

Mrs BARIRA FAREED (31 Y 2 M 4 D/ F)
 TISSUE
 LBPA0445
 BA26065896020
 BAH-00651306

Shelkar

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

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SURGERY DETAILS

BAH-00651306 IP5-00175716
 Mrs BARIRA FAREED
 27-04-1995 31 Y 2 M 4 D (F)
 Dr. PRANATHI REDDY A

Date : 1/2/26

Patient Name : Date of Birth : Age :

Gender : UHID No. :

Date of Surgery : ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Emergency LSC under Spinal Anesthesia

Time in : 11.30 AM Time Out : 12.30 PM

	NAME	AMOUNT
1. Surgeon	Dr. Pranathi Reddy	
2. Anaesthetist	Dr. Adhi	
3. Assistant Surgeon	Dr. Bhargavi	
4. OT Technician	Vijay	
5. Circulating Nurse	J Sheraasha	
6. Assistant Nurse	Sis. Laxmi	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9682686

Order by:

Patient Sticker


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CONSUMABLES OF OTCirculating staff : Technician : Kulsum Date : 1/7 **3679** Time :

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube			Major Pack <u>LS63</u>	<u>01</u>	<u>01</u>	Inj Vit.K	<u>01</u>	<u>01</u>
LMA			Sutures <u>2346</u>	<u>01</u>	<u>01</u>	Cord Clamp	<u>01</u>	<u>01</u>
ECG leads : <u>A/P/N</u>	<u>03</u>	<u>03</u>	<u>2364</u>	<u>01</u>	<u>01</u>	Suction Catheter <u>89</u>	<u>01</u>	<u>01</u>
HME filter : A/P/N			<u>2762</u>	<u>01</u>	<u>01</u>	Feeding Tube		
Syringes : 10 cc	<u>03</u>	<u>03</u>				Vaccum Suction Set	<u>01</u>	<u>01</u>
05 cc	<u>03</u>	<u>03</u>	Gloves <u>6/642</u>	<u>14</u>	<u>14</u>	Surgical Gloves <u>7/642</u>	<u>14</u>	<u>14</u>
02 cc	<u>03</u>	<u>03</u>				Gauze Pack <u>N</u>	<u>01</u>	<u>01</u>
01 cc			<u>PF-7</u>	<u>01</u>	<u>01</u>	Syringe 1ml / 2ml	<u>02</u>	<u>02</u>
Cautery plate : <u>A/P/N</u>	<u>01</u>	<u>01</u>	Surgical blade <u>22</u>	<u>01</u>	<u>01</u>	Surgical Blade # 202	<u>01</u>	<u>01</u>
IV set			NG tube			Koochies (S)	<u>01</u>	<u>01</u>
RL	<u>02</u>	<u>02</u>	Cautery pencil	<u>01</u>	<u>01</u>			
NS : 10ml / 100ml / 500ml / 1000ml	<u>00</u>	<u>00</u>	Koochies <u>XL</u>	<u>01</u>	<u>01</u>			
<u>minispike</u>	<u>01</u>	<u>01</u>	Ointments					
<u>box 27</u>	<u>01</u>	<u>01</u>	Suction Catheter					
Fentanyl	<u>01</u>	<u>01</u>	Cap, Mask	<u>10</u>	<u>10</u>			
Morphine			Gauze Pack <u>R</u>	<u>01</u>	<u>01</u>			
Ketamine			Mop Pack	<u>02</u>	<u>02</u>			
Propofol			Steristrip <u>Sterizone</u>	<u>01</u>	<u>01</u>			
Rocuronium			Underpad	<u>01</u>	<u>01</u>			
Glycopyrolate			Draw sheet <u>ouick salt</u>	<u>01</u>	<u>01</u>			
Myopyrolate			Abgel	<u>01</u>	<u>01</u>			
Ondansetron	<u>01</u>	<u>01</u>	Foleys catheter					
Pencan 25g Spinal Needle 22	<u>01</u>	<u>01</u>	Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)	<u>01</u>	<u>01</u>	Romodrain bag					
Antibiotics :			Bandage					
			Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg	<u>01</u>	<u>01</u>	Vaccum Suction set	<u>01</u>	<u>01</u>			
Justin : 12.5 mg / 25mg / 100mg	<u>01</u>	<u>01</u>	Plastic Bed Sheet					
Tab. Misoprost : 200mg	<u>02</u>	<u>02</u>	Betadine Solution	<u>02</u>	<u>02</u>			
<u>Oxytocin</u>	<u>03</u>	<u>03</u>	Microshield	<u>01</u>	<u>01</u>			
<u>carbitocin</u>	<u>01</u>	<u>01</u>	Cotton Balls	<u>01</u>	<u>01</u>			
<u>Tranexa</u>	<u>02</u>	<u>02</u>	Latex Gloves	<u>00</u>	<u>00</u>			
<u>glove 6</u>	<u>01</u>	<u>01</u>	Ramdione Scrub					
<u>gauze</u>	<u>01</u>	<u>01</u>	Saral <u>D/A</u>	<u>02</u>	<u>02</u>			

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. : Ordered by : R. K. S.

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

ADMISSION SHEET



Registration Details :

Admission No : IP5-00175716 Admit Date : 29-Jun-2026 Admit Time : 01:23 AM UHID : BAH-00651306

Patient Details :

Patient Name	: Mrs BARIRA FAREED	Age	: 31 Y 2 M 2 D
Guardian	: MR FAIZAN AHMED	DOB	: 27-04-1995
Gender	: Female	Religion	:
Occupation	:	Marital Status	: Married
Address (H)	: MEDCHAL Medchal Hyderabad Telangana INDIA 501401	Phone No	: 9949661907
		E-mail	: NO@GMAIL.COM

Admission Details :

Bed Type : SHARED WARD Bed No : SW 416 Ward Name : 4F-BIRTHING CENTRE
Room No : SW 416 Admission Type : First Visit

Contact Details :

Name : MR FAIZAN AHMED Relationship : Husband
Contact Address : MEDCHAL Medchal Hyderabad Telangana Phone No : 9949661907
INDIA 501401

[Signature]
Signature

Doctor Details :

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

Payment Details :

Deposit Amount : 0.00
Payment Mode : Cash Payor Name : SELF PAY

ACTIVITY RECORD FOR BILLING

Name : BAH-00651306 IP5-00175716
Mrs BARIKA FAREED
27-04-1993 31 Y 2 M 2 D (F)
UHID No. : Dr. PRANATHI REDDY A



Consultant: _____ Dept: _____

Date of Admission: _____ Time: _____ Date of Discharge: _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
17/1/26	5:30pm	MCU	3rd floor (312)	df
21/1/26	3pm	BRP floor	BRP	Alalya
21/1/26	6:30pm	BRP	72	Alalya

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Dinesh Kumar	29/6/26	9681379	Shapna
2	DR. Shreya proddatur	1/6/26	9683563	Rimo
3	DR. praveetha	21/7/26	-	Alalya
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
30/6	^{Screen} Iron, Ferritin, vit-B12	26065404	Reese
30/6	Albumin:creatic (Trace)		Reese
30/6	AFT Doppler	265032446	
30/6	^{pre} RBS 107 ppe lunch ✓	26065587	Reese
30/6	^{post} RBS 113 mg/dl ✓		Reese
30/6	NST - (5) ✓	265032548	Reese
30/6	Electrolytes, Cr Creatinine ✓	26065559	Reese
30/6	Cross matching ✓	26065458	Reese
30/6	^{pre} RBS 106 mg/dl	26065618	Reese
30/6	^{post} RBS (111) mg/dl	26065619	Reese
30/6	NST - (8)		Reese
30/6	NST - (8)	265032559	Reese
30/6	NST - (8)	265032560	Reese
30/6	NST - (9)	265032561	Reese
1/6/26	^{pre} CRBS - 92 mg/dl	26065947	Reese
1/6/26	^{post} CRBS - 85 mg/dl		Reese
1/6/26	AFT Doppler		Reese
2/7/26	CBP	26066059	Reese
3/7/26	USG abdomen & pelvis	265032965	Reese
3/7/26	CVE & urine culture	26066579	Reese

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
1/13/26	20 10 8r placement	1	9682919	bf
1/17/26	PAC	01	9682980	2
1/20/26	Catheterization	01	9682979	8
2/7/26	IV IRan	①	9684658	AW

ANY OTHER INFORMATION

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Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

ACTIVITY RECORD FOR BILLING

Name : **BAH-00651306** IP5-01757
Mrs BARIKA FAREED
27-04-1993 31 Y 2 M 2 D
UHID No. **Dr. PRANATHI REDDY A**

Consultant: _____ Dept: _____
Date of Admission: _____ Time: _____
Date of Discharge: _____ Time: _____
Room / Bed No: _____ Ward: _____ Suggested Billable bed type: _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Niveditha (Telephone Consultation)	29/6/26		Sareeba
2	Dr. Dineesh	29/6/26	9681379	Surekha
3	Dr. Tuheena Sharma	3/7/26	9686003	Sangeetha
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
29/6	NST-1	265032365 ✓	Shobha
29/6	GRBS ① 119 mg/dl	26065224 ✓	Shobha
29/6	NST-②	26503264 ✓	Shobha
29/6	Cbp. 2ft. creat electro	26065035 ✓	Shobha
	LDH-		Shobha
29/6	NST-③	265032363 ✓	Shobha
29/6	GRBS 8:30 AM (120 mg/dl)	26065/24 ✓	Surekha
29/6	Growth Scan Doppler	265-032200 ✓	Surekha
29/6	CVE, ch. Spot Protein / Creatinine ratio	26064988 ✓	Surekha
29/6	GRBS ③ 155 mg/dl (Post lunch)		Surekha
29/6	NST - ④	265032372 ✓	Surekha
29/6	Pre dinner 162 mg/dl	265032348 ✓	Shobha
29/6	2d Echo	26065441 ✓	Shobha
29/6	Post Dinner 159 mg/dl	26065441 ✓	Shobha
30/6	148 mg/dl		Shobha
30/6	Cbp. 2DH creat. LFT electrolytes	260653321 ✓	Shobha
30/6	Preh GRBS - 146 mg/dl	26065442 ✓	Shobha
30/6	Post PBS 130 mg/dl		

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
29/6/26	iv placement	01	out seck	Shobher

ANY OTHER INFORMATION

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.....

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Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

came to doc increased BP
renewed at home. w/o Blumig
vision @
headache, epigastric
pain @
clo ↓ FM aneconomy

Obstetric Formula:

Primu

Obstetric History:

LMP:

10/11/25

EDD:

Corrected EDD:

14/8/26

GA:

33+3 wks

Menstrual History: Regular: ☒ Yes ☐ No

Obstetric Examination

Fundal Height:

32 wks

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

Liquor: ☒ Adequate ☐ Oligo ☐ Poly

PP: ☐ Cephalic ☐ Breech

Others Transverse

Head Fifts Palpable:

FHS: ☒ Normal ☐ Tachy ☐ Brady ☐ Absent

Present Pregnancy Record:

Primigravida - IVF concep

Booked @ 23 wks

RISK FACTORS:

- IVF conception
- GDM on diet :: 27 wks
- PE :: 33⁺ wks

Per Speculum Examination

- not done

Draining: ☐ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination

not done

Cervix: ☐ Long ☐ Partially effaced ☐ Effaced

Os: Closed ☐ Dilated ☐

Membranes: ☐ Present ☐ Absent

Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Presenting Part: ☐ Vertex ☐ Breech ☐ Others

Sutton: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Pelvis: ☐ Adequate ☐ Doubtful

Height: 158 cm

Weight: 78.5 kg

Allergies: NKDA

Breast: ☒ Normal ☐ Abnormal

General Examination: fair

Consciousness: Yes

Pallor: absent

Icterus: absent

Edema: Grade 1

Temp: afebrile

PR: supra pedal edema

BP: 131/81 mmHg

DTR: normal

CVS: 6/6 @

RS - BLNBS @

Liver/Spleen: Not palpable

Urine Output: Normal, 30-40 ml/day

DIAGNOSIS

Primu | 33+3 wks | IVF conception | GDM on diet | Pre Eclampsia
Severe features ↓ fetal movements for observation/delivery Anemia.



Family History: Nil	Surgical History: Hysteroscopy - 2021
Medical History: Nil	Medication History: see Medical recirculation fm.
Plan of Care: - Admission - NST now flb T10 - vitals and hly - Start hly. MgSO₄ loading dose flb maintenance dose. - hly Betamethasone 12mg IM stat flb and dose 2hly - Self root measurement - drugs as per charted - Send CUE, Urine/ls, spot PCR. 6 Trace. - Urine Alb - 2+ - Stat CRBS - 119mg/dL	Investigations: B positive vitals NR. 29/6 CBP - 9.3 / 11, 110 / 2.28L. creat - 0.3 CFI - TB - 0.3 - 0.1 ShO1 - 16 SHPT - 13 ACP - 1112 Uric Acid - 6.8; PT - 14.2, INR - 1.0 APT - 29.7. Urea - 13.7, Na⁺ - 139 / 4.1 / 110, COH - 17/6 3rd wk, cephalic, 1576gms, 10C. AC - 41. AFI - 11.8cm. dopplm. - MCA - redistribution TAPPA (N) - 4 Runtine im CH. A. Amin

Doctor Name: Dr. Ranathi

Signature: [Signature]

Date & Time: 21/6/20 @ 1:30 AM

Consultant Name: Dr. Ranathi Reddy

Signature: [Signature]

Date & Time: [Blank]



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/6/26 3:30 AM	Pt comfortable No s/s Imminent Eclampsia O/E ac-fair PR - 72 bpm BP - 138/90 mmHg SpO₂ - 98% on RA P/A uterus Relaxed FHR (F) Ongoing Iuj MgSO₄ 25ml/hr	Adv - drugs as per charted - vitals regularly - cuff read measurement (2/0 charting.) - w/f s/s Imminent eclampsia - Trace LHM, - SpO₂ PCR, CUE, - Urine cl/s - Inform SOT
29/6/26 6:30 AM	Primi 33+3 wks IVF concep GDM m diet PE E JFM. Pt comfortable No s/s Imminent Eclampsia Ongoing Iuj: MgSO₄ maintaining 25ml/hr dbr. spot PCR - 1.44	Dr. Samir same features O/E ac-fair PR - 73 bpm BP - 132/88 mmHg (MAP-100) SpO₂ - 100% on RA P/A uterus Relaxed FHR (F)

BAH-00651306 IP5-00175

Mrs BARIKA FAREED

27-04-1993 31 Y 2 M 2 D

Dr. PRANATHI REDDY A



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	CLH Dr. Pranathi	
	- NBM	
	- Continue by MgSO ₄ maintenance dose	
	- PAC	
	- NNC	
	- Send CBP, UFT, creatinine, Sr. Electrolytes, LDH now & Trace	
	- NIST-TID	
	- Growth scan & dopplers today	
	- vitals & HR by doppler - qnhly	
	- Infusions	
	- Self void measurement	
	- GRBS qnhly	
		Dr. Samir
	Serum Iron	
	Ferritin	
	Vit-B12	
	after delivery	
	by Ch. Deepika	

RAH-00651306 IP5-001757

Mrs BARIKA FAREED

2.04.1993

31 Y 2 M 2 D

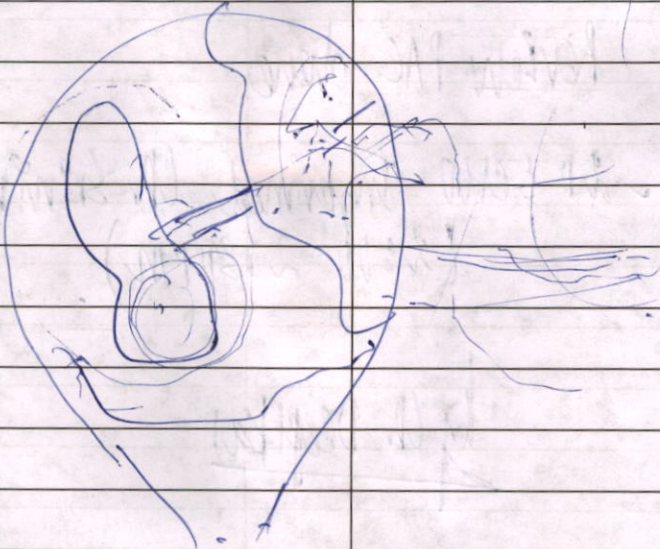
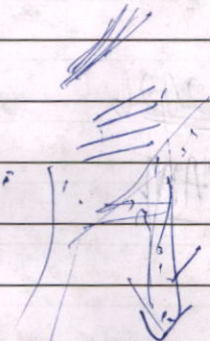
Dr. PRANATHI REDDY A



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/6/26 9 AM	 Discussed with Couple. - Severe Preeclampsia. - Maternal Compromised. - On Magnesium Sulphate Infusion. - U. alb: ++ Spot PCR: 1.46. - For Growth Scan. - Rpt Maternal Hematocrit & Biochemical Parameters. Decision for Delivery.	 Pranathi Dr. Pranathi Reddy

BAH-006 1306 IP5-001757

Mrs BARI A FAREED

27-04-1995

31 Y 2 M 2 D

Dr. PRANALI REDDY A



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/6/2026 9:45 AM	Review PAE done. 2D ECHO - Informed (Mr. Srinivas) (2:00 - 2:30 PM) by Mr. Deepika	
29/6/2026 12:30 AM	Growth Scan - 33 rd Transverse lie. Placenta - left lateral, high APL - 12cm EFW - 1961 grams (16%) AC - 9% Doppler - NAD Uterine Artery - Med Resistance by Mr. Deepika	



3

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/6/2026 11:30 AM	U/D/W Dr. Pranathi Growth Scan ✓ BP - 133/96. On MgSO₄ 25mg/hr Self void urine measurement : 585ml (6 AM) Informed Dr. Pinesh : NMC. 1 PRBC Reserved CBP - 9.9 / 10.72 / 2.36 LFT - SGPT - 12 / SGOT - 15 breast milk - 0.6 Sr. electrolyte - 136 / 5.1 / 110 LDH - 8211	✓ PAC Advice ✓ ✓ strict Fetal kick count ✓ Soft diet / Oral hydration. ✓ Continue same treatment ✓ Monitor vitals / FHR x 2nd half ✓ 2D ECHO - Informed Dr. Srinivas ✓ Self void urine measurement ✓ Inform SES ✓ Pre & Post meal Sugars By Dr. Deepika

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/6/2020 12:00PM	cl by Dr. Nivedha ash ① Check pre & post meal sugar & Inform Dr. Nivedha	Dr. Anshu
29/6/2020 1:30PM	PFM well Comfortable Vitals BP - 118/13 (102) PR - 87 bpm SpO ₂ - 99% on RA P/A - Vessels Relaxed NST Reactive.	Adm 10: ✓ LST ✓ Oral hydration ✓ Diabetic + High Protein diet ✓ Strict PRBC ✓ NST x TID ✓ Ambulation ✓ Self void urine measurement ✓ Pre & Post meal sugar & inform ✓ 2D ECHO - Dr. Sri Nivas (12:30PM) ✓ Inform KRS ✓ w/f S & S of Imminent eclampsia
NMC - (Dr. Nivedha)		
2nd dose steroid - 2:00PM		
U/O: 160ml (12PM)		
PBBS - 155mg/dl		
1 PRBC Reserved by Ch. Deepika		



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/5/26 5:30 PM	Preme 33 ⁺ wks with severe foetus	thru / from on diet / P&L
NINC Sensib ON MgSO ₄	No complaints afebrile PR - 90/min BP - 112/73 mmHg SpO ₂ - 98% @ Rn	adu ① Strict FRC ② Diabetic / High protein diet ③ NGT TD ④ pre & post meal sugars { Inform Dr. Nmedika.
10 PRK - normal	P/A - ut relaxed FHS ①	⑤ Ambulation. ⑥ Self void urine Measured.
2D Echo - normal.		⑦ Inform BP > 40/20 mmHg
On 7. Labetalol 100mg tid.		⑧ w/ S&S Imminent Eclampsia
		Dr. Arshad

29/6/2026
6:45 PM

C/S/B Dr. Pranathi

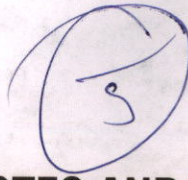
108/72 (86)
92 bpm
99% RA
FHR ①

- ✓ MgSO₄ 24 hrs.
- ✓ w/ 3mm S&S.
- ✓ Strict hourly vitals, I/O
- ✓ CBP, LDH, Screat, LFT, electrolytes 5AM**
- ✓ very close monitoring
- NBM after 5AM (30/6/26)
- AFI + Doppler (30/6/26)

Dr. Sneh
(P.T.O.)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/6/26 9pm	PE + GDM on dict. No imminent signs BP-125/84 [98] PR-86bpm SpO₂-99% on RA Pln-Ut ~ POC relaxed FHR ⊕ U/O-220ml in 2hrs.	<u>Advice:</u> ① Diabetic diet ② Pre & post meal a/c ③ Strict vitals hourly monitoring ④ FHR 1st hourly ⑤ W/O signs of Pre-eclampsia ⑥ Drugs V/O charted ⑦ Strict F/O charting ⑧ NST-TID ⑨ Strict fetal movement count
- Mg Sou on Flow (H/H - 2:30 AM) - Steroid ✓ - NVC ✓ GABBS-162 pre-meal	⇒ Send CBP, LDH, LFT, Sr-Creat, electrolytes c ⑩ Send SAM on 30/6/26	
	⇒ AFI + Dopplers on 30/6/26 ⇒ NBM from SAM on 30/6/26	
		<u>Smith</u>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6/26 1 AM	No Imminent Signs BP - 114/69 (Fo) PR - 88bpm SpO₂ - 98% on RA P/A - Ut ~ POC relaxed FHR ⊕	Advice - Vitals - 2nd hly. - FHR 4th hly - NST - TID - Strict Z/o cholesting - w/f Signs of PE. Srinu
30/6/26 4 AM	NST - reactive U/P - 250ml in 2hrs.	Advice - Vitals 2nd hly. - FHR 4th hly. - NST TID - Strict Z/o cholesting - w/f Signs of PE. Srinu

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6/26	- Primi 33+4wks IVF Conception GDM on diet (now insulin) PC = severe Reaction - No imminent signs. - BP- 110/90 [100] PR- 86 bpm. SpO₂- 100% on RA. PIA- ut ~ 104 relaxed FUS ⊕ U/O- 200ml in 2hrs.	
7 AM		<u>Advice</u> ① Diabetic diet → P/B ② Drugs as charted ③ Vitals qtd hrly & FHR ④ NST TID ⑤ W/p Signs of pre-eclampsia ⑥ Rec & post meal GBS ⑦ Strict I/O monitoring ⑧ Strict fetal movement count
MgSO ₄ ✓		
Stimulants ✓		
NVC ✓		
10 PRBC reserved		
	⇒ NBM ⇒ AFI + Dopplers today. ⇒ Tracea CBP, LFT, LDH, Sr Creat & electrolytes.	
	Hb- 8.6 TC- 13.9k. MT- 2.32	Act- 136 K⁺- 4.8 Cl⁻- 110
	Creat- 0.7. LDH- 213 LFT- (N)	<u>Synthetic</u> SGOT- 13 SGPT- 15 Protein- 6.1 Albumin- 2.9



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6/26 9:45 AM	- Primi 33 rd wk / IVF aneup / GDM on diet severe features - Anemic	Adv. - NBM
	PE comfortable No s/s Imminent Eclampsia on Tab Lab Army 10	- drugs as per charted - vitals - PHR - 2nd day - NST - 10 - AFI + doppler - delay - Strict 8/10 monitoring
	Myson ✓ steroid ✓ NAC ✓ 10 PRBC received 2 DECHO 10.	SP02 - 98% on air P/A - uterus Relaxed. FHRE.
	labs - 30/6 CBP - 8.6 / 13.9 / 2.32 UAT - SAOT - 13 - SUP - 15 creat - 0.7 LDH - 213 Na+/K+ / Cl- - 136 / 4.8 / 110	post-meal GRBS - 40mg qd.
	- Send. Sr. Amnion / Sr. Ion / vit B12 - now	
	- Urine Alb - neg ↓ Trace	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6/26	COSTM: 33 th .	
11 AM	- AFI: (11) Umb Ar Doppler: (11) MCA Redistribution.	
	PHYSICIAN ✓	STEROID COURSE.
	ANESTHETIST ✓	
	NEONATOLOGIST ✓	
	ECHO ✓	
	CREATININE RISING.	Mg SO ₄ STOPPED
	PLAN	
	1) MONITOR BP.	
	2) ORAL LIBROLOL 100 TID.	
	3) BLOOD SUGARS Being Monitored → Dr. MURDITA	
	4) EVALUATE ANEMIA IN TERM SOS BASED ON REPORTS	
	5) NIST THRICE DAILY.	
	6) RPT S. CREATININE / GLUCOSE AT 5 PM.	
	7) DAILY DOPPLERS.	
		Pranathi
		(Dr. Pranathi)



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6/26 12pm	816 Dr Sundhara (Apm) Case reviewed. 33⁺4 wks E PE. Haemodynamically stable. Bl ↓ control E labetalol 100 mg tid. No imminent SIS @ present. U/O adeq. Creat ↑ 0.3 → 0.7 Rest Inv (N). LDH (N). 2D Echo (N). Adv- Dig Clexane 40 mg SLQ od. — Dig IV Fe if no plan to deliver. — CST.	
30/6/26 2.30pm	Primi 33⁺4 wks / Inv / 40 mon on diet / PE / Severe features / Anemia No complaints. Heart. akbale. PR - 72/min RP - 130/min Spg - 98% @ En Pl/A - ut relaxed FND (N).	ad: (1) NST 700 (2) S. creatinine / electrolytes at 5pm (3) Pre & post meal sugar perform Dr Niveditha (4) Daily toppls (5) Vetal Monitor 4th (6) Pre 2th (7) W/press of Immune

Date & Time	Progress Notes	Doctor's Order
30/6/20 12:30pm.	Pt comfortable No S/S imminent eclampsia o/e ac-fair PR-72gms BP-136/88 mmHg MAP-101 SpO ₂ -100% on RA P/n. uterus relaxed FHR ⊕	Adv - Diabetic diet, plenty of oral fluids - deny on per character - vital signs every FHR by doppler and NST-TID - pre & post meal sugar monitoring ↓ Inform Dr immediately - Inform bed
	MgSO ₄ ✓ Steroid ✓ 20 PRBC received Sr-Pentun - 794 ↓ Daily doppler. Repeat Sr-Creatinine Eleborate @ spm.	
		Dr Samir



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/6/2026 u. 10pm.	Pt comfortable no s/s Immature Eclampsia	Adv. diabetic diet, plenty of oral fluids
Mgso4 ✓ Stead ✓ 20 PRBC Kernel ✓	Plt - 400 PR - 88 bpm BP - 150/90 mmHg CMT (H)	drugs as per charted Tab. Gab 100mg stat ↓
	SpO2 - 98% on RA p/A - ut relaxed HRT (H)	Recheck BP after 30 min & inform
Gr. Remin + 4g Wt BP - 150/90		- vitals - 4th hourly - NST - TD
	primr 33th wk / IVF / amniotic PE with seven features / tremor.	Pre post meal sugar - monitoring ↓
30/6/2026 6:00pm.	pt clch Gc 4g	inform on medication.
ruddy ✓ steroid ✓ cr 70.7 Na - 135 K - 4.5 Cl - 111 mmol	BP - 140/72 (92) mmHg PR - 66 bpm. SpO2 - 98% on RA p/A - ut relaxed. FHR (H)	inform 1st Adv ① Diabetic diet ② Monitor BP hourly ③ vitals 4th hourly ④ FHR - 4th hourly ⑤ NST TD ⑥ pre & post meal sugar ⑦ Inform 1st
20 PRBC - received, Daily Dopplers. Inform Bt @ 4:00pm		Dr. Divya

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6/26 10:00 PM	do: SOB on waiting. - chest clas. O/E - G1 fair Bp - 143/90/63 mmHg PR - 98 bpm SpO2 - 99% on RA. P/A - ut relaxed FHR	Adv ① Monitor Bp 3rd hourly ② NST TID ③ IV Fcm SSS ④ Daily Doppler ⑤ 20% fetal movement ⑥ Drugs as chartd ⑦ Inform SSS Dr. Druggs
steroids ✓ NAC ✓ MgSO4 ✓	pt has taken carbohydrate (rice) diet, instead of counseling of risk of sugar followed to it.	
✓	Reassured Pt/Husband/attender (Dr. Gastro Enterologist) need for follow up/close maternal fetal monitoring. need for Anemia correction. need for delivery if ↓ FM/absent FM abnormal doppler non reactive NST ↑ Bp/imminent SSS	Dr. Druggs

BAH-00651306 IP5-00175716
Mrs BARIRA FAREED
27-04-1995 31 Y 2 M 4 D (F)
Dr. PRANATHI REDDY A



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6/2026 7:00PM	PT c/o ↓FM (today) @ NST ~ 3 to 4 movements felt now nil.	
	OlE: Bed side USG : FHR ⊕ 1 FM seen PT still could not appreciate.	Reassured counselled.
		Dr Y Dr Y. Sneha
30/6/2026 9PM	PT requested @ diet inspite of counselling about diabetic diet / sugars / need for insulin.	
		Dr Y Dr Y. Sneha



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/26 2:00 pm.	primi/ 3375 wky/ 1st/ GDM on diet PT with severe februm PT comfortable	
	<u>Off</u> G. f. c. g.	<u>Adv</u>
Sturodi ✓	Bp- 128/63 mmHg	① NST at 4:00 pm
NNC ✓	PR- 61 Bpm	② monitor vitals 2nd half
Mgso4 ✓	SpO2 98% RA	③ Inform sos
	PIA- at 50% relaxed FHR ⊕	④ AS FHR 4th hourly ⑤ pre & post sugar inform to Dr. Niveditha
		Dr. Divya

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31 Y 2 M 3 D

(F)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/7/26 6 AM	BP: 160/96 (114) mm Hg PR: 60 bpm PIA: Relaxed NST on going SpO ₂ : 100% RA FBS: 92 mg/dl c/o Epigastric discomfort. Not perceiving FM	- PAC - NST now - NBM - IVF@ 50 ml/hr RL - I/O charting - Vitals - T. Nicardipine R 20 Po stat - 2mg PANTOP 40 mg IV stat
	Patient / attenders counselled the need for delivery of persistently absent FM / imminent SSS. Explained chances of Eclampsia / IUFD / Anti HTN maternal & fetal morbidity.	
Q1		
11/7/26 7:30 AM	Moments ⊕⊕⊕ NST Reactive. 104/77 (87); 88; 90% RA	AFI + Doppler 9 AM Dr. Y. Suresh Dr. Y. Suresh Radio



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/7/26 9:40 AM	Primii 33 ^W 2 Wks (1VF GDM on diet / O/b ac fac Pl comfortable PR - 87 bpm No S/S Imminent Eclampsia BP. 104/77 mmHg UAD - 28% mHA P/A ut relaxed GTA @ Myo 4 ✓ Hemo 4 ✓ NVC ✓	As c severe features / Anemic Adv - NBM - W/F S/S Imminent Eclampsia - NST-TID - FHR, vitals & chdly - AFI + doppler - today - Inform for
		Dr. Samir
		NB Suband

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/7/26 10:15 AM	c/s/B Dr. Pranathi	
	Patient clearly explained need for delivery by ces. chances of	
	✓ Abruption	
	✓ Eclampsia	
	✓ Maternal / fetal mortality / morbidity	
	ilv/o ✓ uncontrolled, fluctuation BP	
	✓ 2nd Anti HTN	
	✓ ↓ FM	
	Patient wants to discuss and let us know	
		- NBM
		- consent
		- parts prep
		- Drugs as chart
		Dr. Y. Suresh
	noted by for SONG	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/26 1:30pm	<u>BDO</u> Gafar. akboul PR - 86/min. RP - 122/83 mmHg P2 - 9.5% O2 P/A - ut (P2) used P/A - N/A	adv. - N/A for 2hr vital 2nd - Dose archaic - if not needed - (W) Fluid 100ml - 1/2 F 818 Immunel Edinger Inform RP 100/70 mmHg - Inform's
	✓ BP @ 6AM [2/7/2026]	<u>Dr. Azhar</u>
	✓ T ₁ labetalol 100mg TID. (T ₁ Nicandia Retard 10mg - SOS).	
	Noted by Dr. Azhar	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/5/26 4:30pm	PODO Pt comfortable NO S/S Immature clamping	Adv IV fluids @ - Allow sip of 250ml water from 7pm. if tolerating allow liquids
U/O - 250ml (clear)	PR - 84/60 BP - 89/60 mmHg (MAP 80) SpO ₂ - 98% on P/A intub retracted well.	- Left chest from 6AM 2/7/26 - lungs as per charted - vitals 2nd day - Up charting - w/active Buddy PR Inform SR
- Remove Foley's @ 6AM on 2/7/26	BS absent U/O no active Bleeding	- Monitor BP 2nd day and inform > 140/90 mmHg
- CBP @ 6AM on 2/7/26		
	Shift to room	
	noted by Sr. SRS	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/7/20	<u>POD-0</u>	
8pm	GC fair afebrile PR - 10/min BP - 125/90 mmHg SpO₂ - 98% @ RA U/A - good. CBP 6AM P/A - ut (P) well P/V - norm.	adv NBM - Jell. Now Stal liquid (blue) - Soft diet - 6AM - vitals 5ph - Drug as charted - Wp Janki bleed - (W) Plwd - 75ml/h - No charty - Remove Foley at 6AM (2/4hr) - Inform BP > 140/90 mm - Wp PR 3 of Immune Elongation <u>Dr. Arun</u>
2/7/20	c/s/B - Dr. Suresh POD-1 / 4pm on diet / PE / Aves	noted by Pim 8pm
9am		
11b	GC fair B.P - 122/84 PR - 80 SpO₂ - 100% - RA P/A: ut (P) well B3 (+) P/W: NAB	1) soft diet & plenty of oral fluid 2) Drug as charted 3) Monitor vitals 4ph Inform if Bps 140/90 4) clunkation, w/ 555 of J.E 5) w/ plw bleeding 6) Inform scs
voided		
SX		
D-Nico		

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>2/7/2026</u>	<u>C/S/B Dr. Pranathi Reddy</u>	
<u>9:30 AM</u>	Comfortable Ambulating	<u>Advice</u>
<u>Baby well</u>	Vitals - BP - 122/84 (96) PR - 130bpm	- Oral hydration
<u>voided ✓</u>	Spla -	- Soft diet
<u>Platlets ✓</u>	P/A - vitals improving well	- Ambulation
<u>Stools x.</u>	BS (+) VRE - lochia (+) healthy	- Drugs as charted
		- Monitor vitals 3rd hourly
		- Inform SCS
	Hb - 7.7 P/Lt - 2.04 WBC - 12.25	
		<u>by Dr. Deepika</u>



PRANATHI REDDY A



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/2/20 2:30 PM	C/SB or Shilpa BP, uses for severe PE & anemia (32wks) on Paracetamol / tramadol analgesia. HR - 98. BP - 140/100 mm Hg on Labetalol. conscious, oriented feels sleepy / as her sleep disturbed last night no h/o dizziness / postural changes / headache, nausea. can go ahead & be seen & monitored	
		Dr. Sule



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/04/2025 6pm	POD₂ / Eng USes / Anemic came for IV Iron. Pre transfmin o/e vitak ac-fail PR - 91/6mm BP - 135/90mm CMAP 100 SpO₂ - 98% (m) P/A uterine retracted well UG - Lochia heavy Received by fam 1pm w Eng in no reactions noted O/e ac-fail PR - 89/6mm BP - 138/93 mmHg SpO₂ - 98% (m) P/A uterine retracted well UG - Lochia heavy	Adv - days as prechatt vitak adhe 2/0 chatty Eng in <i>[Signature]</i> Dr. Samir

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 Mrs. BARIRA FAREED
 27-04-1995 31 Y 2 M 5 D (F)
 Dr. PRANATHI REDDY A



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/7/26		
7:30pm	clo 1 fever spike Temp - 99.6°F clo pain @ inline site. O/E GC - fair PR - 98bpm BP - 133/99mmHg (MAP 70) SpO2 - 98% on RA P/A - uterus relaxed well U/G - No active bleeding	Adv - Recheck Temp after 1hr and inform. - vitals q2hly - keep on as charted - Ambulate - w/f active Bleeding or - Inform us
		noted by ALK Dr. Sanna



Date & Time	Progress Notes	Doctor's Order
3/7/2026 9:50 AM	Cl. Pains while passing urine - Circumfer. T - 90/60 BP - 112/88 P/A - Soft Rx - Dressing - Dry P/O - nas	USG - As done / Pelvis Sp. Trandol (cont) 19 Res (cont) Diclofenac sup Analgesic CE / Circuits
	S/B Dr. Praveen: FF Fosfomycin Sachets - 15 15ml of water	Johnson



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7/2026 1:30pm	POD 2 / fm-bus / Anemia c/o Burning micturition o/f pt comfortable Ambulating well	
B-N/M		
✓✓ ✓ SX	o/f - Gc-fair BP - 130/88mmHg PR - 98 bpm SpO ₂ - 98% RA PlA - wt @ well Plu - BWNL	Ad ① Soft diet ② Ambulation ③ Hydration ④ Drugs as charted ⑤ Monitor vitals ⑥ In line for
Trace WF x urine culture		
	DR. Divya	Noted by Rangasetha @ 608/28 3/7/26
3/7/26 8pm	C/S/B - Dr. Shrutai c/o : Burning micturition Gc: fair B.P - 130/90 P.R - 95 bpm SpO ₂ - 100% on RA PlA: wt @ well Soft Plu: WAB	1) Soft diet 2) Ambulation 3) Drug as charted 4) Monitor vitals 5) In line for - Dr. Shrutai
B-N/M ✓ ✓ ✓		
Trace WF x urine culture		

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/7/2026 6 AM	Dr. Pranathi Comfortable. Sleeping. Does not want to be disturbed. By Mr Deepika	
4/7/2026 7 AM	POD-2 / Emg. USS Pain while passing urine GC Pain /afebrile Vitals - BP - 121/85 (95) PR - 79 bpm SpO2 - 99% on RA P/A - Sept, Vitals improving well BS ⊕ VUE - lochia ⊕ healthy	IV Fcm ✓
Baby Well		
V ✓		
F ✓		
S ✓		
CNS - PRS USS - 4-6 / Epi cells - 12-15 / RBCs - 25-40. Advice		
Track urine e/s		✓ UOI ✓ Oral hydration ✓ Monitor Vitals x 3rd hml ✓ Ambulation ✓ Review in OPD by Dr. Pranathi today ✓ Inform SSI
USG ABDOMEN - (R) study		
Mild R/L pleural effusion (R > L)		

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27-04-1995 31 Y 2 M 5 D (F)

31 Y 2 M 5 D

(F)

Dr. PRANATHI REDDY A



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

PRANATHI REDDY

31 Y 2 M 6 D (F)

31 Y 2 M 6 D

(F)

27-04-1995
Dr. PRANATHI REDDY A

[illegible]



CROSS CONSULTATION FORM

Doctor Name : Dr. C. Hiredike Date : 2/7/26 Time : 12:20 p.m

Diagnosis : PE + GDM

Hospital : Star Hosp

Type of Referral :

☐ Emergency

☒ Urgent

☐ Non Urgent

Referred for : ☒ Opinion ☐ Co-Management ☐ Transfer of care

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

PE

Signature: [Signature]

Findings and Recommendations : Ap Rm LCS - 1st pos

PE on T. labet 100/TID

GDM on diet

no drowsiness now - after 10mg labet

ok - 1/2 pedal edema int

PR - 80/min

BP - 130/80 mm Hg

CR -

CVS - S1, S2

no B2, clear

Ab - 7.9

Consultant :

Name : Dr. C. Hiredike Signature : [Signature] Date & Time : 12:25 p.m

Q1-

① T.MET XL 50mg

1—9pm

② T.MET-XL 25mg
1—9pm

Step T. label

for order
fine
T.MET-XL
1—9pm

Step FERRIC CARBONATE
1000 mg in 100 ml NS/IV

over 10 min
after
(text done)



CROSS CONSULTATION FORM

Doctor Name : Shravya Proddutur Date : 01/07 Time : 8pm

Diagnosis :

Hospital :

Type of Referral :

☐ Emergency

☐ Urgent

☐ Non Urgent

Referred for : ☐ Opinion ☐ Co-Management ☐ Transfer of care

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature:

Findings and Recommendations :

Breastfeeding amenment done.
Baby in NICU, Mother's breast to be stimulated
every 2 hours. breasts are currently dry.
Lactation consultant from NICU to
take sessions regarding galactogogues.
Nalini Maam or Supriya Maam to
be informed in the morning of 2/07/2026.

Consultant :

Name : Shravya Signature : Date & Time : 01/07

8pm

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Dr. PRANATHI REDDY A



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RESULT SHEET

Date	28/6/26	29/6/26	30/6/26	30/6/26	
Time		7 Am	5 pm	5:19 pm	
Hb	9.3	9.9	8.6		
PCV	28.3	33.0			
RBC	4.88	4.88	4.35		
WBC	11.1	10.72	13.90		
N/L			81.5/13.4		
Platelets	228	2.36	2.35		
CRP					
ESR					
PCT					
RBS					
Na	139	136	136	135	
K	4.1	5.1	4.8	4.5	
Cl	110	110	110	111	
Ca/Mg					
Phosphate					
Urea	13.7				
Creatinine	0.3	0.6	0.7	0.7	
ALP	142	154			
SGPT	13	12	15		
SGOT	16	15	13		
T.Bill/Conj	0.35/0.1	0.4/0.3	0.2/0.1		
T.Protein	6.0	6.6	6.1		
S.Albumin	3.0	3.1	2.9		
S.Globulin	3	3.6	3.2		
A/G Ratio	1	3.6	0.9		
Uric Acid	6.8				
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR	14.2/1.0				
APTT	29				
CSF Protein / Sugar					
Cells	LDH	211	213		
N/L					

Date	29/6/26					
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones	Negative					
CUE - PUS Cells	18-20					
CUE - RBC Cells	3-4					
CUE						
Epithelial protein	6-8 present++					
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Blood group - B+ve (JO Referred).						
Hiv & HBsAg - NR.						
Spot protein	52.7					
Spot creatinine	36.5					
Ratio	1.44					

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

X-Ray :

ECHO :

CT :

MRI :

Others (ECG, Contrast Studies etc..) :

Bariera.

Sheet No: **REGULAR PRESCRIPTIONS** Weight Ward

DRUG : TAB TRAMADOL				Date																
				Time																
Dose	Route	Frequency	Start Dt.																	
100mg	ph	TID	1/7/26																	
Name & Signature of the Doctor																				
Starting the Drugs:																				
Additional Instructions:				Stop Dr. Ashu 1/7/2026, 1:00PM																
Daily Doctor's Endorsement by a Sign																				

DRUG : Li PARACETAMOL				Date	1/7	2/7														
				Time	7 AM	5 AM														
Dose	Route	Frequency	Start Dt.																	
1gm	lv	TID	1/7/26																	
Name & Signature of the Doctor																				
Starting the Drugs:				8/2P Dr. Susha'y 2/7/26 3PM																
Additional Instructions:				11:30pm 2/7/26																
Daily Doctor's Endorsement by a Sign																				

DRUG : Li TRAMADOL				Date	1/7	2/7														
				Time	7 AM															
Dose	Route	Frequency	Start Dt.																	
100mg	lv	TID	1/7/26																	
Name & Signature of the Doctor																				
Starting the Drugs:				11:30pm 2/7/26																
Additional Instructions:				in bonety 12:30pm 2/7/26																
Daily Doctor's Endorsement by a Sign																				

DRUG : Li CEFOTAXIME				Date	1/7	2/7/26														
				Time	10 AM	10 AM														
Dose	Route	Frequency	Start Dt.																	
1gm	lv	BD	1/7/26																	
Name & Signature of the Doctor																				
Starting the Drugs:				10 PM 2/7/26																
Additional Instructions:				Until discharge followed by oral 10 PM 2/7/26																
Daily Doctor's Endorsement by a Sign																				

Docu. No. : RCHBH /FRM / CLINICAL / 108

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 Dr. PRANATHI REDDY A



Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

DRUG : T. DICLOFENAC				Date Time															
Dose	Route	Frequency	Start Dt.																
Sony	PO	TID	4/7/20																
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																			

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

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

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

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

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

VERIFIED BY : Name Signature



DRUG CHART

Date of Admission: 20/06/20 Drug Allergies: NKDA ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
 - Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
 - Discontinue a drug by drawing a line **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



REGULAR PRESCRIPTIONS

Weight: 78.5 kgs Ward: 088

DRUG : Tab CABETALOL				Date Time	29/6	20/6	1/7	2/7												
Dose 100mg	Route PO	Frequency TID	Start Date 29/6	12	Am															
Name & Signature of the Doctor Starting the Drugs: Dr. Praneetha Dr.				8	Am															
Additional Instructions:				4	Pm															
Daily Doctor's Endorsement by a Sign																				
DRUG : hy CLEXANCE				Date Time	29/6															
Dose 40mg	Route SLC	Frequency OD	Start Date 30/6	4	Pm															
Name & Signature of the Doctor Starting the Drugs: Dr. Praneetha Dr.																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : TAB PARALOGAM				Date Time																
Dose 100mg	Route PO	Frequency OD	Start Date 30/6																	
Name & Signature of the Doctor Starting the Drugs: Dr. Praneetha Dr.																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : TAB DICLOFENAC				Date Time																
Dose 50mg	Route PO	Frequency TID	Start Date 30/6																	
Name & Signature of the Doctor Starting the Drugs: Dr. Praneetha Dr.																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				



Weight. 78.5 kgs Ward. OBS

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
29/6/20	2:5 AM	inj. Mysol	4gm	IV	[Signature]	Shobha, Sunitha
29/6/20	2:10 AM	inj. BETAMETHASONE	12mg	IM	[Signature]	Shobha, Sunitha
29/6/20	2:10 PM	inj. BETA METHASONE	12mg	IM	[Signature]	Shobha, Sunitha
29/6/20	11:00 AM	INS. NOVAPAD	6U	SC	[Signature]	Shobha, Sunitha
30/6/20	6:30	INS. NOVAPAD	5U	SC	[Signature]	Shobha, Sunitha
30/6	6:20 AM	INS. ZOFER	4mg	IV	[Signature]	Shobha, Sunitha
30/6	6:30 AM	INS. PANTOPRAZOLE	40mg	IV	[Signature]	Shobha, Sunitha
30/6	7:50 PM	T. LABETOLOL	100mg	PO	[Signature]	Shobha, Sunitha
1/7/20	12 AM	T. LABETOLOL	200mg	PO	[Signature]	Shobha, Sunitha
1/7/20	7:15 AM	T. NILARDIAR	20	PO	[Signature]	Shobha, Sunitha

27-04-1995 31 Y 2 M 2 D

Dr. PRANATHI REDDY A

Weight. 78.5 kgs Ward. 083

[illegible]



MEDICATION RECONCILIATION FORM

Drug Allergies: NKDA ☒ Not known any Drug Allergies

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

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

Shifting From: NA Shifted to: NA

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Tab. CABETALOL	100mg	PO	TID	28/6	☒ C ☐ DC
2	Tab. IRON		PO	OD	mlb	☒ C ☐ DC
3	Tab CALCIUM		PO	OD	mlb	☒ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Jannu

Date & Time : 29/6/20 @ 1:30 PM

Nurse Name & Signature: Shobha

Date & Time : 29/6/20 @ 1:30 PM

IP5-001757

27-D4-1595

31 Y ? M 2 D

Dr. PRANATHI REDDY A



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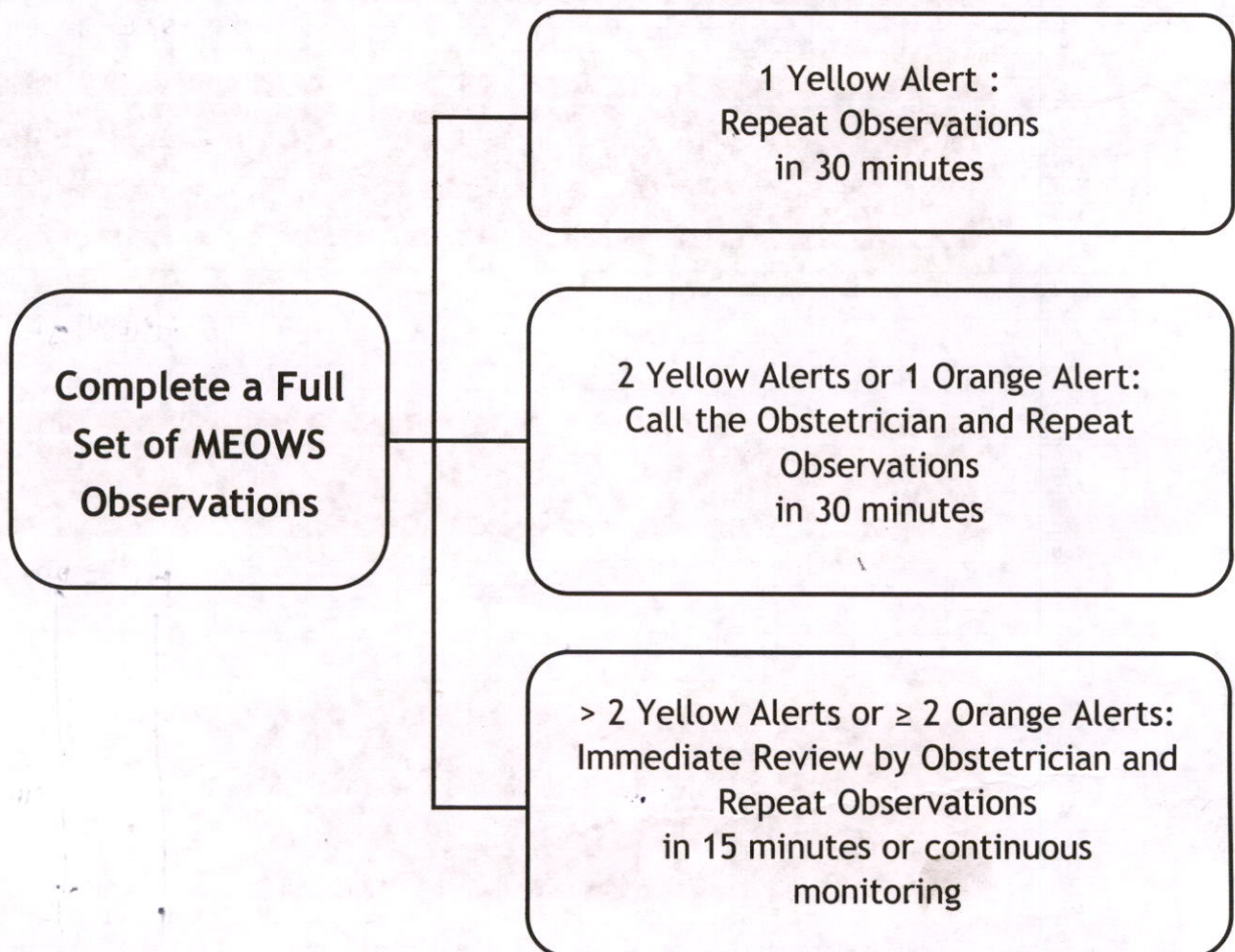


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Your Right to a Safe Delivery

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)

Date . f.H.R 29/6/26 .
2pm 135b/min .
Gpu 130b/min .

BAH-00651306 IP5-00175
Mrs BARIRA FAREED
27-04-1993 31 Y 2 M 2 D
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

29/6/25		Date																												
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7				
RESP (write rate in corresp. box)	> 30																													
	21 - 30																													
	11 - 20	18	18	20	18	20	18	18	12	14	19	20	20																	
	0 - 10																													
Saturations	94 - 100 %	100	100	100	100	100	98	99	100	100	99	100	99																	
	< 94 %																													
Administered O ₂ (L/min.)																														
Temp °C	40																													
	39																													
	38																													
	37	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	
	36																													
	35																													
	< 35																													
Heart Rate	170																													
	160																													
	150																													
	140																													
	130																													
	120																													
	110																													
	100																													
	90	86	84	86	84	94	92	84	86	84	81																			
	80																													
	70																													
	60																													
	50																													
	40																													
↑ Systolic Blood Pressure	190																													
	180																													
	170																													
	160																													
	150																													
	140																													
	130																													
	120	121	133	111	115	113	108	105	110	115	113	119																		
	110																													
	100																													
	90																													
	80																													
	70																													
	60																													
50																														
↓ Diastolic Blood Pressure	130																													
	120																													
	110																													
	100																													
	90																													
	80																													
	70	74	82	76	73	84	72	84	78	75	82	90																		
	60																													
	50																													
	40																													
	NEURO RESPONSE [✓]	Alert	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
		Voice																												
		Pain																												
		Unresponsive																												
URINE mls / hour	> 30																													
	< 30																													
Proteinuria	Protein ++																													
	Protein > ++																													
Lochia	Normal																													
	Heavy / Foul																													
Liquor	Clear / Pink	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	Green																													
TOTAL YELLOW SCORES		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
TOTAL ORANGE SCORES		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Nurse Initial																														

Obstetrics and Gynaecology Early Warning Signs

Complete a Full
Set of MEOWS
Observations

1 Yellow Alert :
Repeat Observations
in 30 minutes

2 Yellow Alerts or 1 Orange Alert:
Call the Obstetrician and Repeat
Observations
in 30 minutes

> 2 Yellow Alerts or ≥ 2 Orange Alerts:
Immediate Review by Obstetrician and
Repeat Observations
in 15 minutes or continuous
monitoring

4:30pm

BP - 140/85 (102)

P - 69b/m

S - 92%

* The Modified Early Warning Score (MEOWS)



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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

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Immediate Review by Obstetrician and
Repeat Observations
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monitoring

* The Modified Early Warning Score (MEOWS)

7am
BP - 167/97
P - 60
S - 98%
(114)

BAH-00651306 IP5-00175716
 Mrs BARI RA FAREED
 27-04-1995 31 Y 2 M 3 D (F)
 Dr. PRANATHI REDDY A

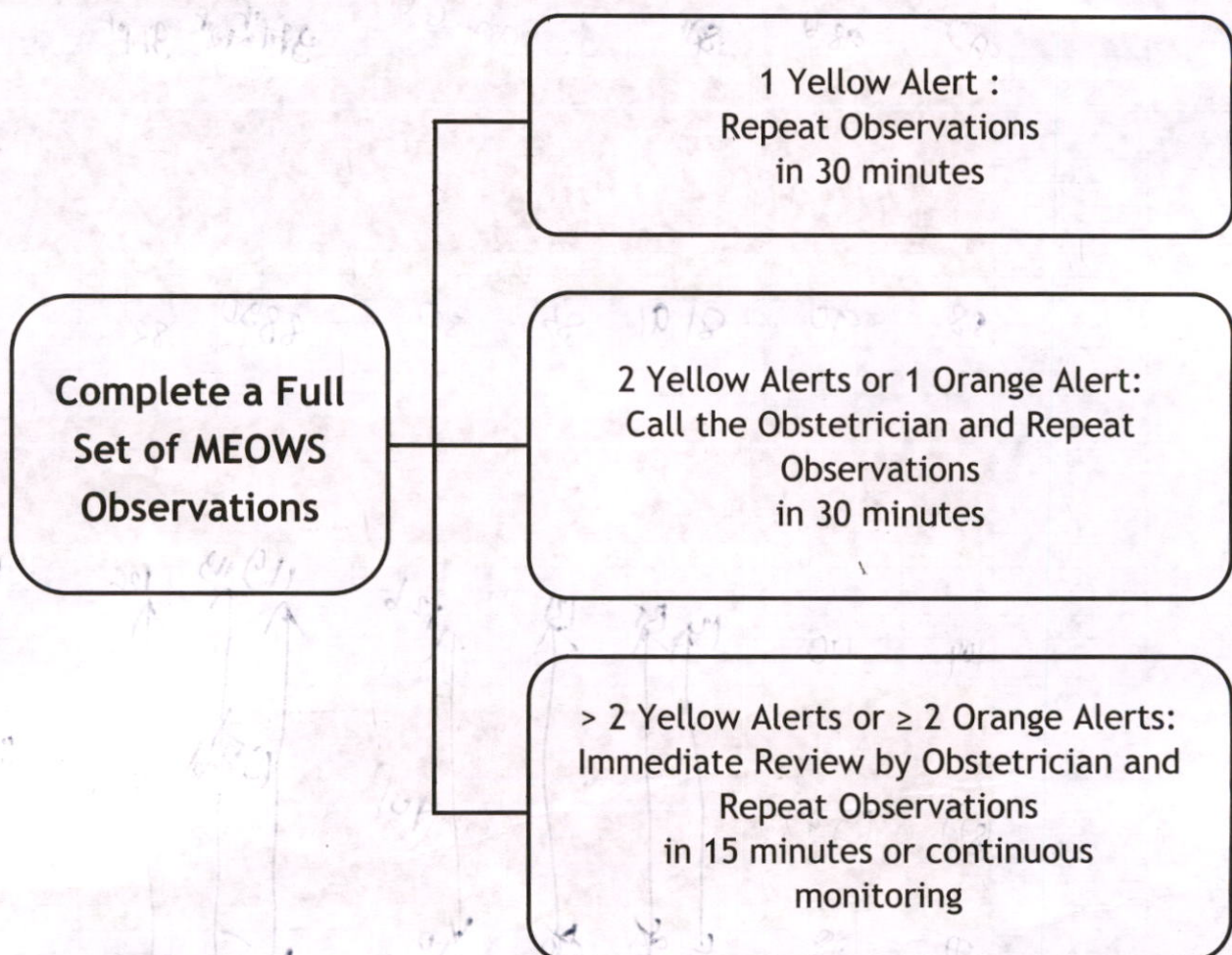


Early Warning Observation Score Chart - Obstetrics

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

		Date	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
		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				19		19	19	19						20	20					20					
	0 - 10																									
Saturations	94 - 100 %		100		99		99	99	99					98	98	98					98					
	< 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		88		90		81	91	83		80		88	90		82									88	
	80																									
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	160																									
	150																									
	140																									
	130																									
	120																									
	110		104		110		125	125	131		126		119	119		126		132								
	100																									
	90																									
	80																									
	70																									
60																										
50																										
↓ Diastolic Blood Pressure	130																									
	120																									
	110																									
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90																										
80																										
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60																										
50																										
40																										
NEURO RESPONSE [✓]	Alert	✓																								
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30																									
	< 30																									
Proteinuria	Protein ++																									
	Protein > ++																									
Lochia	Normal																									
	Heavy / Foul																									
Liquor	Clear / Pink																									
	Green																									
TOTAL YELLOW SCORES			0		0			0	0				0	0	0	0	0	0		0				0		
TOTAL ORANGE SCORES			0		0			0	0				0	0	0	0	0	0		0				0		
Nurse Initial			PM		PM			PM	PM				PM	PM	PM	PM	PM	PM		PM				PM		

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

IPS-00175716

31 Y 2 M 5 D

27-04-1995

31 Y 2 M 5 D

(F)

Dr. PRANATHI REDDY A



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Early Warning Observation Score Chart - Obstetrics

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

CONTACT DOCTOR FOR EARLY INTERVENTION TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME																										
		Date	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20																									
	0 - 10																									
Saturations	94 - 100 %																									
	< 94 %																									
Administered O ₂ (L/min.)																										
Temp °C	40																									
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	38																									
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	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
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	90																									
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	70																									
	60																									

Obstetrics and Gynaecology Early Warning Signs

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in 15 minutes or continuous
monitoring

* The Modified Early Warning Score (MEOWS)

IP5-00175716

27-04-1995

31 Y 2 M 6 D

(F)

Dr. PRANATHI REDDY A



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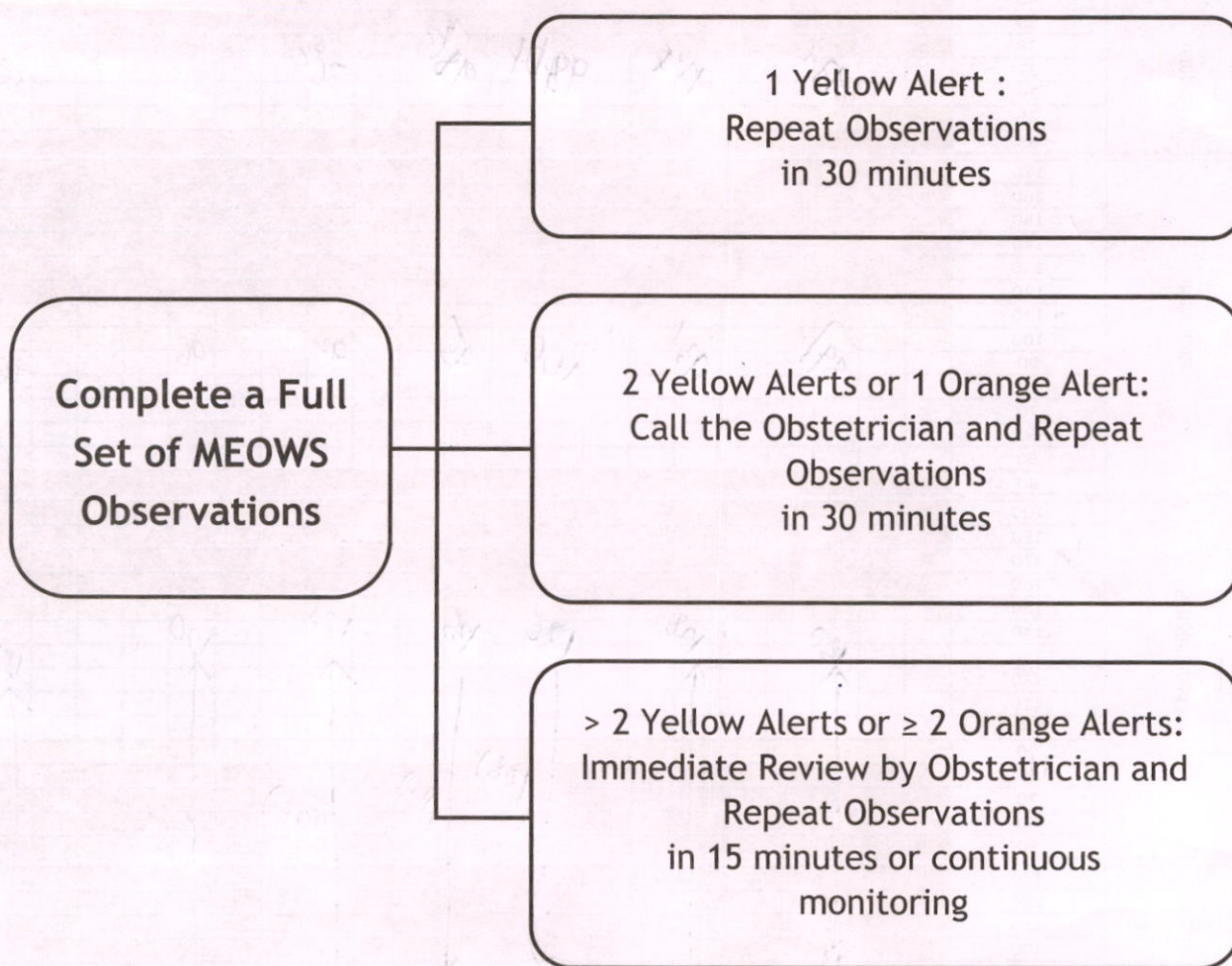


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CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

[illegible]

Obstetrics and Gynaecology Early Warning Signs



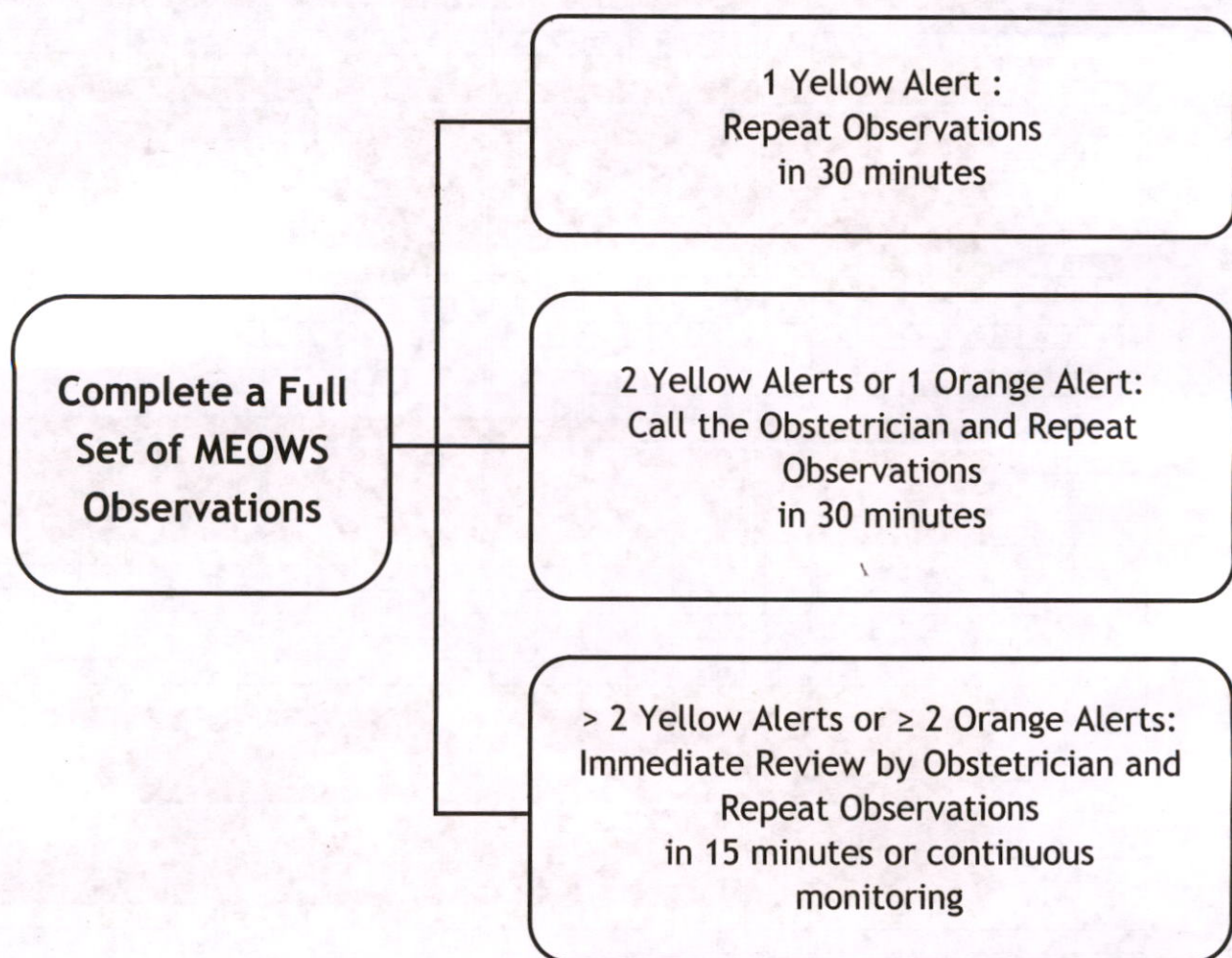
* The Modified Early Warning Score (MEOWS)



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																													
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	70																													
	60																													
	50																													
40																														
Systolic Blood Pressure ↑	190																													
	180																													
	170																													
	160																													
	150																													
	140																													
	130																													
	120																													
	110																													
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NEURO RESPONSE [✓]	Alert																													
	Voice																													
	Pain																													
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TOTAL YELLOW SCORES																														
TOTAL ORANGE SCORES																														
Nurse Initial																														

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

BAH-00651306

IP5-00175716

BAH-00651300
BARIRA FAREED

27-04-1995

31 Y 2 M 6 D

(F)

27-04-1995
Dr. PRANATHI REDDY A

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Your Right to a Safe Delivery

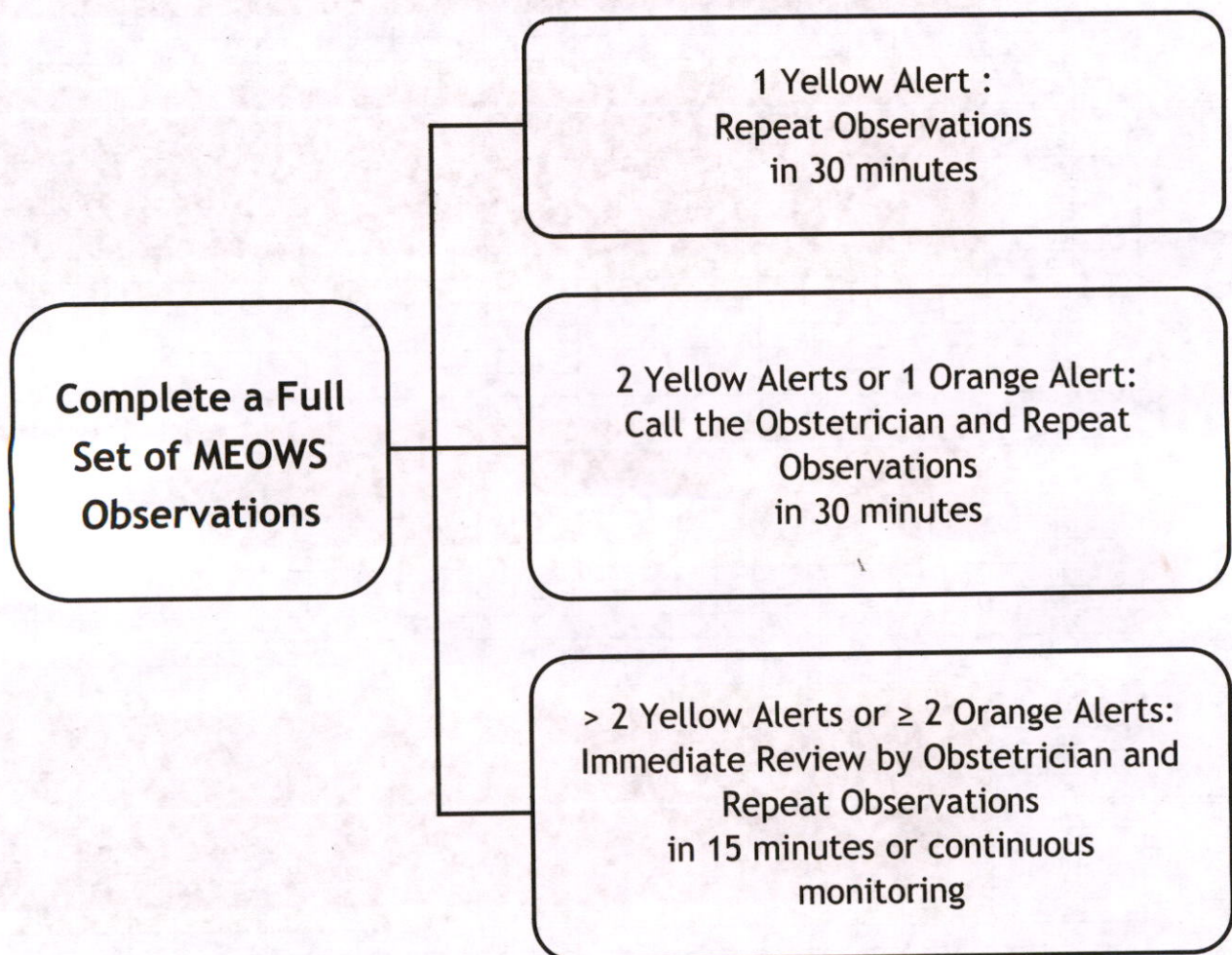
Early Warning Observation Score Chart - Obstetrics

CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT

TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

		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																													
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	60																													
	50																													
40																														
Systolic Blood Pressure ↑	190																													
	180																													
	170																													
	160																													

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)



FLUID CHART

Sheet No. : 1

28/6/26

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 Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am	mg Soy		25ml								
	03:00 am	mg Soy		25ml						35ml	0	Shahy
	04:00 am	pk		100ml							0	Shahy
	05:00 am	mg Soy		25ml							0	Shahy
	06:00 am	mg Soy		25ml						500ml	0	Shahy
	07:00 am	mg Soy		25ml							0	Shahy
Total Intake :						Total Output :						
Total 24 hrs. Intake			250ml			Total 24 hrs. Output			535ml			

EAM-00651306 IP5-001757

Mrs BARI RA FAREED

21-04-1995

31 Y 2 M 2 D

Dr. PRANATHI REDDY A



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Children's
Hospital

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BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

FLUID CHART

Sheet No. : ②

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
29/6	08:00 am	N	25ml	25ml			1			50ml	0	Surekha
	09:00 am	B	25ml				NP				0	Surekha
	10:00 am		25ml								0	Surekha
	11:00 am	H ₂ O (200ml)	25ml								0	Surekha
	12:00 pm	H ₂ O	25ml							150ml	0	Surekha
	01:00 pm		100ml	25ml						210ml	0	Surekha
Total Intake :			Taken			Total Output :			Panned 210ml			
	02:00 pm			mgsoy 25							0	Sup
	03:00 pm	Meeb.	25ml/hr							300ml	0	Sup
	04:00 pm		25ml/hr								0	Sup
	05:00 pm	H ₂ O (200ml)	25ml/hr							170	0	Sup
	06:00 pm		25ml/hr								0	Sup
	07:00 pm		25ml/hr							220	0	Sup
Total Intake :			150ml			Total Output :			890ml			
	08:00 pm	mgsoy	25ml								0	Shobha
	09:00 pm	mgsoy	25ml								0	Shobha
	10:00 pm	mgsoy	25ml							200ml	0	Shobha
	11:00 pm	mgsoy	25ml								0	Shobha
	12:00 am	mgsoy	25ml								0	Shobha
	01:00 am	mgsoy	25ml								0	Shobha
Total Intake :						Total Output :			200ml			
	02:00 am	mgsoy	25ml								0	Shobha
	03:00 am	mgsoy								400ml	0	Shobha
	04:00 am	mgsoy									0	Shobha
	05:00 am										0	Shobha
	06:00 am									350ml	0	Shobha
	07:00 am										0	Shobha
Total Intake :						Total Output :			500ml			

Total 24 hrs. Intake

300ml + 1250ml

Total 24 hrs. Output

200ml

BAH-00651306
Mrs BARI RA FAREED
27-04-1993 31 Y 2 M 3 D (F)
Dr. PRANATHI REDDY A

Patient

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FLUID CHART

Sheet No. : 1

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

Date	Time	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
	08:00 am	H ₂ O								0		Hand
	09:00 am	B				✓				0		Hand
	10:00 am	M							Urine	0		Hand
	11:00 am	H ₂ O								0		Hand
	12:00 pm									0		Hand
	01:00 pm	H ₂ O							✓	0		Hand
Total Intake : 720					Total Output : passed							
	02:00 pm	H ₂ O				✓			✓	0		Hand
	03:00 pm					✓			✓	0		Hand
	04:00 pm	H ₂ O				✓			✓	0		Hand
	05:00 pm	H ₂ O				✓			✓	0		Hand
	06:00 pm					✓			✓	0		Hand
	07:00 pm	H ₂ O				✓			✓	0		Hand
Total Intake : 720					Total Output : 0-3 M							
	08:00 pm					✓			✓	0		Hand
	09:00 pm	Milk				✓			✓	0		Hand
	10:00 pm	H ₂ O				✓			✓	0		Hand
	11:00 pm					✓			✓	0		Hand
	12:00 am	H ₂ O				✓			✓	0		Hand
	01:00 am					✓			✓	0		Hand
Total Intake : 720					Total Output : 0-3 M							
	02:00 am					✓			✓	0		Hand
	03:00 am	H ₂ O				✓			✓	0		Hand
	04:00 am					✓			✓	0		Hand
	05:00 am					✓			✓	0		Hand
	06:00 am					✓			✓	0		Hand
	07:00 am	H ₂ O				✓			✓	0		Hand
Total Intake : 720					Total Output : 0-2 M							
Total 24 hrs. Intake					Total 24 hrs. Output							



FLUID CHART

Sheet No. : (B)

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		
3/4	08:00 am	no fluid								✓	0	Sangee
	09:00 am		H2O								0	Sangee
	10:00 am										0	Sangee
	11:00 am		H2O							✓	0	Sangee
	12:00 pm										0	Sangee
	01:00 pm		H2O				✓				0	Sangee
	Total Intake :			Total Output :								
3/4	02:00 pm	no fluid									0	Sangee
	03:00 pm		H2O						✓	0	Sangee	
	04:00 pm										0	Sangee
	05:00 pm		H2O				✓		✓	0	Sangee	
	06:00 pm									0	Sangee	
	07:00 pm		H2O							0	Sangee	
	Total Intake :			Total Output : U-4 m-2								
3/4	08:00 pm	no fluid									0	Sangee
	09:00 pm		H2O							0	Sangee	
	10:00 pm										0	Sangee
	11:00 pm		H2O							0	Sangee	
	12:00 am						✓		✓	0	Sangee	
	01:00 am		H2O							0	Sangee	
	Total Intake :			Total Output : U-1 m-1								
3/4	02:00 am	no fluid									0	Sangee
	03:00 am		H2O								0	Sangee
	04:00 am										0	Sangee
	05:00 am		H2O						✓	0	Sangee	
	06:00 am									0	Sangee	
	07:00 am						✓		✓	0	Sangee	
	Total Intake :			Total Output : U-2 m-1								
Total 24 hrs. Intake			Total 24 hrs. Output U-7 m-4									

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FLUID CHART

Sheet No. : 4

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
	Total Intake :						Total Output :						
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
	Total Intake :						Total Output :						
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
	Total Intake :						Total Output :						
Total 24 hrs. Intake						Total 24 hrs. Output							

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Sheet No. :

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
	Total Intake :						Total Output :						
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							

Patient Sticker

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Sheet No. :

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

		Intake				Output						IV Site Thrombo- phlebitis Score	Sign. Nurse												
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine															
			Mouth	I.V	N.G																				
	08:00 am																								
	09:00 am																								
	10:00 am																								
	11:00 am																								
	12:00 pm																								
	01:00 pm																								
	Total Intake :					Total Output :																			
	02:00 pm																								
	03:00 pm																								
	04:00 pm																								
	05:00 pm																								
	06:00 pm																								
	07:00 pm																								
Total Intake :					Total Output :																				
	08:00 pm																								
	09:00 pm																								
	10:00 pm																								
	11:00 pm																								
	12:00 am																								
	01:00 am																								
Total Intake :					Total Output :																				
	02:00 am																								
	03:00 am																								
	04:00 am																								
	05:00 am																								
	06:00 am																								
	07:00 am																								
Total Intake :					Total Output :																				
Total 24 hrs. Intake													Total 24 hrs. Output												

Patient Sticker

FLUID CHART

Sheet No. :

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

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

Total 24 hrs. Intake

Total 24 hrs. Output

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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 28/6/26

Assessment: pt complain for 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
1 AM	Assess pt general condition monitor vital	1:10 AM	Assessed pt general condition. Bp spoz pulse checked recorded	pt is stable
4 AM	Administration medication.	4:5 AM	medication given for doctor order	
6 AM	Ensure safety	6:15 AM	Ensure safety provided	
7 AM	prevent infection	7:10 AM	To prevent infection	

Re-Assessment: Re Assessment done

Special Notes:

Nurse Signature: \$

Nurse Name: Shobha

Date & Time: 28/6/26 @ 8 AM

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BirthRight
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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 29/6/26

Assessment: Patient clo fear & anxiety

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8AM	→ Assess the general condition of the Patient.	8AM	→ Assessed the general condition of the Patient.	patient is stable
10AM	→ GRBS Monitoring.	10AM	→ 4th hr GRBS Monitoring done	
11AM	→ Blood reserve.	11AM	→ 10 PRBC blood reserve	
12PM	→ Prevent infection	12PM	→ Preventing infection by	
1PM	→ Maintain VO chat	1PM	→ using hand aub. maintaining VO chat.	

Re-Assessment: Pt is comfortable

Special Notes: NCT TID, GRBS Pre & Post Sugar

Nurse Signature: \$ Nurse Name: \$urecha Date & Time: 29/6/26 @ 2PM

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 Dr. PRANATHI REDDY A



NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 29/6/26

Assessment: few & anxiety related to disease condition.

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
2pm	* Assess the patient condition.	2:10 pm	* Assess the patient condition.	Patient is comfortable BPs are controlled.
3pm	* Advised for R check.	3:10 pm	* for R check done 145/90 mm.	
4pm	* Advised to not to take anxiety regarding diagnosis. The nurse started to decrease the blood pressure.	4:10 pm	* After counselling the doctor her few was decreased.	
6pm	* Advised 2d Echo.	6:15 pm	* 2d Echo done.	
7pm	* U/O Self measurement. Advised	7:15 pm	* patient is doing self measuring	

Re-Assessment: Reassessment done patient is relieved few.

Special Notes: pre & post sugar monitoring.

Nurse Signature:

[Signature]

Nurse Name:

[Signature]

Date & Time:

29/6/26 8pm

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 Mrs. BARIK FAREED
 27-04-1993 31 Y 2 M 2 D
 Dr. PRANATHI REDDY A

IP5-01757

NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 29/6/20

Assessment: pt complain for anxiety

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess pt general condition.	8:30 pm	Assessed pt general condition	pt is stable
10pm	monitor vital	10:10 pm	Bp SpO2 pulse checked and recorded	
12 AM	Administration medication	12:10 AM	medication as per doctor	
2 AM	Mgso4. Dr. medicine	2:10 AM	Mgso4 - done	
4 AM	Ensure safety	4:10 AM	ensure safety provided	
7 AM	prevent infection	7:10 AM	To prevent infection	

Re-Assessment: Re Assessment 24 hourly done

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Shobha

Date & Time: 29/6/20 @ 8am

BAH-00651306 IP5-00175716
 Mrs BARIKA FAREED
 27-04-1993 31 Y 2 M 3 D (F)
 Dr. PRANATHI REDDY A



NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 30/6/20

Assessment: patient having fear and 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
8 AM	Assess The patient general condition	8:30 AM	Assessed The patient general condition	Assessed
9 AM	vital check.	9:20 AM	vital checked and recorded	Assessed
10 AM	Prevent Infection	10:15 AM	maintaining hand hygiene	
11 AM	Ambulation	11:30 AM	ambulation done	
12 PM	IL to chest monitoring	12:20 PM	IL to chest monitoring	
1 PM	RRS pre & post	1 PM	RRS monitoring and Informing to doctor	
2 PM	Ensure Safety	2 PM	General Safety needs	

Re-Assessment: patient is comfortable

Special Notes: RRS pre and post

Nurse Signature: [Signature] Nurse Name: Leanne Date & Time: 30/6/20 PM

BAH-00651306 IP5-00175716
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 Dr. PRANATHI REDDY A



NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 30/6/26

Assessment: patient complaints on pus & smelly

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
9pm	→ Assess the pt condition	2:10pm	→ Assessed the patient condition	
3pm	→ Monitor vitals	3:10pm	→ vitals checked and recorded	
4pm	→ S/o Chest	4:10pm	→ S/o chest monitored	
5pm	→ NST	5:10pm	→ NST T10 checked	
6pm	→ Administer medication	6:10pm	→ Administered pr medication	
7pm	→ Safety	7:10pm	→ Ensured Safety	
8pm	→ Side rails	8:10pm	→ Side rails provided	

Re-Assessment: vitals checked and recorded

Special Notes: Daily Dopplers

Nurse Signature: [Signature] Nurse Name: [Signature] Date & Time: 30/6/26 @ 8 pm

BAH-00651306 IP5-00175716
 Mrs BARIKA FAREED 31 Y 2 M 3 D (F)
 27-04-1993
 Dr. PRANATHI REDDY A

NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 20/6/2016

Assessment: patient Complaint for 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	9pm	Assessed PT condition.	PT is comfortable.
10pm	Monitoring vitals	11pm	vitals checked & record.	
12am	chest monitoring	2am	D/O chest medication given	
4am	regular diet	5am	regular diet given.	
	NBT		NBT done.	
6am	Observation	7:30	Observation done	

Re-Assessment: Re-Assessment 6th noon by.

Special Notes: 1. Daily dopplers

Nurse Signature: [Signature] Nurse Name: R. Reddy Date & Time: 1/7/2016 08:10

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Mrs BARIKA FAREED
27-04-1993 31 Y 2 M 3 D (F)
Dr. PRANATHI REDDY A



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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 1/7/20 @

Assessment: pt complain for Abdominal 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
2pm	Assess pt general condition	2:30 pm	Assess pt general condition	pt is Stable
3pm	- monitor vitals	3:30 pm	- monitoring vitals BP, PR, RR, SpO ₂ , checked & Reassess	
4pm	- NBM	4:30 pm	- NBM still further order	
5pm	- IV medication	5:30 pm	- IV medication given & PR done	
6pm	- Relieve pain	6:30 pm	- Relieve pain & Discomfort	
7pm	- Ensure Safety	7:30 pm	- Ensure safety provided	

Re-Assessment:

Special Notes: NBM still further order

Nurse Signature: [Signature]

Nurse Name: Sonu

Date & Time: 1/7/20 @ 8pm

27-04-1995 31 Y 2 M 4 D (F)
Dr. PRANATHI REDDY A



NURSING CARE RECORD

Rainbow
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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 17/26

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 general condition of patient.	8:30pm	Assessed the general condition of patient.	Now is the Patient Stable
10pm	Administer the medication as per Drug chart.	10:30pm	Administered the medication as per Drug Chart.	
11pm	Maintain the I/O chart.	11:30pm	Maintaining the I/O Chart.	
5am	Continue IV fluids.	5:30am	Continued IV fluids.	
6am	Ensure the safety.	6:30am	Provided the side rails.	

Re-Assessment:

Re-Assessment Done 4th hrly.

Special Notes:

CBP T/m

Nurse Signature: Rim

Nurse Name: Rim

Date & Time:

2/7/26 @ 8Am

BAH-00651306 IP5-00175716
 Mrs. BARIRA FAREED
 27-04-1995 31 Y 2 M 6 D (F)
 Dr. PRANATHI REDDY A



NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 2/7/20

Assessment: patient 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
8 AM	⇒ Assess The patient's General Condition	8 AM	⇒ Assessed The patient's General Condition	
11 AM	⇒ plan for monitor patient vitals	12 PM	⇒ monitoring patient vitals	Patient now stable
2 PM	⇒ plan for monitor patient Bio chart	4 PM	⇒ monitoring patient Bio chart	
5 PM	⇒ plan for outcoflux sy	6 PM	⇒ sapogetry done	
7 PM	⇒ plan for in & out	8 PM	⇒ Shifted to LTR for	

Re-Assessment:

Special Notes: BP checking

Nurse Signature: [Signature]

Nurse Name: Shree Lakshmi

Date & Time: 2/7/20 8 PM

BAH-00651306 IP5-00175716
Mrs. BARIRA FAREED
27-04-1995 31 Y 2 M 6 D (F)
Dr. PRANATHI REDDY A



NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 2/7/26

Assessment: Patient complaining mild pain at surgical site

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	8:40pm	Assessed the pt condition	now for pt is stable
10pm	Plan for monitor vitals	10:30pm	monitored vitals	
11am	Plan for maintain I/O chart	12:30am	Maintained I/O chart & Recorded	
2am	Plan for administer medication as per drug chart	2:30am	Administered medication as per drug chart	
4am	Plan for check BP 3rd hly	4:30am	Stimulated the Breast	
6am	Plan for stimulate Breast	7:20am	Ensured safety	
8am	Ensure safety			

Re-Assessment: Re-assessment done

Special Notes: BP 3rd hly.

Nurse Signature: Pooja

Nurse Name: Pooja (018504)

Date & Time: 3/7/26 @ 3PM

BAH-00651306 IP5-00175716
 Mrs. BARI RA FAREED
 27-04-1995 31 Y 2 M 6 D (F)
 Dr. PRANATHI REDDY A



NURSING CARE RECORD

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Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 3/7/26

Assessment: patient is having Anxiety related to 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
8 AM	→ Assess the patient → Generation condition.	8:20 AM	→ assessed the patient → General condition.	Patient is Stable now
10 AM	→ monitor vitals	10:20 AM	→ monitor vitals	
12 PM	→ maintain I/O chart	12:20 PM	→ maintained I/O chart	
2 PM	→ Administer medication as per chart	2:30 PM	→ Administered medication as per chart	
4 PM	→ Ensure safety	4:20 PM	→ Ensured safety	
6 PM	→ provide comfortable position	6:30 PM	→ provide comfortable position	

Re-Assessment:

As patient is stable

Special Notes:

Will Trace urine clc.

Nurse Signature:

Nurse Name: Sangeetha Suresh

Date & Time: 3/7/26 @ 8 PM



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 31/7/26

Assessment:

Patient is having pain & 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 general condition of the patient	9pm	Assessed the general condition of the patient	patient is stable & comfortable
10pm	Maintain good nutritional status	11pm	Maintained good nutritional status	
12am	Administer medication as per doctor's order	2am	Administered medication as per doctor's order	
3am	plan for vitals	4am	checked vitals & recorded	
5am	Maintain I/O chart	6am	Maintained I/O chart	
7am	Ensure safety	8am	provide side rails	

Re-Assessment:

vitals checked & recorded

Special Notes:

Continue same treatment

Nurse Signature: Swapna

Nurse Name: Swapna / 017692

Date & Time: 31/7/26 @ 8am

BAH-00651306 IP5-00175716
Mrs. BARIRA FAREED
27-04-1995 31 Y 2 M 6 D (F)
Dr. PRANATHI REDDY A

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

BAH-00651306 IP5-00175716
 Mrs. BARIRA FAREED
 27-04-1995 31 Y 2 M 6 D (F)
 Dr. PRANATHI REDDY A

NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

Patient Sticker

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. pranathi Department: OBS. Date of Admission: 29/6/20

SITUATION	Diagnosis: <u>primi 33+3 wks. Inf. conception</u> <u>GDM diet pre ectomphi seven fetal</u> <u>for observation delivery</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area	<u>OBS</u> <u>8pm-8am</u>	<u>OBS</u> <u>8am-2pm</u>	<u>OBS</u> <u>2pm-8pm</u>	<u>OBS</u> <u>8pm-8am</u>	<u>OBS</u> <u>8am-11am</u>	<u>OBS</u> <u>11am-5pm</u>	
	Shift Time							
ASSESSMENT	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>	<u>GDM diet</u> <u>pre Ectomphi</u>	<u>GDM diet</u> <u>pre Ectomphi</u>	<u>GDM diet</u> <u>pre Ectomphi</u>	<u>GDM diet</u> <u>pre Ectomphi</u>	
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	<u>97.7F</u>	<u>98.2F</u>	<u>98.1F</u>	<u>98.1F</u>	<u>98.0F</u>	<u>98.5F</u>
		Res:	<u>20</u>	<u>18</u>	<u>18</u>	<u>20</u>	<u>19</u>	<u>20</u>
		SpO ₂ :	<u>100</u>	<u>100</u>	<u>99</u>	<u>99</u>	<u>100</u>	<u>100</u>
		Pulse:	<u>74b/m</u>	<u>82b/m</u>	<u>92</u>	<u>85b/m</u>	<u>72b/m</u>	<u>70b/m</u>
		BP:	<u>131/74</u>	<u>121/70</u>	<u>108/72</u>	<u>125/84</u>	<u>101/62</u>	<u>111/70</u>
	Fall Risk Score:	<u>20</u>	<u>20</u>	<u>35</u>	<u>20</u>	<u>35</u>	<u>35</u>	
	Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	
	Recommendations	Safety Needs:	<u>NA</u>	<u>NA</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>
Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Others Specify:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>T. hantol</u> <u>TID</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>	<u>NA</u>	<u>NA</u>		
Handed Over By Name :	<u>Shobha</u>	<u>Shobha</u>	<u>Shobha</u>	<u>Shobha</u>	<u>Shobha</u>	<u>Shobha</u>		
Signature :	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:	<u>28/6/20</u>	<u>29/6/20</u>	<u>29/6/20</u>	<u>29/6/20</u>	<u>30/6/20</u>	<u>30/6/20</u>		
Time:	<u>8pm</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>	<u>8am</u>	<u>8pm</u>		
Taken Over By Name :	<u>Shobha</u>	<u>Shobha</u>	<u>Shobha</u>	<u>Shobha</u>	<u>Shobha</u>	<u>Shobha</u>		
Signature :	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:	<u>29/6/20</u>	<u>29/6/20</u>	<u>29/6/20</u>	<u>30/6/20</u>	<u>30/6/20</u>	<u>30/6/20</u>		
Time:	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>		



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Pranathi Reddy Department: BC Date of Admission: 29/6/14

SITUATION		Diagnosis: <u>pericarditis 33+3 may IVF Cerebral</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known		
				If Yes Specify:		
BACKGROUND	Area	<u>OBS. surgery</u>	<u>OBS 8am-2pm</u>	<u>2pm-4pm</u>	<u>4pm-8pm</u>	
	Shift Time	<u>8am-2pm</u>	<u>2pm-4pm</u>	<u>4pm-8pm</u>	<u>8pm-12am</u>	
ASSESSMENT	Medical Condition (Any special condition to be noted):	<u>apnoea died</u>	<u>apnoea died</u>	<u>apnoea died</u>	<u>NA</u>	
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
ASSESSMENT	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	<u>98.2</u>	<u>98.6</u>	<u>98.2</u>	<u>98.1</u>
		Res:	<u>20</u>	<u>19</u>	<u>19/17</u>	<u>20/17</u>
		SpO ₂ :	<u>99%</u>	<u>100</u>	<u>100</u>	<u>100</u>
		Pulse:	<u>60 ul</u>	<u>82</u>	<u>82</u>	<u>88</u>
		BP:	<u>108/92</u>	<u>104/77</u>	<u>130/90</u>	<u>126/86</u>
	Fall Risk Score:	<u>35</u>	<u>35</u>	<u>35</u>	<u>35</u>	
	Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	
Recommendations	Safety Needs:	<u>side rail</u>	<u>side rail</u>	<u>side rail</u>	<u>side rail</u>	
	Physiotherapy	☐ 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	
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>Pardhi</u>	<u>Suand</u>	<u>Song</u>	<u>Qimr</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>1/7/14</u>	<u>1/7/14</u>	<u>1/7/14</u>	<u>2/7/14</u>	
Time:		<u>8:05 am</u>	<u>8:07 am</u>	<u>8:01 am</u>	<u>8:00 am</u>	
Taken Over By Name :		<u>Suand</u>	<u>Song</u>	<u>Alanya</u>	<u>Alanya</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>1/7/14</u>	<u>1/7/14</u>	<u>2/7/14</u>	<u>2/7/14</u>	
Time:		<u>8:04 am</u>	<u>2:54 pm</u>	<u>8:00 am</u>	<u>8:00 am</u>	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. pranathi reddy Department: EC Date of Admission: 3/7/26

SITUATION		Diagnosis:		Any Infection: ☐ Yes ☒ No ☐ Not Known		If Yes Specify:		
BACKGROUND	Area							
	Shift Time	2nd shift 8PM-8PM						
BACKGROUND	Medical Condition (Any special condition to be noted):	WDM on diet GDM on diet						
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	98.0F	98.0F				
		Res:	20	19bmt				
		SpO ₂ :	99%	99%				
		Pulse:	98bmt	86bmt				
		BP:	120/80	120/68				
	Fall Risk Score:	0	0					
	Pain Score:	0	0					
	Safety Needs:	Siderails	Siderails					
Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No		
Others Specify:	NA	NA						
Recommendations	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	NA	NA					
	Procedure Special Orders:	NA	NA					
	Name:	Rangellu	Swaghe					
Date:	3/7/26	3/7/26						
Time:	8PM	8AM						
Taken Over By Name:	Swaghe							
Signature:	[Signature]							
Date:	3/7/26							
Time:	8PM							

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:				
BACKGROUND	Area Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp:					
		Res:					
		SpO ₂ :					
		Pulse:					
		BP:					
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
	Post Operative Procedure Special Orders:						
	Handed Over By Name :						
	Signature :						
	Date:						
	Time:						
	Taken Over By Name :						
	Signature :						
	Date:						
	Time:						

BAH-00551306

Mrs BAFIRA FAREED

27-04-1995

31 Y 2 M 1 D

Dr. PRANATHI REDDY A



BRADEN 'Q' SCALE

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

				Date :	28/6/2029	29/6/2029	29/6/2029	30/6/2029
				Time :	10pm & 8am	8AM	2pm	8AM & 8PM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	6	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
				TOTAL SCORE	28	28	28	28
				Evaluator's Name	Shobha	Shobha	Shobha	Shobha

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

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

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

BAH-00651306

IP5-10175

Mrs BARIKA FAREED
27-04-1995 31 Y 2 M 2 D
Dr. PRANATHI REDDY A



BRADEN 'Q' SCALE

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date :	28/06/2016			
					Time :	12:30 PM			
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		4	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4	4	4	4
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FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	4	4
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					TOTAL SCORE	28	28	28	28
					Evaluator's Name	A. Suresh			

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

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
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BAH-00651306

IP5-00175716

Mrs BARIRA FAREED

27-04-1995

31 Y 2 M 3 D

(F)

Dr. PRANATHI REDDY A



BRADEN 'Q' SCALE

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

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

					Date :	15/6	17/2	3/2	1/7
					Time :	7:45 AM	8 AM	6 AM	8 AM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		4	4	4	4
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Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	26	26	28	28
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	Dr	Prin	Pap	Prage

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
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BRADEN 'Q' SCALE

					Date :				
					Time :				
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.					
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Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.					
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TOTAL SCORE									
Evaluator's Name									

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

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PAIN ASSESSMENT FORM

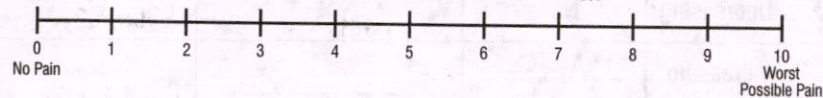
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
29/6	2pm	0/10	NO pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shobha
29/6	8Am	0/10	NO pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shobha
29/6	12pm	0/10	NO pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shobha
29/6	4pm	0/10	NO pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shobha
29/6	8pm	0/10	NO pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shobha
29/6	8Am	0/10	NO pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shobha
30/6	10Am	0/10	NO pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shobha
30/6	2pm	0/10	NO	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shobha
30/6	6pm	0/10	NO pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Shobha
1/7/26	am	0/10	NO pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shobha

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

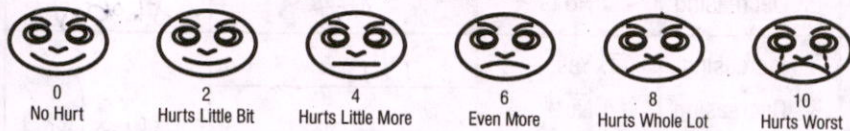
Numerical Pain Scale (Obstetric and Gynecology)



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, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

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	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
30/6/20	8pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Reddy
30/6/20	10pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Reddy
1/7/20	12am	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Reddy
1/7/20	2am	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Reddy
1/7/20	4am	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Reddy
1/7/20	7am	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Reddy
1/7/20	9am	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Swanda
1/7/20	11am	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Swanda
1/7/20	2pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Swanda
1/7/20	3pm	0/10	Surgery site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Inj: pcm opioid	Swanda

Re-assessment Frequency:

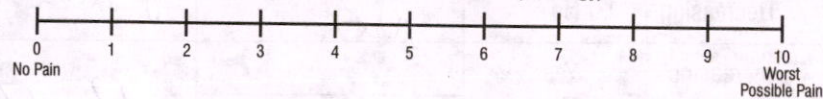
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

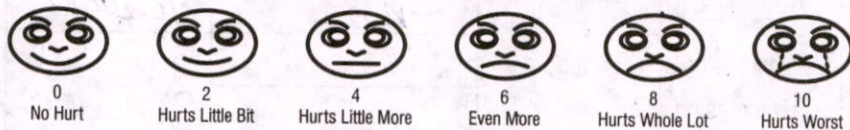
Numerical Pain Scale (Obstetric and Gynecology)



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

Wong - Baker (Pediatrics) Above 7 Years





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
17/10	4pm	0/10	Burke wte	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	2ml p.m. given	sf
1/7/26	7pm	0/10	2/8/8	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	2ml Tramadol given	sf
1/7/26	8pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Rim
2/7/26	9:30pm	1/10	8/8	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	2ml p.m. given	Rim
1/7/26	10:30pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Rim
2/7/26	3AM	1/10	8/8	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☒ Increasing ☒ Decreasing	☒ Yes ☐ No	2ml Tramadol given	Rim
2/7/26	9AM	0/10	TRAMADOL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Rim
2/7/26	11AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	sf
2/7/26	7pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Ahead
2/7/26	8pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Rim

Re-assessment Frequency:

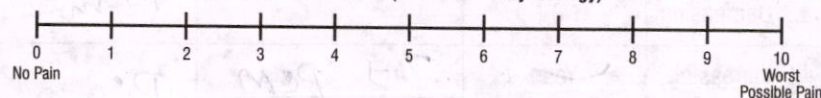
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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

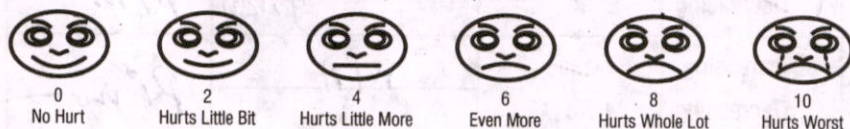
Numerical Pain Scale (Obstetric and Gynecology)



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)
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Wong - Baker (Pediatrics) Above 7 Years



0
No Hurt

2
Hurts Little Bit

4
Hurts Little More

6
Even More

8
Hurts Whole Lot

10
Hurts Worst



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
3/7/26	1:30 AM	1/10	Upper Side	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☐ Yes ☒ No	Inf. Pain given	Roop
3/7/26	2:30 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☒ No	NA	Roop
3/7/26	6 AM	0/10	Lower abdomen	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☒ No	Inf. Pain given	Sangeetha
3/7/26	12 PM	1/10	Lower abdomen	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☒ No	Inf. Pain given	Sangeetha
3/7/26	6 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☒ No		Sangeetha
3/7/26	10 PM	0/10	NA	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☒ No	NA	Sangeetha
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☒ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☒ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☒ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☒ No		

Re-assessment Frequency:

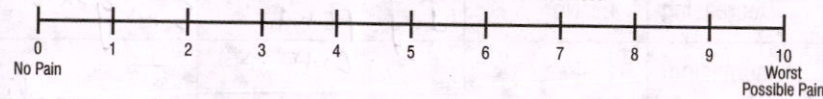
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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

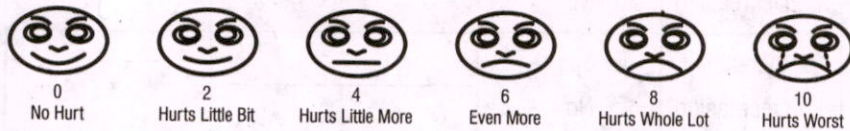
Numerical Pain Scale (Obstetric and Gynecology)



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)
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Wong - Baker (Pediatrics) Above 7 Years



BAH-00651306 IP5-00175716
 Mrs BARIJA FAREED
 27-04-1995 31 Y 2 M 6 D (F)
 Dr. PRANATHI REDDY A



PAIN ASSESSMENT FORM

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

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

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

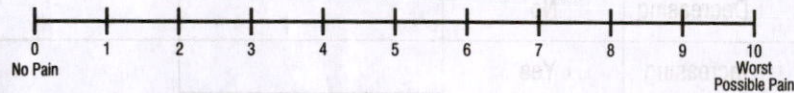
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PAIN ASSESSMENT TOOLS

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CATEGORY	SCORING		
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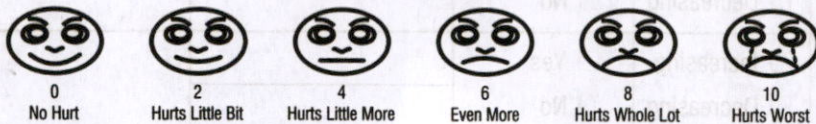
Numerical Pain Scale (Obstetric and Gynecology)



Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

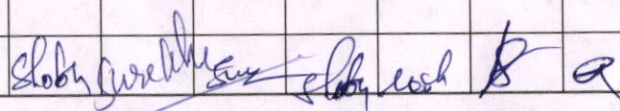
Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
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Wong - Baker (Pediatrics) Above 7 Years





CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0	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 cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			-	-	-	-	-	-		
Signature of the Nurse													

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

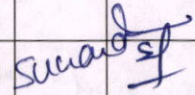
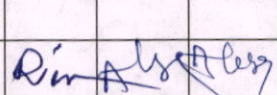
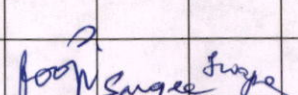
Signature :  Name : Surupa

Signature of Ward In Charge :

Signature :  Name : Ulena

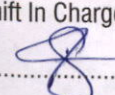


CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	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	-	-	-	-	-	-	-	-		
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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	-	-	-	-	-	-	-	-		
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Signature of the Nurse				  									

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Signature of Shift In Charge :

Signature :  Name : Sharada

Signature of Ward In Charge :

Signature :  Name : veena

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
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2	One of the following signs is evident: * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1										
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2										
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3										
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4										
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5										
Signature of the Nurse													

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0										
2	One of the following signs is evident: * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1										
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2										
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3										
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4										
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5										
Signature of the Nurse													

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personnel. Ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :

Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	Score	Fall Risk Grading					
History of Falling (immediately or w/in 3 months)	Yes	25	20/6/26 8pm-8AM	29/6/26 8AM-2pm	29/6/26 2pm-5pm	Risk Level	Morse Fall Score (MFS)	Action	
	No	0							
Secondary Diagnosis (more than one diagnosis)	Yes	15			15	Low Risk	0 - 24	Standard Fall Precaution	
	No	0							
Ambulatory Aid	Furniture	30				Moderate Risk	25-50	Implement Moderate Fall Prevention Intervention	
	Crutches, Cane(S), Walker	15							
	None /Bed Rest /Nurse Assist	0	0						
IV / Heparin Lock or Saline	Yes	20	20	20	20	High Risk	≥ 51	Implement High Risk Fall Prevention Intervention	
	No	0	0						
GAIT / Transferring	Impaired	20				Total Morse Fall Scale Score:	20	20	35
	Weak (uses touch for balance)	10							
	Normal /On Bed Rest /Immobile	0							
Mental Status	Forgets limitations	15				Signature	Shobha	Suresh	Surya
	Oriented to own ability	0							

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

BAH-00651306 IP5-0017
 Mrs BARIRA FAREED
 27-04-1993 31 Y 2 M 1 D
 Dr. PRANATHI REDDY A

Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	29/6/20	30/6/20	30/6/20	Fall Risk Grading		
		Score						
History of Falling (immediately or w/in 3 months)	Yes	25				Risk Level	Morse Fall Score (MFS)	Action
	No	0						
Secondary Diagnosis (more than one diagnosis)	Yes	15	15	15	15	Low Risk	0 - 24	Standard Fall Precaution
	No	0						
Ambulatory Aid	Furniture	30				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0					
IV / Heparin Lock or Saline	Yes	20	20	20	20	High Risk	≥ 51	Implement High Risk 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						
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0						
Total Morse Fall Scale Score:			35	35	35			
		Signature	Shobha	Neetha	Pragna			

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
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- ☐ 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

BAH-00651306 IP5-00175716
 Mrs BARIRA FAREED
 27-04-1993 31 Y 2 M 3 D (F)
 Dr. PRANATHI REDDY A

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	Fall Risk Grading		
		Score			
History of Falling (immediately or w/in 3 months)	Yes	25	Risk Level	Morse Fall Score (MFS)	Action
	No	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15	Low Risk	0 - 24	Standard Fall Precaution
	No	0			
Ambulatory Aid	Furniture	30	Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0			
IV / Heparin Lock or Saline	Yes	20	High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	No	0			
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0			
Mental Status	Forgets limitations	15			
	Oriented to own ability	0			
Total Morse Fall Scale Score:		38			
Signature					

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



Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	Fall Risk Grading		
		Score			
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0	0	0	0
Secondary Diagnosis (more than one diagnosis)	Yes	15	15	15	15
	No	0			
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0			
IV / Heparin Lock or Saline	Yes	20	20	20	20
	No	0			
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0	0	0	
Mental Status	Forgets limitations	15			
	Oriented to own ability	0	0	0	
Total Morse Fall Scale Score:			35	35	35
Signature			Rim	Ther	poor

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

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time		Fall Risk Grading		
		Score				
History of Falling (immediately or w/in 3 months)	Yes	25	4/7/20 Sam			
	No	0				
Secondary Diagnosis (more than one diagnosis)	Yes	15	15			
	No	0				
Ambulatory Aid	Furniture	30				Low Risk
	Crutches, Cane(S), Walker	15				
	None /Bed Rest /Nurse Assist	0				
IV / Heparin Lock or Saline	Yes	20	20			
	No	0				
GAIT / Transferring	Impaired	20				Moderate Risk
	Weak (uses touch for balance)	10				
	Normal /On Bed Rest /Immobile	0				
Mental Status	Forgets limitations	15				
	Oriented to own ability	0				
Total Morse Fall Scale Score:			35			
Signature			Swape			

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
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Morse Fall Risk Assessment Form

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

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis:

Primie / 33 Weeks / IVF unmap / GDM m diet / PE i severe features. for observation / delivery

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
29/6/26 @ 1:30pm	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Primie / 33 Weeks / IVF unmap / GDM m diet / PE i severe features	for safe delivery	for observation/ delivery		☒ Nursing ☐ Others:
29/6/26 @ 1:35pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	patient need is fear and anxiety	provide patient is safety.	to reduce the fear and anxiety.		☒ Medical ☐ Others:
2/7/26 10:40 am dietician	☐ Medical ☐ Nursing ☒ Others:	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	POD-1	soft diet	soft high protein diet		☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

BAH 00651.06
Mrs EARIKA FAREED
27-04-1993 31 Y 2 M 2 D
Dr. PRANATHI REDDY A

IP5-0017571



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

**Rainbow
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Part - I.

Patient's / Learner Language: ign, Hindi, 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		
29/6/26	1:30 AM	12	Diagnosis, Treatment & care plan	PT, M	1	0	1	1	—	<i>[Signature]</i>
29/6/26	1:35 AM	7	Infection control measures	PT, M	1	0	1	1	—	<i>[Signature]</i>
27/6/26	10:46 am	9	nutrition diet	PT, M	1	0	1	1	—	<i>[Signature]</i>

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:	<table border="0"> <tr> <td>1. No Learning Barriers</td> <td>4. Language Barrier</td> <td>7. Impaired Thought Process/Cognitive limitations</td> <td>10. Financial Difficulties</td> <td>13. Cultural/Religion Practice</td> </tr> <tr> <td>2. Physical Impairment</td> <td>5. Educational Level</td> <td>8. Responsibilities at Home</td> <td>11. Beliefs and Values</td> <td>14. Others (Specify)</td> </tr> <tr> <td>3. Emotional Barriers</td> <td>6. Desire / Motivate to Learn</td> <td>9. Cultural Differences</td> <td>12. Impaired Vision/ or Hearing</td> <td></td> </tr> </table>								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	
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:	<table border="0"> <tr> <td>1. None</td> <td>3. Reassurance & Support</td> <td>5. Respect values & beliefs</td> <td>7. Other, Specify</td> </tr> <tr> <td>2. Obtain translator</td> <td>4. Teach Family / Others</td> <td>6. Respect Cultural / Religion Preference</td> <td></td> </tr> </table>								1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify	2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference								
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Understanding:	<table border="0"> <tr> <td>1. Verbalizes Understanding</td> <td>2. Demonstrates Understanding</td> <td>3. Needs Review</td> </tr> </table>								1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review												
1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review																					



OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 29/6/26 Time of Arrival: 1:10 AM Time Seen by Nurse: 1:15 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: Pore Eclampsia

3) **Vital Signs:** Temperature: 97.7f Pulse: 84b/min RR: 20 SpO₂: 100 BP: 131/74 Weight:

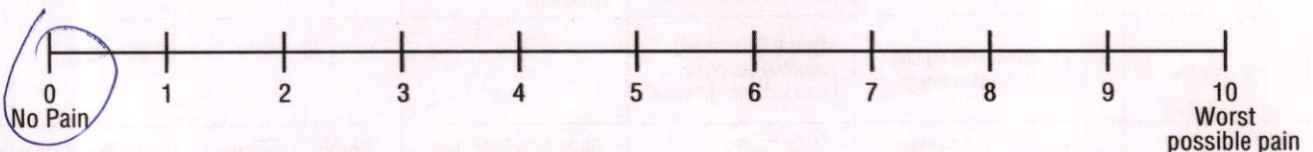
4) **Gestational Criteria:**

Gravida:	G <u>1</u>	P	L	A
----------	------------	---	---	---

LMP: 10/11/25 EDD: 14/8/26 Gestational Age: 33+3 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: NA
- Duration: Days / Weeks/ Months (Strike out which is not applicable)
- Character: NA
- Frequency: NA
- Interventions: NA

6) **Past History:**

- a) Surgeries: Hysterectomy - 2024
- b) Medical: NA

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)

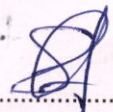
Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

- ☐ 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/ SROM > 37 weeks	Discomforts of Pregnancy
Bleeding	Active Vaginal bleeding with/ without abdominal pain	Bleeding associated with cramping ($<$ spotting) < 37 weeks	Bleeding associated with cramping ($>$ spotting) > 37 weeks	Spotting	
Hypertension	Seizure activity	Hypertension $> 160/110$ and / or headache, visual disturbance, RUQ pain	Mild hypertension $> 140/90$ with/without associated signs and symptoms		
Fetal Assessment	Abnormal FHR tracing Non-Fetal Movement	Atypical FHR tracing, abnormal dopplers Diseased fetal movement			
Others	- Acute onsite severe abdominal pain - Altered level of consciousness - Cord prolapse - Severe respiratory distress - Suspected sepsis	- Major trauma - Shortness of breath - Unplanned and unattended birth	- Abdominal/back pain greater than expected in pregnancy - Flank pain / hematuria - Nausea /vomiting and /or diarrhea with suspected dehydration	- Ongoing assessment from out patient clinic (for hypertension, blood work) - Minor trauma (minor MVC/fall) - Nausea/Vomiting and /or diarrhea - Signs of infection (ie dysuria ,cough, fever, chills)	- Anything that does not seem to pose threat to mother or fetus - Cervical ripening - Out patient placenta previa protocols - Pre-booked visits (ie Rh and progesterone injections, NST - Assessment for version - Rashes

Time seen by Doctor: Dr. Sarina 2:00 PM

Nurse Name: Shebha Nurse Signature: 

Date: 29/6/26 Time: 1:30 AM

BAH-00651306 IP5-00175716
Mrs BARIIRA FAREED
27-04-1993 31 Y 2 M 4 D (F)
Dr. PRANATHI REDDY A



312

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NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 2/7/26

Time: 10:40am

Origin: Indian Height: 158cm Weight: 78.5kg's BMI: 31.07kg/m²

Food Allergies: No

Diagnosis: POD-1 / LSCS (lower segment cesarian section)

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

Diet Advised:

soft high protein diet
include plenty of oral liquids
avoid spicy, chilled and outside foods

Patient's / Attendant's

Dietician's

Signature: Fareed

Signature: Saima

Name: Fareed

Name: SAJMA

Date & Time: 2/7/26
10:40am

Date & Time: 2/7/26
10:40am

DIETARY NOTES

[illegible]

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00651306 IP5-00175716 Mrs BARI RA FAREED 27-04-1993 31 Y 2 M 4 D (F) Dr. PRANATHI REDDY A 		Date & Time of Admission 29/6/20 @ 1:23 Am	Date & Time of Transfer Order 1/7/20 @ 5:30 PM
		Transfer Ordered by Dr. Arslan	Reason for Transfer post op
From Unit new	To Unit 8rd floor 312)	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If Yes, what?	Patient shifted with ID band: Yes ☒ No ☐ If No:	
Number of Imaging Films			
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	→ 20cho	①	
2.	→ AFI DOPPY	①	
3.	→ NST	①	
4.	→ gale CRBS.	①	
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Dr. Seng		Name of Person Ordered Transfer Dr. Arslan	
Patient & Clinical Records Received by : Alexis			
Date & Time of Patient Received : 1/7/20 6:20 PM			

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

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

BAH-00651306
Mrs. BARIRA FAREED
27-04-1995 31 Y 2 M 4 D (F)
Dr. PRANATHI REDDY A



CAESAREAN SECTION OPERATIVE NOTES

Surgeon's Name: Dr. Pranathi Reddy	Date of Delivery: 1/2/26
Assistant Surgeon: Dr. Bhargavi Reddy	Time of Delivery: 12.01 PM
Anaesthetist's Name: Dr. Adithi	Gender of Baby: male
Type of Anaesthesia: ↓ Spinal	Weight of Baby: 1.623 kg
Neonatologist: Dr. Anusha, Dr. Pinesh	AGPAR Score: 7, 8
Scrub Nurse: Lenu	NICU Admission: ☒ Yes ☐ No

Pre-Operative Diagnosis: Primigravida 33¹⁵ / IVF / GDM on Diet / Immminent eclampsia
Anemia

☐ Elective ☒ Emergency Indication: ↓ Uncontrolled BPs.

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:

If there was a delay give the reasons:

Surgical Procedure: Emergency LSC under spinal

Post Operative Diagnosis: Piy-PAD

Peri-Operative Complications: ✓ Breech delivery
✓ Right ovary adherent to posterior uterine surface.
✓ Posterior uterine wall - endometriotic spots present

Amount of Blood Loss: ~ 400 ml Blood Transfused (in ML): Nil

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

Examination Findings when Appropriate:

Presentation: ☐ Cephalic ☒ Breech ☐ Other 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 *breech extraction*
Delivery of head: ☒ Manual ☐ 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 *None* Suture
Sheath Closure: *No 1 Vicryl* Suture
Fat Closure: ☒ Yes ☐ No *No 3-0 Monocryl* Suture
Skin Closure: ☒ Subcuticular ☐ Mattress *No 3-0 Monocryl* Suture

Vaginal Evacuated ☒ Yes ☐ No
Drain: ☐ Yes ☒ No ☐ Remove in days ☐ Await instructions
Catheter: ☒ Yes ☐ No ☐ Remove in *24 hrs* 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: *Norm for 4-6 hours*

WBP x 6 AM (2/7/26)
✓ I/V f Analgesic as charted
✓ Monitor vitals x hourly
✓ Urine output monitoring x hourly
✓ 1g cefotaxim 1 gram IV BD until discharge
✓ Continue Tab. Gabapentin 100mg TID
✓ Tab. Vicodin 10mg (40s)
✓ Mobilization ✓ w/f excessive bleeding

Doctor Name: *R. Gupta* Doctor Signature: *hp*

Date & Time: *1/7/2026 1 PM*

BAH-00651306 IP5-00175716

Mrs BARIRA FAREED

27-04-1995

31 Y 2 M 4 D

(F)

Dr. PRANATHI REDDY A

Patient S



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POST-SURGICAL CARE PLAN FORM

Procedure Done:

Emergency LSC under Spinal

Post-Surgical Diagnosis:

Pit - PPD-O

Post-Operative Monitoring Parameters /Frequency:

BP/HR/SpO₂ - hourly monitoring

Wound Care:

Dressing x 48 hrs

Drain /Special Lines/Catheters:

✓ Foley insitu

✓ V/O hourly monitoring

Special Patient Positioning and Requirements:

Nutritional Instructions:

✓ NBM for 4-6 hours

✓ liquids after 4-6 hours

✓ Soft diet after 8-10 hours.

When to Start Mobilization:

✓ As soon as anesthesia wears off

✓ Ambulation after Foley Removal

Special Referrals:

Nil

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

☐ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

✓ CRP x 6 AM (2/7/26)

Treating Surgeon
(Signature & Stamp)

Date: 1/07/2026

Time: 1:00 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)	X	4
Previous VTE provoked by major surgery	X	3
Known high-risk thrombophilia	X	3
Medical comorbidities e.g. cancer, heart failure; active systemic lupus erythematosus, inflammatory poly arthropathy or inflammatory bowel disease; nephrotic syndrome; type-I diabetesmellitus with nephropathy; sicklecell disease; current intravenous drug user	X	3
Family history of unprovoked or estrogen-related VTE in first-degree relative	X	1
Known low-risk thrombophilia (no VTE)	X	1
Age (? 35 years)	X	1
Obesity	↓	1 or 2
Parity ≥ 3	X	1
Smoker	X	1
Gross varicose veins	X	1
Obstetric Risk Factors		
Pre-eclampsia in current pregnancy	↓	1
ART/IVF (antenatal only)	X	1
Multiple pregnancy	X	1
Caesarean section in labour	↓	2
Elective caesarean section	X	1
Mid-cavity or rotational operative delivery	X	1
Prolongedlabour (? 24hours)	X	1
PPH (?1litreortransfusion	X	1
+0 Preterm birth? 37 weeks in current pregnancy	↓	1
Still birth in current pregnancy	X	1
Transient Risk Factors		
Any surgical procedure in pregnancy or puerperium except immediate repair of theperineum, e.g. appendicectomy, postpartum sterilization	X	3
Hyperemesis	X	3
OHSS (first trimester only)	X	4
Current systemic infection	X	1
Immobility, dehydration	X	1
Total		4

Signature of the Doctor: *[Signature]* Date: *17/2026* Time: *1:00pm*

Action Plan: *inj claxone 40mg x 5 ex po x 10 days.*

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-00651306 IP5-00175716
 Mrs BARIRA FAREED
 27-04-1995 31 Y 2 M 4 D (F)
 Dr. PRANATHI REDDY A

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 11/2/26

Department : OBG-GYN Duration of Procedure : 1 hr.

Name of Surgeon : Dr. Pranathi Reddy Date of Admission : 11/2/26

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 : Cefazolin 1gm	
2.	Hair Removal ☒ Yes ☐ No if Yes : Surgical Clipper Department where Hair Removed : ☒ Ward ☐ Operating Room ☐ Other : Skin preparation done (cleanse surgical area with antiseptic agent) ? ☒ Yes ☐ No	
3.	Patient's body temperature immediately post operation (Recovery Room) 36 °C ☐ Oral Or ☒ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : Dr. Deepika Date & Time of antibiotic administration : 11/2/26 9.30 AM Date & Time procedure started : 11/2/26 @ 10.30 AM	

- 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

PATIENT TRANSFER FORM

Patient Name & UHID No. <i>Mr. Bainsa fared</i>	Date & Time of Admission <i>1/7/26</i>	Date & Time of Transfer Order <i>1/7/26 12-30 PM</i>
Treating Consultant Name <i>Dr. Praveenreddy</i>	Transfer Ordered by <i>Dr. Deepika</i>	Reason for Transfer <i>post OP</i>
From Unit <i>OBG-05</i>	To Unit <i>observation</i>	Information to Attendant Yes ☒ No ☐
Number of Sheets in Clinical File <i>36</i>	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If Yes, what?	Patient shifted with ID band: Yes ☒ No ☐ If No:
Number of Imaging Films <i>—</i>		
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 <i>S. Leta</i>		Name of Person Ordered Transfer <i>Dr. Deepika</i>
Patient & Clinical Records Received by : <i>Sr. Shanoffu</i>		
Date & Time of Patient Received :		

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Pranathi Idy
Asst. Surgeon : Dr. Raghav
Anaesthetist : Dr. Aditi
Scrub Nurse : bum

Patient N
UHID No.
Date :

BAH-00651306 IP5-00175716
Mrs BARI RA FAREED
27-04-1993 31 Y 2 M 4 D (F)
Dr. PRANATHI REDDY A


Gender :
ut-time : 12:00 PM


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Before Induction of Anaesthesia ➤ ➤

SIGN IN		Time: <u>11:30 AM</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. Pranathi</u>		
Name :		

Before Skin Incision ➤ ➤

TIME OUT		Time: <u>11:30 AM</u>
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? <u>200 ml</u> ☒ 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 : <u>Dr. Raghav</u>		
Name :		

Before Patient Leaves Operating Room

SIGN OUT		Time: <u>12:30 PM</u>
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. Aditi</u>		
Name :		

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

BAH-00651306 IP5-00175716
Mrs BARI RA FAREED
27-04-1993 31 Y 2 M 4 D (F)
Dr. PRANATHI REDDY A



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Patient Name : Banra Fareed Gender: ☐ Male ☒ Female Age : 31
UHID No : BAH-00651306 Date : 11/7/26

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

BARI RA FAREED

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, Septis, Injury to Bowel & Bladder, Injury to major Blood vessels, need for Blood & Blood products

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 : Banra Fareed

Name : Banra Fareed

Date & Time : 11/7/26 @ 10:45 AM

Witness :

Signature : [Signature]

Name : Sumande

Date & Time : 11/7/26 11 PM

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

Patient Attendant :

Signature : [Signature]

Name : FAIZAN AHMED

Relationship with Patient: Husband

Date & Time : 11/7/26 @ 10:45 AM

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Rameene

Date & Time : 11/7/26 @ 10:45 AM

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

BAH-00651:06 IP5-001757
Mrs BARIIRA FAREED
27-04-1995 31 Y 2 M 2 D
Dr. PRANATHI REDDY A



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Name: Mrs. Barira Fareed Age: 31 Sex: f. UHID.No: BAH-00651306

Date: 29/8/26 Time: 7:52 AM Proposed Operation: LSCS / delivery

Diagnosis: Pre-eclampsia & severe features PE.

B.P / CRT: H.R: Weight: 78 ASA Physical Status: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Lab Data

Hgb: 9.3	Glucose: 13.7	Protein: 0.3	HIV: -	X-Ray: -
PCV: 27.8	Urea: 0.3	Alb: 0.3	HBS Ag: -	ECG: -
WBC: 11.1	Creat: 0.3	Total Bill: 0.3	HCV: -	2D Echo: -
Plate: 2.78	Na: 139	Dir. Bill: 0.1	Blood group: B+	Stress/Angio: -
PT: 14.2	K: 4.1	LDH: 1112	T3: -	Other: -
PTT: 29.7	Ca++: 1.10	Alk phos: 1112	T4: -	
INR: 1.00	Mg++: -	Amylase: -	TSH: -	
	Cl-: -	SGOT/SGPT: 14/13		

Allergies: NKA

Medical History: CVS: - Preeclampsia 33 weeks - Δ sed as TBP (160/110) - Put on lab + IVF conception. Diabetes: - 100mg tid since 27/6/26

RESP: -

CNS: - H/O of blurry vision → temporary for 15 min - road yesterday

Renal: - H/O Headache. At present clear

Hepatic / GE: - H/O Acidity @ X 3-5 days. Physical Activity: - Neck pain - only yes

Others: - METS 10.

Past Anaesthetic History: - H/O IVF & A/O Hysteroscopy & GA / V/E

Physical Exam: H/O Pedal Oedema BIL LL.

Airway: MP 1 (2) 3 4 Mouth Opening: >3f Mentohyoid Distance: (N) Neck: (N) Teeth: Intell.

Lungs: BAC

Heart: S520

CNS: NKA

Pregnant: ☒ Yes ☐ No ☐ NA Venous Access Site: (P) Spine Exam for regional: palpable.

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

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

CURRENT MEDICATIONS	DOSAGE
TAB LABETALOL	100mg TID
2 doses of B methasone given	
29/8/26 1mg MgSO ₄ loading dose given	
NOVARAPID → Since 29/6/26	
INULIN	

Signature: Adil Name: Dr Adil

Pre-Operative Instructions:

- DVT Prophylaxis:
 - Water / ORS 2 Hours
 - Others 6 Hours
- NIL ORAL
- Informed Consent: ☐ Standard ☒ High Risk
- Post Operave Pain Management: ☐ Discussed with Patient
- Other Instructions: 2D Echo

BAH-00651306 IP5-00175716
Mrs BARIRA FAREED
27-04-1993 31 Y 2 M 4 D (F)
Dr. PRANATHI REDDY A

Pre Induction Assessment:

ANAESTHESIA CHART



Change in Patient Condition:

☐ Yes ☒ No

Physical Status:

☒ Patient Identified

Fasting Status:

Adequate

☒ Consent Present

☒ Chart Reviewed

H.R.:

B.P / CRT:

SpO₂:

R.R.:

Last Feed:

Pre-OP Diagnosis:

Surgeon:

Operation:

Anaesthesiologist:

Technician:

Date: 17/26

TIME
N₂O / AIR / O₂ LPM
HALO / SO / SEVO
Drugs:

Panexamic 1800
Acetaminophen 4mg
Oxycodone 350

FI_{O₂} / 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

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

ABG

GRBS

Others

Antibiotic

Suppository

Blood Loss

NOTES

Re-200 Oxycodone

- ☒ Equipment Checked and Functional
- ☒ BP
- ☒ Cuff Site:
- ☒ Art Site:
- ☒ EKG Lead
- ☒ Temp Site
- ☒ FIO₂ Monitor
- ☒ Agent Monitor
- ☒ Pulse Oximeter
- ☒ Endotracheal Tube
- ☒ Ventilator
- ☒ Wave Stimulator
- ☒ Pressure Points Checked

Temp:

- ☒ HME
- ☒ Cling Film
- ☒ Hugger's
- ☒ Other
- ☐ Fluid Warmer
- ☐ OH Warmer
- ☐ Cotton Wool

Times:

Anaes Start: 11:50
OP Start:
OP End:
Leave OR:

Anesthesia:

- ☒ GA
- ☒ Monitored Anesthesia Care
- ☒ Regional

Line (Site & Location)

- ☒ CVP
- ☒ Art
- ☒ IV
- ☒ IV

Induction

- ☐ IV
- ☐ Pre O₂
- ☐ Others
- ☐ Inhal
- ☐ RSI

- ☐ Mask
- ☐ Airway
- ☐ ETT#
- ☐ Oral
- ☐ Tracheostomy
- ☐ Drug:
- ☐ SGA
- ☐ Oral
- ☐ Nasal
- ☐ Cuff
- ☐ Topical

- ☐ Awake
- ☐ Video Laryngoscopy
- ☐ Fiberoptic
- ☐ Direct Vision
- ☐ Stylette / Bougie

Blade# Attempts: Difficulty Why?

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

Regional:

- ☒ Extremity
- ☒ Spinal
- ☐ Epidural
- ☐ Caudal

Others:

Position: 1.8 cm of 0.57 cm

Site: Supravacine + 20 mg of ketamine

Needle Size: Depth:

Parasthesia ☐ Yes ☐ No

Catheter at skin cm

Drug Name & Conc:

Bolus:

Infusion:

Block Level:

Comments:

Transportation to

Relaxant Reversed

Name of the Doctor:

Signature of the Doctor:

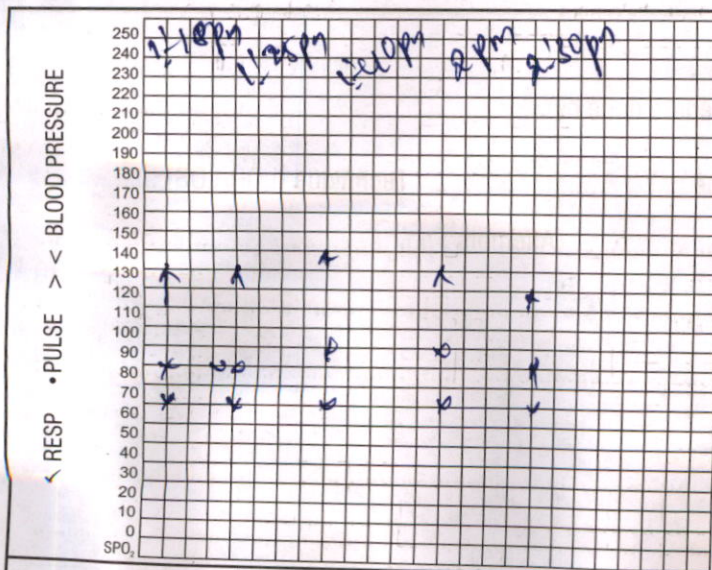


POST ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Dr. Rhesli

Time Received : 1:10pm

Time Discharged :



IV Cannula Site : Right
☐ O₂ Mask ☐ Nasal Prongs
☐ Tracheostomy ☐ T-Piece
☐ Oral Airway ☐ Nasal Airway

Vomiting : ☒ Yes ☒ No

Drug:

NG Tube : ☐ Yes ☒ No

Drain: ☐ Yes ☒ No

Urinary Catheter: ☒ Yes ☐ No

Chest Tube: ☐ Yes ☒ No

Nil Oral ☐ Yes ☒ No

IV Fluids: Le

Oral Feeds: ABM

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	2	2	2	A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to move 2 extremities voluntary or on command	= 1		2	2	2	2	
Able to move 0 extremities voluntary or on command	= 0		2	2	2	2	
Able to deep breathe & cough freely	= 2	RESPIRATION	2	2	2	2	
Dyspnea or limited breathing	= 1		2	2	2	2	
Apneic	= 0		2	2	2	2	
BP $\pm$ 20 of Pre Anaesthetic level	= 2	CIRCULATION	2	2	2	2	
BP $\pm$ 20-50 of Pre Anaesthetic level	= 1		2	2	2	2	
BP $\pm$ 50 of Pre Anaesthetic level	= 0		2	2	2	2	
Fully awake	= 2	CONSCIOUSNESS	2	2	2	2	
Arousable on calling	= 1		2	2	2	2	
Not responding	= 0		2	2	2	2	
Pink	= 2	COLOR	2	2	2	2	
Pale, dusky, blotchy, jaundiced, other	= 1		2	2	2	2	
Cyanotic	= 0		2	2	2	2	
TOTAL		9	10	10	10	10	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
11/2/21	1:30pm	0/10	NA	
11/2/21	3pm	0/10	Sm: fcm guided	

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

Anaesthesiologist Name : Dr. Rhesli

Anaesthesiologist Signature: Dr. Rhesli

Date & Time: 11/2/21 6:52pm

PACU Nurse Name : Soy

PACU Nurse Signature: Soy

Date & Time: 11/2/21 @ 5:30pm

Reassessment:

1. Every eight hrs

2. For post surgic. hos.

a. Every eight hrs

b. After 2 hrs 24 hrs

c. Prior to

d. With in 3 hrs

Terred to Unit by

Time

After relief intervention

patient with severe pain

Patient

Department of Anaesthesiology
EPIDURAL ANALGESIA RECORD

b)

[illegible]

APGAR: SVD / Instrumental / LSCS (if LSCS Details)

Delivery Details : Time : ...
 Meter Removed by and : ...
 Section : ...

Catheter Removal
Patient Satisfaction :
Shifting order by
re:

Discharge / Shifting order by
Signature:
Name: