

FDH-00034607 IP5-00175843
Mrs BHOMIKA GAJPAL
28-07-1996 29 Y 11 M 4 D (F)
Dr. HIMABINDU VEERLA



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

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SURGERY DETAILS

Date : 2/7/2026

Patient Name: Bhomika Date of Birth: 28/7/1996 Age: 29yrs

Gender: F Ward :

UHID No.: FDH-00034607

Date of Surgery: 2/7/2026 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☒ OBG OT-2

Name of the Surgery : Emergency DSCS - ↓ Spinal

Time in : 8.30 AM

Time Out : 9.30 AM

	NAME	AMOUNT
1. Surgeon	Dr. V. Himabindu	
2. Anaesthetist	Dr. Amreen	
3. Assistant Surgeon	Dr. Arshiya	
4. OT Technician	Sis. Kulsum	
5. Circulating Nurse	Sis. Gayathri	
6. Assistant Nurse	Sis. Lakshmi	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9684135

Order by: [Signature]

CONSUMABLES OF OTDate: 2/7 3686Circulating staff : Technician : Kulsum Time :

Anaesthesia Disposables		Qty	Surgical Disposables		Qty	Disposables (Baby Side)		Qty
Issued	Used		Issued	Used		Issued	Used	
ET tube			Major Pack	<u>1x1 Drip</u>	<u>1</u>	Inj Vit.K		<u>2</u>
LMA			Sutures	<u>2346</u>	<u>02</u>	Cord Clamp		<u>1</u>
ECG leads : <u>A</u> P / N	<u>05</u>			<u>2364</u>	<u>01</u>	Suction Catheter		
HME filter : A / P / N				<u>2262</u>	<u>01</u>	Feeding Tube	<u>2x10</u>	<u>1</u>
Syringes : 10 cc	<u>02</u>					Vaccum Suction Set		<u>1</u>
05 cc	<u>03</u>		Gloves	<u>6 1/2, 7/8</u>	<u>3/2</u>	Surgical Gloves	<u>6/7</u>	<u>2/2</u>
02 cc	<u>03</u>			<u>P.F 7</u>	<u>1</u>	Gauze Pack		<u>1</u>
01 cc	<u>03</u>					Syringe 1ml / 2ml		<u>2</u>
Cautery plate <u>A</u> / P / N	<u>01</u>		Surgical blade	<u>22</u>	<u>1</u>	Surgical Blade # 20		<u>1</u>
IV set	<u>00</u>		NG tube			Koochies (S)	<u>1'S</u>	<u>1</u>
RL	<u>02</u>		Cautery pencil		<u>1</u>	Underpad		<u>1</u>
NS : 10ml / 100ml / 500ml / 1000ml	<u>01</u>		Koochies	<u>XL</u>	<u>1</u>			
<u>Lox 2/1</u>	<u>00</u>		Ointments					
<u>Ephedrine</u>	<u>01</u>		Suction Catheter					
Fentanyl	<u>01</u>		Cap, Mask		<u>10/10/10</u>			
Morphine			Gauze Pack		<u>3</u>			
Ketamine			Mop Pack		<u>2</u>			
Propofol			Steristrip	<u>20w</u>	<u>1</u>			
Rocuronium			Underpad		<u>1</u>			
Glycopyrolate	<u>02</u>		Draw sheet	<u>Quick cut</u>	<u>1</u>			
Myopyrolate			Abgel					
Ondansetron	<u>01</u>		Foleys catheter					
<u>Pencan 25g</u> Spinal Needle 22	<u>01</u>		Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)	<u>01</u>		Remodrain bag					
Antibiotics <u>P.E</u>	<u>01</u>		Bandage					
<u>Atropine</u>	<u>01</u>		Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg	<u>01</u>		Vaccum Suction set		<u>1</u>			
Justin : 12.5 mg / 25mg / 100mg	<u>01</u>		Plastic Bed Sheet					
Tab. Misoprost : 200mg	<u>02</u>		Betadine Solution		<u>2</u>			
<u>Oxytocin</u>	<u>03</u>		Microshield					
<u>Glove (6)</u>	<u>02</u>		Cotton Balls		<u>1</u>			
<u>Gauze</u>	<u>00</u>		Latex Gloves		<u>20</u>			
<u>Adrenaline</u>	<u>01</u>		Ramdone Scrub					
<u>Tranexa</u>	<u>02</u>		Sara	<u>DIA</u>	<u>1</u>			

9686/15/176

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. : Ordered by :

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

ADMISSION SHEET

Registration Details :

Admission No : IP5-00175843

Admit Date : 01-Jul-2026

Admit Time : 08:50 PM **UHID** : FDH-00034607

Patient Details :
Patient Name : Mrs BHOMIKA GAJPAL

Age : 29 Y 11 M 3 D

Guardian : Mr KSHITIJ CHOUDHARY

DOB : 28-07-1996

Gender : Female

Religion :

Occupation :

Martial Status : Married

Address (H) : FLAT NO-1803 TOWER 7NCC URBAN ONE,
Narsingi Hyderabad Telangana INDIA 500075

Phone No : 9717131905/ 9399743741

E-mail : NO@GMAIL.COM

Admission Details :
Bed Type : SHARED WARD

Bed No : SW 416

Ward Name : 4F-BIRTHING CENTRE

Room No : SW 416

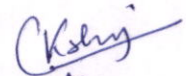
Admission Type : First Visit

Contact Details :
Name : Mr KSHITIJ CHOUDHARY

Relationship : Husband

Contact Address : FLAT NO-1803 TOWER 7NCC URBAN ONE,
Narsingi Hyderabad Telangana INDIA 500075

Phone No : 9717131905 / 9399743741


Signature

Doctor Details :
Doctor Name : Dr. HIMABINDU VEERLA

Specialisation : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :
Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : MEDI ASSIST INSURANCE TPA PVT
LTD

FDH-00034607 IP5-00175843
 Mrs BHOO MIKA GAJPAL
 26-07-1996 29 Y 11 M 4 D (F)
 Dr. HIMABINDU VEERLA



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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
2/7	5:00 PM	OBG	2nd Floor (300)	Shobly

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Tabeena Shamma (PT)	3/7/26		
2				
3				
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

[illegible]

2000

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
1/7/26	1v placement	1	9684237	Radha
2/7/26	PAC	1	9684028	←
2/7/26	catheterization	1	9684029	Smrithi

ANY OTHER INFORMATION

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Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

for 70L.

Obstetric Formula:

Prim

Obstetric History:

1- Sp conception booked at 7th week, H. Hypothyroid

Present Pregnancy Record:

LMP:

11/10/25.

EDD:

Corrected EDD:

9/7/26

GA:

38th

Menstrual History: Regular : ☐ Yes ☐ No

Obstetric Examination

Fundal Height:

38cm

Ut. Activity:

☒ Relaxed

☐ Mild

☐ Mod

☐ Severe

Liquor:

☒ Adequate

☐ Oligo

☐ Poly

PP:

☒ Cephalic

☐ Breech

Others

Head Fifts Palpable:

RISK FACTORS:

G. Hypothyroid.

FHS:

☒ Normal

☐ Tachy

☐ Brady

☐ Absent

Per Speculum Examination

Draining:

☐ Present

☐ Absent

☐ Bleeding

Colour of Liquor:

☐ Clear

☐ Meconium

☐ Blood Stained

Vaginal Examination

Cervix:

☒ Long

☐ Partially effaced

☐ Effaced

Os: Closed

closed.

Dilated

Membranes:

☐ Present

☐ Absent

Liquor:

☐ Clear

☐ Meconium

☐ Blood Stained

Presenting Part:

☐ Vertex

☐ Breech

☐ Others

Sutton:

☐ -3

☐ -2

☐ -1

☐ 0

☐ +1

☐ +2

Pelvis:

☐ Adequate

☐ Doubtful

Height: cm

Weight: kg

Allergies: Nil

Breast: ☐ Normal ☐ Abnormal

General Examination:

Consciousness: Conscious

Pallor: above

Icterus: absent

Edema: none

Temp: afebrile

PR: 86/min

BP: 120/70mmHg

DTR: 2+

CVS: S1 S2

RS: BAC

Liver/Spleen: Not palpable

Urine Output: adequate

DIAGNOSIS

Primigravida. 38th wks G. Hypothyroid for 70L.



Family History: Mother - HTN	Surgical History: Nil.
Medical History: G. Hypothyroid	Medication History: T. Iron T. Selenal T. Thyronorm 125mcg
Plan of Care: Admission. Not on admission Prep of parts check blood availability, send CBP. Urab Monitory. Not 3rd h FHR 4th w/f POL T. PG 2 25mcg (P) 4th NBSM From 4th.	Investigations: 0 +ve. Urab - NR. 1/7/26 CBP. HB. 6/8/20: 35⁺2 / wt 3kg - 88% / AFI - 19.7 / pl. ant / Doppler.

Doctor Name: Dr. Anshu

Signature: [Signature]

Date & Time: 1/8/26, 8:30pm

Consultant Name: Dr. Himabindu Veerla

Signature: [Signature]

Date & Time: 1/8/26, 8:30pm

Date & Time	Progress Notes	Doctor's Order
2/7/20 6 AM	clo mild par Gata, afboule PR - 80/min BP - 112/80 mmHg SpO₂ - 97% @ R_h Pl_a - at Juxta-arterial	ad - NBM - PAC - (12) Plumb: 1500 μg - Not 3rd - w/ppt - 3rd for phg - 20mg
	Pl_a - G-long 1 Fung Memb (e)	Dr. H. H. H.
2/7/20 7:30 AM	clo by Dr. H. H. H. Gata, afboule PR - 80/min BP - 120/80 mmHg SpO₂ - 98% @ R_h	ad - Emles Yata - Non-saline NS - PAC - Pre op Meds - shift of meal
ONMR.	Pl_a - at Juxta-arterial First For Emergency XSCS	Dr. H. H. H.

Date & Time	Progress Notes	Doctor's Order
27/26 2:30 PM	S/O. Mr. Himabindu. Pt - Comfortable PA - at term, cephalic, oblique lie FH S + PV - 1/2 long OS - few BOM + PP - High up Pelvis - Gynaecoid.	- NSE - pathological - F&E Emergent JSS - PAC
28		Dr. Himabindu DR. HIMABINDU VEERLA Registration No: 37245

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Bloomin

Patient Stick



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/2/24 4:30 pm	POD-D	R
	Gc: /giv	1) NBM pr 4-Gluc
	B.p - 115/73	2) Flw /wch - 100ml/hr
	P-R - 76	3) Flo Charting
	SpO ₂ - 100% on RA	4) Monitor vitals - 1/2 hr x 2 hr
	PlA: ut (R) well	5) Dwg as charted
	Soft	6) w/f Plv Bleeding
	Plv: NAB	7) Ambulation 1x per
		8) Tufu s/s
		← Dr Sravathi
2/2/24 4:30 pm	POD-D / Euclos. / P/L 1 G-hypotensd.	R
	Gc: /giv	1) Allow oral sim. - now
	B.p - 113/72 (87)	2) Liquid diet - 5:30 pm
	P-R: 93	3) Soft diet - 6:30 pm
	SpO ₂ : 100% on RA	4) Flw /wch - 100ml/hr
	PlA: ut (R) well	5) Flo Charting
	Soft, Bx (+)	6) Monitor vitals
	Plv: NAB	7) Dwg as charted
		8) w/f Plv Bleeding
		9) Ambulation
		10) Tufu s/s
	Shift to Room	

FDH-00034807
 Mrs BHOMIKA GAJPAL
 28-07-1996
 Dr. HIMABINDU VEERLA
 IPS-00175843
 28 Y 11 M 4 D
 (F)



GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/8/16 9:40pm	A comfortable O/E AC fair Vital - stable P/A uterus retracted well U/G - Lochia healthy 2/8/16 no adequate Baby m/s	Adv Soft diet, plenty of milk feeds - keep on perchailed Vital closely - I/O charting - w/f ache Bleeding m - m/p m/s
- Remove Foley's @ 6am on 3/8		<i>[Signature]</i> Dr. Sameer
3/8/16 POD 1 / 14G	noted by Sucha 3/8/16 @ 8am O/E AC fair Vital - stable P/A - uterus retracted well Soft distension ⊕ U/G - Lochia healthy	Adv - keep on perchailed - vital closely - Ambulate - w/f ache Bleeding m - m/p m/s - Soft diet
U		
L		
M		
Baby well		<i>[Signature]</i> Dr. Sameer

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 Dr. HIMABINDU VEERLA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7/26 10:40 AM	8/13. Dr. Himabindu Pt - Comfortable Ambulating Passed urine & motion flatus	(1) Soft diet & plenty of oral fluids (2) Remove Perineal
	PA - Soft - BS + + wound involuting PV - looks healthy	(Dr. Himabindu Veerla) Registration No: 37245
3/7/26 12:00 PM	POD - 1/154	
V ✓ W ✓ SV ✓	pt comfortable vital - stable PLA - ut @ low LF - BwNL Lochia healthy	Adv (1) Soft diet (2) Ambulation (3) Hydration (4) Wtft cervical bleeding (5) monitor vitals (6) Drugs as needed (7) Inform SW
	Dr. Dugg	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/8/26 8 pm	POD-1 / Lax / Emen / G. hypotensive	
5-week U✓ F✓ S(x)	GC: fair vitals: stable P/A: U(+) w/ soft distention (+) BS (+) Plw: NAB	1) Ambulation 2) soft diet & plenty of oral fluid 3) Drug as charted 4) w/f plw bleeding 5) Fucose ss
		— Dr. Sravatu
4/8/26 9 AM	POD-2 / Lax / Emen / G. hypotensive	
B-week U✓ F✓ S✓ S/E-De	GC: fair vitals: stable P/A: U(+) w/ soft BS (+) Plw: NAB plan- discharge	1) soft diet & plenty of oral fluid 2) Drug as charted 3) w/f plw bleeding 4) Ambulation 5) Fucose ss — Dr. Sravatu

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/7/26 10:45 AM	S/O. no Hxma Bowel Pt Comfortable Ambulatory PA - arms involatile	① NPO diet — ② 2

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

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RESULT SHEET

Date	17/2026				
Time	09:00 AM				
Hb	10.9				
PCV	32.8				
RBC	3.69				
WBC	10.76				
N/L					
Platelets	190				
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Blood Group ^{+ve} O						
Viscous NR						

Culture and Sensitivities :

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Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.) :



MEDICATION RECONCILIATION FORM

Drug Allergies:

☒ Not known any Drug Allergies

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

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

Shifting From:

Shifted to:

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T-iron	1 tab	po	qd		☐ C ☒ DC
2	T-thelecal	1 tab	po	qd		☐ C ☒ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Anshu

Date & Time : 1/7/26, 8pm

Nurse Name & Signature : Radhika

Date & Time : 1/7/26 @ 9pm

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28-07-1996 29 Y 11 M 4 D (F)
Dr. HIMABINDU VEERLA




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Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG :				Date Time
Dose	Route	Frequency	Start Dt.	
4mg	PO	O.D	21/7/26	
Name & Signature of the Doctor Starting the Drugs: <i>Dr. Himabindu Veerla</i>				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG :				Date Time
Dose	Route	Frequency	Start Dt.	
4mg	PO	BD	21/7	
Name & Signature of the Doctor Starting the Drugs: <i>Dr. Himabindu Veerla</i>				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG :				Date Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG :				Date Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG :				Date Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

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

Signature

VERIFIED BY : Name



DRUG CHART

Date of Admission: 17/12 Drug Allergies: ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name



REGULAR PRESCRIPTIONS

Weight. 71-4 Ward. BC

DRUG: <u>Ty Cefotaxime</u>				Date Time	<u>2/7</u>
Dose <u>1gm</u>	Route <u>IV</u>	Frequency <u>RD</u>	Start Date <u>2/7/26</u>	<u>10am</u>	<u>12pm</u>
Name & Signature of the Doctor Starting the Drugs: <u>Dr Anshu K</u>				<u>STOP Dr Anshu</u>	
Additional Instructions:				<u>10am</u>	
Daily Doctor's Endorsement by a Sign					
DRUG: <u>T-PARACETAMOL</u>				Date Time	<u>2/7</u> <u>3/7</u> <u>4/7</u>
Dose <u>1gm</u>	Route <u>ORAL</u>	Frequency <u>QID</u>	Start Date <u>2/7/26</u>	<u>12pm</u>	<u>1pm</u>
Name & Signature of the Doctor Starting the Drugs: <u>Dr Anshu K</u>				<u>12pm</u>	
Additional Instructions:				<u>1pm</u>	
Daily Doctor's Endorsement by a Sign					
DRUG: <u>T. TRAMADOL</u>				Date Time	<u>2/7</u> <u>4/7</u>
Dose <u>100mg</u>	Route <u>ORAL</u>	Frequency <u>TID</u>	Start Date <u>2/7</u>	<u>1am</u>	<u>1pm</u>
Name & Signature of the Doctor Starting the Drugs: <u>Dr Anshu K</u>				<u>1pm</u>	
Additional Instructions:				<u>2pm</u>	
Daily Doctor's Endorsement by a Sign					
DRUG: <u>T-DICLOFENAC</u>				Date Time	<u>2/7</u> <u>3/7</u>
Dose <u>50mg</u>	Route <u>ORAL</u>	Frequency <u>TID</u>	Start Date <u>2/7</u>	<u>4am</u>	<u>1pm</u>
Name & Signature of the Doctor Starting the Drugs: <u>Dr Anshu K</u>				<u>1pm</u>	
Additional Instructions:				<u>1pm</u>	
Daily Doctor's Endorsement by a Sign					

VERIFIED

VERIFIED

VERIFIED



Weight. 74.4g Ward. DC

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
1/7/26	9:30 PM	T. PGE ₂	25mg	PO	[Signature]	Radhika Yamuna
2/7/26	1:30 PM	T. PGE ₂	25mg	PO	[Signature]	Radhika Yamuna
2/7/26	5:30 AM	T. PGE ₂	25mg	PO	[Signature]	Radhika Yamuna
2/7/26	8 AM	Inj PANTOP	40mg	IV	[Signature]	Radhika Yamuna
2/7/26	8:05 AM	Inj PERINORM	10mg	IV	[Signature]	Radhika Yamuna
2/7/26	8:50 AM	Inj. METHERGIN	0.2mg	IV	[Signature]	Radhika Yamuna
2/7/26	9:15 AM	Sup. TRAMADOL	100mg	P/R	[Signature]	Radhika Yamuna
2/7/26	9:15 AM	Sup. DICLOFENAC	100mg	P/R	[Signature]	Radhika Yamuna

Signature
VERIFIED BY : Name



I.V. FLUIDS CHART

Weight: 72 kg Ward: B3

Date	Time	Composition of I.V. Fluid (If infusion, mention ml/hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
28/7/26	5pm	RINGER LACTATE	IV	100			21/7/26		
28/7/26		RINGER LACTATE	IV	100			21/7/26		
28/7/26	8:55am	RINGER LACTATE	IV	1000ml N			21/7/26		
28/7/26	9am	RINGER LACTATE	IV	500ml N			21/7/26		
28/7/26	11am	RINGER LACTATE	IV	800ml			21/7/26		
28/7/26	1pm	RINGER LACTATE	IV	1000ml			21/7/26		
28/7/26	3pm	RINGER LACTATE	IV	1000ml			21/7/26		

Signature

VERIFIED BY: Name

Mrs BHOOMIKA GAJPAL
28-07-1996 29 Y 11 M 4 D (F)
Dr. HIMABINDU VEERLA



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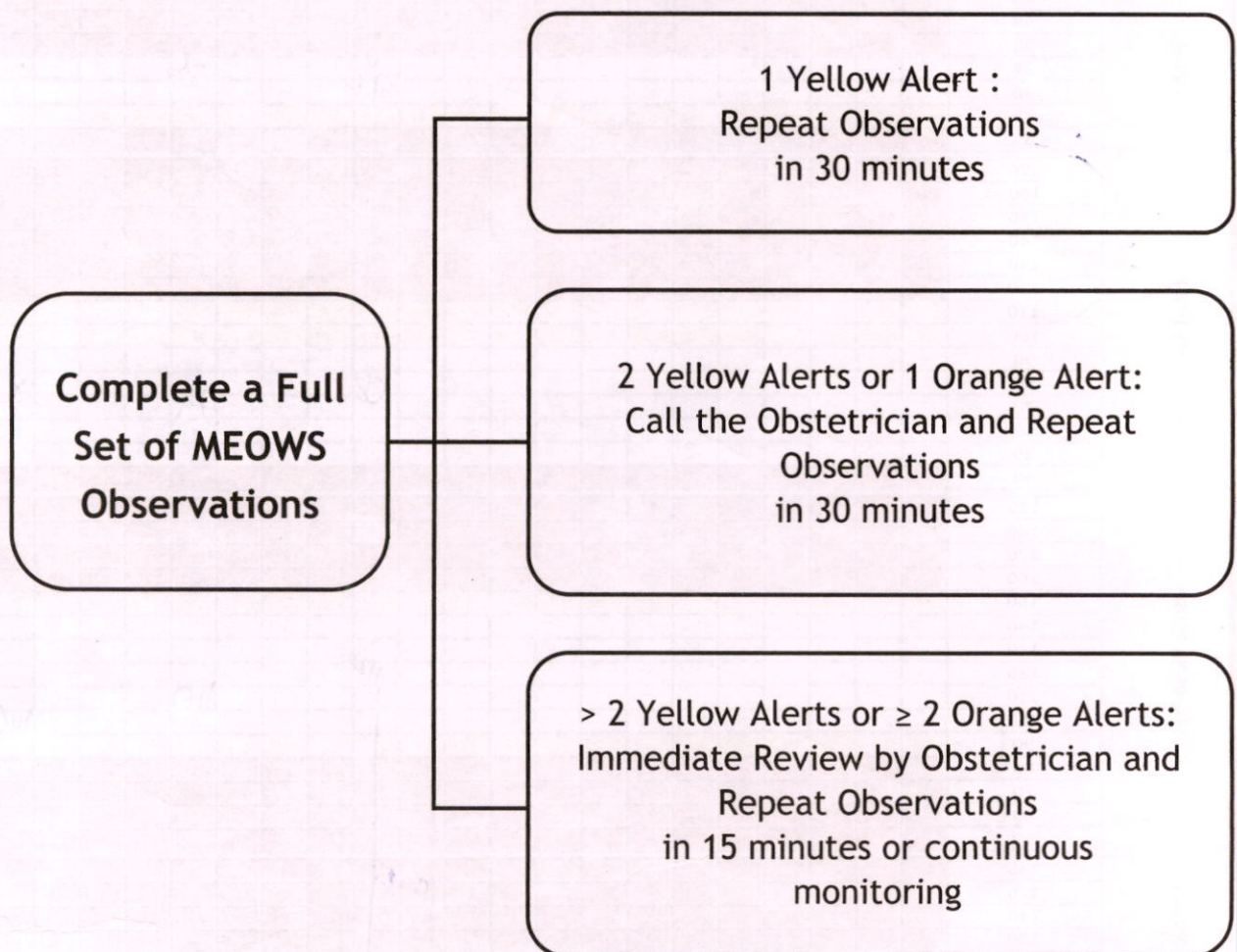


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CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

[illegible]

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

2/2/98



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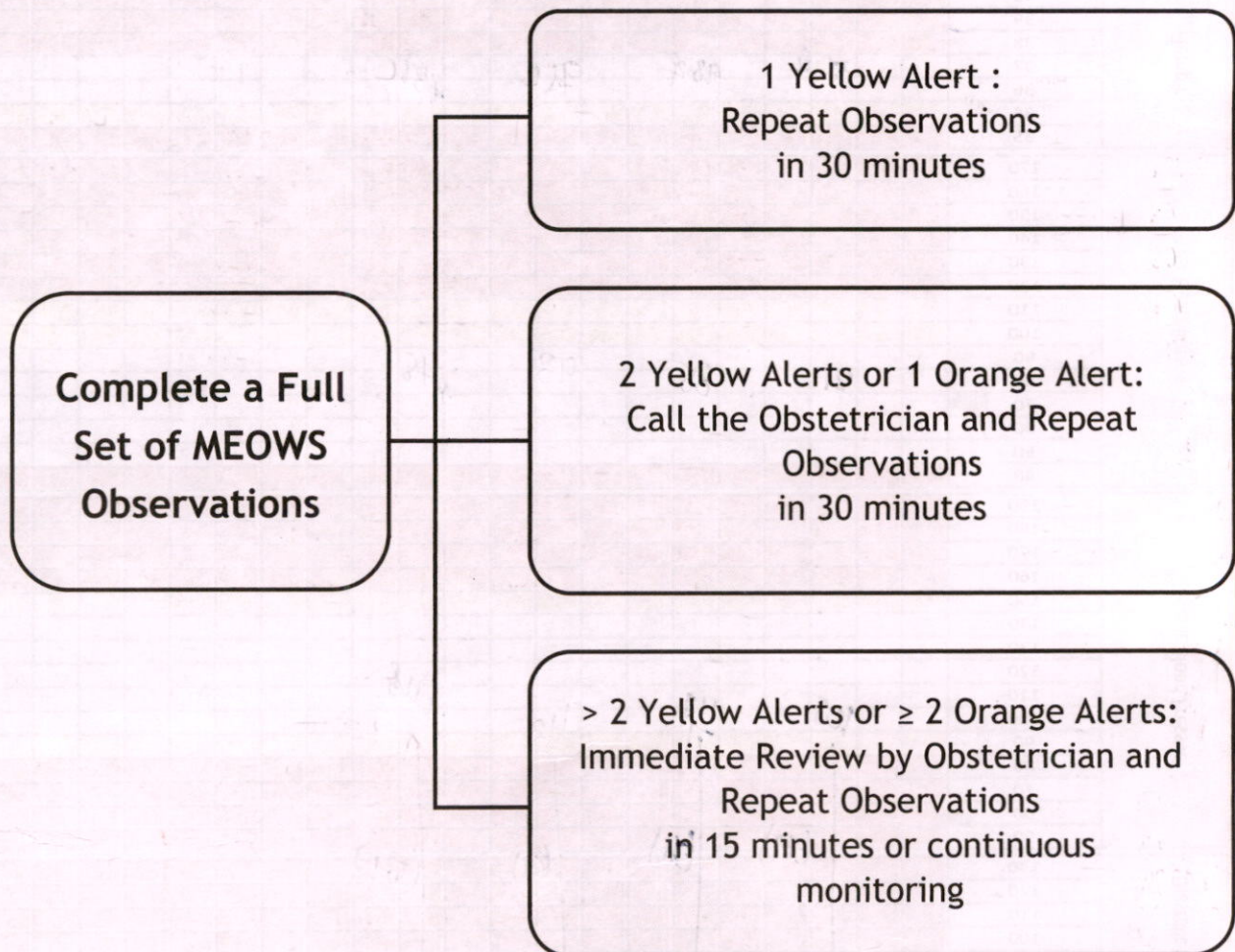
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CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

		Date																												
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7				
RESP (write rate in corresp. box)	> 30																													
	21 - 30																													
	11 - 20																													
	0 - 10																													
	94 - 100 %																													
Saturations	< 94 %																													
Administered O ₂ (L/min.)																														
Temp °C	40																													
	39																													
	38																													
	37																													
	36																													
	35																													
	< 35																													
Heart Rate	170																													
	160																													
	150																													
	140																													
	130																													
	120																													
	110																													
	100																													
	90																													
	80																													
	70																													
	60																													
	50																													
40																														
Systolic Blood Pressure	190																													
	180																													
	170																													
	160						</																							

30/12/15

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

FDH-00034607 IP5-00175843

Mrs BHOMIKA GAJPAL

28-07-1996

29 Y 11 M 5 D (F)

Dr. HIMABINDU VEERLA



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3/7/26

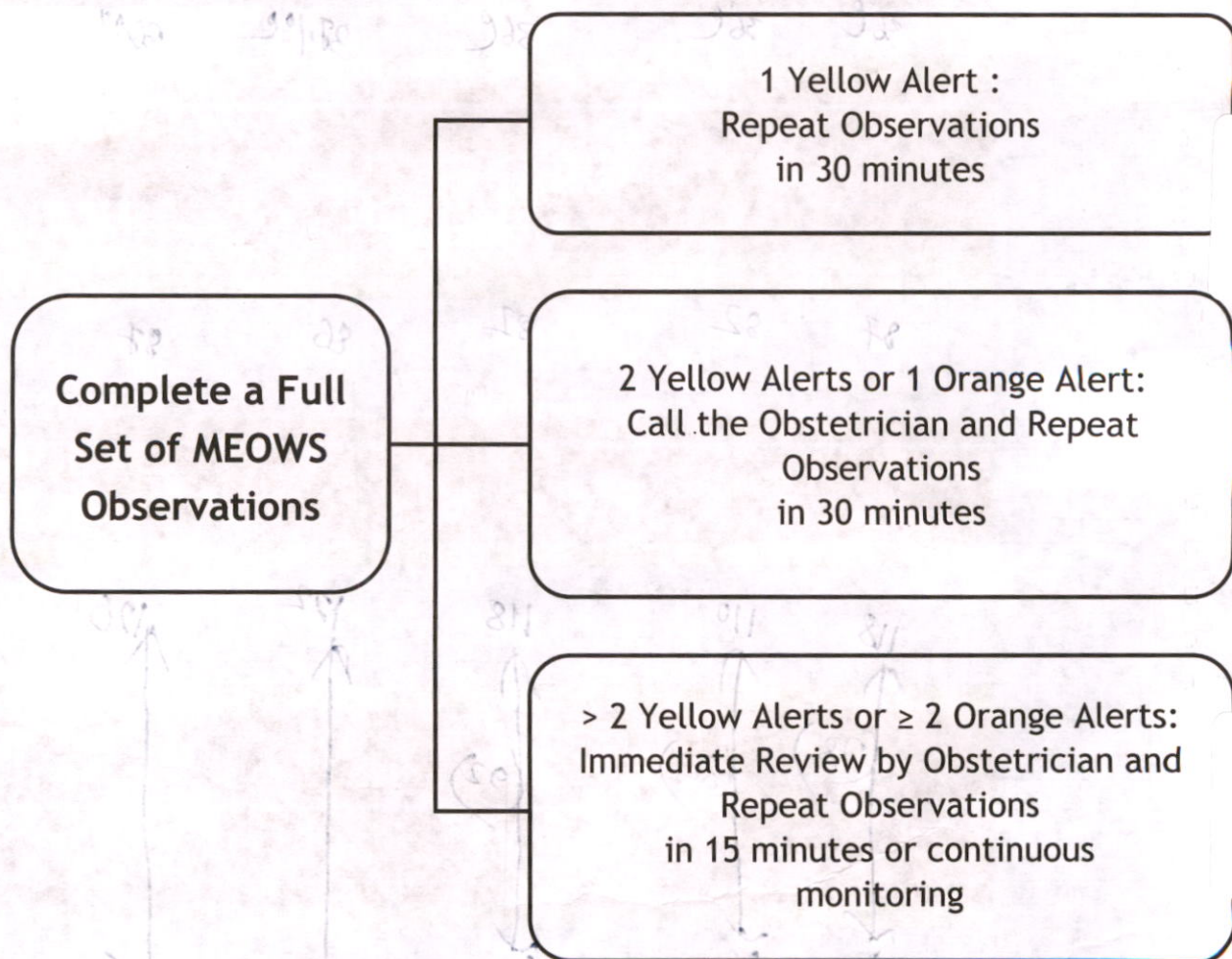
Early Warning Observation Score Chart - Obstetrics

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

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

Refused
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Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

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Mrs BHOO MIKA GAJPAL

28-07-1996

29 Y 11 M 4 D

(F)

Dr. HIMABINDU VEERLA



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FLUID CHART

Sheet No. :

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

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



FLUID CHART

Sheet No. : (2)

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

		Intake			Output						IV Site	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	
			Mouth	I.V	N.G							
27/20	08:00 am	RL	NBM	150ml							0	Swetha
	09:00 am	RL	"	100ml						400ml	0	Swetha
	10:00 am	RL		100ml			NO				0	Swetha
	11:00 am	RL		150ml			P				0	Swetha
	12:00 pm	RL		150ml							0	Swetha
	01:00 pm	RL		150ml							0	Swetha
Total Intake : Taken					Total Output : 410 - 400ml							
	02:00 pm	RL		150ml							0	Shobha
	03:00 pm	RL		150						300ml	0	Shobha
	04:00 pm	RL		150ml							0	Shobha
	05:00 pm	RL		150ml						300ml	0	Shobha
	06:00 pm		H2O								0	Shobha
	07:00 pm		H2O								0	Shobha
Total Intake : Taken					Total Output : 350ml							
	08:00 pm										0	Shobha
	09:00 pm	RL	H2O								0	Shobha
	10:00 pm	RL	H2O								0	Shobha
	11:00 pm	RL	H2O								0	Shobha
	12:00 am										0	Shobha
	01:00 am		H2O								0	Shobha
Total Intake :					Total Output : 4 - 2 m - 0							
	02:00 am										0	Shobha
	03:00 am		H2O								0	Shobha
	04:00 am	RL	H2O								0	Shobha
	05:00 am	RL	H2O								0	Shobha
	06:00 am										0	Shobha
	07:00 am		H2O								0	Shobha
Total Intake :					Total Output : 4 - 2 m - 0							
Total 24 hrs. Intake		Total 400ml										
Total 24 hrs. Output		4 - 2 m - 0										

FDH-00034607
Mrs BHOMIKA GAJPAL
28-07-1996
Dr. HIMABINDU VEERLA
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IP5-00175843
(F)



FLUID CHART

Sheet No. :

3/7/20

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am						1					0	sum
	09:00 am	H ₂ O					2					0	sum
	10:00 am									✓		0	sum
	11:00 am	H ₂ O					1					0	sum
	12:00 pm									✓		0	sum
	01:00 pm											0	sum
Total Intake :						Total Output : 5 - 2 m = 3							
	02:00 pm											0	sum
	03:00 pm	H ₂ O					2					0	sum
	04:00 pm									✓		0	sum
	05:00 pm											0	sum
	06:00 pm	H ₂ O					1					0	sum
	07:00 pm											0	sum
Total Intake :						Total Output : 4 - 1 m = 3							
	08:00 pm											0	} Rine
	09:00 pm	Water					✓			✓		0	
	10:00 pm											0	
	11:00 pm											0	
	12:00 am	Water								✓		0	} Rine
	01:00 am											0	
Total Intake :						Total Output : 5 = 2 m = 3							
	02:00 am											0	} Rine
	03:00 am	Water								✓		0	
	04:00 am											0	
	05:00 am									✓		0	
	06:00 am	Water										0	} Rine
	07:00 am									✓		0	
Total Intake :						Total Output : 5 = 3 m = 2							
Total 24 hrs. Intake													
Total 24 hrs. Output			5 4 m = 1										



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.

		Intake				Output						IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
28-07-2012	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
28-07-2012	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
28-07-2012	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
28-07-2012	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							

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 Dr. HIMABINDU VEERLA

NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 1/7/26

Assessment: Patient clo fear & Anxiety

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

Time	Plan of Care	Time	Implementation	Evaluation
9pm	Assess the general condition of the patient.	9pm	Assessed the general condition of the patient.	patient is stable
11pm	NST	11pm	NST 3rd baby taken	
2am	Administer the medication	2am	Administered the medication as per doctor order.	
4am	Yo chat.	4am	Maintained Yo chat	
7am	Prevent infection.	7am	Preventing infection by using hand rub.	

Re-Assessment: Patient is comfortable

Special Notes: NST

Nurse Signature: [Signature] Nurse Name: B. Ladhya Date & Time: 2/7/26 @ 8AM

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 2/7/26

Assessment: patient complement is fear and anxiety

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8 AM	Assess the patient General condition	8:15 AM	Assessed the patient General condition.	patient is stable.
10 AM	provide monitor vitals		provided monitor vitals	
12 PM	provide I/O chart	10:10 AM	provided I/O chart.	
1 PM	provide comfortable position	12:15 PM	provided comfortable position	
	provide medication	1:10 PM	provided medication	
2 PM	provide patient safety	2:15 PM	provided patient safety	

Re-Assessment: Re-assessment is done, patient vitals is Good.

Special Notes:

Nurse Signature: *[Signature]*

Nurse Name: Sunita

Date & Time: 2/7/26 @ 2 PM

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 Mrs BHOOMIKA GAJPAL
 28-07-1996 29 Y 11 M 4 D (F)
 Dr. HIMABINDU VEERLA

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 2/7/20

Assessment: pt complain for Abdominal pain

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess pt general condition	2:10 PM	Assessed pt general condition	pt is stable
3pm	monitor vital	3:10 PM	Bp SpO2 pulse checked and recorded	
4pm	Administer medication	4:30 PM	medication as per doctor order	
6pm	Ensure safety	6:30 PM	Ensure safety provided	

Re-Assessment: Re Assessment done

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Shobee Gokaraj

Date & Time: 2/7/20 @ 8pm

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 21/7/26

Assessment: Patient is having discomfort

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the general condition of the patient	8pm	Assessed the general condition of the patient	Patient is stable
10pm	plan for vitals	11pm	checked vitals	
12am	plan for I/O chart	12am	Maintain I/O chart	
2am	Administer medication as per doctor's order	3am	Administered medication as per doctor's order	
4am	Maintain good nutritional status	5am	Maintained good nutritional status	
6am	ensure safety	7am	provide safety	

Re-Assessment: vitals checked & recorded

Special Notes: Foley's removal @ 8am T/M

Nurse Signature: Sheela

Nurse Name: Sheela

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



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 3/4/26 @ 8 PM

Assessment: Patient having pain

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8 AM	→ Assess the general condition of the patient and check vital.	8 AM	→ assessed the general condition of the patient and checked vitals.	patient is stable
10 AM	→ giving medication as advised.	10:00 AM	→ Given medication as advised.	
12 AM	→ maintaining good nutritional status.	12:00 AM	→ maintained good nutritional status.	
4 AM	→ maintaining fluid balance.	4:00 AM	→ maintained fluid balance.	
6 AM	→ checking urine output.	6:00 AM	→ checked urine output.	
8 AM	→ Ensure safety.	8:00 AM	→ Ensured safety.	

Re-Assessment: pain reduced

Special Notes: NA

Nurse Signature: *[Signature]*

Nurse Name: *[Signature]*

Date & Time: 4/7/26 @ 8 AM

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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. HIMABINDU Department: OBS Date of Admission: 1/7/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
	<u>primi 38+6 wkg for DOL</u>							
BACKGROUND	Area	Shift Time	<u>OBS 9pm</u>	<u>OBS 8am-2pm</u>	<u>OBS 2pm-8pm</u>	<u>3rd floor 8pm-9pm</u>	<u>3rd floor 8am-8pm</u>	<u>3rd floor 8am-8pm</u>
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:		Temp: <u>97.8°F</u>	Temp: <u>97.6°F</u>	Temp: <u>97.6°F</u>	Temp: <u>98°F</u>	Temp: <u>98°F</u>	Temp: <u>97.8°F</u>
			Res: <u>18b/m</u>	Res: <u>19b/m</u>	Res: <u>20</u>	Res: <u>19b/m</u>	Res: <u>22b/m</u>	Res: <u>20b/m</u>
			SpO ₂ : <u>100%</u>	SpO ₂ : <u>97%</u>	SpO ₂ : <u>97%</u>	SpO ₂ : <u>99%</u>	SpO ₂ : <u>99%</u>	SpO ₂ : <u>100%</u>
			Pulse: <u>88b/m</u>	Pulse: <u>81</u>	Pulse: <u>81</u>	Pulse: <u>86b/m</u>	Pulse: <u>81b/m</u>	Pulse: <u>80b/m</u>
			BP: <u>112/70</u>	BP: <u>113/73(60)</u>	BP: <u>113/75</u>	BP: <u>118/68</u>	BP: <u>110/72</u>	BP: <u>115/72</u>
			Fall Risk Score: <u>35</u>	Fall Risk Score: <u>35</u>	Fall Risk Score: <u>35</u>	Fall Risk Score: <u>38</u>	Fall Risk Score: <u>32</u>	Fall Risk Score: <u>35</u>
Recommendations	Safety Needs:		<u>Side rails</u>	<u>yes</u>	<u>yes</u>	<u>side rails</u>	<u>side rails</u>	<u>side rails</u>
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>	<u>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>Swathi</u>	<u>Swathi</u>	<u>Shobha</u>	<u>Shobha</u>	<u>Swathi</u>	<u>Rim</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>2/7/26</u>	<u>2/7/26</u>	<u>2/7/26</u>	<u>3/7/26</u>	<u>3/7/26</u>	<u>4/7/26</u>	
Time:		<u>8AM</u>	<u>2PM</u>	<u>8PM</u>	<u>8AM</u>	<u>8AM</u>	<u>8AM</u>	
Taken Over By Name :		<u>Swathi</u>	<u>Shobha</u>	<u>Shobha</u>	<u>Swathi</u>	<u>Rim</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>2/7/26</u>	<u>2/7/26</u>	<u>2/7/26</u>	<u>3/7/26</u>	<u>3/7/26</u>		
Time:		<u>8AM</u>	<u>2PM</u>	<u>8PM</u>	<u>8AM</u>	<u>8PM</u>		

FDH-00034607 IP5-00175843
Mrs BHOMIKA GAJPAL
28-07-1996 29 Y 11 M 4 D (F)
Dr. HIMABINDU VEERLA



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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

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

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Mrs BHOOMIKA GAJPAL
28-07-1996 29 Y 11 M 4 D (F)
Dr. HIMABINDU VEERLA



BRADEN 'Q' SCALE

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					Date :	17	27	27	31
					Time :	SPM	2AM-2PM	2PM-5PM	5PM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:xtremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		4	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4	4	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4	4	4	4
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	4	4
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE				
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name				
					Datta Sanku Shobu Kum				

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

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
1/17/26	9pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Kachay
1/17/26	11pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Polly
2/2/26	1am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	✓
2/2/26	3am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Polly
2/2/26	4am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Polly
2/7/26	8pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Swifler
2/7/26	11am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Swifler
2/7/26	1pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Swifler
2/7/26	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Swifler
2/7/26	4pm	0/10	NO pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Shobup

Re-assessment Frequency:

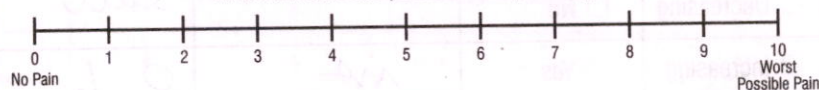
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

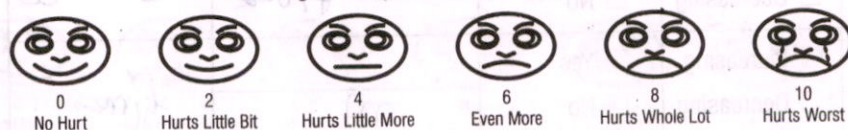
FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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 brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

Signature : [Signature] Name : Sudha

Signature of Ward In Charge :

Signature : [Signature] Name : veena



CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :

FDH-00034807 IP5-00175843
 Mrs BHOOMIKA GAJPAL
 28-07-1996 29 Y 11 M 4 D (F)
 Dr. HIMABINDU VEERLA



Morse Fall Risk Assessment Form

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

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

25/6/

25/B/8

25/05/2012

(208) 700-4148

Nov 2 92



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis:

Patient 38th wks. G. My thyroid for POC

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
1/7/26 8pm	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	For for	Safe delivery	NVD	L.	☐ Nursing ☐ Others:
1/7/26 9pm	☐ Medical ☒ Nursing ☐ Others:	☐ Initial ☒ Modified ☐ Per-Op ☐ Post Op	Patient 38 th wks	safe delivery	POC	[Signature]	☒ Medical ☐ Others:
8/3/26 8:30 am	☐ Medical ☐ Nursing ☒ Others: dietitian	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	POD-1 Em. dscs	soft diet	soft High protein diet	Saino	☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

Patient's / Learner Language: 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		
14/2e	8pm	4.	Informed cons.	PI	1	0	1	1		
1/8/18	9am	7	Infection control measures	PT's	1	0	1	1	-	
5/7/16	8:30 am	9	lactation diet	PT	1	0	1	1	-	Sains

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							



OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 11/7/26 Time of Arrival: 8pm Time Seen by Nurse: 8:05pm

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: POL.

3) Vital Signs: Temperature: 98.2°F Pulse: 60bpm RR: 18bpm SpO₂: 100% BP: 112/70 mmHg Weight: 70kg

4) Gestational Criteria:

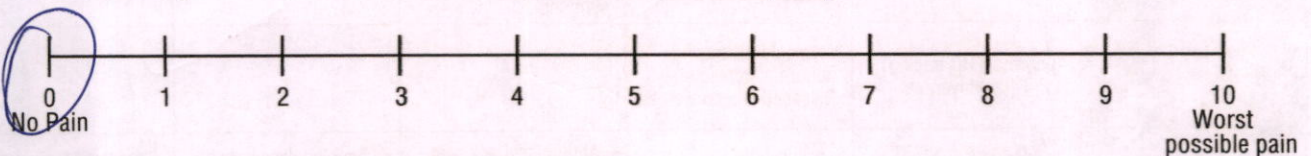
Gravida:	G	P	L	A
----------	---	---	---	---

LMP: 11/10/25 EDD: 9/7/26 Gestational Age: 38+6 wks

Uterine Contraction	☒ Yes ☒ No ☐ NA	Onset	Time	Frequency:
Membrane Rupture	☐ Yes ☐ No ☐ NA	Onset	Time	Fluid Color:
Vaginal bleeding	☐ Yes ☒ No ☐ NA	Onset	Time	Amount:
Pre Eclampsia Symptoms	☐ Yes ☒ No ☐ NA	If Yes specify: Headache / Visual Symptoms / Pain Abdomen / Vomiting		
Good fetal Movement	☒ Yes ☐ No ☐ NA	If No specify:		

5) Pain Screening:

Numerical Pain Scale (NPS)



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

6) Past History:

- a) Surgeries: ni g
b) Medical: a. hypothyroid



☐ No, ☒ If Yes :

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

9) **Prenatal Medical History:**

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

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

- ☐ **Category I:** Resuscitative (Time to Physician: Immediate & Reassessment: Continuous nursing care)
☐ **Category II:** Emergent (Time to Physician: ≤ 15 minutes & Reassessment: Every 15 minutes)
☐ **Category III:** Urgent (Time to Physician: ≤ 30 minutes & Reassessment: Every 15 minutes)
☐ **Category IV:** Less Urgent (Time to Physician: ≤ 60 minutes & Reassessment: Every 30 minutes)
☒ **Category V:** Non Urgent (Time to Physician: ≤ 120 minutes & Reassessment: Every 60 minutes)

OBCU Obstetrical Triage Acuity Scale (OTAS)

OTAS	Level 1 (Resuscitative)	Level 2 (Emergent)	Level 3 (Urgent)	Level 4 (Less Urgent)	Level 5 (Non Urgent)
Level 1 (Resuscitative)	Immediate	≤ 15 minutes	≤ 30 minutes	≤ 60 minutes	≤ 120 minutes (2 Hours)
Re-Assessment	Continuous Nursing Care	Every 15 Minutes	Every 15 Minutes	Every 30 Minutes	Every 60 Minutes
Labour / Fluid	Imminent Birth	Suspected Pre-term Labour / PPROM < 37 Weeks	Signs of Active Labour > 37 weeks	Signs of Early Labour/ SROM > 37 weeks	Discomforts of Pregnancy
Bleeding	Active Vaginal bleeding with/ without abdominal pain	Bleeding associated with cramping (< spotting) < 37 weeks	Bleeding associated with cramping (> spotting) > 37 weeks	Spotting	
Hypertension	Seizure activity	Hypertension > 160/110 and / or headache, visual disturbance, RUQ pain	Mild hypertension > 140/90 with/without associated signs and symptoms		
Fetal Assessment	Abnormal FHR tracing Non-Fetal Movement	Atypical FHR tracing, abnormal dopplers Diseased fetal movement			
Others	- Acute onsite severe abdominal pain - Altered level of consciousness - Cord prolapse - Severe respiratory distress - Suspected sepsis	- Major trauma - Shortness of breath - Unplanned and unattended birth	- Abdominal/back pain greater than expected in pregnancy - Flank pain / hematuria - Nausea /vomiting and /or diarrhea with suspected dehydration	- Ongoing assessment from out patient clinic (for hypertension, blood work) - Minor trauma (minor MVC/fall) - Nausea/Vomiting and /or diarrhea - Signs of infection (ie dysuria ,cough, fever, chills)	- Anything that does not seem to pose threat to mother or fetus - Cervical ripening - Out patient placenta previa protocols - Pre-booked visits (ie Rh and progesterone injections, NST - Assessment for version - Rashes

Time seen by Doctor: 9pm

Nurse Name : Radhika Nurse Signature: [Signature]

Date: 11/7/26 Time: 9pm

FDH-00034607
Mrs BHOMIKA GAJPAL
28-07-1996 29 Y 11 M 4 D (F)
Dr. HIMABINDU VEERLA

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OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 1/7/26

Baseline Information:

Admission From: ☐ ER ☐ OPD ☒ Admission Desk ☐ Others, specify
Primary Language: ☒ Telugu ☐ English ☐ Hindi ☐ Others, specify
Do you require an interpreter? ☐ Yes ☒ No if Yes specify
Source of Information: ☐ Patient ☐ Family ☐ Others, specify

Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other:
If yes, identify

Chief Complaints: 20L Doctor Notified on Admission: ☐ Yes ☒ No
Name of the Doctor: Dr. Ashwini
Time Notified: 9pm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
G. Hy pathygal	aliv	NA
Gynecology Assessment: ☐ Not Applicable Menstrual History: Onset of Menarche: Menstrual Cycle: ☒ Regular ☐ Irregular Last Menstrual Period:	Gynecology Surgical History: Caesarean Section: ☒ No ☐ Yes Cervical Cerclage: ☒ No ☐ Yes Ectopic Pregnancy: ☒ No ☐ Yes Myomectomy: ☐ No ☐ Yes Others:	Gynecological History: Contraceptives: ☐ No ☐ Yes Vaginal Discharge: ☐ No ☐ Yes Post-Coital Bleeding: ☐ No ☐ Yes Infertility: ☐ No ☐ Yes If Yes Type: ☐ Primary ☐ Secondary

Obstetric History: G P 2nd L A

Previous LSCS: 1st

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

Family History: ☒ No Abnormalities Detected

☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Stroke ☐ Seizures ☐ Kidney disease
☐ Liver disease ☐ Other

Vital Signs / Measurements: Temp: 98.2°f HR: 80b/min RR: 18b/min
BP: 112/70 mmHg Weight: 74kg Height: BMI:

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



PHYSICAL ASSESSMENT

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

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

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

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

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☒ No Abnormality Detected

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

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

Inform consultant for positive criteria

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

SOCIAL SCREENING:

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

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

Social History: Lives With Husband

Orientation has been given regarding the following aspects:

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

Above information given to Patient

Name of Person Orientation was given to: Mrs. Bhoomika

Orientation not given Reason: NA

Nurse Signature: [Signature]

Nurse Name: Roshni

Date & Time: 1/7/26 12:00 PM

FDH-00034607
Mrs BHOMIKA GAJPAL
28-07-1996 29 Y 11 M 4 D (F)
Dr. HIMABINDU VEERLA

IP5-00175843

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CESAREAN SECTION OPERATIVE NOTES

Surgeon's Name: Dr. Himabindu.V	Date of Delivery: 2/7/26
Assistant Surgeon: Dr. Arshiyel	Time of Delivery: 8.46 AM
Anaesthetist's Name: Dr. Ambreen	Gender of Baby: female
Type of Anaesthesia: ↓ spinal	Weight of Baby: 3.640 kgf
Neonatologist: Dr. Lokith	AGPAR Score: 8, 9
Scrub Nurse: Dr. Lakmi	NICU Admission: ☐ Yes ☒ No

Pre-Operative Diagnosis: Primigravida 13 weeks 1 G. Hypothyroid

☐ Elective

☐ Emergency

Indication: fetal distress

Urgency

- ☒ Immediate Threat to life of woman or fetus
☐ Maternal or fetal compromise not immediately life threatening
☐ No maternal or fetal compromise but needs early delivery
☐ Delivery timed to suit woman and staff

Decision time: Knife to rectus: 2 mins

CTG Description: Non-Reassuring

If there was a delay give the reasons:

Surgical Procedure: Em-LSU + SA

Post Operative Diagnosis: Post-op Pild Em-LSU

Peri-Operative Complications: Nil

Amount of Blood Loss: ~ 500 ml

Blood Transfused (in ML): Nil

Name and Number of Surgical Specimen sent for examination:

Examination Findings when Appropriate:Presentation: ☒ Cephalic ☐ Breech ☐ OtherCervical Dilatation: 1 finger cm5th Palpable: ulster

Fetal Position:

Station: ☒ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2Moulding: ☐ None ☐ + ☐ ++ ☐ +++Caput: ☐ + ☐ ++ ☐ +++Meconium: ☐ None ☐ + ☐ ++ ☐ +++Bladder Catheterized: ☒ Yes ☐ NoUrine: ☐ Clear ☐ Blood StainedSkin Incision: ☒ Pfannenstiel ☐ Transverse ☐ Midline ☐ OtherUterine Incision: ☒ Lower Segment ☐ Classical ☐ Inverted T ☐ J IncisionPrevious Scar: ☐ Intact ☐ Thinned out ☐ Ruptured ☒ No ScarIncision Through Placenta: ☐ Yes ☒ NoDelivery of head: ☐ Manual ☒ ForcepsLiquor: ☒ Clear ☐ Meconium: ☐ I ☐ II ☐ III ☐ Blood ☐ Offensive ☐ Not OffensiveDelivery of Placenta: ☐ Manual ☒ CCT ☒ Complete ☐ Incomplete ☐ PiecemealCord Appearance: 3 loops of cord around the neck Cord around the neck ☒ Yes ☐ NoAppearance of placenta: Normal Cavity explored ☒ Yes ☐ NoUterus, tubes and ovaries: ☒ Normal ☐ Not Normal Sterilization: ☐ Yes ☒ NoUterine Closure: ☐ One Layer ☒ Two LayersPeritoneal Closure: ☒ Pelvic ☐ Abdominal ☐ None

Sheath Closure:

Fat Closure: ☒ Yes ☐ NoSkin Closure: ☒ Subcuticular ☐ MattressVaginal Evacuated ☒ Yes ☐ NoDrain: ☐ Yes ☒ No ☐ Remove in days ☐ Await instructionsCatheter ☒ Yes ☐ No ☐ Remove in days ☐ Await instructionsSwap & Instruments count correct? ☒ Yes ☐ No ☐ Post-op Antibiotics ☒ Yes ☐ NoIntra-Operative Antibiotics Cover: ☒ Yes ☐ No ☐ Thromboprophylaxis ☐ Yes ☒ No

Post-Operative Notes:

- NBM x 6 hrs- IV fluids - Axon- Drugs as charted- Monitor vitals hourly- 10 charted- with excessive bleeding plac- Intake 50 SDoctor Name: Dr. V. Hema Bindu Doctor Signature: [Signature]Date & Time: 2/2/26 10 AM

FDH-00034607
Mrs BHOOMIKA GAJPAL
28-07-1996 29 Y 11 M 4 D (F)
Dr. HIMABINDU VEERLA



T-SURGICAL CARE PLAN FORM

Procedure Done: Em-Usu + SA

Post-Surgical Diagnosis: Pop-ol Pil, 1 Em-Usu

Post-Operative Monitoring Parameters /Frequency:

- Monitor vitals hrs
- I/O charting

Wound Care:

- check for wound Soakage

Drain /Special Lines/Catheters:

- Foley's insitu

Special Patient Positioning and Requirements:

—

Nutritional Instructions:

- NBM x 6 hrs
- followed by liquids

When to Start Mobilization:

- After 12 hrs

Special Referrals:

—

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

☒ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

Treating Surgeon
(Signature & Stamp)

Date: 2/7/26 Time: 10 AM

Note: Plan of care will be readjusted if necessary.



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

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

Signature of the Doctor: Hindu (Mr. Himabindu) Date: 8/7/2026 Time: 10 AM

Action Plan: Good Hydration, IUF

Risk Assessment Tool for Deep Vein Thrombosis

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

FDH-00034607
Mrs BHOMIKA GAJPAL
28-07-1996 29 Y 11 M 4 D (F)
Dr. HIMABINDU VEERLA

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 2/7/26

Department : OBG OT, Duration of Procedure : 1 hr

Name of Surgeon : Dr Himabindu Date of Admission :

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

		Staff Signature
1.	Antibiotic given prior to surgery ? ☒ Yes ☐ No ☒ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☒ Yes ☐ No Name of the Antibiotic : INT: Cefotaxime	Sis. Gayathri
2.	Hair Removal ☒ Yes ☐ No if Yes : Surgical Clipper Department where Hair Removed : ☒ Ward ☐ Operating Room ☐ Other : Skin preparation done (cleanse surgical area with antiseptic agent)? ☒ Yes ☐ No	Sis. Gayathri
3.	Patient's body temperature immediately post operation (Recovery Room) 36.5 °C ☐ Oral Or ☒ Axilla (Goal : 36-37 °C)	Sis. Gayathri
4.	Name of doctor or staff administering the antibiotic : Sis. Sumitha Date & Time of antibiotic administration : 2/7/26 @ 8am Date & Time procedure started : 2/7/26 8:35 Am	Sis. Gayathri

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

PATIENT TRANSFER FORM

Patient Name & UHID No. FDH-00034607 IP5-00175843 Mrs BHOOMIKA GAJPAL 28-07-1996 29 Y 11 M 4 D (F) Dr. HIMABINDU VEERLA 		Date & Time of Admission 1/7/26 @ 8:50pm	Date & Time of Transfer Order 2/7/26 @ 9:40am
		Transfer Ordered by Dr. Himabindu	Reason for Transfer Observation
From Unit ORG OT	To Unit OBS	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File -35-	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If Yes, what?		Patient shifted with ID band: Yes ☒ No ☐ If No:
Number of Imaging Films 2			
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	/		
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Sis. Laxmi		Name of Person Ordered Transfer Dr. Himabindu	
Patient & Clinical Records Received by : Sis. Shobug 2/7			
Date & Time of Patient Received : 2/7 10:00am			

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

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



Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Bhoonika Jaypal Age: 29y 11m Sex: F UHID.No: FDH 000 34607
Date: 2/7/2018 Time: 7.15 Proposed Operation: Primigravida 38 weeks for emergency Caesarean Section
Diagnosis: Primigravida 38 weeks for emergency Caesarean Section
B.P / CRT: H.R: Weight: ASA Physical Status: ☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 10.9 Glucose: Protein: HIV: X-Ray:
PCV: 32.3 Urea: Alb: HBS Ag: ECG:
WBC: 10.7 Creat: Total Bill: HCV: 2D Echo:
Plate: 195 Na: Dir. Bill: Blood group: Stress/Anglo:
PT: K: LDH: T3 Other:
PTT: Ca++: Alk phos: T4
INR: Mg++: Amylase: TSH
Cl -: SGOT/SGPT:

Allergies: No known drug allergy

Medical History: CVS: ✓

RESP: ✓

Diabetes: ✓

CNS: ✓

Renal: ✓

Hepatic / GE: Weak but OK

Physical Activity: ET 2 floor

Others: ✓

Past Anaesthetic History: ✓

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: Mentohyoid Distance: Neck: Teeth:

Lungs: ✓

Heart: ✓

CNS: ✓

Pregnant: ☒ Yes ☐ No ☐ NA

Venous Access Site: ✓

Spine Exam for regional: ✓

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

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

CURRENT MEDICATIONS	DOSAGE
<u>Thyroid 25</u>	

Pre-Operative Instructions:

- DVT Prophylaxis: 400mg → POOD
- NIL ORAL Water / ORS 2 Hours
Others 6 Hours
- Informed Consent: ☒ Standard ☐ High Risk
- Post Operative Pain Management: ☐ Discussed with Patient
- Other Instructions:

Signature: Aditi Name: Dr. Aditi

Change in Patient Condition:	☐ Yes	☒ No	Fasting Status:	Adequate
------------------------------	------------------------------	--	-----------------	----------

Physical Status:	☒ Patient Identified	☒ Consent Present	☒ Chart Reviewed
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H.R: 92/min	B.P / CRT: 100/60 mm	SpO ₂ : 100%	R.R: 16/min	Last Feed:
-------------	----------------------	-------------------------	-------------	------------

Pre-OP Diagnosis: Prim @ 40 weeks Operation: Elective LSCs Date: > 6 hr

Surgeon: Dr. Hema Baidya Anaesthesiologist: Dr. Anjeen Technician: Kulsum

[illegible]

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

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

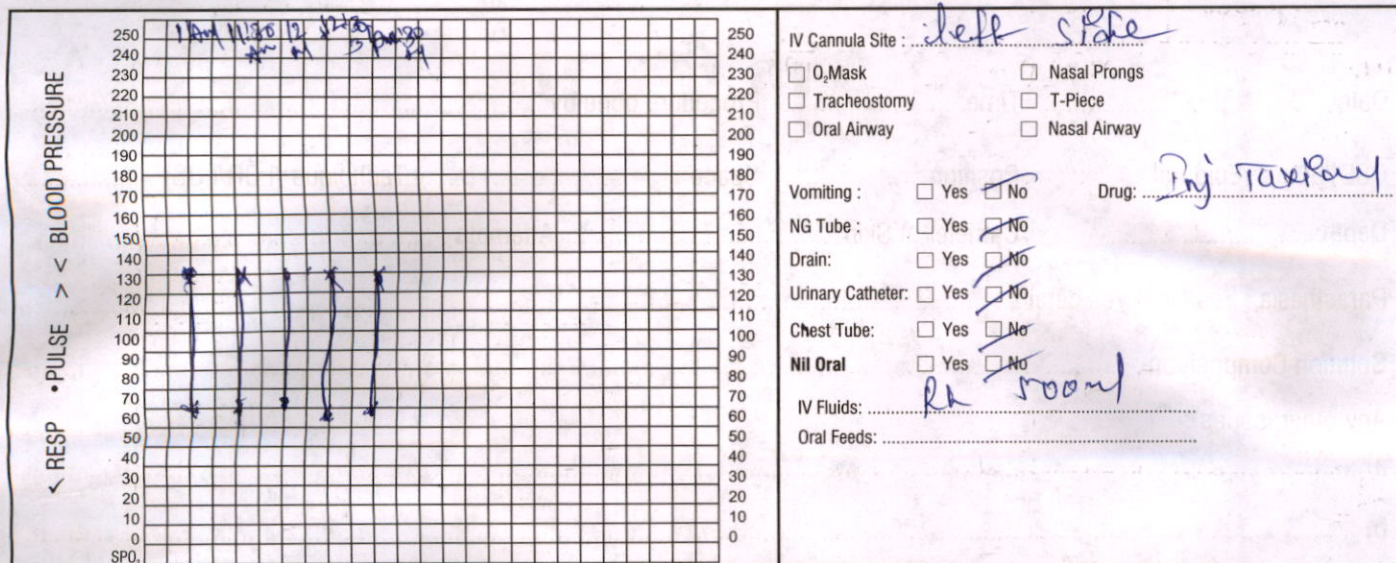
240
220
200
180
160
140
120
100
80
60
40
20
10
0

LAB Values	ABG	
	GRBS	
	Others	

☒ Equipment Checked and Functional ☒ BP ☒ Cuff Site: @u ☒ Art Site: ☒ EKG Lead - 3 clean ☐ Temp Site ☐ FIO ₂ Monitor ☐ Agent Monitor ☒ Pulse Oximeter ☐ Capnograph ☐ Ventilator ☐ Nerve Stimulator Position: supine ☐ Pressure Points Checked Eye Care: ☐ Oint ☐ Tape ☐ Padding ☒ Awake	Temp: ☐ HME ☐ Fluid Warmer ☐ Cling Film ☐ OH Warmer ☐ Hugger's ☐ Cotton Wool ☒ Other Times: Anaes Start: 8:30 AM OP Start: ✓ OP End: Leave OR: 9:30 AM Anaesthesia: ☐ GA ☐ Monitored Anaesthesia Care ☒ Regional Line (Size & Location) ☐ CVP: ☐ ART: ☒ IV: @ 18G ☐ IV: ☐ IV:	Induction ☐ IV ☐ Inhal ☐ Pre O ₂ ☐ RSI ☐ Others ☒ Mask ☐ SGA ☐ Airway ☐ Oral ☐ Nasal ETT # _____ at _____ cm ☐ Oral ☐ Nasal ☐ Cuff ☐ Tracheostomy ☐ Topical ☐ Drug: ☐ Awake ☐ Direct Vision ☐ Video Laryngoscopy ☐ Stylette / Bougie ☐ Fiberoptic Blade # _____ Attempts: _____ Difficulty Why? _____	Regional: Extremity Specify: _____ ☒ Spinal ☐ Epidural ☐ Caudal Others: _____ Position: sitting Site: L3/L4 Needle Size: 25G Depth: _____ Paresthesia ☐ Yes ☐ No Catheter at skin _____ cm Drug Name & Conc: 0.5% Bupivacaine Bolus: 10mg + 2mg Bupivacaine Infusion: _____ Block Level: T4 Comments: _____ Transportation to ☐ PACU ☐ ICU ☒ Other Relaxant Reversed ☐ Yes ☐ No ☒ NA Name of the Doctor: Dr. Anwar Signature of the Doctor: [Signature]
--	--	---	--

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Time Received : Time Discharged :



POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	MINUTES			OUT	SCORING INTERPRETATION
				30	60	90		
Able to move 4 extremities voluntary or on command = 2	ACTIVITY	2	1	2	2	2	A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:	
Able to move 2 extremities voluntary or on command = 1								
Able to move 0 extremities voluntary or on command = 0								
Able to deep breathe & cough freely = 2	RESPIRATION	2	2	2	2			
Dyspnea or limited breathing = 1								
Apneic = 0								
BP $\pm$ 20 of Pre Anaesthetic level = 2	CIRCULATION	2	2	2	2			
BP $\pm$ 20-50 of Pre Anaesthetic level = 1								
BP $\pm$ 50 of Pre Anaesthetic level = 0								
Fully awake = 2	CONSCIOUSNESS	2	2	2	1	2		
Arousable on calling = 1								
Not responding = 0								
Pink = 2	COLOR	2	2	2	2			
Pale, dusky, blotchy, jaundiced, other = 1								
Cyanotic = 0								
TOTAL			10	9	10	9	10	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
2/7		0		

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

Anaesthesiologist Name : Dr. J. L. L. L. L.

Anaesthesiologist Signature: _____

Date & Time: 2/7/26 4:04

PACU Nurse Name : Shobhi

PACU Nurse Signature: _____

Date & Time: 2/7/26 4pm

Reassessment Frequency:

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

Transferred to Unit by (PACU): _____

Date & Time:

Patient Sticker

Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: Time: Procedure done by

CSE /Spinal /Epidural Position : Space : Technique (LOR/LOS)

Depth: Catheter at Skin: Attempts :

Parasthesia : Yes/No if yes details :

Solution Composition :

Any other issues :

a)

b)

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level		Maternal		FHR	Comments
			Left	Right	BP	Pulse		

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

Catheter Removed by and Tip Inspected :

Patient Satisfaction :

Discharge /Shifting ordered by

Doctor Signature:

Doctor Name:

Date and Time :



CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☐ Patient Attendant

Operative Procedure: Emergency Cesarean Section

Anaesthesiologist: DR ADITI Surgeon: Dr HIMABINDU VEERLA

Please read this before you consent for Anaesthesia

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery. Prolonged pain relief can be achieved by infusing weak solutions of local anaesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

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

☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders

☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease

☐ Others HYPOTENSION, BRADY CARDIA, TACHY CARDIA ; SEVERE PDPH

Declaration by Patient Attendant

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team
☐ Regional Anaesthesia ☐ General Anaesthesia ☐ Monitored Anaesthesia Care
- I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, allergic reactions, headaches, variations in blood pressure, nausea and vomiting.
- I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Access, arterial line, use of suppositories and or nerve blocks for pain relief, changing from regional to general anaesthesia etc) which are considered necessary by them during the course of surgery.
- I also authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter if need arises.
- I acknowledge that the anaesthesiologist have informed me about the anaesthetic procedure, risk, benefits and alternative treatments.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: [Signature]

Name: _____

Relationship with patient: _____

Date & Time: 2/7/26 7.15

Witness:

Signature: [Signature]

Name: KSHITIJ CHOUDHARY

Date & Time: 2/7/26 7.15

Doctor (who is taking consent):

Signature: [Signature] Name: Pradip N

Date 2/7/26 Time: 7.15

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స:

అనస్థీషియా వైద్యుడు: శస్త్రచికిత్స నిపుణుడు:

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

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

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

స్పెసిఫిక్ హై రిస్క్స్:

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

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

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

☐ ఇతరవి:

రోగి / రోగి అటెండెంట్

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

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Him - Bindu
Asst. Surgeon : Dr. + Liya
Anaesthetist : Dr. Amreen
Scrub Nurse : Str. Jaxmi

Patient
UHID N
Date : ..

FDH-00034607 IP5-00175242
Mrs BHOMIKA GAJPAL
28-07-1996 29 Y 11 M 4 D
Dr. HIMABINDU VEERLA

e : Gender :
Out-time :

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Your Right to a Safe Delivery

Before Induction of Anaesthesia >>

SIGN IN	Time: <u>8 AM</u>
Patient Has Confirmed	
Identity	☒ Yes ☐ No
Site	☒ Yes ☐ No
Procedure	☒ Yes ☐ No
Consent	☒ Yes ☐ No
Site Marked	☒ Yes ☐ No ☐ NA
Anaesthesia Safety Check Completed	☒ Yes ☐ No
Pulse Oximeter on Patient & Functioning	☒ Yes ☐ No
Does Patient have a:	
Known Allergy?	☐ Yes ☒ No
Difficult Airway / Aspiration Risk?	
Yes, & Equipment / Assistance Available	☐ Yes ☒ No
Risk of > 500ml Blood Loss (7ml/kg In Children)?	
Yes, and Adequate Intravenous Access and Fluids Planned	☒ Yes ☐ No ☐ NA
Blood Units Reserved	☒ Yes ☐ No ☐ NA
Has Antibiotic Prophylaxis been given within the last 60 minutes?	
	☒ Yes ☐ No ☐ NA
Signature : <u>Am</u>	
Name : <u>Dr Amreen</u>	

Before Skin Incision >>

TIME OUT	Time:
Confirm all team members have introduced themselves by Name and Role ☐ Yes ☐ No	
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm	
Correct Patient (Check ID Band)	☒ Yes ☐ No
Correct Site	☒ Yes ☐ No
Correct Procedure	☒ Yes ☐ No
Anticipated Critical Events	
Surgeon Reviews:	
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? <u>200 ml / hr</u>	
☒ Yes ☐ No ☐ NA	
Anaesthesia Team Reviews:	
Are There Any Patient-specific Concerns? ☐ Yes ☒ No ☐ NA	
Nursing Team Reviews:	
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☒ Yes ☐ No ☐ NA	
Is Essential Imaging Displayed? ☐ Yes ☐ No ☐ NA	
Power Supply, Earthing, Power Backup and functioning of equipment checked. ☐ Yes ☒ No	
Signature : <u>[Signature]</u>	
Name : <u>Silva</u>	

Before Patient Leaves Operating Room

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

SURGICAL SAFETY CHECKLIST

Surgeon :
Asst. Surgeon :
Anaesthetist :
Scrub Nurse :

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



Before Induction of Anaesthesia ➤ ➤

SIGN IN		Time: 9:00 AM
Patient Has Confirmed		
Identity	☒ Yes ☐ No	
Site	☒ Yes ☐ No	
Procedure	☒ Yes ☐ No	
Consent	☒ Yes ☐ No	
Site Marked	☒ Yes ☐ No ☐ NA	
Anaesthesia Safety Check Completed	☒ Yes ☐ No	
Pulse Oximeter on Patient & Functioning	☐ Yes ☒ No	
Does Patient have a:		
Known Allergy?	☐ Yes ☒ No	
Difficult Airway / Aspiration Risk?		
Yes, & Equipment / Assistance Available	☐ Yes ☒ No	
Risk of > 500ml Blood Loss (7ml/kg In Children)?		
Yes, and Adequate Intravenous Access and Fluids Planned	☒ Yes ☐ No ☐ NA	
Blood Units Reserved	☐ Yes ☒ No ☐ NA	
Has Antibiotic Prophylaxis been given within the last 60 minutes?	☒ Yes ☐ No ☐ NA	
Signature : <i>Aditi</i>		
Name : <i>Dr. Aditi</i>		

Before Skin Incision ➤ ➤

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

Before Patient Leaves Operating Room

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

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

FDH-00034607 IP5-00175843
Mrs BHOOMIKA GAJPAL
28-07-1996 29 Y 11 M 4 D (F)
Dr. HIMABINDU VEERLA



Right
W HOSPITALS
a Safe Delivery

Patient Name : Bhoomika Gender: ☐ Male ☒ Female Age : 29
UHID No : FDH-00034607 Date : 2/7/20

Instruction:

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

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

EMERGENCY LOWER SEGMENT CESAREAN SECTION
upon Bhoomika
(Name of the Patient)

I have been advised of the benefits and reason of the procedure(s) as indicated by the clinical observations and / or diagnostics performed. I recognized that the practice of medicine is as much an art as a science and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcomes. My questions regarding the condition, the proposed surgery and the outcome have been answered to my satisfaction prior to signing this form by the surgeon.

I have been explained the risks of this surgery /procedure and also about the reasonable alternative and the relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment.

I have been explained that the following complications though rare are possible and will not hold Surgeon, Anesthesiologist or the hospital staff responsible for any untoward event thereof.

Bleeding, Blood Transfusion, Infection, Injury to Bowel, loops & Bladder.

My signature on this form indicates that

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

Name of the Doctor who is performing the Surgery / Procedure: Dr. Himabindu Veerla

Consentee :

Signature : Bhoomika

Name : _____

Date & Time : 2/7/20 @ 9AM

Witness :

Signature : [Signature]

Name : [Name]

Date & Time : 2/7/20 @ 9AM

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

Patient Attendant :

Signature : [Signature]

Name : KSHITIJ CHOUDHARY

Relationship with Patient: HUSBAND

Date & Time : 2/7/20 @ 9AM

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Himabindu Veerla

Date & Time : 2/7/20

FDH-00034607 IP5-00175843
Mrs BHOO MIKA GAJPAL
28-07-1996 29 Y 11 M 4 D (F)
Dr. HIMABINDU VEERLA



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INDUCTION OF LABOR CONSENT

Name: Bhoomika Age: 27 Gender: Male ☐ Female ☒
UHID.No: FDH-00034607 Date: 1/7/20

You are scheduled for an induction of labor on 1/7/20 (date) at 3:45 (weeks of gestation).

The reason for your induction is Term.

The goal of induction of labor is to achieve vaginal delivery by starting uterine contractions before the spontaneous start of labor.

Induction of labor for a medical indication is done when continuation of pregnancy is considered detrimental to the health of the mother or fetus. This can be done at any stage of pregnancy irrespective of fetal maturity if there is a valid indication.

Elective induction of labor (scheduled induction without a medical indication) may not be done until you are at least 39 weeks. This is important so that your newborn does not have complications due to possible prematurity.

The alternative to induction of labor is to wait for labor to start spontaneously.

I have read the information provided and also discussed the process with my doctor.

I understand the risks and benefits of this procedure and wish to proceed.

Patient

Signature: Bhoomika

Name: Bhoomika Gajpal

Date & Time: 1/7/20 @ 9pm

Patient Attendant:

Signature: Kshitij

Name: KSHITIJ CHOUDHARY

Relationship with Patient: HUSBAND

Date & Time: 1/7/20 @ 9pm

Doctor:

Signature: Dr. Ashu

Name: Dr. Ashu

Date & Time: 1/7/20

Witness

Signature: Pardhi

Name: Pardhi

Date & Time: 1/7/20 @ 9pm

INFORMED CONSENT FOR VAGINAL BIRTH

Patient Name : Bhoonika

UHID No : FDH-00034607

Gender: ☐ Male ☒ Female

Date : 1/7/20

Time : 8pm

I hereby authorized the performance of the following procedure:

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

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

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

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

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

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

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

Name of the Doctor performing the procedure: Dr. Himabindu Veerla

Consentee :

Signature : Bhoonika

Name : Bhoonika Gajpal

Date & Time : 1/7/20 9pm

Witness :

Signature : [Signature]

Name : [Signature]

Date & Time : 1/7/20 9pm

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

Patient Attendant :

Signature : [Signature]

Name : KSHITIJ CHOUDHARY

Relationship with Patient : HUSBAND

Date & Time : 1/7/20 9pm

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Ashay

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

సహజ ప్రసవం కొరకు సమ్మతి పత్రము

రోగి పేరు : వయస్సు లింగం పు స్త్రీ

యు.పాప్.బి.డి. విభాగము

తేదీ

ఈ ప్రక్రియ యొక్క వివరములను నేను అమోదించాను:

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

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

సహజ ప్రసవం విజయవంతం కాకపోతే, తగిన అనశ్మీషియా ఇచ్చి పొత్తికడుపు కోతతో సిజేరియన్ ద్వారా డెలివరీ చేయవలసిన అవసరం కలగవచ్చు

సహజంగా లేదా పరికరం సహాయంతో అంటే ఫోర్స్ప్స్ లేదా వాక్యూమ్ సహాయంతో జడ్డను ప్రసవించే ప్రయత్నంలో, ప్రమాదాలు ఉండవచ్చు: అంటువ్యాధులు, అలెర్జి, మచ్చలు, రక్త నష్టం, రక్త మార్పిడి అవసరం పడటం, నొప్పి మరియు అసౌకర్యం, మూత్ర నాళానికి గాయం, శిశువుకు గాయం అయ్యే అవకాశం (లేసరేషన్, హెమటోమా, పుర్రె గాయం అయి అవకాశం, నరాలకు గాయం మరియు మెదడు గాయం) మరియు భవిష్యత్తులో కటి ప్రదేశంలోని ఎముకల వలయం పనిచేయకపోవడం

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

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

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

ఈ ప్రక్రియను నిర్వహించే డాక్టరు పేరు:

సహాయకుడు(అటెండెంట్)

సాక్షి

సంతకము

సంతకము

పేరు

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

తేదీ మరియు సమయము

సంతకము

పేరు



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NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 3/7/26

Time: 8:30am

Origin: Indian Height: 158cm Weight: 74kg's BMI: 29.7kg/m²

Food Allergies: No

Diagnosis: P00-1 / Em. LSCS (lower segment cesarian section)

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

Diet Advised:

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

Patient's / Attendant's

Signature: [Signature]

Name: Bhoomika

Date & Time: 3/7/26
8:45am

Dietician's

Signature: [Signature]

Name: SAJMA

Date & Time: 3/7/26
8:30am

DIETARY NOTES

[illegible]