LSCS, POD-1

Previous Surgical/Medical History : -

Assessment :

On Observation: Mother seen in ☒ lying down /sitting/ reclined position

Mother is ☒ active & alert / drowsy / tired or exhausted / mobile by herself & ambulatory / needs assistance with mobility

Iv line ☒ / -

Catheter + / - ☒

Postural alignment -

On Palpation : Edema – absent / up to ☒ ankle / up to knee/ above knee

On Examination : Breathing pattern – abdominal/ ☒ apical/ diaphragmatic

Diastasis recti abdominis – present / absent / ☒ could not be assessed

Able to initiate Pelvic Floor Activation – ☒ Yes ☐ No

Spl Notes -

Treatment Plan :

☒ Lateral Breathing

☒ Pelvic Floor Activation

☒ Transversus Abdominis Activation

☒ Gluteus Activation

☒ Active Motion for Limbs

☒ Transfer Training & Mobility

☒ Sit to Stand

☒ Monitored Walk

☒ Posture & Ergonomic Education

Signature : T.S.

Name : Dr. Tuheena Sharma (PT)

Date & Time: 11/7/26 4:15 pm



OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 10/12/26 Time of Arrival: 7:00 AM Time Seen by Nurse: 7:05 AM

1) Level of Consciousness: ☒ Conscious ☐ Semi-Conscious ☐ Unconscious

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

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

3) Vital Signs: Temperature: 98°F Pulse: 82 bpm RR: 20 bpm SpO₂: 100% BP: 116/72 Weight: 99.9 kg

4) Gestational Criteria:

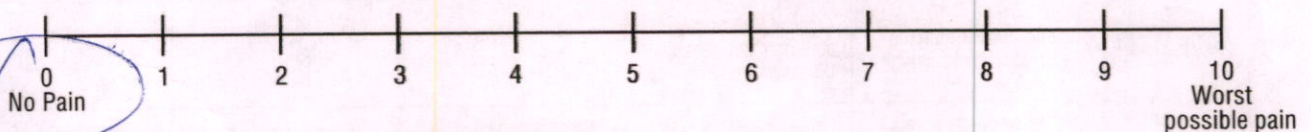
Gravida:	G	P	<u>primi</u>	L	A
----------	---	---	--------------	---	---

LMP: 9/10/26 EDD: 16/7/26 Gestational Age: 39+1 wks

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: No pain
- Interventions:

6) Past History:

- a) Surgeries: Nil
 b) Medical: cholelithiasis



7) Allergy: ☐ Yes ☒ No, If Yes :

8) Current Medications: ☐ Prenatal Vitamin ☒ None ☐ Others:

9) Prenatal Medical History:

- ☒ None ☐ Gestational Diabetes
☐ Chronic Hypertension ☐ Low placenta
☐ Gestational Hypertension ☐ Others if yes, specify
☐ Diabetes

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/ SRROM > 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: 7:10 AM

Nurse Name : Swaroopa Nurse Signature: Swaroopa

Date: 10/12/2016 Time: 7:00 AM



OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: <u>10/12/26</u>		
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: <u>clt leaking PV 6am</u>		Doctor Notified on Admission: ☐ Yes ☐ No
		Name of the Doctor:
		Time Notified:
Past Medical History: Obtained From ☐ Patient ☐ Family Member ☐ Medical Record ☐ Other (specify)		
Past Medical History	Past Surgical History	Previous Hospital Admission
<u>OTH X C</u>	<u>—</u>	<u>—</u>
Gynecology Assessment: ☐ Not Applicable	Gynecology Surgical History:	Gynecological History:
Menstrual History: <u>Regular</u>	Caesarean Section: ☐ No ☐ Yes	Contraceptives: ☒ No ☐ Yes
Onset of Menarche:	Cervical Cerclage: ☐ No ☐ Yes	Vaginal Discharge: ☒ No ☐ Yes
Menstrual Cycle: ☒ Regular ☐ Irregular	Ectopic Pregnancy: ☐ No ☐ Yes	Post-Coital Bleeding: ☒ No ☐ Yes
Last Menstrual Period: <u>9/10/20</u>	Myomectomy: ☐ No ☒ Yes	Infertility: ☒ No ☐ Yes
	Others:	If Yes Type: ☐ Primary ☐ Secondary
Obstetric History: G <u>1</u> P <u>2</u> L <u>—</u> A <u>—</u>		
Previous LSCS: <u>Neo</u>		
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: <u>98.2°F</u>	HR: <u>82/min</u>	RR: <u>20/min</u>
BP: <u>116/72</u>	Weight: <u>99.9</u>	Height: <u>1.58</u> 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 20 (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 husband

Orientation has been given regarding the following aspects:

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

Above information given to patient

Name of Person Orientation was given to: Mrs. Vaishnavi

Orientation not given Reason:

Nurse Signature: Ashwika

Nurse Name: Ashwika

Date & Time: 10/12/2020 6:00 AM



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

Patient's / Learner Language: Telugu/English Patient / Learner Literacy: ☒ Read ☐ Write ☐ Speak Willingness to Learn: ☐ Yes ☒ No Healthcare Literacy: ☒ Yes ☐ No

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
10/12/26	7:30	1, 2, 3, 4	Diagnosis, Treatment & care plan, pain management, Informed consent	PT	1	0	1	1		W Lu
10/7	9 AM	7, 9	Infection control measure	PT	1	0	1	1		S
11/2/26	8 AM	9	Topic not Lockdown hit	PT	1	0	1	1		few me

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C: Caregiver O: Other (Specify)							
Learning Barriers:							
1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice			
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)			
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing				
Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed							
Mechanism/s to overcome barrier/s:							
1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify				
2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference					
Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review							



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: primi / 39+4 wks / Spontaneous labour

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
10/1/26	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	primi / 39+4 wks / Spont	Safe Delivery	vaginal delivery	Dr. Pr	☐ Nursing ☐ Others:
10/1/26	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	care with heaving	prevent infection	NBT vitals medication	S.	☐ Medical ☐ Others:
11/7/26 8 am	☐ Medical ☐ Nursing ☒ Others: <u>high risk</u>	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	pon-1/LSCS	soft diet	soft high protein diet	Saima	☐ Medical ☐ Nursing ☐ Others:
11/7/26 4:15 pm	☐ Medical ☐ Nursing ☒ Others:	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	Post LSCS	Post partum recovery	Deep core retraining & functional training	T.S	☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

EM USG

PRE - OPERATIVE CHECK LIST

Patient's Name **BAH-00640605** **IP5-00176190**
Mrs VAISHNAVI SHARMA
Blood Group : **13-12-1997 28 Y 6 M 27 D (F)**
Planned Surgeon **Dr. PRANATHI REDDY A**
Anesthetist : ...



Date : **10/11/26**
Age : Gender : ☐ M ☒ F
.....
geon :
Operation : **10/11/26 @ 7pm**

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

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

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

Billing Clearance Taken : ☐ Yes ☐ No

Billing Executive Name : OT Nurse Name : **PL** ER/Ward Nurse Name : **Amr**
Billing Executive Signature : Signature of OT Nurse : **Rajon** Signature of ER/Ward Nurse : **Amr**
Date & Time : **10/11/26 @ 7pm** Date & Time : **10/11/26 @ 7pm**
Doc. No. : RCHBH/FRM/CLINICAL/007

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00640605 IP5-00176190 Mrs VAISHNAVI SHARMA 13-12-1997 28 Y 6 M 27 D (F) Dr. PRANATHI REDDY A 		Date & Time of Admission 10/7/16 2:30 PM	Date & Time of Transfer Order 10/7/16 11 PM
		Transfer Ordered by Dr Divya	Reason for Transfer Obstetric
From Unit OBS	To Unit Room (314)	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File No	Number of Imaging Films Nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	/		
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Dr Turner		Name of Person Ordered Transfer Dr Divya	
Patient & Clinical Records Received by : Yanna @ 11pm 10/7/16			
Date & Time of Patient Received : 10/7/16			

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

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Pranathi Reddy
Asst. Surgeon : Dr. Deepika
Anaesthetist : Dr. Shripa
Scrub Nurse : S. S. Bharathi

BAH-00640605 IPS-00176190
Mrs VAISHNAVI SHARMA
13-12-1997 28 Y 6 M 27 D (F)
Dr. PRANATHI REDDY A

je : Gender : F
Name :

Rainbow
Children's
Hospital
It takes a lot to treat the little.

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date : In-time : Out-time :

Before Induction of Anaesthesia >>

Before Skin Incision >>

Before Patient Leaves Operating Room

SIGN IN		Time: <u>6:04pm</u>
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 : <u>Dr. Shripa</u>		
Name : <u>Dr. Shripa</u>		

TIME OUT		Time:
Confirm all team members have introduced themselves by Name and Role		
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?		
Power Supply, Earthing, Power Backup and functioning of equipment checked. ☐ Yes ☒ No		
Signature : <u>Dr. Anjali</u>		
Name : <u>Dr. Anjali</u>		

SIGN OUT		Time:
Nurse Verbally Confirms with the Team:		
The Name of the Procedure Recorded	☒ Yes ☐ No	
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	☒ Yes ☐ No ☐ NA	
The Specimen is Labelled (including patient name)	☒ Yes ☐ No ☐ NA	
Whether there are any Equipment Problems to be addressed	☒ Yes ☐ No ☐ NA	
To Surgeon, Anaesthetist and Nurse:		
What are the key concerns for recovery and management of this patient? ☐ Yes ☒ No		
Signature : <u>Dr. Deepika</u>		
Name : <u>Dr. Deepika</u>		

SURGICAL SAFETY CHECKLIST

Surgeon :
Asst. Surgeon :
Anaesthetist :
Scrub Nurse :

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



Before Induction of Anaesthesia ➤ ➤

SIGN IN		Time:.....
Patient Has Confirmed		
Identity	☐ Yes ☐ No	
Site	☐ Yes ☐ No	
Procedure	☐ Yes ☐ No	
Consent	☐ Yes ☐ No	
Site Marked	☐ Yes ☐ No ☐ NA	
Anaesthesia Safety Check Completed	☐ Yes ☐ No	
Pulse Oximeter on Patient & Functioning	☐ Yes ☐ No	
Does Patient have a:		
Known Allergy?	☐ Yes ☐ No	
Difficult Airway / Aspiration Risk?		
Yes, & Equipment / Assistance Available	☐ Yes ☐ No	
Risk of > 500ml Blood Loss (7ml/kg In Children)?		
Yes, and Adequate Intravenous Access and Fluids Planned	☐ Yes ☐ No ☐ NA	
Blood Units Reserved	☐ Yes ☐ No ☐ NA	
Has Antibiotic Prophylaxis been given within the last 60 minutes?	☐ Yes ☐ No ☐ NA	
Signature :		
Name :		

Before Skin Incision ➤ ➤

TIME OUT		Time:.....
Confirm all team members have introduced themselves by Name and Role ☐ Yes ☐ No		
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm		
Correct Patient (Check ID Band)	☐ Yes ☐ No	
Correct Site	☐ Yes ☐ No	
Correct Procedure	☐ Yes ☐ No	
Anticipated Critical Events		
Surgeon Reviews:		
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? ☐ Yes ☐ No ☐ NA		
Anaesthesia Team Reviews:		
Are There Any Patient-specific Concerns? ☐ Yes ☐ No ☐ NA		
Nursing Team Reviews:		
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☐ Yes ☐ No ☐ NA		
Is Essential Imaging Displayed? ☐ Yes ☐ No ☐ NA		
Power Supply, Earthing, Power Backup and functioning of equipment checked. ☐ Yes ☐ No		
Signature :		
Name :		

Before Patient Leaves Operating Room

SIGN OUT		Time:.....
Nurse Verbally Confirms with the Team:		
The Name of the Procedure Recorded	☐ Yes ☐ No	
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	☐ Yes ☐ No ☐ NA	
The Specimen is Labelled (including patient name)	☐ Yes ☐ No ☐ NA	
Whether there are any Equipment Problems to be addressed	☐ Yes ☐ No ☐ NA	
To Surgeon, Anaesthetist and Nurse:		
What are the key concerns for recovery and management of this patient? ☐ Yes ☐ No		
Signature : <i>Deen</i>		
Name : <i>Deen</i>		



INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

Patient Name : Vaishnavi Sharma Gender: ☐ Male ☒ Female Age : 28
UHID No : BAH-00640605 Date : 10/7/26

Instruction:

This consent form should be signed by Patient (If an adult 18 years or older) or by a parent / guardian, if the patient is a minor or lacks the ability to make an informed decision. The purpose of this form is to verify that you have received this information and have given your consent to the surgery or special procedure recommended to you.

I hereby authorize the performance of the following operation (s) or procedure (s) (use no abbreviation / Avoid technical terms)

EMERGENCY LOWER SEGMENT CAESAREAN SECTION

upon

VAISHNAVI SHARMA 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.

Hemorrhage, Sepsis, Injury to Bowel & Bladder, Injury to major Blood vessels, Need for Blood & blood products, Need for prolonged Hospital stay

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. Pranathi Reddy

Consentee :

Signature : [Signature]

Name : Vaishnavi Sharma

Date & Time : 10/7/26 @ 5:30pm

Witness :

Signature : [Signature]

Name : Reddy

Date & Time : 10/7/26 @ 5:30pm

Docu. No. : RCHBH / FRM / CLINICAL / 027

Patient Attendant :

Signature : [Signature]

Name : Pijush Nakata

Relationship with Patient : Husband

Date & Time : 10/7/26 @ 5:30pm

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Rameene

Date & Time : 10/7/26 @ 5:30pm

CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☒ Patient Attendant

Operative Procedure: EMILEY

Anaesthesiologist: DR. K. SPIRANAYA Surgeon: Dr. Pranamini Reddy

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 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 ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders
☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease
☐ Others Hypotension, Apnoea

Declaration by Patient Attendant

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team
☒ Regional Anaesthesia ☒ General Anaesthesia ☐ Monitored Anaesthesia Care
- 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, allergic reactions, headaches, variations in blood pressure, nausea and vomiting.
- I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Access, arterial line, use of suppositories and or nerve blocks for pain relief, changing from regional to general anaesthesia etc) which are considered necessary by them during the course of surgery.
- I also 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 if need arises.
- I acknowledge that the anaesthesiologist have informed me about the anaesthetic procedure, risk, benefits and alternative treatments.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: Pijush Nahata

Name: Pijush Nahata

Relationship with patient: Husband

Date & Time: 10/7/26 @ 6 pm

Witness:

Signature: Dr. Pranamini Reddy

Name: Dr. Pranamini Reddy

Date & Time: 10/7/26 @ 6 pm

Doctor (who is taking consent):

Signature: Dr. Shree Name: Dr. Shree

Date: 10/7/26 Time: 6 pm

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స:

అనస్థీషియా వైద్యుడు: శస్త్రచికిత్స నిపుణుడు:

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

సాధారణ అనస్థీషియా అనేది శస్త్రచికిత్స ముందు రోగిని పూర్తిగా అవస్థాపక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్థాపన ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు.

రీజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్కోటిక్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై రిస్క్:

క్రింద పేర్కొన్న వైద్య సమస్యల కారణంగా ఉండే అధిక ప్రమాదాల గురించి వైద్యులు నాకు వివరంగా చెప్పారు. నాకు ఉన్న సందేహాలను నేను అడిగాను మరియు అవి నివృత్తి చేయబడ్డాయి.

☐ హృదయ వ్యాధి ☐ రక్తపోటు ☐ మధుమేహం ☐ మూత్రపిండాల వైఫల్యం ☐ బహుళ అవయవ వైఫల్యం

☐ కాలేయ సమస్యలు ☐ షాక్ ☐ ఊబకాయం ☐ దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)

☐ ఇతరవి:

రోగి / రోగి అటెండెంట్

- అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
☐ రీజనల్ అనస్థీషియా ☐ జనరల్ అనస్థీషియా ☐ మానిటర్డ్ అనస్థీషియా కేర్
- అనస్థీషియా ఉపయోగంలో అప్పుడప్పుడూ జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. వీటిలో ఇంజెక్షన్ ఇచ్చిన చోట నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అలెర్జిక్ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెనస్ యాక్సెస్, ఆర్టిరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాక్కులు, రీజనల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందానికి నేను అనుమతి ఇస్తున్నాను.
- శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న వైద్యుల బృందానికి కూడా నేను అనుమతి ఇస్తున్నాను.
- అనస్థీషియా విధానం, ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయ చికిత్సల గురించి అనస్థీషియా వైద్యులు నాకు వివరించినట్లు నేను అంగీకరిస్తున్నాను.
- పై సమాచారం అంతా నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో వాటికి సమాధానాలు ఇచ్చారు. ఈ అనుమతి నేను పూర్తిగా స్వచ్ఛమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

BAH-00640605 IPS-00176190
Mrs VAISHNAVI SHARMA
13-12-1997 28 Y 6 M 27 D (F)
Dr. PRANATHI REDDY A



Rainbow
Children's
Hospital
It takes a lot to treat the little.

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: Vaishnavi sharma Age: 28 Sex: F UHID.No:

Date: Time: Proposed Operation:

Diagnosis: pnm: 39+2w 1st x/clo cholelithiasis

B.P / CRT: H.R: Weight: ASA Physical Status: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 12.5 Glucose: Protein: HIV: X-Ray:
PCV: Urea: Alb: HBS Ag: } NR ECG:
WBC: 11.80 Creat: Total Bill: HCV: } NR 2D Echo:
Plate: 267 Na: Dir. Bill: Blood group: B+ve Stress/Angio:
PT: K: LDH: T3 Other:
PTT: Ca++: Alk phos: T4
INR: Mg++: Amylase: TSH
Cl -: SGOT/SGPT:

Allergies: OPloxacin
wasabi

Medical History: CVS:

RESP:

Diabetes:

CNS:

Renal:

Hepatic / GE:

Physical Activity:

Others:

Past Anaesthetic History:

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: > 4cm Mentohyoid Distance: 4cm Neck: (2) Teeth: (1)

Lungs: RLL (1) clear

Heart: (1) clear

CNS: (1) clear

Pregnant: ☒ Yes ☐ No ☐ NA

Venous Access Site: (1) clear

Spine Exam for regional:

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

- DVT Prophylaxis:
 - Water / ORS 2 Hours
 - Others 6 Hours
- NIL ORAL: } 30 min
- Informed Consent: ☒ Standard ☐ High Risk
- Post Operative Pain Management: ☒ Discussed with Patient
- Other Instructions: last lab done 3 o'clock

Signature: [Signature] Name: Dr. P. R. Ramesh

Patient Induction Assessment:		☐ Yes ☒ No	Fasting Status: <u>Guhmed</u>
Physical Status:	☒ Patient Identified	☐ Consent Present	☒ Chart Reviewed
H.R.: <u>67</u>	B.P / CRT: <u>128/70-86</u>	SpO ₂ : <u>99</u>	R.R.: <u>15 BPM</u>
Pre-OP Diagnosis: <u>p.m.i. 39+10 k.k/a Cholelithiasis</u>		Operation: <u>EMLEY</u>	Last Feed: <u>Sun 2:00PM</u>
Surgeon:		Anaesthesiologist:	Technician:
TIME: <u>5:45 x 45 - 7 x 30 x 30.</u> N₂O / AIR / O₂ LPM HALO / SO / SEVO Drugs: Antibiotic Suppository Blood Loss NOTES FiO₂ / SaO₂ ETCO₂ ECG Temperature Urine Output Fluids Blood B.P V Systolic A Diastolic X Mean * Heart Rate Tourniquet on Time Tourniquet off Time Throat Pack In Throat Pack Out LAB Values ABG GRBS Others			
☒ Equipment Checked and Functional ☐ BP ☒ Cuff Site: <u>(R)</u> ☐ Art Site: ☒ EKG Lead <u>green</u> ☐ Temp Site ☐ FIO ₂ Monitor ☐ Agent Monitor ☒ Pulse Oximeter ☐ Capnograph ☐ Ventilator ☐ Nerve Stimulator Position: <u>spinal</u> ☒ Pressure Points Checked		Temp: ☐ HME ☐ Fluid Warmer ☐ Cling Film ☐ OH Warmer ☐ Hugger's ☐ Cotton Wool ☐ Other Times: Anaes Start: <u>6:15 PM</u> OP Start: <u>6:20 PM</u> OP End: Leave OR: -Anaesthesia: ☐ GA ☐ Monitored Anaesthesia Care ☒ Regional Line (Size & Location) ☐ CVP: ☐ ART: ☒ IV: <u>@ Right Hand</u> ☐ IV: ☐ IV:	
Induction ☐ IV ☐ Inhal ☐ Pre O₂ ☐ 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?		Regional: Extremity Specify: <u>L Abduct</u> ☒ Spinal ☐ Epidural ☐ Caudal Others: Position: <u>sitting position</u> Site: Needle Size: <u>25</u> Depth: Parathesia ☐ Yes ☐ No Catheter at skin cm Drug Name & Conc: <u>0.5% Bupivacaine (A)</u> Bolus: <u>1.6cc + 20mg PENTAMID</u> Infusion: Block Level: <u>T-12</u> Comments: Transportation to ☒ PACU ☐ ICU ☐ Other Relaxant Reversed ☐ Yes ☐ No ☐ NA Name of the Doctor: <u>D.R.K. SRIPANMAYAL</u> Signature of the Doctor: <u>[Signature]</u>	



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: Bharathi Time Received: 7:30 pm Time Discharged:

250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 SPO ₂	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	IV Cannula Site: <u>Left hand</u> ☐ O ₂ Mask ☐ Nasal Prongs ☐ Tracheostomy ☐ T-Piece ☐ Oral Airway ☐ Nasal Airway
		Vomiting: ☐ Yes ☒ No NG Tube: ☐ Yes ☒ No Drain: ☐ Yes ☒ No Urinary Catheter: ☒ Yes ☐ No Chest Tube: ☐ Yes ☒ No Nil Oral ☒ Yes ☐ No IV Fluids: <u>Ringer lactate</u> Oral Feeds: <u>Nil</u>

POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	MINUTES			OUT	SCORING INTERPRETATION
				30	60	90		
Able to move 4 extremities voluntary or on command	= 2	ACTIVITY	1	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 move 2 extremities voluntary or on command	= 1		2	2	2	2		
Able to move 0 extremities voluntary or on command	= 0							
Able to deep breathe & cough freely	= 2	RESPIRATION	2	2	2	2		
Dyspnea or limited breathing	= 1		2	2	2	2		
Apneic	= 0							
BP $\pm$ 20 of Pre Anaesthetic leve	= 2	CIRCULATION	2	2	2	2		
BP $\pm$ 20-50 of Pre Anaesthetic leve	= 1		2	2	2	2		
BP $\pm$ 50 of Pre Anaesthetic leve	= 0							
Fully awake	= 2	CONSCIOUSNESS	2	2	2	2		
Arousable on calling	= 1		2	2	2	2		
Not responding	= 0							
Pink	= 2	COLOR	2	2	2	2		
Pale, dusky, blotchy, jaundiced, other	= 1		2	2	2	2		
Cyanotic	= 0							
TOTAL			9	9	10	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
10/7	7:30 pm	0	NA	Tony
10/7	7:30 pm	0	NA	Tony

Pain Tool Used: ☐ N PASS ☐ FLACC ☐ Wong Baker ☐ NPS

Reassessment Frequency:

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

Anaesthesiologist Name: Dr. K. R. R. R. R.

Anaesthesiologist Signature: [Signature]

Date & Time: 10/11/26 @ 10:30 pm

PACU Nurse Name: Tony

PACU Nurse Signature: [Signature]

Date & Time: 10/11/26 @ 7:30 pm

Transferred to Unit by (PACU): ORIS

Date & Time: 10/11/26 @ 7:30 pm

Patient Sticker

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		Maternal		FHR	Comments
			Left	Right	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 :



CAESAREAN SECTION OPERATIVE NOTES

Surgeon's Name: <u>Dr. Pranathi Reddy</u>	Date of Delivery: <u>10/7/16</u>
Assistant Surgeon: <u>Dr. Deepika Reddy</u>	Time of Delivery: <u>6:29 pm</u>
Anaesthetist's Name: <u>Mr Shiffa</u>	Gender of Baby: <u>Male</u>
Type of Anaesthesia: <u>Spinal</u>	Weight of Baby: <u>3.289 kg</u>
Neonatologist: <u>Dr. parvathi</u>	AGPAR Score: <u>10/10</u>
Scrub Nurse: <u>Dr. Bhavathi</u>	NICU Admission: ☐ Yes ☒ No

Pre-Operative Diagnosis: <u>Prim 39+ weeks -</u>	
☐ Elective ☒ Emergency	Indication: <u>non progression of labor</u>
Urgency ☐ Immediate Threat to life of woman or fetus ☒ Maternal or fetal compromise not immediately life threatening ☐ No maternal or fetal compromise but needs early delivery ☐ Delivery timed to suit woman and staff	
Decision time: Knife to rectus:	
CTG Description: <u>reactive</u>	
If there was a delay give the reasons:	

Surgical Procedure: <u>Emergency lower segment cesarean section</u>

Post Operative Diagnosis: <u>POD 0, P, 4</u>
--

Peri-Operative Complications: <u>Nil</u>
--

Amount of Blood Loss: <u>500 ml</u>	Blood Transfused (in ML): <u>nil</u>
-------------------------------------	--------------------------------------

Name and Number of Surgical Specimen sent for examination:
--

Examination Findings when Appropriate:

Presentation: ☒ Cephalic ☐ Breech ☐ Other 2cm
 Cervical Dilatation: cm
 5th Palpable:
 Fetal Position:
 Station: ☒ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2
 Moulding: ☒ None ☐ + ☐ ++ ☐ +++
 Caput: ☒ + ☐ ++ ☐ +++
 Meconium: ☒ None ☐ + ☐ ++ ☐ +++
 Bladder Catheterized: ☒ Yes ☐ No
 Urine: ☒ Clear ☐ Blood Stained

Skin Incision: ☒ Pfannenstiel ☐ Transverse ☐ Midline ☐ Other
 Uterine Incision: ☒ Lower Segment ☐ Classical ☐ Inverted T ☐ J Incision
 Previous Scar: ☐ Intact ☐ Thinned out ☐ Ruptured ☒ No Scar
 Incision Through Placenta: ☐ Yes ☒ No
 Delivery of head: ☐ Manual ☒ Forceps Single blade Forceps
 Liquor: ☒ Clear ☐ Meconium: ☐ I ☐ II ☐ III ☐ Blood ☐ Offensive ☐ Not Offensive
 Delivery of Placenta: ☐ Manual ☒ CCT ☐ Complete ☐ Incomplete ☐ Piecemeal
 Cord Appearance: Normal Cord around the neck ☐ Yes ☒ No
 Appearance of placenta: Normal Cavity explored ☒ Yes ☐ No
 Uterus, tubes and ovaries: ☒ Normal ☐ Not Normal Sterilization: ☐ Yes ☒ No

Uterine Closure: ☐ One Layer ☒ Two Layers No 1-0 vicryl Suture
 Peritoneal Closure: ☒ Pelvic ☐ Abdominal ☐ None No 2-0 rapid vicryl Suture
 Sheath Closure: No 1-0 vicryl Suture
 Fat Closure: ☐ Yes ☐ No No 2-0 rapid vicryl Suture
 Skin Closure: ☒ Subcuticular ☐ Mattress No 2-0 rapid vicryl Suture

Vaginal Evacuated ☒ Yes ☐ No
 Drain: ☐ Yes ☒ No ☐ Remove in days ☐ Await instructions
 Catheter ☒ Yes ☐ No ☐ Remove in 12hr days ☐ Await instructions
 Swap & Instruments count correct? ☒ Yes ☐ No ☐ Post-op Antibiotics ☒ Yes ☐ No
 Intra-Operative Antibiotics Cover: ☒ Yes ☐ No ☐ Thromboprophylaxis ☒ Yes ☐ No
 Post-Operative Notes: NBM till tomorrow morning
 clear wounds tomorrow @ 6am
 Drugs & charted
 Vitals every 15min for the 1st 2hrs
 w/ hypotension, tachycardia & bleeding pt
 c/o tomorrow morning

Doctor Name: Dr. Pranathi Reddy

Doctor Signature: Dr. Pranathi Reddy

Date & Time: 10/7/2020 11:00am



POST-SURGICAL CARE PLAN FORM

Procedure Done: Emergency lower segment cesarean section

Post-Surgical Diagnosis: POD-0, P.H.

Post-Operative Monitoring Parameters /Frequency:

BP/PR/spO₂/I/O/w/f bleeding IV - every 15min for
1hr PR 1hrly for 2hrs.

Wound Care:

Dressing x 48hrs

Drain /Special Lines/Catheters:

Catheter x 48hrs
Cannula - 2hrs

Special Patient Positioning and Requirements:

NT

Nutritional Instructions:

NBM x today

When to Start Mobilization:

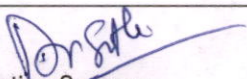
after catheter removed

Special Referrals:

The new order for all required medications documented in the doctor order/medication sheet:

☒ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up


Treating Surgeon
(Signature & Stamp)

Date: 10/7/26 Time: 9:30 PM

Note: Plan of care will be readjusted if necessary.



RISK ASSESSMENT TOOL FOR DEEP VEIN THROMBOSIS (Postnatal Assessment and Management (to be assessed on delivery suite))

Pre-Existing Risk Factors Tick Score	Tick	Score
Previous VTE (except a single event related to major surgery)		4
Previous VTE provoked by major surgery		3
Known high-risk thrombophilia	☒	3
Medical comorbidities e.g. cancer, heart failure; active systemic lupus erythematosus, inflammatory poly arthropathy or inflammatory bowel disease; nephrotic syndrome; type-I diabetes mellitus with nephropathy; sickle cell disease; current intravenous drug user	☒	3
Family history of unprovoked or estrogen-related VTE in first-degree relative		1
Known low-risk thrombophilia (no VTE)	☒	1
Age (? 35 years)	☒	1
Obesity	☒	1 or 2
Parity ≥ 3		1
Smoker	☒	1
Gross varicose veins		1
Obstetric Risk Factors		
Pre-eclampsia in current pregnancy		1
ART/IVF (antenatal only)	☒	1
Multiple pregnancy		1
Caesarean section in labour	☒	2
Elective caesarean section		1
Mid-cavity or rotational operative delivery	☒	1
Prolonged labour (? 24 hours)	☒	1
PPH (? 1 litre or transfusion)	☒	1
+0 Preterm birth? 37 weeks in current pregnancy	☒	1
Still birth in current pregnancy	☒	1
Transient Risk Factors		
Any surgical procedure in pregnancy or puerperium except immediate repair of the perineum, e.g. appendicectomy, postpartum sterilization	☒	3
Hyperemesis	☒	3
OHSS (first trimester only)	☒	4
Current systemic infection	☒	1
Immobility, dehydration	☒	1
Total		

Signature of the Doctor: [Signature] Date: 10/7/20 Time: 9:20 AM

Action Plan: Hydration & Ambulation

Risk Assessment Tool for Deep Vein Thrombosis

- ☐ If total score ≥ 4 antenatally, consider thromboprophylaxis from the first trimester.
- ☐ If total score 3 antenatally, consider thromboprophylaxis from 28 weeks.
- ☐ If total score > 2 postnatally, consider thromboprophylaxis for at least 10 days.
- ☒ If total score = 2, Hydration & Ambulation.
- ☐ If admitted to hospital antenatally consider thromboprophylaxis.
- ☐ If prolonged admission (≥ 3 days) or readmission to hospital within the puerperium consider thromboprophylaxis.
- ☐ For patient with an identified bleeding risk, the balance of risks of bleeding and thrombosis should be discussed in consultation with a haematologist with expertise in thrombosis and bleeding in pregnancy.

Patient Sticker

BAH-00640605 IP5-00176190
 Mrs VAISHNAVI SHARMA
 13-12-1997 28 Y 6 M 27 D (F)
 Dr. PRANATHI REDDY A

rainbow
 children's
 hospital
 a lot to treat the little.

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 10/7/22

Department : OBG OT Duration of Procedure : 1 hour

Name of Surgeon : Dr. Pranathi Date of Admission : 10/7/22

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

		Staff Signature
1.	Antibiotic given prior to surgery ? ☒ Yes ☐ No ☐ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☒ Yes ☐ No Name of the Antibiotic : <u>Inj. Taxim</u>	5:20 pm Bharathi
2.	Hair Removal ☒ Yes ☐ No if Yes : Surgical Clipper Department where Hair Removed : ☒ Ward ☐ Operating Room ☐ Other : _____ Skin preparation done (cleanse surgical area with antiseptic agent)? ☒ Yes ☐ No	Bharathi
3.	Patient's body temperature immediately post operation (Recovery Room) _____ °C ☐ Oral Or ☒ Axilla (Goal : 36-37 °C)	Bharathi
4.	Name of doctor or staff administering the antibiotic : <u>Bharathi</u> Date & Time of antibiotic administration : <u>10/7/22 @ 5:20 pm</u> Date & Time procedure started : <u>10/7/22 @</u>	Bharathi

- 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

Docu. No. : RCHB/ FRM / CLINICAL / 038



Page 1 of 1
Date: 10/10/2010
Time: 10:10:10

UNIT 1: THE HISTORY OF THE UNITED STATES

LESSON 1: THE FOUNDING FATHERS

1.1 The American Revolution and the Founding Fathers

1.2 The Constitution and the Bill of Rights

1.3 The Federalist Papers and the Ratification of the Constitution

1.4 The Early Years of the Republic

1.5 The Legacy of the Founding Fathers

1.6 The Role of the President

1.7 The Role of the Congress

1.8 The Role of the Judiciary

1.9 The Role of the States

1.10 The Role of the People

1.11 The Role of the Media

1.12 The Role of the Economy

1.13 The Role of the Environment

1.14 The Role of the Culture

1.15 The Role of the Education

1.16 The Role of the Science

1.17 The Role of the Technology

1.18 The Role of the Art

1.19 The Role of the Literature

1.20 The Role of the Music

1.21 The Role of the Film

1.22 The Role of the Television

1.23 The Role of the Internet

1.24 The Role of the Social Media

1.25 The Role of the Mobile Phone

1.26 The Role of the Cloud Computing

1.27 The Role of the Big Data

INFORMED CONSENT FOR VAGINAL BIRTH

Patient Name: Ms VAISHNAVI UHID No: BAH-0064060
Gender: ☐ Male ☒ Female Date: 10/7/2025 Time: _____

I hereby authorized the performance of the following procedure:

- The Procedure has been explained to me in general terms and I understand that:
- The indication requiring the procedure of vaginal birth is pregnancy.
- The purpose of this procedure of vaginal birth pregnancy.
- The purpose of this procedure is to deliver the baby vaginally.

The outcome of the vaginal birth is the delivery of infant through birth canal either naturally or with possible use of force vacuum extraction. An episiotomy (a cut performed for enlarging of the vaginal opening in the space between the vaginal and the rectum) may be performed as part of a vaginal delivery.

Should vaginal delivery be unsuccessful, delivery by cesarean section with an abdominal incision under appropriate anesthesia may be necessary.

In an attempt to deliver the baby either naturally or with the help of instrument i.e. forceps or vacuum, there may be risks of: infection, allergic reaction, scarring, blood loss, need for blood transfusion, pain and discomfort, injury to urinary tract, possible injury to the baby (laceration, hematoma, skull fracture, nerve injury and brain injury) and possible future pelvic floor dysfunction,

I understand and accept that there are complications, benefits, alternatives including the remote risk of death or serious disability, which exists for me and my baby.

I am aware that in most cases, vaginal delivery results in a healthy mother and baby; however, I realize that there are no guarantees.

I voluntarily consent to the procedures described or otherwise referred to herein. I am aware that they will be performed by a qualified gynecologist.

Name of the Doctor performing the procedure: Dr. Pranathi Reddy

Consentee :

Signature: [Signature]

Name: Varshavi Sharma

Date & Time: 10/2/26 9:15 AM

Witness :

Signature: [Signature]

Name: Krishna Kanth Sharma

Date & Time: 10/2/26 9:15 AM

Docu. No. : RCHBH / FRM / CLINICAL / 028

Patient Attendant :

Signature: [Signature]

Name: Piyush Mahata

Relationship with Patient: Husband

Date & Time: 10/2/26 9:15 AM

Doctor (who is taking the consent) :

Signature: [Signature]

Name: Dr. Grace Kony

Date & Time: 10/7/2026 7:30 AM

సహజ ప్రసవం కొరకు సమ్మతి పత్రము

రోగి పేరు : వయస్సు లింగం పు స్త్రీ

యు.హెచ్.ఐ.డి. విభాగము

తేదీ

ఈ ప్రక్రియ యొక్క వివరములను నేను అమోదించాను:

- ఈ ప్రక్రియ నాకు సాధారణ పద్ధతిలో వివరించబడింది మరియు నేను అర్థం చేసుకున్నాను:
- గర్భం దాల్చిన వారికీ సహజ ప్రసవ ప్రక్రియ అవసరమవుతుంది.
- ఈ ప్రక్రియ యొక్క ఉద్దేశ్యం (యోని) ద్వారా సహజ ప్రసవం చేయడం.
- ఈ ప్రక్రియ యొక్క ఉద్దేశ్యం బిడ్డను సహజమయిన పద్ధతిలో ప్రసవించటం

సహజ ప్రసవం (యోని జననం) యొక్క ప్రక్రియ సహజంగా లేదా శక్తిని ఉపయోగించి గర్భాశయం ద్వారా శిశువును ప్రసవించడం. వాక్యూమ్ ద్వారా శిశువును వెలికితీయడం, ఎపిసియొటమీ (యోని మరియు యోని మధ్య ఖాళీలో యోని మార్గమును సుగమం చేయుట కొరకు చేసిన కోత (కట్). సహజ ప్రసవం కొరకు చేయు ప్రక్రియలలో భాగము.

సహజ ప్రసవం విజయవంతం కాకపోతే, తగిన అనస్థీషియా ఇచ్చి పాత్రికడుపు కోతతో సిజేరియన్ ద్వారా డెలివరీ చేయవలసిన అవసరం కలగవచ్చు

సహజంగా లేదా పరికరం సహాయంతో అంటే ఫోర్సెప్స్ లేదా వాక్యూమ్ సహాయంతో బిడ్డను ప్రసవించే ప్రయత్నంలో, ప్రమాదాలు ఉండవచ్చు; అంటువ్యాదులు, అలెర్జీ, మచ్చలు, రక్త నష్టం, రక్త మార్పిడి అవసరం పడటం, నొప్పి మరియు అశాకార్యం, మూత్ర నాళానికి గాయం, శిశువుకు గాయం అయ్యే అవకాశం (లేసరేషన్, హెమటోమా, పుర్రె గాయం ఆయె అవకాశం, నరాలకు గాయం మరియు మెదడు గాయం) మరియు భవిష్యత్తులో కటి ప్రదేశంలోని ఎముకల వలయం పనిచేయకపోవడం

నాకు మరియు నా బిడ్డకు మరణం లేదా తీవ్రమైన వైకల్యం వంటి సమస్యలు తలెత్తు అవకాశం, ప్రయోజనాలు మరియు ప్రత్యామ్నాయాలు ఉన్నాయని నేను అర్థం చేసుకుని అంగీకరిస్తున్నాను.

చాలా సందర్భాలలో, యోని ద్వారా ప్రసవించడం వల్ల తల్లి మరియు బిడ్డ ఆరోగ్యంగా ఉంటారని నాకు తెలుసు; అయితే, ఎటువంటి హామీలు ఇవ్వలేరని నేను గ్రహించాను

ఇక్కడ వివరించిన లేదా సూచించిన విధానాలకు నేను స్వచ్ఛందంగా సమ్మతిస్తున్నాను. ఈ ప్రక్రియ అర్హతగల గైనకాలజిస్ట్ చేత నిర్వహించబడతాయని నేను తెలుసుకున్నాను

ఈ ప్రక్రియను నిర్వహించే డాక్టరు పేరు:

సహాయకుడు(అటెండెంట్)

సాక్షి

సంతకము

సంతకము

పేరు

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

తేదీ మరియు సమయము

సంతకము

పేరు



URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 10/7/26

Date of Removal: 11/7/26 @ 12pm

Parameters	Date	Shift Time						
Need for the Catheter	10/7/26	8pm 8am	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hand Hygiene			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Usage of Sterile Equipment			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the Collection bag below the level of bladder			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Check the Tube for Obstruction (Free of Kinking)			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Catheter dated as policy			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Collecting bag is been emptied regularly?			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Maintenance of closed system for the catheter			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing clean and dry?			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the line removed as Policy?			☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Performance of Perineal Care			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Onset of New Fever			☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Asses for the leakage at the site of insertion			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Nurse			Punp					
Signature of the Nurse			TM					

BAH-00640605 IP5-00176190
Mrs VAISHNAVI SHARMA
13-12-1997 28 Y 6 M 27 D (F)
Dr. PRANATHI REDDY A



314

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

NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 11/7/26 Time: 8 am

Origin: Indian Height: 108 cm Weight: 99.9 kg BMI: 65.86 kg/m²

Food Allergies: NO

Diagnosis: post-1/LSCS lower segment cesarean section

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

Diet Advised: Soft diet @ 9 am

Patient's / Attendant's

Dietician's

Signature: Krishna

Signature: Rama

Name: Krishna Karth Sharma

Name: Rama

Date & Time: 11/7/26 8 am

Date & Time: 11/7/26 8 am

DIETARY NOTES[illegible]

BREAST FEEDING HANDOVER AND ASSESSMENT FORM

1. Breastfeeding initiated?

- ☒ a. Yes ☐ b. No

2. If No, Reason

3. Nipple condition:

- ☒ a. Nipple well formed
☐ b. Flat nipple
☐ c. Inverted nipple
☐ d. Short nipple

4. Milk flow:

- ☐ a. Good
☒ b. Drops of colostrums
☐ c. Dry

5. Steps for Positioning and attachment:

- ☒ a. Baby goes to the breast
☐ b. Mother always sits with a back support
☐ c. Ear-shoulder-hip should be in a straight line
☐ d. The baby takes a latch on the areola and not on the nipple



Feeding Positions:
Cross Cradle



Feeding Positions:
Football / Clutch

6. Was the position explained:

- ☒ a. Yes
☐ b. No

7. For Caesarian mothers:

- ☒ a. Mother is required sit and feed from the 4th feed
☐ b. Please explain football hold

8. NICU admission:

- ☐ a. Mother needs to stimulate her breast for 2 min every 2 hours

9. Additional notes:

Continuity of Care:

Date: 10/7/26

Nipple well formed
Drops of Colostrum coming

Handover given by Shanthi

Signature [Signature]

Date & Time: 10/7/26 @ 8pm

Handover taken by Tony

Signature TM

Date & Time: 10/7/26 @ 8pm

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DISCHARGE PLANNING FORM

Nationality: Indian

NOTES: * To be completed by a NURSE within (24) hours of admission.

1. Anticipated Date of Discharge:

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☐ Self Care ☐ Family Home Care ☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☐ Medication ☐ Yes ☒ No

☐ Bathing ☐ Yes ☒ No

☐ Eating ☐ Yes ☒ No

☐ Walking ☐ Yes ☒ No

☐ Dressing ☐ Yes ☒ No

☐ Toileting ☐ Yes ☒ No

do need any
Assistance

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☒ Patient ☐ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☒ Patient ☐ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: Hand hygiene

☐ Patient's Educational Topic/s discussed with the:

☒ Patient ☐ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: Swarupa

Date and Time: 10/7/26 @ 9AM