

VIH-00186794 IP5-00176660  
Mrs ANITHA LAKAVATH  
15-07-1992 34 Y 0 M 7 D (F)  
Dr. NIRAJ K YANAMANDRA



## EFFICIENCY CHECK LIST OF CASE SHEET

| Sl.No.             | List of Records                            | No. of Pages | Legibility | Completeness | Remarks |
|--------------------|--------------------------------------------|--------------|------------|--------------|---------|
| 1                  | Admission sheet                            | 1            |            |              |         |
| 2                  | Discharge Summary                          | 1            |            |              |         |
| 3                  | Nursing Initial assessment                 | 1            |            |              |         |
| 4                  | Patient Transfer form                      | 1            |            |              |         |
| 5                  | In-patient Medical record                  | 1            |            |              |         |
| 6                  | Doctors progress sheets                    | 3            |            |              |         |
| 7                  | Nursing plan of care and handover sheets   | 3+1          |            |              |         |
| 8                  | Consultation sheet                         | 1            |            |              |         |
| 9                  | General consent for treatment              | 1            |            |              |         |
| 10                 | Consent for Surgery                        | 1            |            |              |         |
| 11                 | Consent for blood transfusion              | 1            |            |              |         |
| 12                 | Consent for chemotherapy                   | 1            |            |              |         |
| 13                 | Consent for high risk                      | 1            |            |              |         |
| 14                 | Consent for Restraint                      | 1            |            |              |         |
| 15                 | LAMA consent                               | 1            |            |              |         |
| 16                 | Consent for special procedure / Sedation   | 1            |            |              |         |
| 17                 | Consent for Formula feed                   | 1            |            |              |         |
| 18                 | Consent for MTP                            | 1            |            |              |         |
| 19                 | Consent for Radiological Investigations    | 1            |            |              |         |
| 20                 | Consent for HIV test                       | 1            |            |              |         |
| 21                 | Anaesthesia notes (Pre Anaesthesia & post) | 1            |            |              |         |
| 22                 | Neonatal Admission/Delivery/Physical Exam  | 1            |            |              |         |
| 23                 | Medication Reconciliation                  | 1            |            |              |         |
| 24                 | Emergency Triage record                    | 1            |            |              |         |
| 25                 | Pre operative check list                   | 1            |            |              |         |
| 26                 | Surgical safety checklist                  | 1            |            |              |         |
| 27                 | Operation Theatre notes                    | 1            |            |              |         |
| 28                 | Nurses clinical Presentation               | 1            |            |              |         |
| 29                 | TPR & BP chart                             | 3            |            |              |         |
| 30                 | Intake and Out take chart (fluid chart)    | 3            |            |              |         |
| 31                 | Drug chart (Regular Prescription)          | 1            |            |              |         |
| 32                 | Investigation Values (result sheet)        | 1            |            |              |         |
| 33                 | Nebulization chart                         | 1            |            |              |         |
| 34                 | Nutritional review chart                   | 1            |            |              |         |
| 35                 | Intensive care unit (ICU Charts)           | 1            |            |              |         |
| 36                 | Consent for Admission in PICU / NICU       | 1            |            |              |         |
| 37                 | The Humpty dumpty scale                    | 1            |            |              |         |
| 38                 | Braden Q Scale                             | 1            |            |              |         |
| 39                 | Bed side check list                        | 2            |            |              |         |
| 40                 | PICU bed formula Dilution feeds            | 1            |            |              |         |
| 41                 | Gastro monitoring chart                    | 1            |            |              |         |
| 42                 | Rch ED doctors note                        | 1            |            |              |         |
| 43                 | BP Monitoring chart                        | 1            |            |              |         |
| 44                 | RBS monitoring chart                       | 1            |            |              |         |
| 45                 | Integ - Disciplinary form                  | 1            |            |              |         |
| 46                 | Multi - Disciplinary form                  | 1            |            |              |         |
| Total No. of Pages |                                            |              |            |              |         |



## ERROR LOG

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

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

VIH-00186794 IP5-00176660  
Mrs ANITHA LAKAVATH  
15-07-1992 34 Y O M 6 D (F)  
Dr. NIRAJ K YANAMANDRA

Name



Date

21/7/26

Room:

Observation 104

High protein diet plan: ~1700 kcals; 75g protein; 150g carbs; 50g fats

Planned menu

DIABETIC DIET

Instructions ☐ Home

☒ Canteen

7am Milk

Supplement 1 tsp ☐

KABIBITE Biscuits two ☐

☒ Milk

8am Small Breakfast (Idli/Dosa/Oats/Dhali/Upma/Kitchidi)

(2) (small) (1 cup)

Egg - Boiled ☒ Omelet ☐

☐ Panner 50g

☐ Tofu 50g

10am Soup and Toast (Garlic Nan for diabetic ☒)

☐ Vegetable

☒ Chicken

1pm Lunch (Rice and Roti <sup>(1)</sup>) (Oats/Dhali for diabetic ☒)

Dal, Veg, Curd, Fruit/Salad (Pheera)

☐ Egg - Boiled ☐ Omelet ☐

☐ Paneer 50g

☐ Tofu 50g

☒ Chicken 100g curvy

4pm Milk

Supplement 1 tsp ☐

KABIBITE Biscuits two ☐

☒ Milk

6pm Soup and Garlic Nan

☒ Vegetable

☐ Chicken

8pm Dinner (Rice and Roti <sup>(1)</sup>) (Oats/Dhali for diabetic ☒)

Dal, Veg, Curd, Fruit/Salad (Pheera)

Sweet/Dessert (No sweet for diabetic ☒)

☐ Egg - Boiled ☐ Omelet ☐

☒ Paneer 50g curvy

☐ Tofu 50g

☐ Chicken 100g

10pm Milk

Supplement 1 tsp ☐

KABIBITE Biscuits two ☐

☒ Milk

[NO ROOTS, TUBERS, SUGAR, CORNFLOUR]

Dietitian  
Nounica



## ADMISSION SHEET

### Registration Details :



Admission No : IP5-00176660

Admit Date : 20-Jul-2026

Admit Time : 03:53 PM UHID : VIH-00186794

### Patient Details :

Patient Name : Mrs ANITHA LAKAVATH

Age : 34 Y 0 M 5 D

Guardian : Mr RAMDAS BHANOTH

DOB : 15-07-1992

Gender : Female

Religion :

Occupation :

Martial Status : Married

Address (H) : H NO 10-5-632/5/1, TUKARAMGATE Lallaguda  
Hyderabad Telangana INDIA 500017

Phone No : 8985772076 / 9959686076

E-mail : NA@GMAIL.COM

### Admission Details :

Bed Type : SHARED WARD

Bed No : SW 415

Ward Name : 4F-BIRTHING CENTRE

Room No : SW 415

Admission Type : First Visit

### Contact Details :

Name : Mr RAMDAS BHANOTH

Relationship : Husband

Contact Address : H NO 10-5-632/5/1, TUKARAMGATE Lallaguda  
Hyderabad Telangana INDIA 500017

Phone No : 8985772076 / 9959686076

Signature

### Doctor Details :

Doctor Name : Dr. NIRAJ K YANAMANDRA

Specialisation : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant :

### Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : STATE BANK OF INDIA



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 Dr. NIRAJ K YANAMANDRA

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## ACTIVITY RECORD FOR BILLING

Name : \_\_\_\_\_

UHID No. : \_\_\_\_\_ IP No. : \_\_\_\_\_ 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. Niruditha. | 21/7/26 | 9-115-705 | Shobha    |
| 2  | Dr. Brundarani | 21/7/26 | ✓         | Sandhya   |
| 3  |                |         |           |           |
| 4  |                |         |           |           |
| 5  |                |         |           |           |
| 6  |                |         |           |           |
| 7  |                |         |           |           |
| 8  |                |         |           |           |
| 9  |                |         |           |           |
| 10 |                |         |           |           |



# INVESTIGATIONS

| Date | Investigations                  | Order No.  | Signature |
|------|---------------------------------|------------|-----------|
| 20/7 |                                 |            |           |
| 20/7 | 84mg/dl 24:30pm <sup>Self</sup> | Self       | Sandy     |
| 20/7 | 85mg/dl 8:00pm                  | Self       |           |
| 20/7 | nlst - (1) Self                 | 265036294  |           |
| 20/7 | GRBS 113 post dinner            | Self       | Sandy     |
| 20/7 | HVS.                            | 26073010   | Sandy     |
| 21/7 | GRBS 140 post breakfast         | Self       | Shobu     |
| 21/7 | Sr. K+                          | 26073031   | Shobu     |
| 21/7 | pre lunch GRBS 84mg/dl          | Self       | Shobu     |
| 20/7 | cap. creatinine electrolytes    | 26072916   | Shobu     |
| 20/7 | pre dinner 70mg/dl              | Self       | S         |
| 21/7 | ART Dropper                     | 26503634   | Sandy     |
| 21/7 | nlst - (2)                      | 265-03650  | Sandy     |
| 21/7 | nlst - (3)                      | 265-036502 | Sandy     |
| 21/7 | post dinner 12mg/dl             | Self       | Sandy     |
| 20/7 | PR 138mg/dl                     | Self       | Sandy     |
| 22/7 | post breakfast 153mg/dl         | Self       | Shobu     |
| 22/7 | nlst Twins -                    | 265036613  | Shobu     |
| 21/7 | ART Dropper                     | 265036613  | Shobu     |
|      |                                 |            |           |
|      |                                 |            |           |
|      |                                 |            |           |
|      |                                 |            |           |



### MEDICAL EQUIPMENT (WARD & ICU)

[illegible]



NO. 9 OF 1967

## This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins or other markings on the paper.

Prepared By :

| Staff Nurse | Shift / Ward | Billing Assistant | Billing Supervisor |
|-------------|--------------|-------------------|--------------------|
|             |              |                   |                    |





## IP ADMISSION SHEET FOR OBSTETRICS

### Presenting Complaints

Came for Mgson.

LMP: 6/12/2015

EDD: 12/9/2016

Corrected EDD: 7/9/2016

GA: 33 wks.

Obstetric Formula: G2P1L1

Menstrual History: Regular: ☒ Yes ☐ No

### Obstetric History:

### Obstetric Examination

2013-1515 - IVF conception  
@ 37 wks. (Maternal request) -

Fundal Height: ~ 32-34 wks.

Present Pregnancy Record: Grav - 2-9kgs

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

Sheennay Nursing @ Secunderabad.

Liquor: ☒ Adequate ☐ Oligo ☐ Poly

PP: ☒ Cephalic ☐ Breech ☐ Others

PP - IVF conception - Booked at 30 wks of GA with Dr. Niraj.

Head Fifts Palpable:

### RISK FACTORS:

FHS: ☒ Normal ☐ Tachy ☐ Brady ☐ Absent

→ Abdominal cerclage (15 wks)

Per Speculum Examination

→ gest. Hypothyroid since conception

Draining: ☐ Present ☐ Absent ☐ Bleeding

→ GDM on diet - 27 wks

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

on Insulin - 29 wks.

→ Sick cell trait.

### Vaginal Examination

→ Twin-II - abnormal Doppler - 25 wks.

Cervix: ☐ Long ☐ Partially effaced ☐ Effaced

Height: ..... cm AEDF - 29 wks.

Os: Closed Dilated

Weight: ..... kg

Membranes: ☐ Present ☐ Absent

Allergies: ..... wk out

Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Breast: ☒ Normal ☐ Abnormal

Presenting Part: ☐ Vertex ☐ Breech ☐ Others

### General Examination:

Consciousness: clear

Pallor: absent

Icterus: absent

Edema: 1

Temp: 37.5

PR: 95 BPM.

BP: 119/75 (80 mmHg)

DTR: (+)

CVS: S1, S2

RS: BAT

Liver/Spleen: not palpable

Urine Output: ad equal

### DIAGNOSIS

G2P1L1 / 33 wks / OCPA twins / GDM on Insulin / gest. Hypothyroid  
Abdominal cerclage / Abnormal twin-II Doppler changes & with FGR  
for (Mgson) observation.





|                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Family History:</p> <p>Sister - Hypothyroid</p>                                                                                                                                                                                                                                            | <p>Surgical History:</p> <p>Bartolion cyst - 2018, 2020<br/>LCS - 2023</p>                                                                                                                                                                       |
| <p>Medical History:</p> <p>Iron deficiency.</p>                                                                                                                                                                                                                                               | <p>Medication History:</p>                                                                                                                                                                                                                       |
| <p>Plan of Care:</p> <ul style="list-style-type: none"> <li>- Admission</li> <li>- NST 3rd hour</li> <li>- Monitor vitals 4th hour</li> <li>- steroid cover done</li> <li>Dose 1 - 24/6/26</li> <li>Dose 2 - 30/6/26.</li> <li>1/7/26.</li> <li>- Inform SUS</li> </ul> <p>GRBs - 87mg/dL</p> | <p>Investigations:</p> <p>BGT - B positive.</p> <p>Viral - NR</p> <p>ANA profile <math>\Rightarrow</math> APLA - positive.</p> <p>ITS - low risk.</p> <p>NT - Twin - 1.8 mm.</p> <p>Twin - 1.1 mm</p> <p>TITTA - (N)</p> <p>fetal echo - (N)</p> |

Doctor Name: Dr. Divya

Signature: DR

Date & Time: 20/7/26; 5:30 PM,

Consultant Name: Dr. Niraj.

Signature:

Date & Time:



| Date & Time          | Progress Notes                                                                                                                                                                                                                                                                                                                                                    | Doctor's Order            |
|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|
| 20/7/2026<br>4:00 PM |                                                                                                                                                                                                                                                                                                                                                                   |                           |
| 20/7/2026.           | <p>Di D/A twins.</p> <p>→ Twin (1) - placenta, Ant./High, lower pole, cephalic px (Maternal right), sup - 4.0 cm, EFW - 56%, fetal Doppler (2)</p> <p>→ Twin (2) - placenta - post / High, upper pole, cephalic Maternal left - Breech px, Sup - 2.3 cm, EFW - &lt; 1% FGR</p> <p>u m. ant Doppler - AEDF with cerebral redistribution &amp; (1) du dopplers.</p> |                           |
|                      | <p>✓ T<sub>2</sub> FGR :: 28-29 wks<br/>ans c Doppler changes</p> <p>✓ NNC by Dr. Nitasha on OPD.</p>                                                                                                                                                                                                                                                             | <p>Biweekly Dopplers.</p> |





## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time          | Progress Notes                                                                                                                                     | Doctor's Order                                                                                                                         |
|----------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| 20/7/2026<br>5:45 PM | <p>0/1<br/>G. fair</p> <p>BP - 119/76/87 mm</p> <p>PR - 90 bpm</p> <p>SpO<sub>2</sub> - 98% RA</p> <p>PIA - ut relaxed</p> <p>FHR (+)</p>          | <p>Adv</p> <p>① Start inf. region maintain</p> <p>② Monitor vitals 2nd hr</p> <p>③ I/O charting (self voiding)</p> <p>④ Inform SAs</p> |
|                      | <p>MgSO<sub>4</sub> loading dose ✓</p> <p>ongoing</p> <p>NST - ongoing</p>                                                                         |                                                                                                                                        |
|                      |                                                                                                                                                    | Dr. Diugs                                                                                                                              |
| 20/7/26<br>7 PM      | <p>G2P1L1 33 wks / DCD A</p> <p>PR: 92 bpm</p> <p>BP: 103/70(80) mmHg</p> <p>SpO<sub>2</sub>: 100% RA</p> <p>P/A: Relaxed</p> <p>Temp: 97.6 °F</p> | <p>- T2 A&amp;D F</p> <p>FGR</p> <p>GDM Insulin</p> <p>G. Hypothyro</p> <p>Ab. cerclage</p> <p>S. cell tr</p>                          |
|                      | <p>Bed side scan: FHR 1, 2 (+)</p> <p>Cephalic both.</p>                                                                                           | <p>① Pre + Post Sugars Chart</p> <p>② I/O Charting (manual)</p> <p>③ NST 30 min</p> <p>④ Diabetic diet</p> <p>⑤ Vitals 4 hrly</p>      |
|                      | <p>MgSO<sub>4</sub> on flow - started</p> <p>SPM</p>                                                                                               | <p>FHR</p> <p>Dr. Y. Sneha</p>                                                                                                         |



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## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time       | Progress Notes                                                                                                                                                                                         | Doctor's Order                                       |
|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|
| 20/7/2026<br>7pm  | c/o/w Dr. Niraj                                                                                                                                                                                        |                                                      |
|                   | <ol style="list-style-type: none"> <li>① NST BD</li> <li>② Dopplers 9AM</li> <li>③ CBP, creatinine, electrolytes now</li> <li>④ strict I/O</li> <li>⑤ plan delivery after Mgso<sub>4</sub>.</li> </ol> |                                                      |
|                   | <u>NMC</u> - informed<br>Dr. Arishwarya                                                                                                                                                                | Dr. Y. Sneha                                         |
| 20/7/2026<br>10pm | Pt comfortable<br>Trace CBP/ creatinine/ electrolytes & inform<br>u/o: 330ml (160 + 170ml)<br>108/76 (85)mm Hg<br>93bpm<br>99-7-RA<br>FHR 1,2 (+)                                                      | - PAC<br>- Mgso <sub>4</sub> on flow<br>Dr. Y. Sneha |
|                   | <del>nib Sandeepg<br/>10:10pm</del>                                                                                                                                                                    |                                                      |



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## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time     | Progress Notes                                                                                                                                                                                                                      | Doctor's Order                                                                                  |
|-----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| 21/7/26<br>2 AM | <p>Pt c/o pain on &amp; off mild.</p> <p>PR: 90</p> <p>BP: 102/74 98.7°F</p> <p>Spo<sub>2</sub>: 100% RA ~</p> <p>P/A: Relaxed</p> <p>Lax Abdomen</p> <p>FHR 1, 2 ⊕ P/B os closed</p> <p>Greenish white D/s ⊕</p> <p>HVS taken.</p> | <p>✓ MgSO<sub>4</sub> on flow</p> <p>✓ IV PCM 1gm stat</p> <p>✓ Breakfast by 4 AM &amp; NBM</p> |
|                 | <p>To Inform inv to Dr. Niraj</p> <p>Dr. Y. Snehra</p>                                                                                                                                                                              |                                                                                                 |
|                 | <p>NRB Sarda 2:5 AM</p>                                                                                                                                                                                                             |                                                                                                 |



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## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time                | Progress Notes                                                   | Doctor's Order                                                                  |
|----------------------------|------------------------------------------------------------------|---------------------------------------------------------------------------------|
| 21/7/2026<br>6 AM          | G <sub>2</sub> P <sub>1</sub> L <sub>1</sub> 33 <sup>+</sup> wks | Prev vcs<br>GDM Insulin<br>Hypothyroid<br>Abd cerclage (+)<br>Sickle cell trait |
|                            | PR: ganglial                                                     | ① NBM                                                                           |
|                            | BP: 117/76 (83)                                                  | ② IVF @ 100 ml/hr RL                                                            |
|                            | SpO <sub>2</sub> : 100%                                          | ③ Pre & post meal sugar<br>(If NBM cont then 4 hrly)                            |
|                            | P/A: Relaxed                                                     | ④ NST BD                                                                        |
|                            | FHR 1, 2 <del>mon</del> (+)                                      | ⑤ Vitals FHR 4 hrly                                                             |
|                            |                                                                  | ⑥ PAC                                                                           |
|                            |                                                                  | ⑦ AFI + Doppler 9 AM                                                            |
|                            |                                                                  | ⑧ MgSO <sub>4</sub> till SPM on flow                                            |
|                            |                                                                  | ⑨ Inform sos.                                                                   |
| ✓ 1 PRBC to be reserved    |                                                                  |                                                                                 |
| ✓ <del>Revised</del>       |                                                                  |                                                                                 |
| NMC - OPD - Dr. Nitasha    |                                                                  |                                                                                 |
| NIB<br>Sandeepa<br>6:10 AM |                                                                  | Dr Y. Sune                                                                      |
| 21/7/26<br>7 AM            | cl/w Dr. Niveditha                                               |                                                                                 |
|                            | repeat Sr K <sup>+</sup>                                         | Dr Y. Sune                                                                      |



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## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time                                                                                                              | Progress Notes                                                                                                         | Doctor's Order                                                                                                                                              |
|--------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 21/7/2020<br>9 AM                                                                                                        | Bp 14/33 wk<br>OODA twin 1, 2, AEDF / 1 Pouch / Symmetrical<br>Hypothyroid + FUR abdominal crease / sublell<br>back    | Chm Dr. Nandha<br>Chf Dr. Neeraj<br>abdominal crease / sublell<br>back                                                                                      |
| 11/7/2020                                                                                                                | Ga fair<br>afebrile<br>PR - 92/min<br>Rsp - 167/109 (20) mmHg<br>SpO2 - 98% @ Rn<br>P/A - ut relaxed<br>PHS < 1+<br>2+ | adv ① trace - flu,<br>s. K+.<br>② NBM<br>③ ④ Fluid - 150ml<br>④ NBT BD<br>⑤ vitals & PR 4th<br>⑥ PAC<br>⑦ APJ doppla - no<br>⑧ Mgrs - full spm.<br>⑨ Infona |
| U/L - 120 ml<br>at 8 AM                                                                                                  |                                                                                                                        |                                                                                                                                                             |
| GRS - 140 mg/dl<br>↓<br>No need f insulin                                                                                |                                                                                                                        |                                                                                                                                                             |
| 21/7/2020                                                                                                                |                                                                                                                        | Dr. Arshya                                                                                                                                                  |
| AFI Dopplers,<br>cephalic.                                                                                               |                                                                                                                        |                                                                                                                                                             |
| twinn - 1 - pt - ant, sup - 4.7 cm. cephalic<br>fetal doppler - ②                                                        |                                                                                                                        |                                                                                                                                                             |
| Twinn - 2 - pt. post, Breech, sup - 33 cm<br>um. art Dopler shows - AEDF → cerebral redistribution<br>normal DV Doppler. |                                                                                                                        |                                                                                                                                                             |
| Trace S.K.<br>S.K. - 5.3                                                                                                 | ut. art dopplers red resistan BF                                                                                       | note by<br>shadig                                                                                                                                           |



(4)

## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time                 | Progress Notes                  | Doctor's Order                |
|-----------------------------|---------------------------------|-------------------------------|
| 21/7/2026<br>12:35 PM       |                                 |                               |
| steroid ✓<br>NNLV ✓         | O/E<br>Acute                    | - ongoing trig 04<br>P25 melm |
| K=5-3                       | Bp-104/75(88)                   | - Monitor vital               |
| VO-12pmt.<br>voided<br>now. | PR-76 BPM.                      | - I/O charting (self void)    |
|                             | SpO2-98% on RA                  | - Drugs as charted.           |
|                             | PlA-ut relaxed.                 | - NST BD                      |
|                             | +HR ⊕                           | - vitals (FHR) + th heavy     |
|                             | Both F&B 2                      | - Inform SOS.                 |
|                             |                                 | Dr. Divya                     |
|                             | c/o/w Dr. Niveditha             |                               |
|                             | informed S. Potassium (K-5.3)   |                               |
|                             | Advised                         |                               |
|                             | Asthalin nebulization plan stat |                               |
|                             | Note by<br>Shobha               | Dr. Divya                     |







VIH-00186794  
Mrs ANITHA LAKAVATH  
15-07-1992 34 Y 0 M 7 D (F)  
Dr. NIRAJ K YANAMANDRA  
IP5-00176660

## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time                   | Progress Notes                                                                                                                             | Doctor's Order                                                                                                                                                          |
|-------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 21/7/26<br>9:30 am            | G <sub>2</sub> P <sub>1</sub> L   33+1 wks  <br>GDM on insulin  <br>fruit/abdominal                                                        | DCDA twins  <br>G <sub>1</sub> hypothyroid   sickle cell<br>  ECG & AEDF in twin 2.                                                                                     |
| mgson V<br>NST-post dinner.   | BP- 115/76 [86]<br>PR- 94 bpm<br>SpO <sub>2</sub> - 100% on RA.<br>P/A- ut ~ 36 wks<br>relaxed<br>FHS < 1 ⊕<br>2 ⊕                         | <u>Advice:</u><br>① diabetic diet<br>② Vitals 4th hrly<br>③ FHS 4th hrly<br>④ NST BD.<br>⑤ Pre & post sugar monitoring & inform.<br>⑥ Repeat AFI & dopplers on 22/7/26. |
| ⇒ Post dinner NST - reactive. |                                                                                                                                            | <u>Smti</u>                                                                                                                                                             |
| 22/7/26<br>1:30 AM            | - Pt is sleeping comfortable.<br>- BP- 120/78 [86]<br>PR- 86 bpm<br>SpO <sub>2</sub> - 100% on RA.<br>P/A- ut ~ 36 wks<br>FHS < 1 ⊕<br>2 ⊕ | <u>Advice:</u><br>① FHS 4th hrly & vitals<br>② NST - BD.<br>③ Pre & post sugar monitoring & inform.<br>④ Repeat AFI & dopplers on 22/7/26                               |
| MB Sanjay                     |                                                                                                                                            | <u>Smti</u>                                                                                                                                                             |



## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time     | Progress Notes                                                                                                                                                                                         | Doctor's Order                                                                                                                                                                               |
|-----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 22/7/20<br>6 AM | G <sub>2</sub> P <sub>14</sub>   33+2wks   D.C.D.A. twins   W.F. conception<br>GDM on insulin   G. hypothyroid   sickle cell trait<br>= previous LSC   abdominal cerclage   2 FGR &<br>ACDF in twin 2. |                                                                                                                                                                                              |
|                 | BP - 112/76<br>PR - 80 bpm<br>SpO <sub>2</sub> - 98% on RA<br>P/A - ut w 36 wks<br>relaxed<br>FHR $\begin{matrix} +1 \\ -2 \end{matrix}$                                                               | <u>Advice</u><br>① diabetic diet<br>② Vitals 4th hly<br>③ Fns 4th hly<br>④ NST BD<br>⑤ Pre & post sugar monitoring & inform<br>⑥ Repeat NFI + Doppler today 22/7/20<br>⑦ NBM after breakfast |
| 22/7/20<br>9 AM | Gafar<br>atebaule<br>PR - 99/min<br>BP - 112/70 mmHg<br>SpO <sub>2</sub> - 93% @ RA<br>P/A - ut relaxed<br>FHR $\begin{matrix} +1 \\ -2 \end{matrix}$                                                  | <u>Smith</u><br><u>adv.</u> Diabetic diet<br>- NBM<br>- NIT BD<br>- post prandial<br>sugar { Inform<br>- AFZ Doppler today                                                                   |
|                 | NBM - BD                                                                                                                                                                                               |                                                                                                                                                                                              |





## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes                                                                                                                                                                                                                                                                                                                                                              | Doctor's Order                                                                                                                                                                                                                                |
|-------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|             | <p>—</p> <p>Uteral. &amp; FHR Monitory strip</p> <p>Infocams</p> <p>Tolan 80. Aspirin —</p> <p>GRB - 130mg.</p>                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                               |
|             |                                                                                                                                                                                                                                                                                                                                                                             | Dr. Arshay                                                                                                                                                                                                                                    |
| 22/7/20     | AFI Doppler                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                               |
| 11AM        | <p>33<sup>2</sup> / Twin 1 - pl. Ant High, lower pole, maternal</p> <p>Regul. Cephalic, AFI - 3.2cm Dopple. (N)</p> <p>Twin-2 - placenta. posterior high, upper pole, maternal</p> <p>left, Breech presentation. AFI - 3.8cm Umbilical</p> <p>artery Doppler - shows AEDF with cerebral redistribution</p> <p>&amp; normal DV Dopple.</p> <p>uterine artery Dopple. (N)</p> | <p>noted by</p> <p>Shobha</p> <p>Dr. Arshay</p>                                                                                                                                                                                               |
| 22/7/20     | C/D/W - Dr. Niraj                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                               |
| 2:30pm      | <p>GC: fair</p> <p>Vitals: stable.</p> <p>Pl/A: Unremarkable</p> <p>32-34w</p> <p>FHR (N)</p> <p>(N)</p>                                                                                                                                                                                                                                                                    | <p>case discussed</p> <p>patient &amp; attending</p> <p>1 IWL - 55g 5lb - Twin 2</p> <p>Doppler - abnormal - AEDF &amp;</p> <p>cerebral redistribution (N)</p> <p>DV Doppler, ut artery Dopple (N)</p> <p>Decided to take for</p> <p>Embo</p> |



[



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BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery



VIH-00186794 IP5-00176660  
Mrs ANITHA LAKAVATH  
15-07-1992 34 Y O M 7 D (F)  
Dr. NIRAJ K YANAMANDRA  


①

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

  
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Your Right to a Safe Delivery

## CROSS CONSULTATION FORM

Doctor Name : Dr. C. Niveditha Date : 21/7/26 Time : 1:18 pm

Diagnosis : GDM

Hospital : SPAR 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:

GDM

Signature: M

Findings and Recommendations :

GDM @ 33<sup>+</sup> weeks GA  
DCA turns - while all treat.

GDM on Insulin = 8/8

Lantus 6

steroid coverage given outside

Pt. sleeping

obs

PR - 90/min

BP - 102/88 mmHg

check pre & post meal  
sugars & inform

Consultant :

Name : Dr. C. Niveditha

Signature : N

Date & Time : 21/7/26, 1:20 pm





## MEDICATION RECONCILIATION FORM

Drug Allergies: NKA

☒ Not known any Drug Allergies

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

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

Shifting From: .....

Shifted to: .....

| S.No | MEDICATION NAME<br>(GENERIC NAME CAPITAL LETTERS) | DOSE<br>(mg, mcg) | ROUTE<br>(PO, NG, SC, IV) | FREQUENCY | LAST DOSE<br>Date / Time | ON<br>ADMISSION<br>/ SHIFTING                                     |
|------|---------------------------------------------------|-------------------|---------------------------|-----------|--------------------------|-------------------------------------------------------------------|
| 1    | INT. ACTRAPID                                     | 8U - 8U - 8U      | Before food               |           |                          | <input checked="" type="checkbox"/> C <input type="checkbox"/> DC |
| 2    | T. Duphaston                                      | 10mg              | PO                        | 4/10      | 20/7/26                  | <input checked="" type="checkbox"/> C <input type="checkbox"/> DC |
| 3    | T. Livogen                                        | 1 tab             | PO                        | OD        | 20/7/26                  | <input checked="" type="checkbox"/> C <input type="checkbox"/> DC |
| 4    | T. SHEKAL                                         | 1 tab             | PO                        | OD        | 20/7/26                  | <input type="checkbox"/> C <input checked="" type="checkbox"/> DC |
| 5    | T. Escorin                                        | 10mg              | PO                        | OD        | 20/7/26                  | <input checked="" type="checkbox"/> C <input type="checkbox"/> DC |
| 6    | L. Arginine                                       | 1 tab             | PO                        | Bed time  | 19/7/26                  | <input checked="" type="checkbox"/> C <input type="checkbox"/> DC |
| 7    | INT. LANTUS                                       | 6 units           | (Bed time)                |           |                          | <input checked="" type="checkbox"/> C <input type="checkbox"/> DC |
| 8    | T. thyronorm                                      | 25mcg             | PO                        | OD        | 20/7/26                  | <input checked="" type="checkbox"/> C <input type="checkbox"/> DC |
| 9    |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC            |
| 10   |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC            |

\* C - Continue, DC - Discontinue

### MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Divya

Date & Time: 20/7/2026

Nurse Name & Signature: Shobha

Date & Time: 20/7/26 - 6pm



VIH-00186794  
 Mrs ANITHA LAKAVATH  
 15-07-1992 34 Y 0 M 5 D (F)  
 Dr. NIRAJ K YANAMANDRA



## DRUG CHART

Date of Admission: 20/7/2026 Drug Allergies: None ☒ Not known any Drug Allergies

### FOR THE SAFETY OF THE PATIENT

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

### SOS / PRN (As Required Medication)

| DRUG :                   |       |              |            | Date<br>Time |
|--------------------------|-------|--------------|------------|--------------|
| Dose                     | Route | Frequency    | Start Date |              |
| Doctor's Signature       |       | Valid Period | Pharm.     |              |
| Additional Instructions: |       |              |            |              |

| DRUG :                   |       |              |            | Date<br>Time |
|--------------------------|-------|--------------|------------|--------------|
| Dose                     | Route | Frequency    | Start Date |              |
| Doctor's Signature       |       | Valid Period | Pharm.     |              |
| Additional Instructions: |       |              |            |              |

| DRUG :                   |       |              |            | Date<br>Time |
|--------------------------|-------|--------------|------------|--------------|
| Dose                     | Route | Frequency    | Start Date |              |
| Doctor's Signature       |       | Valid Period | Pharm.     |              |
| Additional Instructions: |       |              |            |              |





REGULAR PRESCRIPTIONS

Weight. 76 kg Ward. 08

|                                                       |       |           |            |              |         |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
|-------------------------------------------------------|-------|-----------|------------|--------------|---------|------|------|--|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>DRUG:</b> Inj ACTRAPID                             |       |           |            | Date<br>Time | 20/7/26 | 21/7 | 22/7 |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                  | Route | Frequency | Start Date |              |         |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 8U                                                    | s/c   | TID       | 20/7/26 AM |              |         |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs: |       |           |            |              |         |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dr. Y. Dr. Y. Sneh                                    |       |           |            |              |         |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                              |       |           |            |              |         |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Before food                                           |       |           |            |              |         |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                  |       |           |            |              |         |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>DRUG:</b> Inj LANCTUS                              |       |           |            | Date<br>Time | 20/7/26 | 21/7 |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                  | Route | Frequency | Start Date |              |         |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 6U                                                    | s/c   | OD        | 20/7/26    |              |         |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs: |       |           |            |              |         |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dr. Y. Dr. Y. Sneh                                    |       |           |            |              |         |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                              |       |           |            |              |         |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Bed time                                              |       |           |            |              |         |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                  |       |           |            |              |         |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>DRUG:</b> T-Thyronorm                              |       |           |            | Date<br>Time | 20/7/26 | 21/7 |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                  | Route | Frequency | Start Date |              |         |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 25mcg                                                 | PO    | OD        | 20/7/26    |              |         |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs: |       |           |            |              |         |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dr. Y. Dr. Y. Sneh                                    |       |           |            |              |         |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                              |       |           |            |              |         |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                  |       |           |            |              |         |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>DRUG:</b> Candid V6 Vg Persau                      |       |           |            | Date<br>Time | 21/7/26 | 22/7 |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                  | Route | Frequency | Start Date |              |         |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1                                                     | PV    | OD        | 21/7/26    |              |         |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs: |       |           |            |              |         |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dr. Y. Dr. Y. Sneh                                    |       |           |            |              |         |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                              |       |           |            |              |         |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                  |       |           |            |              |         |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |





| Date<br>Time                   |            | Nurse Sig. | Nurse Sig. | Nurse Sig. | Nurse Sig. |
|--------------------------------|------------|------------|------------|------------|------------|
| DRUG :                         |            | Dose       | Dose       | Dose       | Dose       |
|                                |            | Dr. Sign.  | Dr. Sign.  | Dr. Sign.  | Dr. Sign.  |
| Route                          | Start Date | Dose       | Dose       | Dose       | Dose       |
|                                |            | Dr. Sign.  | Dr. Sign.  | Dr. Sign.  | Dr. Sign.  |
| Name & Signature of the Doctor |            | Dose       | Dose       | Dose       | Dose       |
|                                |            | Dr. Sign.  | Dr. Sign.  | Dr. Sign.  | Dr. Sign.  |
| Additional Instructions:       |            | Dose       | Dose       | Dose       | Dose       |
|                                |            | Dr. Sign.  | Dr. Sign.  | Dr. Sign.  | Dr. Sign.  |

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

STAT / ONCE ONLY DRUGS

| Date | Time    | Medication            | Dosage & Other Instructions | Route | Signature | Nurses             |
|------|---------|-----------------------|-----------------------------|-------|-----------|--------------------|
| 20/7 | 5:30 PM | 4mg SD4               | 4gm                         | IV    | Deen      | Shobha<br>Radha    |
| 21/7 | 2:00 AM | 2mg PCM               | 1gm                         | IV    | Dr. Y     | Sandhya<br>Ashwika |
| 21/7 | 4:00 AM | 2mg TRAMADOL          | 50mg                        | IM    | Dr. Y     | Ashwika<br>Sandhya |
| 21/7 | 3 PM    | Asthalin nebulization |                             | PIV   | Dany      | Rishi<br>Anish     |
| 21/7 | 8 PM    | INS BETAMETHASONE     | 12g                         | IM    | Dr. Y     | Sandhya<br>Shobha  |
|      |         |                       |                             |       |           |                    |
|      |         |                       |                             |       |           |                    |
|      |         |                       |                             |       |           |                    |
|      |         |                       |                             |       |           |                    |
|      |         |                       |                             |       |           |                    |

Signature  
 VERIFIED BY : Name



Ward. 0123

Nurse  
Sign

Shah  
Yamun

|        |
|--------|
| Shelly |
| Yamun  |

Sandy  
Shelly



Patient Sticker

# INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

**Rainbow<sup>®</sup>  
Children's  
Hospital**  
It takes a lot to treat the little.

**BirthRight<sup>™</sup>**  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

## Part - I.

Patient's / Learner Language: English / Hindi 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 |          |                         |
| 20/7/24 | 5:30 PM | 2/3/4           | Diagnosis, treatment & Care plan<br>Pain management, Infection control | PT                                  | 1                 | 0              | 1                                 | 1             |          | <i>[Signature]</i>      |
| 20/7/24 | 5:30 PM | 7               | Infection control measures                                             | PI                                  | 1                 | C              | E                                 | 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:                                                                                                  |                               |                                                   |                                 |                                |  |  |  |  |  |
| 1. No Learning Barriers                                                                                             | 4. Language Barrier           | 7. Impaired Thought Process/Cognitive limitations | 10. Financial Difficulties      | 13. Cultural/Religion Practice |  |  |  |  |  |
| 2. Physical Impairment                                                                                              | 5. Educational Level          | 8. Responsibilities at Home                       | 11. Beliefs and Values          | 14. Others (Specify) .....     |  |  |  |  |  |
| 3. Emotional Barriers                                                                                               | 6. Desire / Motivate to Learn | 9. Cultural Differences                           | 12. Impaired Vision/ or Hearing |                                |  |  |  |  |  |
| Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed                                          |                               |                                                   |                                 |                                |  |  |  |  |  |
| Mechanism/s to overcome barrier/s:                                                                                  |                               |                                                   |                                 |                                |  |  |  |  |  |
| 1. None                                                                                                             | 3. Reassurance & Support      | 5. Respect values & beliefs                       | 7. Other, Specify .....         |                                |  |  |  |  |  |
| 2. Obtain translator                                                                                                | 4. Teach Family / Others      | 6. Respect Cultural / Religion Preference         |                                 |                                |  |  |  |  |  |
| Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review                            |                               |                                                   |                                 |                                |  |  |  |  |  |



VIH-00186794 IP5-00176660  
 Mrs ANITHA LAKAVATH  
 15-07-1992 34 Y O M 5 D (F)  
 Dr. NIRAJ K YANAMANDRA

## MULTI-DISCIPLINARY PLAN OF CARE FORM

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

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Your Right to a Safe Delivery

Diagnosis:

G2P1L1 33wks 1 DDA twin / GDM on Insulin / Gest Hypertension / Sickle cell trait  
 twin-11 - FGR with abnorm Doppler

| Date Time         | Discipline                                                                                               | Type                                                                                                                                                    | Patient Needs / Problem List                                              | Goal           | Plan / Intervention   | Signature       | Team Verification                                                                                                   |
|-------------------|----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|----------------|-----------------------|-----------------|---------------------------------------------------------------------------------------------------------------------|
| 20/7/26<br>5:30pm | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others: | <input type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input checked="" type="checkbox"/> Per-Op<br><input type="checkbox"/> Post Op | GDM on Insulin<br>Gest Hypertension<br>Sickle cell trait<br>twin-11 - FGR | 1. observation | observe               | Dr. [Signature] | <input type="checkbox"/> Nursing<br><input type="checkbox"/> Others:                                                |
| 20/7/26<br>6pm    | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others: | <input type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input type="checkbox"/> Per-Op<br><input type="checkbox"/> Post Op            | GDM on Insulin<br>Gest Hypertension                                       | Observation    | Psychological Support | Shobcy          | <input type="checkbox"/> Medical<br><input type="checkbox"/> Others:                                                |
|                   | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others: | <input type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input type="checkbox"/> Per-Op<br><input type="checkbox"/> Post Op            |                                                                           |                |                       |                 | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others:            |
|                   | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others: | <input type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input type="checkbox"/> Per-Op<br><input type="checkbox"/> Post Op            |                                                                           |                |                       |                 | <input type="checkbox"/> Medical<br><input checked="" type="checkbox"/> Nursing<br><input type="checkbox"/> Others: |
|                   | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others: | <input type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input type="checkbox"/> Per-Op<br><input type="checkbox"/> Post Op            |                                                                           |                |                       |                 | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others:            |



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 Mrs ANITHA LAKAVATH  
 15-07-1992 34 Y O M 5 D (F)  
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## RESULT SHEET

|                     |         |         |  |  |  |
|---------------------|---------|---------|--|--|--|
| Date                | 20/7/26 | 21/7/26 |  |  |  |
| Time                | 8:30pm  | 8Am     |  |  |  |
| Hb                  | 11.6    |         |  |  |  |
| PCV                 | 33.1    |         |  |  |  |
| RBC                 | 3.72    |         |  |  |  |
| WBC                 | 11.30   |         |  |  |  |
| N/L                 |         |         |  |  |  |
| Platelets           | 270     |         |  |  |  |
| CRP                 |         |         |  |  |  |
| ESR                 |         |         |  |  |  |
| PCT                 |         |         |  |  |  |
| RBS                 |         |         |  |  |  |
| Na                  | 138     |         |  |  |  |
| K                   | 5.3     | 5.3     |  |  |  |
| Cl                  | 109     |         |  |  |  |
| Ca/Mg               |         |         |  |  |  |
| Phosphate           |         |         |  |  |  |
| Urea                |         |         |  |  |  |
| Creatinine          | 0.5     |         |  |  |  |
| ALP                 |         |         |  |  |  |
| SGPT                |         |         |  |  |  |
| SGOT                |         |         |  |  |  |
| T.Bill/Conj         |         |         |  |  |  |
| T.Protein           |         |         |  |  |  |
| S.Albumin           |         |         |  |  |  |
| S.Globulin          |         |         |  |  |  |
| A/G Ratio           |         |         |  |  |  |
| Uric Acid           |         |         |  |  |  |
| S.Amylase           |         |         |  |  |  |
| Sr.Lipase           |         |         |  |  |  |
| Blood Lactate       |         |         |  |  |  |
| S.Cholesterol       |         |         |  |  |  |
| PT/INR              |         |         |  |  |  |
| APTT                |         |         |  |  |  |
| CSF Protein / Sugar |         |         |  |  |  |
| Cells               |         |         |  |  |  |
| N/L                 |         |         |  |  |  |







## OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 20/7/26 Time of Arrival: 8:30pm Time Seen by Nurse: 3:31pm

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

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

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

3) Vital Signs: Temperature: 98.2°F Pulse: 80 RR: 20 SpO<sub>2</sub>: 100 BP: 102/45 Weight: .....

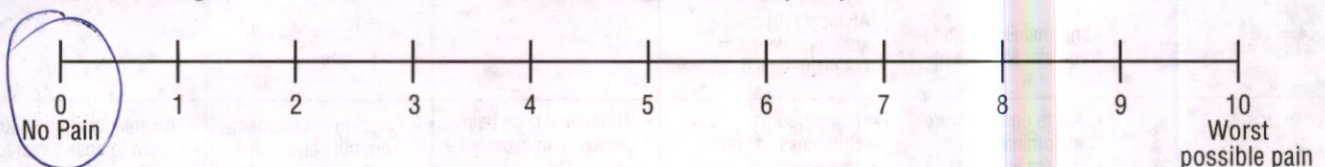
4) Gestational Criteria:

|          |            |            |            |   |
|----------|------------|------------|------------|---|
| Gravida: | G <u>2</u> | P <u>1</u> | L <u>1</u> | A |
|----------|------------|------------|------------|---|

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

|                        |                                                                     |                             |                                                                      |      |              |
|------------------------|---------------------------------------------------------------------|-----------------------------|----------------------------------------------------------------------|------|--------------|
| Uterine Contraction    | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> NA | Onset                                                                | Time | Frequency:   |
| Membrane Rupture       | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> NA | Onset                                                                | Time | Fluid Color: |
| Vaginal bleeding       | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> NA | Onset                                                                | Time | Amount:      |
| Pre Eclampsia Symptoms | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> NA | If Yes specify: Headache / Visual Symptoms / Pain Abdomen / Vomiting |      |              |
| Good fetal Movement    | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> NA | If No specify:                                                       |      |              |

5) Pain Screening: Numerical Pain Scale (NPS)



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

6) Past History:

- a) Surgeries: Bartholin's cyst - 2018, 2020, LSCS - 2023  
 b) Medical: None





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

Time seen by Doctor: ..... 3:55pm

Nurse Name : ..... Shobha ..... Nurse Signature: ..... 9

Date: ..... 20/7/20 ..... Time: ..... 3:55pm



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Mrs ANITHA LAKAVATH  
15-07-1992 34 Y O M 5 D (F)  
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## OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

|                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Date of Admission: <u>20/9/26</u>                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Baseline Information:</b>                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| Admission From:                                                                                                                                                                                                                                                                                                                                                                                 | <input type="checkbox"/> ER                                                                                                                                                                                                                                                                                                                                                                                           | <input type="checkbox"/> OPD <input checked="" type="checkbox"/> Admission Desk <input type="checkbox"/> Others, specify .....                                                                                                                                                                                                                                                                                                                                                         |
| Primary Language:                                                                                                                                                                                                                                                                                                                                                                               | <input type="checkbox"/> Telugu                                                                                                                                                                                                                                                                                                                                                                                       | <input type="checkbox"/> English <input type="checkbox"/> Hindi <input type="checkbox"/> Others, specify .....                                                                                                                                                                                                                                                                                                                                                                         |
| Do you require an interpreter?                                                                                                                                                                                                                                                                                                                                                                  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                   | if Yes specify .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Source of Information:                                                                                                                                                                                                                                                                                                                                                                          | <input checked="" type="checkbox"/> Patient                                                                                                                                                                                                                                                                                                                                                                           | <input type="checkbox"/> Family <input type="checkbox"/> Others, specify .....                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Allergies:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Medications <input type="checkbox"/> Blood Transfusion <input type="checkbox"/> Food <input type="checkbox"/> Other: .....<br>If yes, identify .....                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Chief Complaints:</b> .....<br><u>Came for MGSOP</u>                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                       | Doctor Notified on Admission: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>Name of the Doctor: <u>Dr. Divya</u><br>Time Notified: .....                                                                                                                                                                                                                                                                                                                      |
| <b>Past Medical History:</b> Obtained From <input type="checkbox"/> Patient <input type="checkbox"/> Family Member <input type="checkbox"/> Medical Record <input type="checkbox"/> Other (specify) .....                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Past Medical History</b>                                                                                                                                                                                                                                                                                                                                                                     | <b>Past Surgical History</b>                                                                                                                                                                                                                                                                                                                                                                                          | <b>Previous Hospital Admission</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| _____                                                                                                                                                                                                                                                                                                                                                                                           | <u>Bartholinian cyst - 2018</u><br><u>2020 LSCS - 2023</u>                                                                                                                                                                                                                                                                                                                                                            | _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Gynecology Assessment:</b> <input type="checkbox"/> Not Applicable<br>Menstrual History: <u>Regular</u><br>Onset of Menarche: .....<br>Menstrual Cycle: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular<br>Last Menstrual Period: <u>6/12/25</u>                                                                                                              | <b>Gynecology Surgical History:</b><br>Caesarean Section: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes<br>Cervical Cerclage: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Ectopic Pregnancy: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Myomectomy: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Others: ..... | <b>Gynecological History:</b><br>Contraceptives: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Vaginal Discharge: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Post-Coital Bleeding: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br><b>Infertility:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes<br><b>If Yes Type:</b> <input type="checkbox"/> Primary <input type="checkbox"/> Secondary |
| <b>Obstetric History:</b> G <u>2</u> P <u>1</u> L <u>1</u> A .....<br><b>Previous LSCS:</b> <u>- Yes</u><br><b>Current Medication:</b> <input type="checkbox"/> None <input type="checkbox"/> Yes, If Yes, Fill the reconciliation form                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Family History:</b> <input type="checkbox"/> No Abnormalities Detected<br><input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypertension <input checked="" type="checkbox"/> Diabetes <input type="checkbox"/> Stroke <input type="checkbox"/> Seizures <input type="checkbox"/> Kidney disease<br><input type="checkbox"/> Liver disease <input type="checkbox"/> Other ..... |                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Vital Signs / Measurements:</b> Temp: <u>96.1°F</u> HR: <u>80</u> RR: <u>20</u><br>BP: <u>112/75</u> Weight: ..... Height: ..... BMI: .....                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Pain Assessment:</b> Pain: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No (If Yes, complete the Pain Assessment / Reassessment Form)                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |



## PHYSICAL ASSESSMENT

**General Appearance:** ☒ Healthy ☐ ill looking ☐ Anxious ☐ Agitated ☐ Others: .....

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

**Risk of Pressure Sore:** ☐ Yes ☐ No Score 24 (complete the Braden Q Sheet)

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

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

Inform consultant for positive criteria

**NUTRITIONAL SCREENING:** ☒ No Abnormality Detected

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

Inform consultant for positive criteria

**PSYCHOLOGICAL SCREENING:**

- ☒ Calm & Cooperative ☐ Restless ☐ Depressed ☐ Agitated ☐ Confused  
☐ Others .....

Inform consultant for positive criteria

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

**SOCIAL SCREENING:**

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

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

**Social History:** Lives With Husband

**Orientation has been given regarding the following aspects:**

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

Above information given to patient

Name of Person Orientation was given to: Shobha

Orientation not given Reason: -

Nurse Signature: Shobha

Nurse Name: Shobha

Date & Time: 2/7/20 14:00





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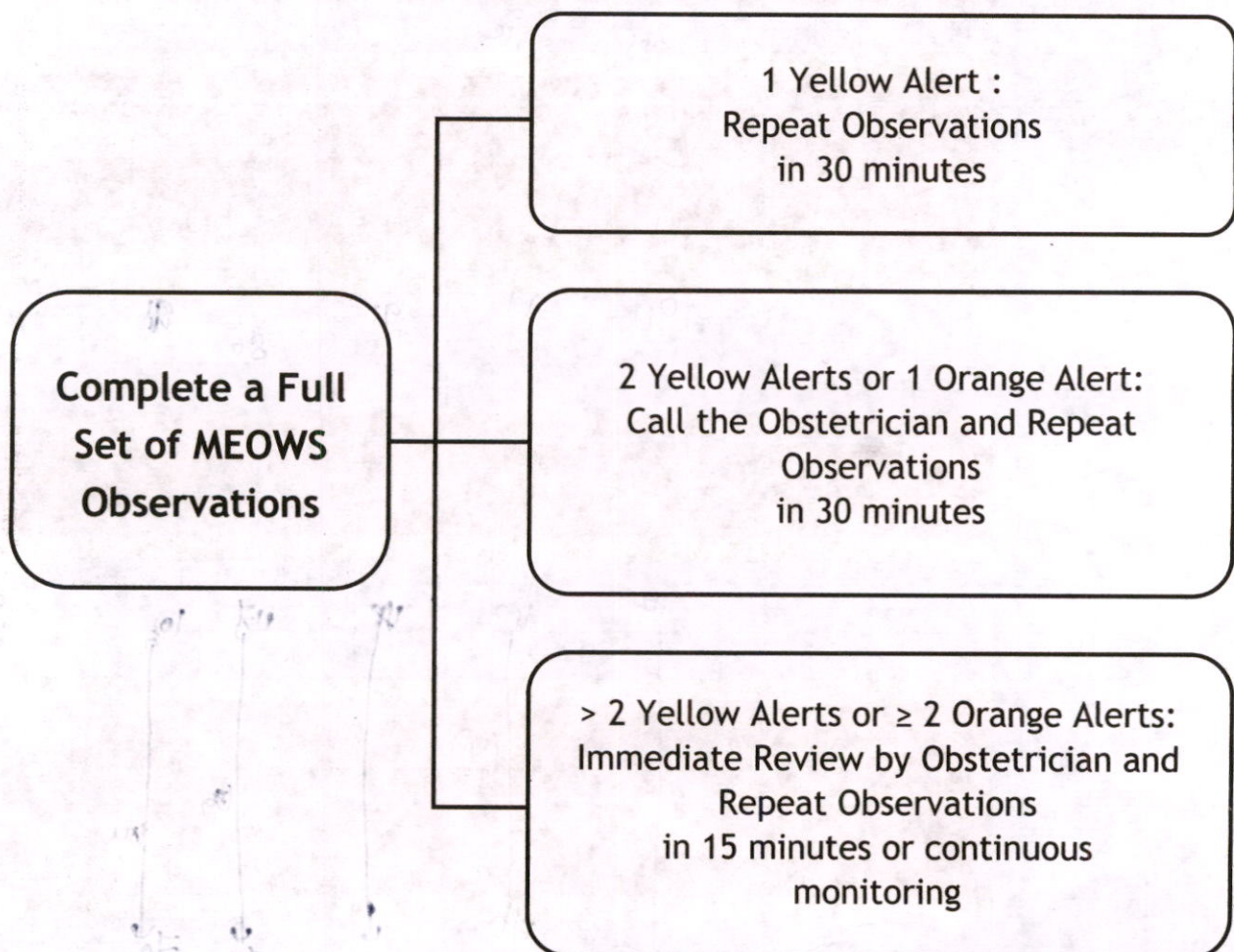
**CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME**

20/7/20

[illegible]



## Obstetrics and Gynaecology Early Warning Signs



\* The Modified Early Warning Score (MEOWS)





21/7/26



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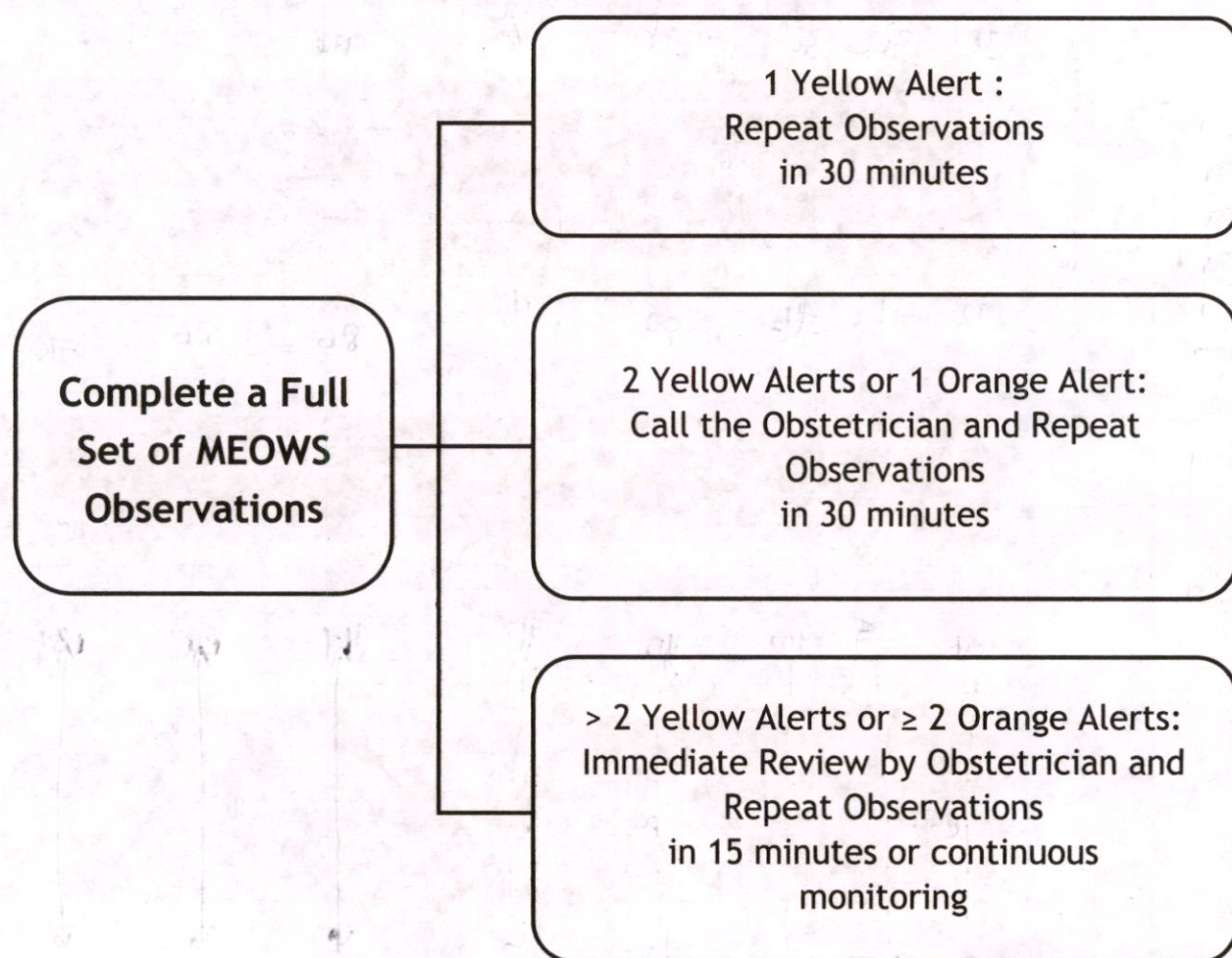
**CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME**

21/7

[illegible]



## Obstetrics and Gynaecology Early Warning Signs



\* The Modified Early Warning Score (MEOWS)



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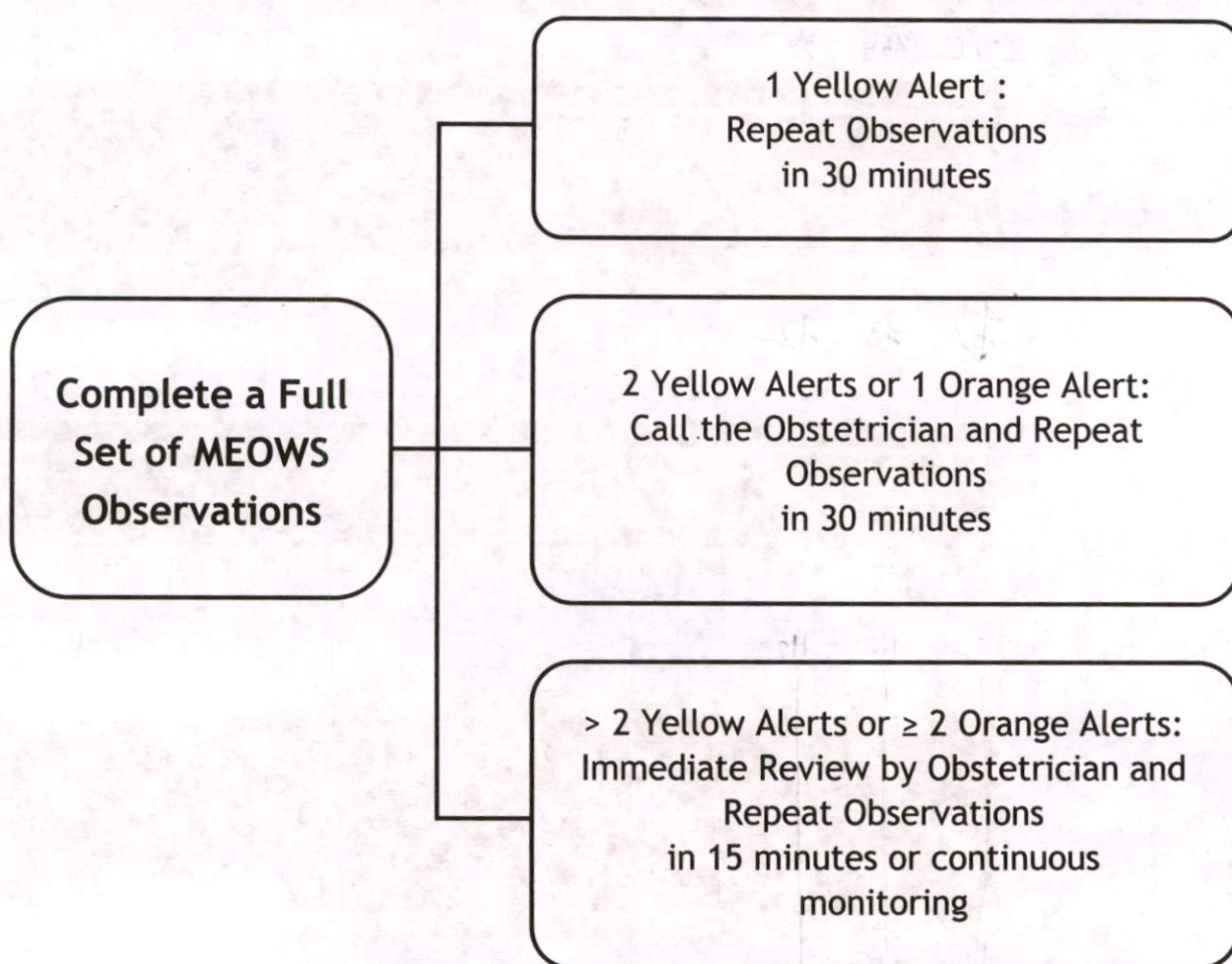
22/4

**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)



VIH-00186794 IP5-00176660  
 Mrs ANITHA LAKAVATH  
 15-07-1992 34 Y 0 M 5 D (F)  
 Dr. NIRAJ K YANAMANDRA



20/7/20

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## FLUID CHART

Sheet No. : 01

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

|                      |          | Intake             |       |      | Output |                |       |          |       | IV Site<br>Thrombo-<br>phlebitis<br>Score | Sign.<br>Nurse |        |  |
|----------------------|----------|--------------------|-------|------|--------|----------------|-------|----------|-------|-------------------------------------------|----------------|--------|--|
| Date                 | Time     | Nature<br>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 | mgsoy              |       | 25ml |        |                |       |          |       | 170ml                                     |                |        |  |
|                      | 07:00 pm | mgsoy              |       | 25ml |        |                |       |          |       |                                           |                |        |  |
| Total Intake : taken |          |                    |       |      |        | Total Output : |       |          |       |                                           |                |        |  |
|                      | 08:00 pm | mgsoy              |       | 25ml |        |                |       |          |       | 160ml                                     | 0              | Sandoz |  |
|                      | 09:00 pm | mgsoy              | tho   | 25ml |        |                |       |          |       | 170ml                                     | 0              |        |  |
|                      | 10:00 pm | mgsoy              |       | 25ml |        |                |       |          |       |                                           | 0              |        |  |
|                      | 11:00 pm | mgsoy              | tho   | 25ml |        |                |       |          |       |                                           | 0              |        |  |
|                      | 12:00 am | mgsoy              |       | 25ml |        |                |       |          |       | 170ml                                     | 0              |        |  |
|                      | 01:00 am | mgsoy              |       | 25ml |        |                |       |          |       |                                           | 0              |        |  |
| Total Intake : taken |          |                    |       |      |        | Total Output : |       |          |       |                                           |                |        |  |
|                      | 02:00 am | mgsoy              |       | 25ml |        |                |       |          |       | 160ml                                     | 0              | Sandoz |  |
|                      | 03:00 am | mgsoy              | tho   | 25ml |        |                |       |          |       |                                           | 0              |        |  |
|                      | 04:00 am | mgsoy              | tho   | 25ml |        |                |       |          |       |                                           | 0              |        |  |
|                      | 05:00 am | mgsoy              |       | 25ml |        |                |       |          |       |                                           | 0              |        |  |
|                      | 06:00 am | mgsoy              | tho   | 25ml |        |                |       |          |       | 200ml                                     | 0              |        |  |
|                      | 07:00 am | mgsoy              |       | 25ml |        |                |       |          |       |                                           | 0              |        |  |
| Total Intake : taken |          |                    |       |      |        | Total Output : |       |          |       |                                           |                |        |  |
| Total 24 hrs. Intake |          |                    |       |      |        |                |       |          |       |                                           |                |        |  |
| Total 24 hrs. Output |          |                    |       |      |        |                |       |          |       |                                           |                |        |  |



21/7/26

# 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.
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 | 200ml           |        | ng 300 |     |                |           |       |          | 180ml | 0                               | pdh         |  |
|                | 09:00 am | 170             |        | 25ml   |     |                |           |       |          |       | 0                               | pdh         |  |
|                | 10:00 am | 170             |        | 25ml   |     |                |           |       |          |       | 0                               | pdh         |  |
|                | 11:00 am | 170             |        | ng 500 |     |                |           |       |          | 170ml | 0                               | pdh         |  |
|                | 12:00 pm | 170             |        | 25ml   |     |                |           |       |          |       | 0                               | pdh         |  |
|                | 01:00 pm |                 |        |        |     |                |           |       |          |       | 0                               |             |  |
| Total Intake : |          |                 | 200    |        |     | Total Output : |           |       |          |       | 180 + 350 = 530                 |             |  |
|                | 02:00 pm |                 |        |        |     |                |           |       |          |       | 0                               |             |  |
|                | 03:00 pm | chopoli         |        | ng 300 |     |                |           |       |          | 160ml | 0                               | pdh         |  |
|                | 04:00 pm |                 |        | 25ml   |     |                |           |       |          |       | 0                               | pdh         |  |
|                | 05:00 pm | 100             |        |        |     |                |           |       |          |       | 0                               | pdh         |  |
|                | 06:00 pm | drinking        |        | ng 300 |     |                |           |       |          | 150ml | 0                               | pdh         |  |
|                | 07:00 pm | 25ml            |        |        |     |                |           |       |          | 80ml  | 0                               | pdh         |  |
| Total Intake : |          |                 | 200    |        |     | Total Output : |           |       |          |       | 390 ml                          |             |  |
|                | 08:00 pm |                 |        |        |     |                |           |       |          |       | 0                               |             |  |
|                | 09:00 pm | 170             |        |        |     |                |           |       |          |       | 0                               |             |  |
|                | 10:00 pm |                 |        |        |     |                |           |       |          |       | 0                               |             |  |
|                | 11:00 pm | 170             |        |        |     |                |           |       |          |       | 0                               |             |  |
|                | 12:00 am |                 |        |        |     |                |           |       |          |       | 0                               |             |  |
|                | 01:00 am | 170             |        |        |     |                |           |       |          |       | 0                               |             |  |
| Total Intake : |          |                 | 200    |        |     | Total Output : |           |       |          |       | 0                               |             |  |
|                | 02:00 am | 170             |        |        |     |                |           |       |          |       | 0                               |             |  |
|                | 03:00 am | 170             |        |        |     |                |           |       |          |       | 0                               |             |  |
|                | 04:00 am | 170             |        |        |     |                |           |       |          |       | 0                               |             |  |
|                | 05:00 am |                 |        |        |     |                |           |       |          |       | 0                               |             |  |
|                | 06:00 am | 170             |        |        |     |                |           |       |          |       | 0                               |             |  |
|                | 07:00 am |                 |        |        |     |                |           |       |          |       | 0                               |             |  |
| Total Intake : |          |                 | 200    |        |     | Total Output : |           |       |          |       | 0                               |             |  |

**Total 24 hrs. Intake**

**Total 24 hrs. Output**



VIH-00186794 IP5-00176660  
Mrs ANITHA LAKAVATH  
15-07-1992 34 Y 0 M 7 D (F)  
Dr. NIRAJ K YANAMANDRA



22/7/26

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## FLUID CHART

Sheet No. : ③

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<br>Thrombo-<br>phlebitis<br>Score | Sign.<br>Nurse |
|------|----------|--------------------|-------|-----|--------|-----------|-------|----------|-------|-------------------------------------------|----------------|
| Date | Time     | Nature<br>of Fluid | Route |     | NG     | Diarrhoea | Vomit | Drainage | Urine |                                           |                |
|      |          |                    | Mouth | I.V | N.G    |           |       |          |       |                                           |                |
|      | 08:00 am | H <sub>2</sub> O   |       |     |        | ✓         |       |          | ✓     | 0                                         | Shobha         |
|      | 09:00 am |                    |       |     |        |           |       |          |       | 0                                         |                |
|      | 10:00 am | H <sub>2</sub> O   |       |     |        |           |       |          | ✓     | 0                                         |                |
|      | 11:00 am |                    |       |     |        |           |       |          |       | 0                                         | Shobha         |
|      | 12:00 pm | H <sub>2</sub> O   |       |     |        |           |       |          |       | 0                                         |                |
|      | 01:00 pm |                    |       |     |        |           |       |          |       | 0                                         | Shobha         |

Total Intake : Taken

Total Output : passed

|  |          |  |  |  |  |  |  |  |  |  |  |
|--|----------|--|--|--|--|--|--|--|--|--|--|
|  | 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

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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<br>Thrombo-<br>phlebitis<br>Score | Sign.<br>Nurse |
|-----------------------------|----------|--------------------|-------|-----|-----|-----------------------|-----------|-------|----------|-------|--|-------------------------------------------|----------------|
| Date                        | Time     | Nature<br>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 |                    |       |     |     |                       |           |       |          |       |  |                                           |                |
| <b>Total Intake :</b>       |          |                    |       |     |     | <b>Total Output :</b> |           |       |          |       |  |                                           |                |
|                             | 02:00 pm |                    |       |     |     |                       |           |       |          |       |  |                                           |                |
|                             | 03:00 pm |                    |       |     |     |                       |           |       |          |       |  |                                           |                |
|                             | 04:00 pm |                    |       |     |     |                       |           |       |          |       |  |                                           |                |
|                             | 05:00 pm |                    |       |     |     |                       |           |       |          |       |  |                                           |                |
|                             | 06:00 pm |                    |       |     |     |                       |           |       |          |       |  |                                           |                |
|                             | 07:00 pm |                    |       |     |     |                       |           |       |          |       |  |                                           |                |
| <b>Total Intake :</b>       |          |                    |       |     |     | <b>Total Output :</b> |           |       |          |       |  |                                           |                |
|                             | 08:00 pm |                    |       |     |     |                       |           |       |          |       |  |                                           |                |
|                             | 09:00 pm |                    |       |     |     |                       |           |       |          |       |  |                                           |                |
|                             | 10:00 pm |                    |       |     |     |                       |           |       |          |       |  |                                           |                |
|                             | 11:00 pm |                    |       |     |     |                       |           |       |          |       |  |                                           |                |
|                             | 12:00 am |                    |       |     |     |                       |           |       |          |       |  |                                           |                |
|                             | 01:00 am |                    |       |     |     |                       |           |       |          |       |  |                                           |                |
| <b>Total Intake :</b>       |          |                    |       |     |     | <b>Total Output :</b> |           |       |          |       |  |                                           |                |
|                             | 02:00 am |                    |       |     |     |                       |           |       |          |       |  |                                           |                |
|                             | 03:00 am |                    |       |     |     |                       |           |       |          |       |  |                                           |                |
|                             | 04:00 am |                    |       |     |     |                       |           |       |          |       |  |                                           |                |
|                             | 05:00 am |                    |       |     |     |                       |           |       |          |       |  |                                           |                |
|                             | 06:00 am |                    |       |     |     |                       |           |       |          |       |  |                                           |                |
|                             | 07:00 am |                    |       |     |     |                       |           |       |          |       |  |                                           |                |
| <b>Total Intake :</b>       |          |                    |       |     |     | <b>Total Output :</b> |           |       |          |       |  |                                           |                |
| <b>Total 24 hrs. Intake</b> |          |                    |       |     |     |                       |           |       |          |       |  |                                           |                |
| <b>Total 24 hrs. Output</b> |          |                    |       |     |     |                       |           |       |          |       |  |                                           |                |





# ① NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 20/7/26

Assessment: please see below

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          |
|------|-----------------------------------------------|--------|-------------------------------------------------|---------------------|
| 4pm  | * Assess the general condition of the patient | 4:30pm | * Assessed the general condition of the patient | * patient is stable |
| 5pm  | * monitor vitals                              | 5:30pm | * monitored vitals                              |                     |
| 6pm  | * IV placement                                | 6:30pm | * IV placement Done                             |                     |
| 7pm  | * Mgso4                                       | 7:30pm | * Mgso4 on going                                |                     |
| 8pm  | * Safety                                      | 8:00pm | * Ensured safety provided                       |                     |

Re-Assessment: Re Assessment done. vital stable

Special Notes: Mgso4

Nurse Signature: [Signature] Nurse Name: Shobha Date & Time: 20/7/26 8pm



VIH-00186794 IP5-00176660  
 Mrs ANITHA LAKAVATH  
 15-07-1992 34 Y O M 6 D (F)  
 Dr. NIRAJ K YANAMANDRA

## NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 20/7/2021

Assessment: patient complaint about fear and 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  
☒ Patient & Family Education

| Time | Plan of Care            | Time | Implementation           | Evaluation   |
|------|-------------------------|------|--------------------------|--------------|
| 8pm  | Assess the pt condition | 9pm  | Assessed pt condition    | pt is stable |
| 10pm | monitor vital           | 11pm | monitored vitals         |              |
| 12am | do chart                | 1am  | maintained do chart self |              |
| 12am | pre-post GRBS.          | 2am  | measured.                |              |
| 3am  | medications             | 3am  | monitored GRBS.          |              |
| 4am  | ALST                    | 4am  | Administered medications |              |
| 6am  | mgso4                   | 7am  | BD ALST                  |              |
| 7am  | Ensure safety           | 8am  | continued mgso4 till 7pm | 6pm          |

Re-Assessment: done after and hourly pt is stable

Special Notes: ALST BD

Nurse Signature: Sandeepa

Nurse Name: Sandeepa (16630)

Date & Time: 21/7/2021 6:00pm



# NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: 21/7/16

Assessment: pt complain for fear and 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   |
|-------|-----------------------------|----------|------------------------------------|--------------|
| 8 AM  | Assess pt general condition | 8:10 AM  | Assessed pt general condition      | pt is stable |
| 10 AM | monitor vital               | 10:10 AM | Bp spot pulse checked and recorded |              |
| 11 AM | Administration medication   | 11:15 AM | medication given as per doctor     |              |
| 12 PM | Ensure safety               | 12:10 PM | Ensure safety provided.            |              |
| 1 PM  | prevent infection           | 1:15 PM  | To prevent infection.              |              |

Re-Assessment: Re assessment done..

Special Notes: pt is stable for surgery.

Nurse Signature: [Signature] Nurse Name: Shobha

Date & Time: 21/7/16 @ 2 PM



VIH-00186794 IP5-00176660  
 Mrs ANITHA LAKAVATH  
 15-07-1992 34 Y O M 6 D (F)  
 Dr. NIRAJ K YANAMANDRA



## NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 21/7/16

Assessment: patient came for my boy.

Goals

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

| Time | Plan of Care            | Time   | Implementation             | Evaluation         |
|------|-------------------------|--------|----------------------------|--------------------|
| 2m   | Assess the Pt (cardiac) | 2:30 M | Assessed the Pt (cardiac)  | Pt is comfortable. |
| 3m   | monitoring vitals       | 3:30 M | vitals checked & normal    |                    |
| 4m   | F.H.R monitoring        | 4:30 M | F.H.R checked.             |                    |
| 5m   | Soft diet               | 5:30 M | Soft diet given.           |                    |
| 6m   | I/O chart monitoring    | 7:30 M | I/O chart medication given |                    |
| 6m   | observation             |        | mob observation done       |                    |

Re-Assessment: Re-assessment with hourly FHR

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Radha

Date & Time: 21/7/16 @ 8m



# NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 21/7/20

Assessment: patent Complaint about fear and 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 condition | 9pm  | assessed pt condition   | pt is stable |
| 10pm | monitor vitals      | 11pm | monitor vitals          |              |
| 12AM | medication          | 1AM  | administered medication |              |
| 4AM  | NST                 | 5AM  | NST BD. (done at night) |              |
| 6AM  | pre-post sugar      | 7AM  | monitored a/b/s (self)  |              |
| 7AM  | flow chart          |      | maintained flow chart   |              |
| 8AM  | Ensure safety       | 8AM  | Ensure safety           |              |

Re-Assessment: done after 2nd hourly pt is stable

Special Notes: NST 3rd hourly!

Nurse Signature: Sandhya Nurse Name: Sandhya (1663P) Date & Time: 22/7/20 6 e am



VIH-00186794 IP5-00176660  
 Mrs ANITHA LAKAVATH  
 15-07-1992 34 Y O M 6 D (F)  
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## NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 22/04/26

Assessment: patient is came for Mgso4 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  
☒ Patient & Family Education

| Time | Plan of Care                | Time  | Implementation                 | Evaluation |
|------|-----------------------------|-------|--------------------------------|------------|
| 8AM  | Assess pt general condition | 8:10  | Assessed pt general condition  | pt is      |
| 10AM | moniter vital               | 10:30 | Bp spo2 pluse checked record   |            |
| 11AM | Administration medication   | 11:30 | medication given as per doctor | Stable     |
| 12pm | Ensure safety               | 12:30 | Ensure safety provided         |            |
| 3pm  | Prevent infection           | 7:30  | Prevent infection              |            |

Re-Assessment: Re Assessment done

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Shobha

Date & Time: 22/04/26 @ 2pm



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

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

Signature of Shift In Charge :

Signature : ..... Name : .....

Signature of Ward In Charge :

Signature : ..... Name : .....





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





## PAIN ASSESSMENT FORM

| Date    | Time | Pain Score (0/10) | Location       | Duration                                                                     | Acuity                                                             | Character                                                                                                                        | Modifying Factors                                                          | Patient / Family Educated                                   | Intervention        | Sign   |
|---------|------|-------------------|----------------|------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------|---------------------|--------|
| 20/3/20 | 5pm  | 0/10              | NA             | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA                  | CS     |
| 20/3/20 | 6pm  | 0/10              | no pain        | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | under observation   | Sarav  |
| 20/3/20 | 11pm | 0/10              | no pain        | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | under observation   | Sarav  |
| 21/3/20 | 5am  | 0/10              | no pain        | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | under observation   | Sarav  |
| 21/3/20 | 3am  | 2/10              | Abdo men       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | Tij: pain given     | Sarav  |
| 21/3/20 | 5am  | 1/10              | Abdo men       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | Tij: Tones of given | Sarav  |
| 21/3/20 | 6am  | 0/10              | no pain        | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | under observation   | Sarav  |
| 21/3/20 | 10am | 0/10              | no pain        | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | under observation   | Shobha |
| 21/3/20 | 12pm | 0/10              | no pain        | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | under observation   | Shobha |
| 22/3/20 | 1pm  | 1/10              | Abdominal pain | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | breathless excess   | 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.

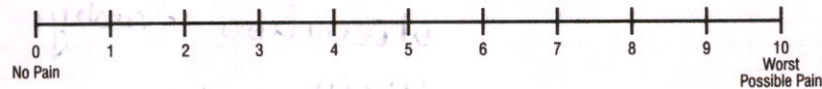


# PAIN ASSESSMENT TOOLS

**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 or sobs, frequent complaints    |
| Consolability | Content, relaxed                             | Reassured by occasional touching, hugging, or being talked to, distractible | Difficult to console or comfort                          |

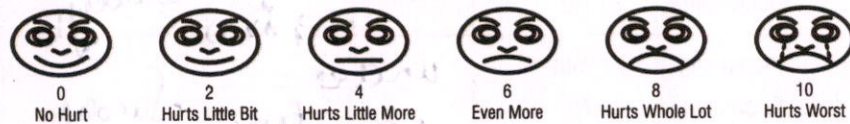
**Numerical Pain Scale (Obstetric and Gynecology)**



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

| Assessment Criteria                            | Sedation                                                |                                                             | Normal                                        | Pain / Agitation                                                                           |                                                                                                                                                         |
|------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------|-----------------------------------------------|--------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                | -2                                                      | -1                                                          | 0                                             | 1                                                                                          | 2                                                                                                                                                       |
| <b>Crying Irritability</b>                     | 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                                                                                                      |
| <b>Behavior State</b>                          | No arousal to any stimuli<br>No spontaneous movement    | Arouses minimally to stimuli<br>Little spontaneous movement | Appropriate for gestational age               | Restless, squirming<br>Awakens frequently                                                  | Arching, kicking constantly awake or<br>Arouses minimally / no movement (not sedated)                                                                   |
| <b>Facial Expression</b>                       | Mouth is lax<br>No expression                           | Minimal expression with stimuli                             | Relaxed Appropriate                           | Any pain expression intermittent                                                           | Any pain expression continual                                                                                                                           |
| <b>Extremities Tone</b>                        | No grasp reflex<br>Flaccid tone                         | Weak grasp reflex<br>decreased muscle tone                  | Relaxed hands and feet<br>Normal Tone         | Intermittent clenched toes, fists or finger splay<br>Body is not tense                     | Continual clenched toes, fists, or finger splay<br>Body is tense                                                                                        |
| <b>Vital Signs HR, RR, BP, SaO<sub>2</sub></b> | No variability with stimuli<br>Hypoventilation or apnea | Less than 10% variability from baseline with stimuli        | Within baseline or normal for gestational age | Increase 10-20% from baseline<br>SaO <sub>2</sub> 76-85% with stimulation - quick recovery | Increase greater than 20% from baseline, SaO <sub>2</sub> less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator |

**Wong - Baker (Pediatrics) Above 7 Years**





2

## PAIN ASSESSMENT FORM

| Date    | Time  | Pain Score (0/10) | Location | Duration                                                                     | Acuity                                                             | Character                                                                                                                        | Modifying Factors                                                          | Patient / Family Educated                                   | Intervention      | Sign   |
|---------|-------|-------------------|----------|------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------|-------------------|--------|
| 21/7/20 | 3 pm  | 0/10              | NO pain  | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | nsa               | Pdly   |
| 21/7/20 | 5 pm  | 0/10              | NO pain  | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | ns                | Pdly   |
| 21/7/20 | 7 pm  | 0/10              | NO pain  | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | ns                | Pdly   |
| 21/7    | 4 pm  | 0/10              | NO       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | under observation | Sandyp |
| 22/7    | 2 am  | 0/10              | NO pain  | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | under observation | Sandyp |
| 22/7    | 7 am  | 0/10              | NO pain  | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | under observation | Sandyp |
| 22/7    | 9 am  | 0/10              | NO pain  | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | under observation | Shobha |
| 22/7    | 11 am | 0/10              | NO pain  | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | under observation | Shobha |
| 22/7    | 1 pm  | 0/10              | NO pain  | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | under observation | Shobha |
|         |       |                   |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> 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.

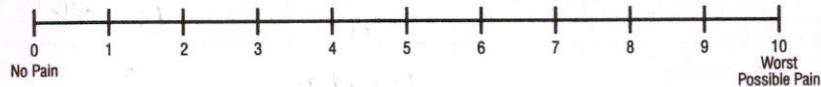


# PAIN ASSESSMENT TOOLS

## 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, 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                                                                                                                                                       |
| <b>Crying Irritability</b>                    | 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                                                                                                      |
| <b>Behavior State</b>                         | No arousal to any stimuli<br>No spontaneous movement    | Arouses minimally to stimuli<br>Little spontaneous movement | Appropriate for gestational age               | Restless, squirming<br>Awakens frequently                                                  | Arching, kicking constantly awake or<br>Arouses minimally / no movement (not sedated)                                                                   |
| <b>Facial Expression</b>                      | Mouth is lax<br>No expression                           | Minimal expression with stimuli                             | Relaxed Appropriate                           | Any pain expression intermittent                                                           | Any pain expression continual                                                                                                                           |
| <b>Extremities Tone</b>                       | No grasp reflex<br>Flaccid tone                         | Weak grasp reflex<br>decreased muscle tone                  | Relaxed hands and feet<br>Normal Tone         | Intermittent clenched toes, fists or finger splay<br>Body is not tense                     | Continual clenched toes, fists, or finger splay<br>Body is tense                                                                                        |
| <b>Vital Signs HR RR, BP, SaO<sub>2</sub></b> | No variability with stimuli<br>Hypoventilation or apnea | Less than 10% variability from baseline with stimuli        | Within baseline or normal for gestational age | Increase 10-20% from baseline<br>SaO <sub>2</sub> 76-85% with stimulation - quick recovery | Increase greater than 20% from baseline, SaO <sub>2</sub> less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator |

## 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



## Morse Fall Risk Assessment Form

| Choose Highest Applicable Score from each Category   |                               | Date / Time | 20/7/26         | 20/7/26 | 21/7/27 | Fall Risk Grading |                               |                                                  |
|------------------------------------------------------|-------------------------------|-------------|-----------------|---------|---------|-------------------|-------------------------------|--------------------------------------------------|
|                                                      |                               | Score       |                 |         |         |                   |                               |                                                  |
| History of Falling<br>(immediately or w/in 3 months) | Yes                           | 25          |                 |         |         | <b>Risk Level</b> | <b>Morse Fall Score (MFS)</b> | <b>Action</b>                                    |
|                                                      | No                            | 0           | 0               |         | 0       |                   |                               |                                                  |
| Secondary Diagnosis<br>(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           |                 |         |         |                   |                               |                                                  |
| GAIT / Transferring                                  | Impaired                      | 20          |                 |         |         | Moderate Risk     | 25 - 50                       | Implement Moderate Fall Prevention Intervention  |
|                                                      | Weak (uses touch for balance) | 10          |                 |         |         |                   |                               |                                                  |
|                                                      | Normal /On Bed Rest /Immobile | 0           | 0               |         |         |                   |                               |                                                  |
| Mental Status                                        | Forgets limitations           | 15          |                 |         |         | High Risk         | ≥ 51                          | Implement High Risk Fall Prevention Intervention |
|                                                      | Oriented to own ability       | 0           | 0               |         |         |                   |                               |                                                  |
| Total Morse Fall Scale Score:                        |                               |             | 35              | 35      | 25      |                   |                               |                                                  |
| Signature                                            |                               |             | By Soney Shobha |         |         |                   |                               |                                                  |

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



(2)

## Morse Fall Risk Assessment Form

| Choose Highest Applicable Score from each Category   |                               | Date / Time | 21/7/16     | 21/7/16     | 22/7/16     | Fall Risk Grading |                        |                                                  |
|------------------------------------------------------|-------------------------------|-------------|-------------|-------------|-------------|-------------------|------------------------|--------------------------------------------------|
|                                                      |                               | Score       |             |             |             | Risk Level        | Morse Fall Score (MFS) | Action                                           |
| History of Falling<br>(immediately or w/in 3 months) | Yes                           | 25          |             |             |             | Low Risk          | 0 - 24                 | Standard Fall Precaution                         |
|                                                      | No                            | 0           |             | 0           | 0           |                   |                        |                                                  |
| Secondary Diagnosis<br>(more than one diagnosis)     | Yes                           | 15          |             |             |             | Moderate Risk     | 25 - 50                | Implement Moderate Fall Prevention Intervention  |
|                                                      | No                            | 0           |             | 0           | 0           |                   |                        |                                                  |
| Ambulatory Aid                                       | Furniture                     | 30          |             |             |             | High Risk         | ≥ 51                   | Implement High Risk Fall Prevention Intervention |
|                                                      | Crutches, Cane(S), Walker     | 15          |             | 15          | 15          |                   |                        |                                                  |
|                                                      | None /Bed Rest /Nurse Assist  | 0           |             |             |             |                   |                        |                                                  |
| IV / Heparin Lock or Saline                          | Yes                           | 20          | 20          | 20          | 20          | Moderate Risk     | 25 - 50                | Implement Moderate Fall Prevention Intervention  |
|                                                      | No                            | 0           |             | 0           | 0           |                   |                        |                                                  |
| GAIT / Transferring                                  | Impaired                      | 20          |             |             |             | High Risk         | ≥ 51                   | Implement High Risk Fall Prevention Intervention |
|                                                      | Weak (uses touch for balance) | 10          |             |             |             |                   |                        |                                                  |
|                                                      | Normal /On Bed Rest /Immobile | 0           |             | 0           | 0           |                   |                        |                                                  |
| Mental Status                                        | Forgets limitations           | 15          |             |             |             | High Risk         | ≥ 51                   | Implement High Risk Fall Prevention Intervention |
|                                                      | Oriented to own ability       | 0           |             | 0           | 0           |                   |                        |                                                  |
| Total Morse Fall Scale Score:                        |                               |             | 20          | 35          | 35          |                   |                        |                                                  |
| Signature                                            |                               |             | [Signature] | [Signature] | [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



VIH-00166794 IP5-00176660  
Mrs ANITHA LAKAVATH  
15-07-1992 34 Y O M 5 D (F)  
Dr. NIRAJ K YANAMANDRA



## BRADEN 'Q' SCALE

Rainbow<sup>®</sup>  
Children's  
Hospital  
It takes a lot to treat the little.

BirthRight<sup>™</sup>  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

|                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Date :                  | 20/11/2017 | 21/11/2017 | 22/11/2017 | 23/11/2017 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------|------------|------------|------------|
|                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Time :                  | 2pm        | 9pm        | 8am        | 2pm        |
| Mobility                                                                                                                                                                     | <b>1. Completely immobile:</b><br>Does not make even slight changes in body or extremity position without assistance.                                                                                                                                                                                                                    | <b>2. Very limited:</b><br>Makes occasional slight changes in body or extremity position but unable to completely turn self independently.                                                                                                                                                                                                                   | <b>3. Slightly limited:</b><br>Makes frequent through slight changes in body or e.tremity position independently.                                                                                                                                                                               | <b>4. No limitations:</b><br>Makes major and frequent changes in position without assistance.                                                                                                                                                                                          | 4                       | 4          | 4          | 4          |            |
| "Activity The degree of physical activity"                                                                                                                                   | <b>1. Bedfast :</b><br>Confined to bed                                                                                                                                                                                                                                                                                                   | <b>2. Chairfast :</b><br>Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."                                                                                                                                                                                                         | <b>3. Walks occasionally:</b><br>Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.                                                                                                                        | <b>4. All patients too young to ambulate; OR walks frequently:</b><br>Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.                                                                                                    | 4                       | 4          | 4          | 4          |            |
| Sensory Perception                                                                                                                                                           | <b>1. Completely limited:</b><br>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.                                                                                                                  | <b>2. Very limited:</b><br>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.                                                                                                                               | <b>3. Slightly limited:</b><br>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.                                                           | <b>4. No impairment:</b><br>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                                                                                                                         | <b>1. Constantly moist:</b><br>Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.                                                                                                                                                                   | <b>2. Very moist:</b><br>Skin is often, but not always, moist. Linen must be changed at least every 8 hours.                                                                                                                                                                                                                                                 | <b>3. Occasionally moist:</b><br>Skin is occasionally moist, requiring linen change every 12 hours.                                                                                                                                                                                             | <b>4. Rarely moist:</b><br>Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.                                                                                                                                                                   | 4                       | 4          | 4          | 4          |            |
| <b>FRICTION-SHEAR</b><br><b>Friction</b> Occurs when Skin moves against support surfaces<br><b>Shear</b> Occurs when skin and adjacent bony surface slide across one another | <b>1. Significant problem:</b><br>Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.                                                                                                                                                                                                        | <b>2. Problem:</b><br>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.                                                                                                                    | <b>3. Potential problem:</b><br>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.            | <b>4. No apparent problem:</b><br>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                                                                                                                                        | <b>1. Very Poor:</b><br>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. | <b>2. Inadequate:</b><br>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. | <b>3. Adequate:</b><br>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. | <b>4. Excellent:</b><br>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                                                                                                                                               | <b>1. Extremely compromised:</b><br>Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.                                                                                                                                                                                   | <b>2. Compromised:</b><br>Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.                                                                                                                                                                                                | <b>3. Adequate:</b><br>Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.                                                                                                                                        | <b>4. Excellent:</b><br>Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.                                                                                                                                                                               | 4                       | 4          | 4          | 4          |            |
| <b>Severe Risk : less than 9   High Risk : 10-12   Moderate Risk : 13-14   Mild Risk : 15-18   Not at Risk: 19-23</b>                                                        |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        |                         |            |            |            |            |
|                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | <b>TOTAL SCORE</b>      |            |            |            |            |
|                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | <b>Evaluator's Name</b> |            |            |            |            |

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                                                                                                                                                                                                                                                                                                                                       | <b>Support Surfaces</b><br>(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       | <ul style="list-style-type: none"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul> | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |
| 13-14       | Moderate Risk | <ul style="list-style-type: none"> <li>• Use the Same Protocol as for “<b>At Risk</b>” Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>                                                                                                                                                        | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |
| 10-12       | High Risk     | <ul style="list-style-type: none"> <li>• Follow the same protocol as for “<b>Moderate Risk</b>” Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>                                                                                                             | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |
| Less than 9 | Severe Risk   | <ul style="list-style-type: none"> <li>• Use same protocol as for “<b>High Risk</b>” Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>                                                                                                                     | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |



VIH-00186794 IP5-00176660  
 Mrs ANITHA LAKAVATH  
 15-07-1992 34 Y O M 6 D (F)  
 Dr. NIRAJ K YANAMANDRA



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|                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Date : | 21-7   | 21-7 |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|--------|------|--|--|
|                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Time : | apm    | apm  |  |  |
| Mobility                                                                                                                                      | <b>1. Completely immobile:</b><br>Does not make even slight changes in body or extremity position without assistance.                                                                                                                                                                                                                    | <b>2. Very limited:</b><br>Makes occasional slight changes in body or extremity position but unable to completely turn self independently.                                                                                                                                                                                                                   | <b>3. Slightly limited:</b><br>Makes frequent through slight changes in body or e:treimity position independently.                                                                                                                                                                              | <b>4. No limitations:</b><br>Makes major and frequent changes in position without assistance.                                                                                                                                                                                          | 4      | 4      |      |  |  |
| "Activity The degree of physical activity"                                                                                                    | <b>1. Bedfast :</b><br>Confined to bed                                                                                                                                                                                                                                                                                                   | <b>2. Chairfast :</b><br>Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."                                                                                                                                                                                                         | <b>3. Walks occasionally:</b><br>Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.                                                                                                                        | <b>4. All patients too young to ambulate; OR walks frequently:</b><br>Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.                                                                                                    | 4      | 4      |      |  |  |
| Sensory Perception                                                                                                                            | <b>1. Completely limited:</b><br>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.                                                                                                                  | <b>2. Very limited:</b><br>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.                                                                                                                               | <b>3. Slightly limited:</b><br>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.                                                           | <b>4. No impairment:</b><br>Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.                                                                                                                                    | 4      | 4      |      |  |  |
| Moisture Degree to which skin is exposed to moisture                                                                                          | <b>1. Constantly moist:</b><br>Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.                                                                                                                                                                   | <b>2. Very moist:</b><br>Skin is often, but not always, moist. Linen must be changed at least every 8 hours.                                                                                                                                                                                                                                                 | <b>3. Occasionally moist:</b><br>Skin is occasionally moist, requiring linen change every 12 hours.                                                                                                                                                                                             | <b>4. Rarely moist:</b><br>Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.                                                                                                                                                                   | 4      | 4      |      |  |  |
| <b>FRICTION-SHEAR</b><br>Friction Occurs when skin moves against surfaces<br>Shear occurs when adjacent bony surface slide across one another | <b>1. Significant problem:</b><br>Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.                                                                                                                                                                                                        | <b>2. Problem:</b><br>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.                                                                                                                    | <b>3. Potential problem:</b><br>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.            | <b>4. No apparent problem:</b><br>Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."                         | 4      | 4      |      |  |  |
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| Tissue Perfusion & Oxygenation                                                                                                                | <b>1. Extremely compromised:</b><br>Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.                                                                                                                                                                                   | <b>2. Compromised:</b><br>Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.                                                                                                                                                                                                | <b>3. Adequate:</b><br>Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.                                                                                                                                        | <b>4. Excellent:</b><br>Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.                                                                                                                                                                               | 4      | 4      |      |  |  |
| <b>TOTAL SCORE</b>                                                                                                                            |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | 21     | 28     |      |  |  |
| <b>Evaluator's Name</b>                                                                                                                       |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Shr    | shoban |      |  |  |

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                                                                                                                                                                                                                                                                                                                                       | <b>Support Surfaces</b><br>(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       | <ul style="list-style-type: none"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul> | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |
| 13-14       | Moderate Risk | <ul style="list-style-type: none"> <li>• Use the Same Protocol as for “<b>At Risk</b>” Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>                                                                                                                                                        | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |
| 10-12       | High Risk     | <ul style="list-style-type: none"> <li>• Follow the same protocol as for “<b>Moderate Risk</b>” Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>                                                                                                             | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |
| Less than 9 | Severe Risk   | <ul style="list-style-type: none"> <li>• Use same protocol as for “<b>High Risk</b>” Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>                                                                                                                     | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |



VIH-00186794 IP5-00176660  
Mrs ANITHA LAKAVATH  
15-07-1992 34 Y 0 M 5 D (F)  
Dr. NIRAJ K YANAMANDRA



## DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: .....

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☒ Transfer

Hospital Facility Notified (Person Contacted)

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

☐ Needs Assistance In:

Remarks

☐ Medication ☐ Yes ☒ No

☐ Bathing ☐ Yes ☒ No

☐ Eating ☐ Yes ☒ No

☐ Walking ☐ Yes ☒ No

☐ Dressing ☐ Yes ☒ No

☐ Toileting ☐ Yes ☒ No

No Need Assistance

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☒ Patient

☐ Family Member

☐ Others: .....

5. Discharge Planning Discussed with the:

☒ Patient

☐ Family Member

☐ Others: .....

6. Patient/Family Educational Plan:

☐ Educational Topic/s: Hand Hygiene

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

☒ Patient

☐ Family Member

☐ Others: .....

Nurse Signature: Shobha

Nurse Name: Shobha

Date and Time: 20/7/26



## NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Niraj Department: AC Date of Admission: 20/7/26

|                                          |                                                                                           |                    |                                                                                                                                                |                                                                     |                                                                     |                                                                     |                                                                     |                                                                     |
|------------------------------------------|-------------------------------------------------------------------------------------------|--------------------|------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|
| SITUATION                                | Diagnosis:<br><u>Gp1c1 / 33wks / RDA twins / -gm on</u><br><u>Insulin for observation</u> |                    | Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known<br>If Yes Specify: ..... |                                                                     |                                                                     |                                                                     |                                                                     |                                                                     |
|                                          | Area                                                                                      | Shift Time         | OBS<br><u>2pm-4pm</u>                                                                                                                          | OBS<br><u>4pm-6pm</u>                                               | OBS<br><u>6pm-8pm</u>                                               | OBS<br><u>8pm-10pm</u>                                              | OBS<br><u>10pm-12am</u>                                             | OBS<br><u>12am-2am</u>                                              |
| BACKGROUND                               | Medical Condition<br>(Any special condition to be noted):                                 |                    | <u>NA</u>                                                                                                                                      | <u>GDM on insulin</u>                                               | <u>GDM on insulin</u>                                               | <u>NA</u>                                                           | <u>GIRAS (self)</u>                                                 | <u>GIRAS self</u>                                                   |
| ASSESSMENT                               | Allergy:                                                                                  |                    | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                            | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|                                          | Tubes/Drains/Catheter:                                                                    |                    | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                            | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|                                          | Vital Signs:                                                                              |                    | Temp:                                                                                                                                          | 96.1°F                                                              | 98.6°F                                                              | 98.6°F                                                              | 98.6°F                                                              | 98.6°F                                                              |
|                                          | Res:                                                                                      |                    | 20                                                                                                                                             | 20b/m                                                               | 20                                                                  | 20                                                                  | 18b/m                                                               | 20                                                                  |
|                                          | SpO <sub>2</sub> :                                                                        |                    | 100                                                                                                                                            | 100%                                                                | 100%                                                                | 100%                                                                | 100 /                                                               | 100%                                                                |
|                                          | Pulse:                                                                                    |                    | 90b/m                                                                                                                                          | 91b/m                                                               | 92b/m                                                               | 90b/m                                                               | 91b/m                                                               | 91                                                                  |
|                                          | BP:                                                                                       |                    | 103/70                                                                                                                                         | 117/70                                                              | 107/66                                                              | 118/78                                                              | 117/70                                                              | 112/72                                                              |
|                                          | Fall Risk Score:                                                                          |                    | 0                                                                                                                                              | 20                                                                  | 20                                                                  | 20                                                                  | 20b/m                                                               | 20                                                                  |
| Recommendations                          | Pain Score:                                                                               |                    | 0                                                                                                                                              | 0                                                                   | 0                                                                   | 0                                                                   | 0                                                                   | 0                                                                   |
|                                          | Safety Needs:                                                                             |                    | <u>side rails</u>                                                                                                                              | <u>yes</u>                                                          | <u>yes</u>                                                          | <u>side rails</u>                                                   | <u>yes</u>                                                          | <u>yes</u>                                                          |
|                                          | Physiotherapy                                                                             |                    | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                            | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|                                          | Others Specify:                                                                           |                    | <u>NA</u>                                                                                                                                      | <u>NA</u>                                                           | <u>NA</u>                                                           | <u>NA</u>                                                           | <u>NA</u>                                                           | <u>NA</u>                                                           |
|                                          | Special Diet:                                                                             |                    | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                            | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| Other Special Orders / Medications:      |                                                                                           | <u>NA</u>          | <u>NA</u>                                                                                                                                      | <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>                                                           | <u>NA</u>                                                           | <u>NA</u>                                                           |                                                                     |
| Handed Over By Name :                    |                                                                                           | <u>Shobha</u>      | <u>Sandhya</u>                                                                                                                                 | <u>Shobha</u>                                                       | <u>Tudly</u>                                                        | <u>Sandhya</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>20/7/26</u>     | <u>21/7/26</u>                                                                                                                                 | <u>21/7/26</u>                                                      | <u>21/7/26</u>                                                      | <u>21/7/26</u>                                                      | <u>21/7/26</u>                                                      |                                                                     |
| Time:                                    |                                                                                           | <u>2pm</u>         | <u>4pm</u>                                                                                                                                     | <u>2pm</u>                                                          | <u>8pm</u>                                                          | <u>8pm</u>                                                          | <u>2pm</u>                                                          |                                                                     |
| Taken Over By Name :                     |                                                                                           | <u>Sandhya</u>     | <u>Shobha</u>                                                                                                                                  | <u>Tudly</u>                                                        | <u>Sandhya</u>                                                      | <u>Shobha</u>                                                       |                                                                     |                                                                     |
| Signature :                              |                                                                                           | <u>[Signature]</u> | <u>[Signature]</u>                                                                                                                             | <u>[Signature]</u>                                                  | <u>[Signature]</u>                                                  | <u>[Signature]</u>                                                  |                                                                     |                                                                     |
| Date:                                    |                                                                                           | <u>20/7/26</u>     | <u>21/7/26</u>                                                                                                                                 | <u>21/7/26</u>                                                      | <u>21/7/26</u>                                                      | <u>21/7/26</u>                                                      |                                                                     |                                                                     |
| Time:                                    |                                                                                           | <u>8pm</u>         | <u>8pm</u>                                                                                                                                     | <u>2pm</u>                                                          | <u>8pm</u>                                                          | <u>8pm</u>                                                          |                                                                     |                                                                     |



## NURSING SHIFT HAND OVER FORM - WARD

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

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