

ADMISSION SHEET

Registration Details :


Admission No : IP5-00175830 Admit Date : 01-Jul-2026 Admit Time : 02:57 PM UHID : BAH-00322855

Patient Details :

Patient Name	: Mrs SANDHYA REDDY M	Age	: 39 Y 7 M 8 D
Guardian	: MR SURESH REDDY M	DOB	: 23-11-1986
Gender	: Female	Religion	:
Occupation	:	Marital Status	: Married
Address (H)	: HNO 3-182/1,PARIMALA COLONY Hanamkonda Warangal Telangana INDIA 506001	Phone No	: 9849680111
		E-mail	: REDVANI@YAHOO.COM

Admission Details :

Bed Type : SHARED WARD Bed No : SW 414 Ward Name : 4F-BIRTHING CENTRE
 Room No : SW 414 Admission Type : First Visit

Contact Details :

Name : MR SURESH REDDY M Relationship : Husband
 Contact Address : HNO 3-182/1,PARIMALA COLONY Phone No : / 9849680111
 Hanamkonda Warangal Telangana INDIA 506001


 Signature

Doctor Details :

Doctor Name : Dr. DR.M PRATHYUSHA REDDY Specialisation : OBSTETRICS AND GYNECOLOGY
 Referral Doctor : Self Phone No :
 Co-Consultant :

Payment Details :

Deposit Amount : 0.00
 Payment Mode : Cash Payor Name : SELFPAY

①

ACTIVITY RECORD FOR BILLING

Name : BAH-00322855 IP5-001/5830
 UHID No Mrs SANDHYA REDDY MALLADI (F)
 Date of 23-11-1986 39 Y 7 M 8 D
Dr. DR.M PRATHYUSHA REDDY
 Consultant: _____ Dept: _____
 Date of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
1/12/26	5:20 PM	OR	OT	Deepa Jay
2/12/26	2:00 PM	OR	ROOM (337)	Deepa Jay

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Teheena Sharma (PT)	3/7/26	9686221	Roubhasini
2				
3				
4				
5				
6				
7				
8				
9				
10				

[illegible]

Date

Investigations

Order No.

Signature

17th

NST Twin-①

26503 2263.

Free Inv

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
1/7/06	IV placement	01	9683195	Healy
1/7/06	Pac	01	9683196	Healy
1/7/06	Catheterization	01	9683195	Healy

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 elective CS

Obstetric Formula:

G2P1U

Obstetric History:

9-2018, emg. US (fetal
dysm)
Male, 3-kg, AetH

Present Pregnancy Record:

G2- present pregnancy
spontaneous muplun

RISK FACTORS:

booked @ 36th wks

- MCDA twins
- previous US
- Gest HTN ∴ 36th wks.

LMP:

14/10/25

EDD:

Corrected EDD:

23/7/26

GA:

36th wks.

Menstrual History: Regular ☒ Yes ☐ No

Obstetric Examination

Fundal Height:

Over distended

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

Liquor: ☒ Adequate ☐ Oligo ☐ Poly

PP: ☐ Cephalic ☐ Breech

Others

multiple
fetal parts
of C/L

Head Fifts Palpable:

FHS:

☒ Normal

☐ Tachy

☐ Brady

☐ Absent

FHR $\uparrow$ < .

Per Speculum Examination

not done.

Draining: ☐ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination

not done.

Cervix: ☐ Long ☐ Partially effaced ☐ Effaced

Os: Closed _____ Dilated _____

Membranes: ☐ Present ☐ Absent

Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Presenting Part: ☐ Vertex ☐ Breech ☐ Others

Sutton: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Pelvis: ☐ Adequate ☐ Doubtful

Height: 157 cm

Weight: 106.6 kg

Allergies: NKDA.

Breast: ☒ Normal ☐ Abnormal

General Examination: fair

Consciousness: Yes Pallor: absent

Icterus: absent Edema: absent

Temp: afebrile PR: 90bpm

BP: 126/80 mmHg DTR: normal

CVS: S1 S2 RS - BLN VBS

Liver/Spleen: Not palpable Urine Output: Normal, SpO2 - 99% on RA

DIAGNOSIS

G2P1U | 36th wks / previous US / MCDA twm / Gest HTN
for elective CS.



Family History: NOI.	Surgical History: Prostatectomy - 2018
Medical History: NOI.	Medication History: see Medical communication form.
Plan of Care: - Admission - NBM - Ctg now - vitals uttally - preop part. - Foley's catheterization - PAC - Pre-op medication - Shift to OT on call. - Blood availability. WPRBC.	Investigations: 29/6/26 @ positive CBP → 12.5 / 5990 / 2.04C. UTT-Ⓢ, creat- 0.6! Spot PUL-0.25, CDH-190 Urab. NR. 10/6/26 T₁ cephalic T₂, Beech 2026 gm 2187g 121 30C AC-10, AC-20! Wt 10m -Ⓢ Ti Ha -Ⓢ NIP1. - low Rmb

Doctor Name: Dr. Saneve
 Signature: [Signature]
 Date & Time: 1/8/26 @ 4pm

Consultant Name: Dr. Prathymshetty
 Signature: [Signature]
 Date & Time: 2/7/26 12pm

BAH-00322855 IP5-00175830
Mrs SANDHYA REDDY MALLADI
23-11-1986 39 Y 7 M 8 D (F)
Dr. M PRATHYUSHA REDDY



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/7/20 8pm	Pod-o/Fiber + Bt/Bz free air afebrile PR - 84/min BP - 110/70 mmHg SpO₂ - 98% @ RA P/A - ut (P) well	adv. NBM - till 4pm - vitals 2hrly - Drip anchored - w/f active bleed - Inform by
	P/A - NAB. noted by Sr. Radha.	Dr. Ashu
2/7/20 2.15Am	Pod-o free air afebrile PR - 86/min BP - 128/70 mmHg SpO₂ - 98% @ RA P/A - ut (P) well P/Bt P/A - NAB.	adv. - oral liquid - 4Am - soft diet - 6Am - vitals 2hrly - Drip anchored - Inform BP > 140/90 mmHg - w/f active bleed - (10) fluid - 100ml - w/f 40% - Imminent Eclampsia - Inform by
	Shift to room.	Dr. Ashu

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/7/26 12pm	Pod-1 ELWor + BTL / P₂ L₃ GC: fair vitals: stable P/A: wt @ woe salt, Bx (+) P/v: NAB Remove Foley at 12pm	1) soft diet 2) Drug as charted 3) w/f PW bleeding 4) Amelation 5) I/O charting 6) Temp sor - Dr. Praveen
11/7/26 12pm	Pod-5 pt stable vitals (N) I/A - wt Rwe P/v - Bld wve Baby's ASH	Adv - Out liquids - Soft diet - TPR / BP 4th hly - w/f bleeding - Drugs as advised - Dr. Praveen
11/7/26 2pm today	T. Bulcolax 2tbl P/O at 3pm today	Dr. Praveen

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/12/26 9:20 PM	It comfortable o/e ac full vital stable p/a uterus retracted well o/e - lochia healthy	Adv drugs as per charted - vitals closely - Ambulate - soft diet Plenty of oral fluids - Inform NS Dr. Sameer
31/12/26 8:00 AM	POD - 2/2/3 LUS + BTL o/e G: full Vital stable Tem. afebrile p/a - uterine o/e - lochia healthy soft Distension (+)	Adv ① Drugs as charted ② Soft diet ③ Hydration ④ Ambulation ⑤ uterine bleeding ⑥ Inform NS Dr. Divya Dr. Anusha

Date & Time	Progress Notes	Doctor's Order
	cl/w Dr. pradyumn <u>Adv</u> T. labeled lumpy po/sus if BP > 140/90 mmHg <u>plan discharge</u> <u>Dr. Dhang</u>	
2/7/26 12:45pm U ✓ B ✓ flatus ✓	pt stable Vitals (15) P/A - wt RWT Lax abdominal wall P/v - Bord w/w Baby's A 9H.	<u>Adv</u> - Regulated - Plenty of liquids - Ambulation - Drugs as advised
	Dressing to be done	<u>Discharge</u> Noted by Nis. Kalyani 06394 at 2pm

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 23-11-1986 39 Y 7 M 9 D (F)
 Dr. DR.M PRATHYUSHA REDDY



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/12/26 2:30pm	POD-2 / LUS / Pals /	
		Re
	Gc: per	1) Regular diet
	Vitals: Stable	2) Drug as charted
B-wei	Plat: Ut (2) w/	3) w/ Plv Bleeding
	Self	4) Ambulation
D/E S/E / ✓	Plv: NAB	5) Temp 36.5
	Plan discharge	- Dr. Srawasti
		M.B. Soubhasini
4/12/26 9am	POD-3 / LUS / Pals	
	no complaints	R
	Gc: per	1) (2) diet
B-wei	Vitals: Stable	2) plenty of oral fluid
	Plat: Ut (2) w/	3) w/ Plv Bleeding
D/E S/E / ✓	Self	4) Ambulation
	Plv: NAB	5) Temp 36.5
	Plan discharge	- Dr. Srawasti



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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

BAH-00322855 IP5-00175830
 Mrs SANDHYA REDDY MALLADI (F)
 23-11-1986 39 Y 7 M 8 D
 Dr. DR.M PRATHYUSHA REDDY

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RESULT SHEET

Date	29/6/16				
Time					
Hb	12.5				
PCV					
RBC	3.93				
WBC	5990.0				
N/L					
Platelets	2.04				
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 gray stool						

Culture and Sensitivities :

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Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :

BAH-00322855 IP5-00175830
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MEDICATION RECONCILIATION FORM

Drug Allergies: None ☐ Not Known any Drug Allergies

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

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

Shifting From: NA Shifted to: NA

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Tab IRON		PO	OD	1/7	☐ C ☒ DC
	Tab CALCIUM		IV	OD	1/7	☐ C ☒ DC
3	Tab LABETALOL	100mg	PO	1BD	29/6	☒ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Suresh S

Date & Time: 17/06/2024 4pm

Nurse Name & Signature: Prathusha S

Date & Time: 17/06/2024 4pm



Weight 106.6 Ward BC

VERIFIED

VERIFIED BY: Name:

[illegible]

Patient Sticker

REGULAR PRESCRIPTIONS

Weight

Ward

Signature _____

VERIFIED BY: Name

[illegible]



DRUG CHART

Date of Admission: 17/26 Drug Allergies: NKDA ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name

Weight. 166.5 Ward. 30

Weight. 106.5 lb. Ward. B1c

Page: 2/4

VERIKI

VERIFIED

VERIFIED

उत्तराखण्ड

Weight. 106.6 Ward. Bk



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
1/7/26	5:20pm	by: CEFOTAXIM	2gm	IV	[Signature]	Sandhya Caxmi
1/7/26	5pm	by: PANTOP	40mg	IV	[Signature]	Sandhya Caxmi
1/7/26		by: PARACETAMOL				
1/7/26	5pm	by: PERINORM	10mg	IV	[Signature]	Sandhya Caxmi
1/7/26	526	INJ OXYTALIN	3V+3V	IV	[Signature]	Sandhya Caxmi
1/7/26	3.28	INJ METHERGON	0.2mg	IM	[Signature]	Sandhya Caxmi
1/7/26	7:00pm	TRAMADOL SUPPOSITION	100mg	PR	[Signature]	Sandhya Caxmi
1/7/26	7:00pm	DILGRENAL SUPPOSITION	100mg	PR	[Signature]	Sandhya Caxmi
		Inj PARACETAMOL	1gm	IV	[Signature]	Sandhya Caxmi

Signature

VERIFIED BY : Name



I.V. FLUIDS CHART

Weight. 106 kg Ward. B6

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
1/7/26	12:20 pm	RINGER LACTATE 500ml	IV	100ml/hr	[Signature]	[Signature]	01/7/26	[Signature]	Pashpalg Anitha
1/7/26	5:00 pm	RINGER LACTATE	IV	FF	[Signature]	Pashpalg Anitha	1/7/26	[Signature]	Pashpalg Anitha
1/7/26	6:45 pm	RINGER LACTATE	IV	FF	[Signature]	Pashpalg Anitha	1/7/26	[Signature]	Pashpalg Anitha
1/7/26	7:00 pm	RINGER LACTATE	IV	100	[Signature]	Radhag Yamun	1/7/26	[Signature]	Radhag Yamun
1/7/26	8:00 pm	RINGER LACTATE	IV	100ml/hr	[Signature]	Radhag Yamun	1/7/26	[Signature]	Radhag Yamun
1/7/26	10:30 pm	RINGER LACTATE	IV	100ml/hr	[Signature]	Radhag Yamun	1/7/26	[Signature]	Radhag Yamun
2/7/26	1:00 am	RINGER LACTATE	IV	100ml/hr	[Signature]	Radhag Yamun	2/7/26	[Signature]	Radhag Sreeni

Signature

VERIFIED BY : Name



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CAESAREAN SECTION OPERATIVE NOTES

Surgeon's Name: <u>Dr Prathyusha Reddy</u>	Date of Delivery: <u>1/07/26</u>
Assistant Surgeon: <u>Dr Cavanya</u>	Time of Delivery: <u>Twin-1 6:20pm</u> <u>Twin-2 6:21pm</u>
Anaesthetist's Name: <u>Dr Aditi</u>	Gender of Baby: <u>Female</u> <u>Female</u>
Type of Anaesthesia: <u>ASA</u>	Weight of Baby: <u>2.804kg</u> <u>2.500kg</u>
Neonatologist: <u>Dr Lohith</u> , <u>Dr Rupanjali</u>	AGPAR Score: <u>9/10</u> <u>9/10</u>
Scrub Nurse: <u>Sr Caxmi</u>	NICU Admission: ☐ Yes ☒ No

Pre-Operative Diagnosis:

☒ Elective ☐ Emergency

Indication: 1st ces + MCD from

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: Knief to rectus:

CTG Description:

If there was a delay give the reasons:

Surgical Procedure:

Elective ces + Bilateral tubectomy

Post Operative Diagnosis:

P000 / E114 + B1.

Peri-Operative Complications:

Amount of Blood Loss:

Blood Transfused (in ML):

Name and Number of Surgical Specimen sent for examination:

Presentation: ☐ Cephalic ☐ Breech ☐ Other

5th Palpable:

Station: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Caput: ☐ + ☐ ++ ☐ +++

Bladder Catheterized: ☐ Yes ☐ No

Cervical Dilatation: cm

Fetal Position:

Moulding: ☐ None ☐ + ☐ ++ ☐ +++

Meconium: ☐ None ☐ + ☐ ++ ☐ +++

Urine: ☐ Clear ☐ Blood Stained

Skin Incision: ☒ Pfannenstiel ☐ Transverse ☐ Midline ☐ Other

Uterine Incision: ☒ Lower Segment ☐ Classical ☐ Inverted T ☐ J Incision

Previous Scar: ☐ Intact ☐ Thinnedout ☐ Ruptured ☒ No Scar

Incision Through Placenta: ☐ Yes ☒ No *Breech Extraction of 2 tw*

Delivery of head: ☐ Manual ☐ Forceps

Liquor: ☒ Clear ☐ Meconium: ☐ I ☐ II ☐ III ☐ Blood ☐ Offensive ☒ Not Offensive

Delivery of Placenta: ☐ Manual ☒ COT ☐ Complete ☐ Incomplete ☐ Piecemeal

Cord Appearance: *normal* Cord around the neck ☐ Yes ☒ No

Appearance of placenta: *normal* Cavity explored ☒ Yes ☐ No

Uterus, tubes and ovaries: ☒ Normal ☐ Not Normal Sterilization: ☐ Yes ☒ No

Uterine Closure:	☐ One Layer	☒ Two Layers		Suture
Peritoneal Closure:	☐ Pelvic	☒ Abdominal	☐ None	
Sheath Closure:				
Fat Closure:	☒ Yes	☐ No		
Skin Closure:	☒ Subcuticular	☐ Mattress		
Vaginal Evacuated	☒ Yes	☐ No		
Drain:	☐ Yes	☒ No	☐ Remove in days	☐ Await instructions
Ctheter	☒ Yes	☐ No	☐ Remove in days	☐ Await instructions
Swap & Instruments count correct?	☒ Yes	☐ No	☐ Post-op Antibiotics	☐ Yes ☒ No
Intra-Operative Antibiotics Cover:	☒ Yes	☐ No	☐ Thromboprophylaxis	☒ Yes ☐ No

Post-Operative Notes:
 Norm for sh. Pls deliques at 4Am
 Vital end in
 Down ascharit
 w/p othe Bleepy
 Tr fluid 100ml

Doctor Name:

Doctor Signature:

Date & Time: 11/7/22, 8:15

BAH-00322855 IP5-00175830
Mrs SANDHYA REDDY MALLADI (F)
23-11-1986 39 Y 7 M 8 D
Dr. DR.M PRATHYUSHA REDDY

POST-SURGICAL CARE PLAN FORM

Procedure Done:	Elective Lsg + BT. POD-0
Post-Surgical Diagnosis:	
Post-Operative Monitoring Parameters /Frequency:	Temp, PR, BP, SpO2 every 2hr
Wound Care:	afk 48h.
Drain /Special Lines/Catheters:	(1) comb Foley (1)
Special Patient Positioning and Requirements:	Supine 14-16h
Nutritional Instructions:	NBM 6h. Flb. oral liquid -
When to Start Mobilization:	after Foley removal
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)	1/11/20. Date: Time: 8pm
Note: Plan of care will be readjusted if necessary.	



Patient

RISK ASSESSMENT TOOL FOR DEEP VEIN THROMBOSIS

(Postnatal Assessment and Management (to be assessed on delivery suite))

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

Signature of the Doctor: Date: 1/7/20 Time: 8 PM

Action Plan: cloxone 400mg x 10 days.

Risk Assessment Tool for Deep Vein Thrombosis

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

Patient Sticker

BAH-00322855 IP5-00175830
 Mrs SANDHYA REDDY MALLADI
 23-11-1986 39 Y 7 M 8 D (F)
 Dr. DR.M PRATHYUSHA REDDY



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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date: 1/07/26

To Be Filled In By Assigned Nurse :

Department : OBG OT Duration of Procedure :Name of Surgeon : Dr. M. Prathyusha Reddy Date of Admission : 1/7/26

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

		Staff Signature
1.	Antibiotic given prior to surgery ? ☒ Yes ☐ No ☒ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☒ Yes ☐ No Name of the Antibiotic : <u>Inf: Taxim</u>	<u>Sandhya</u>
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	<u>Sandhya</u>
	Patient's body temperature immediately post operation (Recovery Room) _____ °C ☐ Oral Or ☒ Axilla (Goal : 36-37 °C)	<u>Sandhya</u>
4.	Name of doctor or staff administering the antibiotic : <u>5:20 PM</u> Date & Time of antibiotic administration : <u>1/07/26 @ 5:20 PM</u> Date & Time procedure started : <u>1/7/26 @ 6 AM</u>	<u>Sandhya</u>

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

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

SURGICAL SAFETY CHECKLIST

Surgeon :
Asst. Surgeon :
Anaesthetist :
Scrub Nurse :

00322855
Mrs SANDHYA REDDY MALLADI
23-11-1986 39 Y 7 M 8 D (F)
Dr. DR. M PRATHYUSHA REDDY

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

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Before Induction of Anaesthesia >>

Before Skin Incision >>

Before Patient Leaves Operating Room

SIGN IN	Time: 3.50
Patient Has Confirmed	
Identity	☒ Yes ☐ No
Site	☒ Yes ☐ No
Procedure	☒ Yes ☐ No
Consent	☒ Yes ☐ No
Site Marked	☐ Yes ☐ No ☒ NA
Anaesthesia Safety Check Completed	☒ Yes ☐ No
Pulse Oximeter on Patient & Functioning	☐ Yes ☒ No
Does Patient have a:	
Known Allergy?	☐ Yes ☒ No
Difficult Airway / Aspiration Risk?	
Yes, & Equipment / Assistance Available	☒ Yes ☐ No
Risk of > 500ml Blood Loss (7ml/kg In Children)?	
Yes, and Adequate Intravenous Access and Fluids Planned	☒ Yes ☐ No ☐ NA
Blood Units Reserved	☐ Yes ☒ No ☐ NA
Has Antibiotic Prophylaxis been given within the last 60 minutes?	
	☒ Yes ☐ No ☐ NA
Signature : Name : Dr. Ashish N	

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 :	

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 : Dr. Ashish N	

MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: G2P4 / 36⁶ wks / previous USS / MCDA twins / Gest HTN for elective USS

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
1/3/26 @ 4pm	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	G2P4 / 36 ⁶ wks / previous USS / MCDA twins / Gest HTN!	for safe delivery.	Elective USS	<i>[Signature]</i>	☐ Nursing ☐ Others:
1/3/26 4pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	patient come for Anxiety	→ To Reduce the Anxiety	→ To Educate the patient	<i>[Signature]</i>	☐ Medical ☐ Others:
2/3/26 8:30 am	☐ Medical ☐ Nursing ☒ Others: dietitian	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	POD-1 El. LSCS	soft diet	soft High protein diet	<i>[Signature]</i>	☐ Medical ☐ Nursing ☒ Others:
3/7/26 4pm	☐ Medical ☐ Nursing ☒ Others:	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	Post LSCS	Post partum recovery	Deep core retraining & functional training	<i>[Signature]</i>	☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
1/3/26	3pm	1/44	Diagnosis, treatment & care plan, informed consent	PT.S	1	0	1	1		
1/3/26	3pm	3	pain management	pt	1	0	1	1		Saini
2/3/26	8:30 am	9	Lactation diet	pt	1	0	1	1		Saini

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							

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OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 1/7/20		
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: St-accy mem Twice		Doctor Notified on Admission: ☒ Yes ☐ No Name of the Doctor: Dr. Arthey Time Notified: 2:30pm
Past Medical History: Obtained From ☒ Patient ☐ Family Member ☐ Medical Record ☐ Other (specify)		
Past Medical History	Past Surgical History	Previous Hospital Admission
nil	nil	nil
Gynecology Assessment: ☒ Not Applicable Menstrual History: Onset of Menarche: Regular 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 L A		
Previous LSCS: nil		
Current Medication: ☒ None ☐ Yes, If Yes, Fill the reconciliation form		
Family History: ☒ No Abnormalities Detected ☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Stroke ☐ Seizures ☐ Kidney disease ☐ Liver disease ☐ Other		
Vital Signs / Measurements: Temp: 98.6 BP: 119/70 HR: 87 RR: 19 Weight: 106.6 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 20 (complete the Morse Fall Risk Assessment Sheet)

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

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

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☒ No Abnormality Detected

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

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

Inform consultant for positive criteria

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

SOCIAL SCREENING:

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

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

Social History: Lives With

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 Healy

Orientation not given Reason:

Nurse Signature: [Signature]

Nurse Name: Healy

Date & Time: 17th Dec 2:30 pm



OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 17/10/20 Time of Arrival: 2:20 PM Time Seen by Nurse: 2:30 PM

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: Ch-HSCS

3) Vital Signs: Temperature: 98.6 Pulse: 87 RR: 19 SpO₂: 100% BP: 119/70 Weight: 119 lbs

4) Gestational Criteria:

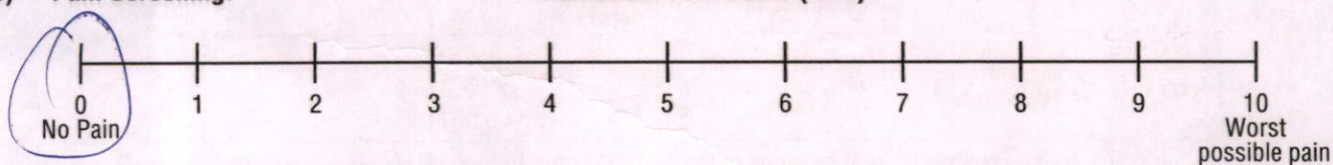
Gravida: G2 P: 1 L: 1 A: A

LMP: 14/10/15 EDD: 23/7/16 Gestational Age: 36+3

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

6) Past History:

- a) Surgeries: nil
b) Medical: nil



☒ 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: 2:20pm

Nurse Name : Nurse Signature:

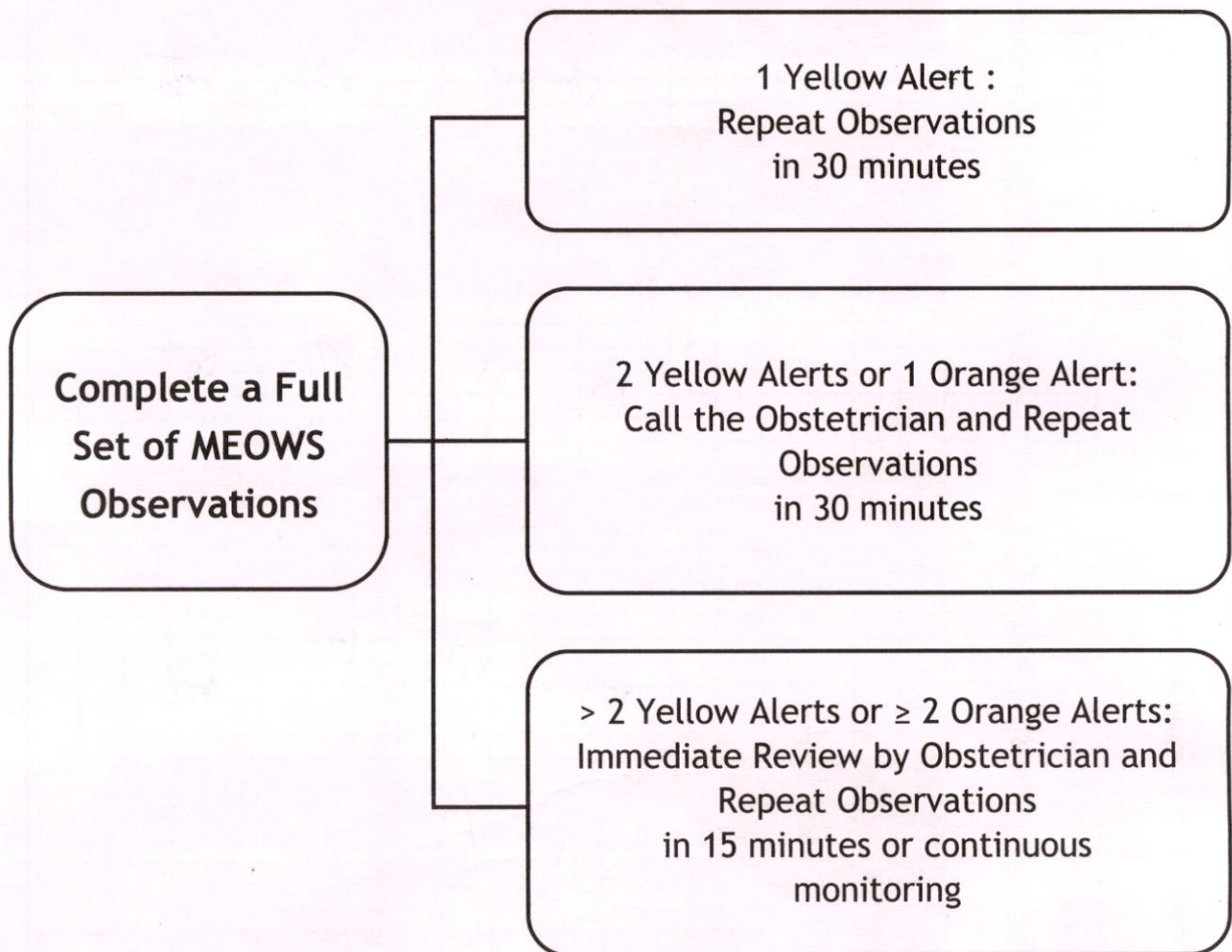
Date: 11/7/20 Time: 2:20pm



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

Obstetrics and Gynaecology Early Warning Signs



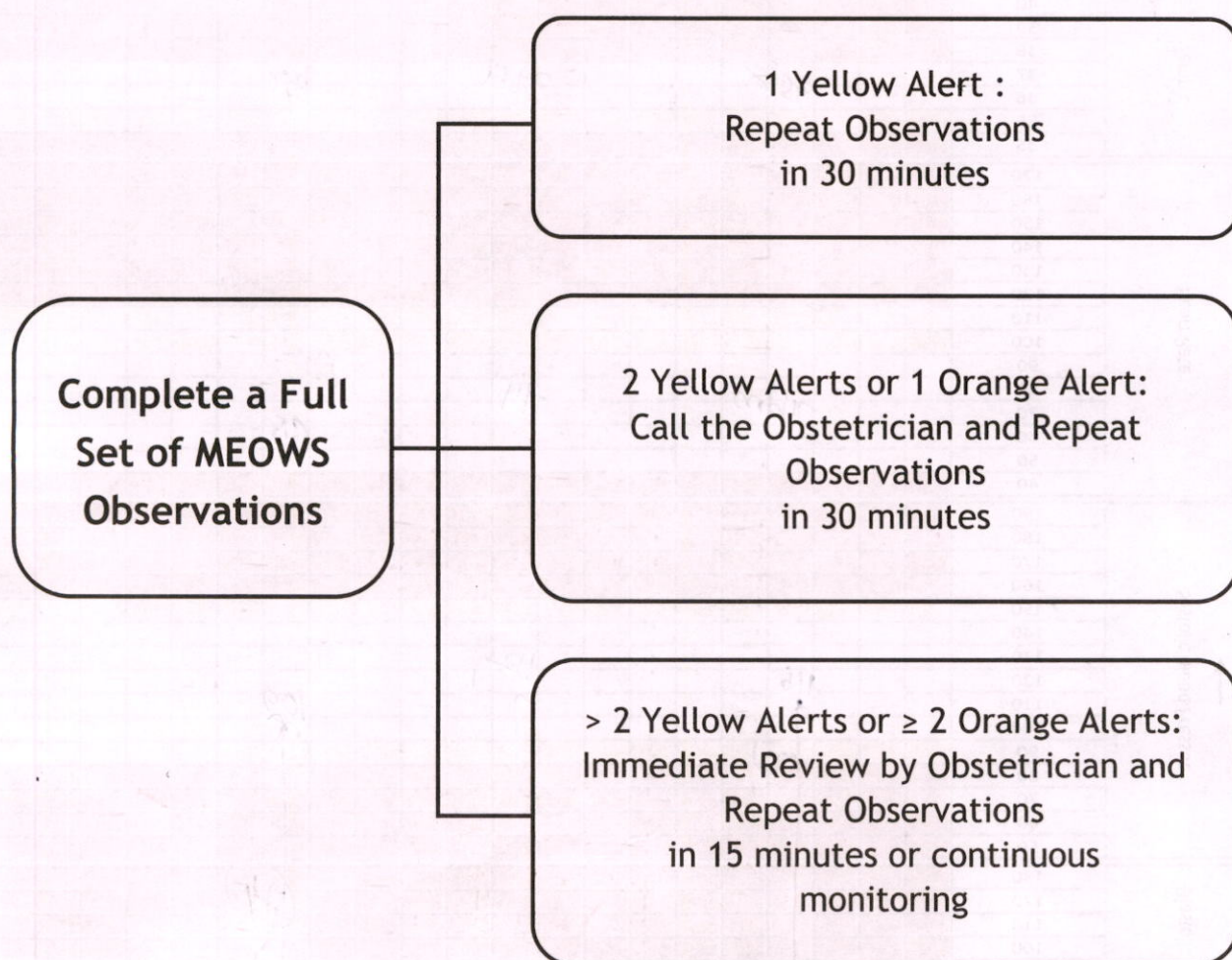
* The Modified Early Warning Score (MEOWS)



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

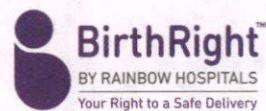
Date																									
Time		8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																								
	21 - 30																								
	11 - 20																								
	0 - 10																								
Saturations	94 - 100 %																								
	<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

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

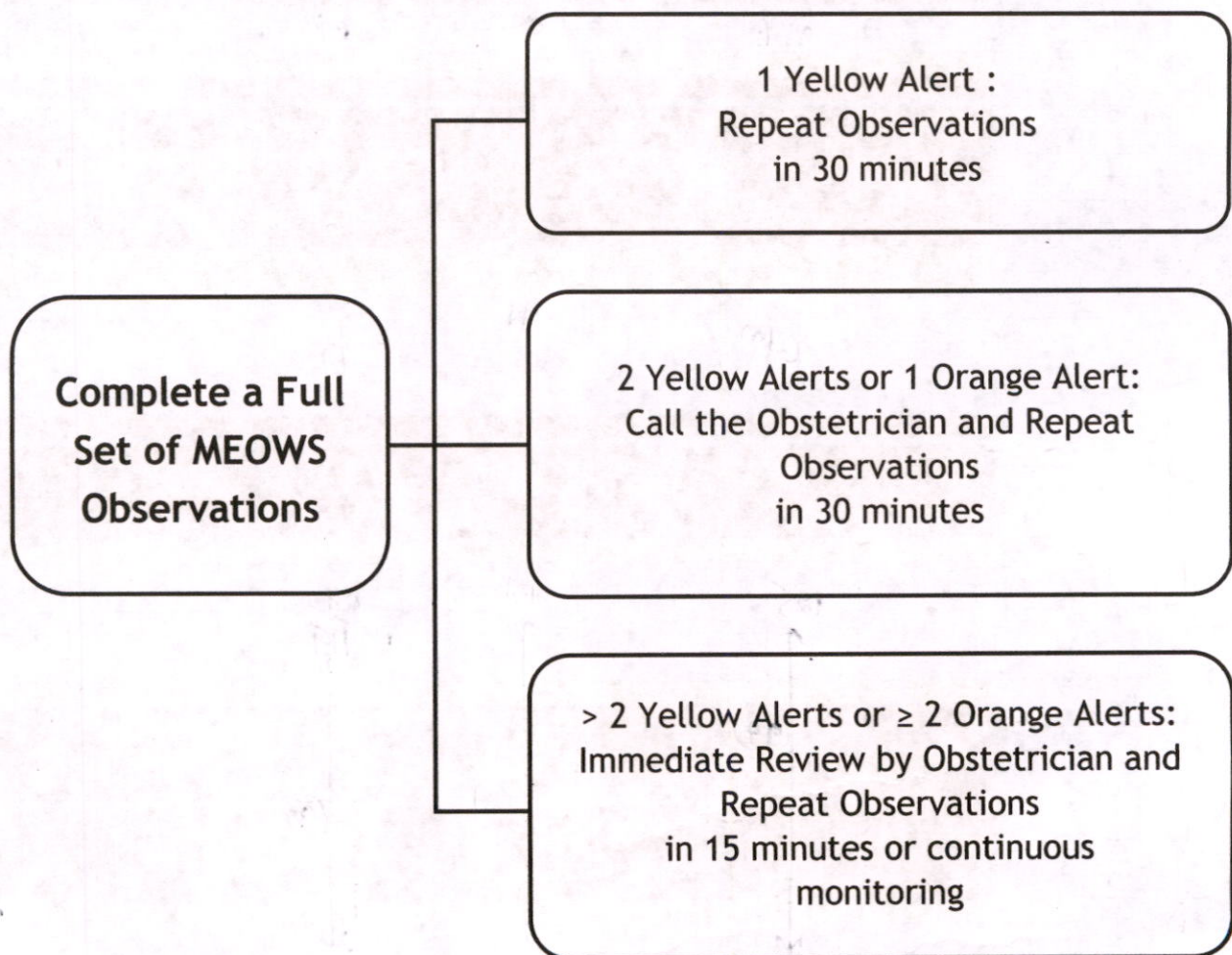
3/7/26



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

[illegible]

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

BAH-00322855 IP5-00175830
 Mrs SANDHYA REDDY MALLADI (F)
 23-11-1986 39 Y 7 M 8 D
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FLUID CHART

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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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm	M											
	04:00 pm	B	100 ml							100 ml	0	Free	
	05:00 pm	B	100 ml							100 ml	0	Free	
	06:00 pm	M	100 ml								0	Free	
	07:00 pm	M	100 ml								0	Free	
Total Intake :						Total Output :							
	08:00 pm		100 ml							500 ml	0	Free	
	09:00 pm		100 ml								0	Free	
	10:00 pm		100 ml								0	Free	
	11:00 pm		100 ml								0	Free	
	12:00 am		100 ml								0	Free	
	01:00 am		100 ml							700 ml	0	Free	
Total Intake :						Total Output :							
	02:00 am		100 ml							100 ml	0	Free	
	03:00 am		100 ml								0	Free	
	04:00 am		100 ml								0	Free	
	05:00 am		100 ml								0	Free	
	06:00 am		100 ml							300 ml	0	Free	
	07:00 am		100 ml								0	Free	
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							

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						
21/26	08:00 am									0	Rajani
	09:00 am	H ₂ O								0	
	10:00 am							200ml		0	
	11:00 am	H ₂ O								0	
	12:00 pm							100ml		0	
	01:00 pm	H ₂ O				✓				0	
Total Intake :					M=1 Total Output : U=1						
	02:00 pm									0	Saurha
	03:00 pm									0	
	04:00 pm	H ₂ O								0	
	05:00 pm									0	
	06:00 pm	H ₂ O								0	
	07:00 pm									0	
Total Intake :					Total Output : M=0 U=1						
	08:00 pm									0	Seema
	09:00 pm	H ₂ O								0	
	10:00 pm									0	
	11:00 pm	H ₂ O								0	
	12:00 am									0	
	01:00 am	H ₂ O								0	
Total Intake :					Total Output : M=0 U=2						
	02:00 am									0	Seema
	03:00 am	H ₂ O								0	
	04:00 am									0	
	05:00 am									0	
	06:00 am	H ₂ O								0	
	07:00 am									0	
Total Intake :					Total Output : M=0 U=2						
Total 24 hrs. Intake											
Total 24 hrs. Output		M=0 U=6									

BAH-00322855 IP5-00175830
 Mrs SANDHYA REDDY MALLADI
 23-11-1986 39 Y 7 M 9 D (F)
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Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
3/7/20	08:00 am	H ₂ O								✓	0	Sathyan
	09:00 am										0	
	10:00 am	H ₂ O					MP			✓	0	
	11:00 am										0	
	12:00 pm	H ₂ O								✓	0	
	01:00 pm										0	
Total Intake :						M=0 Total Output : U=3						
	02:00 pm										0	Sathyan
	03:00 pm										0	
	04:00 pm	H ₂ O								✓	0	
	05:00 pm						MP				0	
	06:00 pm	H ₂ O								✓	0	
	07:00 pm										0	
Total Intake :						Total Output : M=0 U=2						
	08:00 pm										0	Sathyan
	09:00 pm	H ₂ O								✓	0	
	10:00 pm										0	
	11:00 pm						MP				0	
	12:00 am	H ₂ O								✓	0	
	01:00 am										0	
Total Intake :						Total Output : M=0 U=2						
	02:00 am										0	Sathyan
	03:00 am	H ₂ O								✓	0	
	04:00 am										0	
	05:00 am						MP				0	
	06:00 am	H ₂ O								✓	0	
	07:00 am										0	
Total Intake :						Total Output : M=0 U=2						
Total 24 hrs. Intake						Total 24 hrs. Output			M=0 U=9			

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 Dr. DR.M PRATHYUSHA REDDY

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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			
4/7/2020			Mouth	I.V	N.G								
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 1/7/20

Assessment: patient came for Sleep 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
2pm	Assess the pt condition	2pm	Assessed the pt condition	patient is comfortable
3pm	Monitor vitals	3:30pm	Vitals checked & recorded	
4pm	Do chest	4:30pm	Do chest monitoring	
5pm	IV fluids	5:45pm	IV fluids on going	
6pm	Safety	6:30pm	pt under safety	
7pm	Drug Administration	7:45pm	Drug monitoring	
8pm	Full monitoring	8:05pm	Medication given as per drug chart	

Re-Assessment: Now pt comfortable

Special Notes: Not Significant

Nurse Signature: [Signature] Nurse Name: [Signature] Date & Time: 1/7/20 8pm

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 1/7/26

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
8pm	Assess the pt condition	9pm	Assess the pt condition	pt is comfortable.
10pm	monitoring vitals	11pm	vitals checked & recorded	
12am	Z/o chest monitoring	2am	Z/o chest medication given.	
4am	IV Fluids &	5am	stated IV Fluids	
	6am observation.	7:30 am	observation done.	

Re-Assessment: Re-Assessment 6th hour

Special Notes: Fecity present

Nurse Signature: [Signature]

Nurse Name: Radh

Date & Time: 2/7/26 C. San

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NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 2/7/26

Assessment: Patient having pain and discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	→ To assess the general condition of the patient	8:30am	→ Assessed the general condition of the patient	Patient stable
9am	→ To monitor vital signs	9:10am	→ Monitored vitals & recorded	Vitals normal
10am	→ To encourage oral intake	10:15am	→ She had soft diet	Soft diet tolerated
11am	→ To administer medicines	11:30am	→ Administered medications	
12pm	→ To maintain I/O chart	12:05pm	→ Maintained I/O chart	
1pm	→ To encourage voiding	1:10pm	→ Voiding done	

Re-Assessment: After given 100 Paracetamol, pain & discomfort has reduced

Special Notes:

Nurse Signature: @

Nurse Name: Kalyanani

Date & Time: 2/7 at 2pm



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 21/7/26

Assessment: patient having minimal pain in surgical site (HTN)

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess to the Patient condition	2.10 pm	Assessed to the patient on sleep	patient well
3pm	To maintain y/o chart.	3.15 pm	Maintained y/o chart.	
4pm	To monitor vitals	5pm	Monitored vitals.	
5pm	plan to encourage orally	6.30 pm	patient taking orally liquid & soft diet.	
6pm	soft diet & plenty of fluid.	7.30 pm	patient ambulated.	
7pm	Ambulation.		medication given as advice	
	Medication.		pain killer & HTN drugs	

Re-Assessment:

Reassessment after 2 hrs pt BP coming to normal

Special Notes: L.M.

Nurse Signature:

Nurse Name: Soubhagini

Date & Time: 21/7/26 @ 8pm

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 Dr. DR.M PRATHYUSHA REDDY

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 21/7/26

Assessment: patient having mild pain in surgical site.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	* Assess the patient condition.	8:30 pm	* Assessed the patient condition, patient is stable.	* patient is stable after ambulate.
10pm	* plan to monitor vital	10:20 pm	* monitor vital stable.	
11pm	* plan to maintain I/O chart.	11:40 pm	* maintain I/O chart	
12am	* plan to W/R bleeding	12:30 am	* Bleeding is normal	
6am	* plan to soft diet	6:30 am	* patient taken soft diet.	
7am	* plan to ambulation	7:40 am	* patient ambulate.	
8am	* plan to medication.	8am	* given medication as per doctor orders.	

Re-Assessment: provide comfortable position.

Special Notes: —NA—

Nurse Signature: 

Nurse Name: Seema

Date & Time: 21/7/26 @ 8am

BAH-00322855 IP5-00175830
 Mrs SANDHYA REDDY MALLADI
 23-11-1986 39 Y 7 M 9 D (F)
 Dr. DR.M PRATHYUSHA REDDY



NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 3/7/26

Assessment: Mild pain and discomfort at surgical site

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	→ To assess the general condition of the pt.	8:00am	→ Assessed the general condition of the pt.	Patient is stable Vitals normal Soft diet tolerated
10am	→ To monitor vital signs	10:30am	→ Monitored vitals and recorded	
11am	→ To encourage oral intake	11:15am	→ She had soft diet	
12pm	→ To maintain I/O chart	12:20pm	→ Maintained I/O chart	
1pm	→ To administer medicines.	1:10pm	→ Administered medicines	

Re-Assessment: Pain and discomfort has reduced after given Tab - Paracetamol

Special Notes:

Nurse Signature:

Nurse Name: Kalyani

Date & Time: 3/7 at 2pm

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Dr. DR.M PRATHYUSHA REDDY (F)

NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 3/7/26

Assessment: Minimal pain in surgical site related to past surgery

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess to the patient condition	2:15pm	Assessed to the patient on sleep	patient well & active.
3pm	Maintain i/o chart.	3:15pm	Maintained i/o chart & monitored vitals.	
4pm	Monitor vitals	4:20pm	patient taking soft diet & plenty of fluid.	
5pm	plan to encourage orally plenty of fluid & soft diet	5:30pm	patient Ambulated & feeling active.	
6pm	Encourage to do ambulation	6:40pm	Medication given as orders.	
7pm	Medication.	7:30pm		

Re-Assessment:

Special Notes: Dressing to be done today.

Nurse Signature: 

Nurse Name: Soubhagini

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

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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 31/7/26

Assessment: patient having mild pain in surgical site.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8 pm	* Assess the patient condition.	8:30 pm	* Assessed the patient condition, patient is stable.	* patient is stable
10 pm	* plan to monitor vitals	10:20 pm	* monitor vitals stable.	
12 am	* plan to maintain I/O chart.	12:30 am	* maintain I/O chart	
6 am	* plan to ambulation	6:40 am	* patient ambulate.	
7 am	* plan to soft diet	7:30 am	* patient taken soft diet	
8 am	* plan to medication.	8 am	* Given medication as per doctor orders.	

Re-Assessment: provide comfortable position.

Special Notes: ———

Nurse Signature:

Nurse Name: Seema

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



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Prathyusha Reddy Department: Ble Date of Admission: 1/7/26

SITUATION		Diagnosis: <u>broken 36+6 of CRANIUM for GC-UEY</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:			
BACKGROUND	Area	Shift Time	<u>OBS 2nd shift</u>	<u>OBS 3rd shift</u>	<u>3rd shift</u>		
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>2SCS</u>	<u>2SCS</u>		
ASSESSMENT	Allergy:	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Tubes/Drains/Catheter:	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp:	<u>98.6</u>	<u>98.2</u>	<u>97.7</u>	<u>98.2</u>	<u>97.7</u>
		Res:	<u>19</u>	<u>20</u>	<u>22</u>	<u>20</u>	<u>22</u>
		SpO ₂ :	<u>100%</u>	<u>99%</u>	<u>100%</u>	<u>99%</u>	<u>100%</u>
		Pulse:	<u>87</u>	<u>90</u>	<u>91</u>	<u>80</u>	<u>89</u>
		BP:	<u>119/20</u>	<u>128/28</u>	<u>124/86</u>	<u>116/81</u>	<u>121/71</u>
	Fall Risk Score:	<u>20</u>	<u>35</u>	<u>35</u>	<u>35</u>	<u>35</u>	
Pain Score:	<u>0</u>	<u>0</u>	<u>0/10</u>	<u>0</u>	<u>0/10</u>		
Recommendations	Safety Needs:	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Reel</u>	<u>Reel</u>	<u>Seemg</u>	<u>Kalyani</u>	<u>Seemg</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>1/7/26</u>	<u>2/7/26</u>	<u>2/7/26</u>	<u>2/7/26</u>	<u>3/7/26</u>	
Time:		<u>8pm</u>	<u>8am</u>	<u>8am</u>	<u>8pm</u>	<u>8am</u>	
Taken Over By Name :		<u>Reel</u>	<u>Seemg</u>	<u>Kalyani</u>	<u>Seemg</u>	<u>Kalyani</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>1/7/26</u>	<u>2/7/26</u>	<u>2/7/26</u>	<u>2/7/26</u>	<u>3/7/26</u>	
Time:		<u>8pm</u>	<u>8am</u>	<u>8am</u>	<u>8pm</u>	<u>8am</u>	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. P. Prathyusha Department: Gyn Date of Admission: 1/12/26

SITUATION	Diagnosis: <u>G2P2L1 / 36+6 weeks</u>			Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:			
	Area	Shift Time	<u>3rd</u> <u>2pm</u>	<u>3rd</u> <u>8pm</u>	<u>3rd</u> <u>8am</u>		
BACKGROUND	Medical Condition (Any special condition to be noted):		<u>1st TN</u>	<u>LSCS</u>	<u>LSCS</u>		
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp:	<u>98°C</u>	<u>98°F</u>	<u>97.8°F</u>		
		Res:	<u>19b/m</u>	<u>20</u>	<u>22b/m</u>		
		SpO ₂ :	<u>99%</u>	<u>99</u>	<u>100%</u>		
		Pulse:	<u>88b/m</u>	<u>85</u>	<u>78b/m</u>		
		BP:	<u>125/79</u>	<u>101/78(87)</u>	<u>125/88</u>		
		Fall Risk Score:	<u>35</u>	<u>35</u>	<u>35</u>		
Pain Score:	<u>0</u>	<u>0</u>	<u>0/10</u>				
Recommendations	Safety Needs:	<u>Side rails</u>	<u>yes</u>	<u>yes</u>			
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>			
	Special Diet:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>			
Post Operative Procedure Special Orders:		<u>NA</u>	<u>M</u>	<u>NA</u>			
Handed Over By Name :		<u>Kalyani</u>	<u>Soubhami</u>	<u>Seema</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>3/12</u>	<u>3/12/26</u>	<u>4/12/26</u>			
Time:		<u>2pm</u>	<u>8pm</u>	<u>8am</u>			
Taken Over By Name :		<u>Soubhami</u>	<u>Seema</u>				
Signature :		<u>[Signature]</u>	<u>[Signature]</u>				
Date:		<u>3/12/26</u>	<u>3/12/26</u>				
Time:		<u>2pm</u>	<u>8pm</u>				

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 Mrs SANDHYA REDDY MALLADI
 23-11-1986 39 Y 7 M 8 D (F)
 Dr. DR.M PRATHYUSHA REDDY



Morse Fall Risk Assessment Form

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Choose Highest Applicable Score from each Category		Date / Time	1/7/20	2/7/20	3/7/20	Fall Risk Grading								
		Score				Risk Level	Morse Fall Score (MFS)	Action						
History of Falling (immediately or w/in 3 months)	Yes	25	0			✓ Low Risk	0 - 24	Standard Fall Precaution						
	No	0	0											
Secondary Diagnosis (more than one diagnosis)	Yes	15		15	15				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention			
	No	0	0											
Ambulatory Aid	Furniture	30										High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Crutches, Cane(S), Walker	15												
	None /Bed Rest /Nurse Assist	0	0											
IV / Heparin Lock or Saline	Yes	20	20	20	20	Total Morse Fall Scale Score:	20	38						
	No	0	0											
GAIT / Transferring	Impaired	20							Signature	Sandy	S			
	Weak (uses touch for balance)	10												
	Normal /On Bed Rest /Immobile	0	0											
Mental Status	Forgets limitations	15												
	Oriented to own ability	0	0											

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

- ☒ Ensure patients use their prescribed eye glasses if any, in the hospital
- ☒ Use chairs with arm rests
- ☒ Use safety straps on stretchers and wheelchairs while transporting patients

Moderate Risk (25-50) Apply all low risk intervention and

- ☐ Assist and/or supervise ambulation. Reinforce to always call for assistance
- ☒ Hourly safety check
- ☐ Assess patient after visitors, leave to ensure safety measures in place

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

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

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Morse Fall Risk Assessment Form

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

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		
	No	0			
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15	1		
	None /Bed Rest /Nurse Assist	0			
IV / Heparin Lock or Saline	Yes	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			
Total Morse Fall Scale Score:			15		
Signature			Seema		

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

- ☐ Ensure patients use their prescribed eye glasses if any, in the hospital
- ☐ Use chairs with arm rests
- ☐ Use safety straps on stretchers and wheelchairs while transporting patients

Moderate Risk (25-50) Apply all low risk intervention and

- ☐ Assist and/or supervise ambulation. Reinforce to always call for assistance
- ☐ Hourly safety check
- ☐ Assess patient after visitors, leave to ensure safety measures in place

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

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

BAH-00322855

IP5-00175830

Mrs SANDHYA REDDY MALLADI

23-11-1986

39 Y 7 M 8 D

(F)

Dr. DR.M PRATHYUSHA REDDY



BRADEN 'Q' SCALE

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

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		Date : 11/8 21/7 31/7 4/7			
		Time : 2pm 2pm 2pm 2pm			
Mobility	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:treimity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	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 insic'e room at least once every 2 hours during walking hours.	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
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
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
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
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
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					
TOTAL SCORE					28
Evaluator's Name					Reddy

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

BAH-00322855 IP5-00175830
 Mrs SANDHYA REDDY MALLADI
 23-11-1986 39 Y 7 M 8 D (F)
 Dr. DR.M PRATHYUSHA REDDY



CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

Signature : Name :

Signature of Ward In Charge :

Signature : Name :



PAIN ASSESSMENT FORM

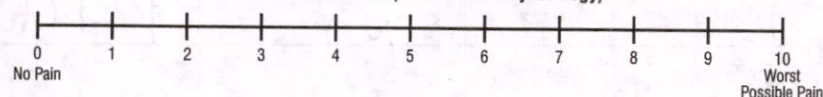
Date	Time	Pre (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
1/7	3pm	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Heely
1/7/26	5pm	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Heely
1/7/26	8pm	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Heely
1/7/26	10pm	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		Heely
2/7/26	12am	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	Heely
2/7/26	2am	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Heely
2/7/26	6am	3/10	SLs	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☐ Yes ☐ No	Tab. Co 100g Given	Seema
2/7/26	7am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Seema
2/7	12pm	4/10	S/S	☒ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☒ Aching ☐ Burning	☒ Increasing ☒ Decreasing	☐ Yes ☒ No	Tab. Paracetamol	Kalyani
2/7	1pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Kalyani

Re-assessment Frequency:

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



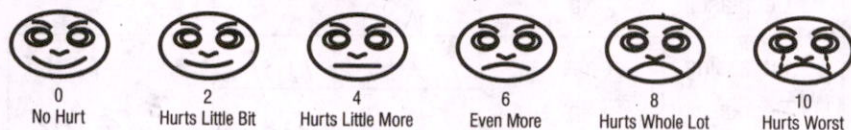
FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs 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

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

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

Wong - Baker (Pediatrics) Above 7 Years





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
2/07/26	4pm	1	S/S	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☒ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	T-Pramadol given	Southamni
2/7/26	5pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Southamni
2/7/26	6pm	1	S/S	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☒ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	T-Carpal given	Southamni
2/7/26	7pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	under observation	Southamni
2/7/26	10pm	3/10	S/S	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	T. TRAMADOL given	Seema
2/7/26	11pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Seema
3/7/26	12AM	2/10	S/S	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	T. Carpal given	Seema
3/7/26	1AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Seema
3/7	6AM	3/10	S/S	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	T. Carpal given	Seema
3/7	7AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Seema

Re-assessment Frequency:

1. Every eight hours for all hospitalized patients.

2. For post-surgical patients, patients with chronic pain, patient with severe pain:

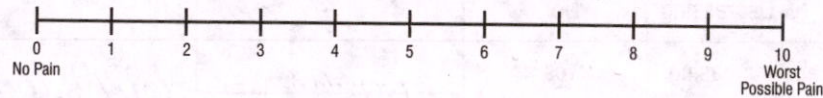
- | | |
|--|---|
| a) At least every 2 hours for the first 24 hours | b) Then every 4 hours. |
| c) Prior to pain relieving intervention. | d) Within 30 – 60 minutes after pain relief intervention. |

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
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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
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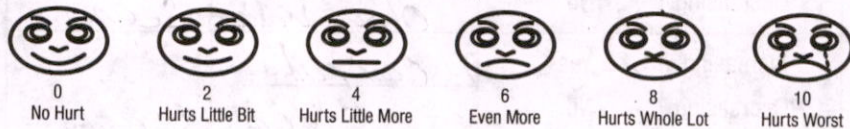
Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
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Vital Signs HR RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
3/7	12pm	4/10	S/S	☒ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☒ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Dolo-Paracetamol	Kalyani
3/7	1pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Kalyani
3/7/26	4pm	1	S/S	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☒ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	T- Tramadol given	Southern
3/7/26	5pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Southern
3/7/26	10pm	2/10	S/S	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	T. TRAMADOL given	Seema
3/7/26	11pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Seema
4/7/26	6am	3/10	S/S	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	T. COCODOL given	Seema
4/7/26	7am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Seema
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

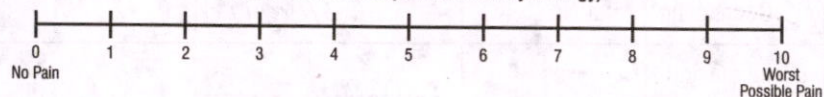
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PAIN ASSESSMENT TOOLS

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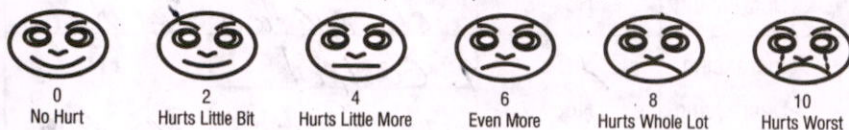
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Wong - Baker (Pediatrics) Above 7 Years



PAIN ASSESSMENT FORM

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				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

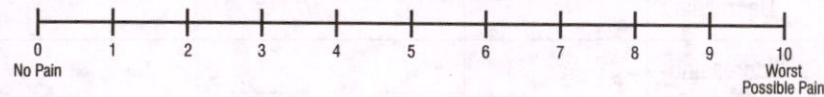
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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

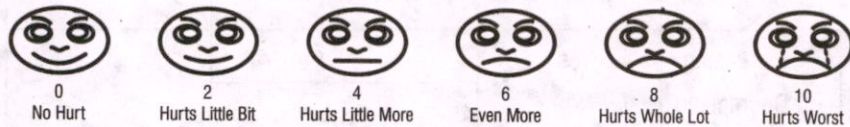
Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



BAH-00322855
Mrs SANDHYA REDDY MALLADI
23-11-1986 39 Y 7 M 9 D
Dr. DR.M PRATHYUSHA REDDY (F)



POST – PARTUM ASSESSMENT FORM – IN-PATIENT

Date: 3/7/26

Chief Complaint : Pain at the suture site

Obstetric/ Birthing History : G2P2L2, LSCS, POD -2

Previous Surgical/Medical History : -

Assessment :

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

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

Iv line + / -

Catheter + / -

Postural alignment -

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

On Examination : Breathing pattern – abdominal/ apical/ diaphragmatic

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

Able to initiate Pelvic Floor Activation – ☒ Yes ☐ No

Spl Notes -

Treatment Plan :

☒ Lateral Breathing

☒ Pelvic Floor Activation

☒ Transversus Abdominis Activation

☒ Gluteus Activation

☒ Active Motion for Limbs

☒ Transfer Training & Mobility

☒ Sit to Stand

☒ Monitored Walk

☒ Posture & Ergonomic Education

Signature : T.S.

Name : Dr. Tuhina Sharma (PT)

Date & Time: 3/7/26 4pm

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

Patient Name : Sandhya Rani Gender: ☐ Male ☒ Female Age : 39
UHID No : BAH-00322855 Date : 11/06/26

Instruction:

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

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

ELECTIVE LOWER SEGMENT CAESAREAN SECTION
upon SANDHYA of the RANI

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

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

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

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

My signature on this form indicates that

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

Name of the Doctor who is performing the Surgery / Procedure: Dr. Prathyusha Reddy

Consentee :

Signature : M. Sandhya
Name : Sandhya
Date & Time : 11/06/26 4pm

Witness :

Signature : [Signature]
Name : [Name]
Date & Time : 11/06/26 4pm

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

Patient Attendant :

Signature : [Signature]
Name : M. Suresh Reddy
Relationship with Patient: Husband
Date & Time : 01/07/26 4pm

Doctor (who is taking the consent) :

Signature : [Signature]
Name : Dr. Samudra
Date & Time : 11/06/26 4pm

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE



Patient Name : Sandhya Rani Gender: ☐ Male ☒ Female Age : 39
UHID No : BAH -00 322835 Date : 1/26/26

Instruction:

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

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

BILATERAL ABDOMINAL TUBECTOMY

upon

SANDHYA RANI (Name of Patient)

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

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

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

Hemorrhage, Sepsis, Injury to surrounding structures, Risk of failure.

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. Prathima Reddy

Consentee :

Signature : M. Sandhya
Name : Sandhya
Date & Time : 1/26/26

Witness :

Signature : [Signature]
Name : [Name]
Date & Time : 1/26/26

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

Patient Attendant :

Signature : [Signature]
Name : M. Suresh Reddy
Relationship with Patient: Husband
Date & Time : 01/07/26 4pm

Doctor (who is taking the consent) :

Signature : [Signature]
Name : Dr. Prathima
Date & Time : 1/26/26 @ 4pm

BAH-00322855 IP5-00175830
Mrs SANDHYA REDDY MALLADI
23-11-1986 39 Y 7 M 8 D (F)
Dr. DR.M PRATHYUSHA REDDY



CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☒ Patient Attendant

Operative Procedure: Elective Caesarean Section

Anaesthesiologist: Dr Aditi Surgeon: Dr Prathyusha Reddy

Please read this before you consent for Anaesthesia

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

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

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

☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease

☐ Others HYPOTENSION, BRADYCARDIA, LARYNGEAL SPASM

TACHYCARDIA, PPH, SHIVERING

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: M. Sandhya

Name: MRS SANDHYA

Relationship with patient: SELF

Date & Time: 11/7/26 5.37

Witness:

Signature: [Signature]

Name: [Name]

Date & Time: 11/7/26 5.37

Doctor (who is taking consent):

Signature: [Signature] Name: Dr Aditi W

Date: 11/7/26 Time: 5.37

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.

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

స్పెసిఫిక్ హై రిస్క్:

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

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

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

☐ ఇతరవి:

రోగి / రోగి అటెండెంట్

- అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
☐ రిజనల్ 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, రిజనల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందానికి నేను అనుమతి ఇస్తున్నాను.
- శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న వైద్యుల బృందానికి కూడా నేను అనుమతి ఇస్తున్నాను.
- అనస్థీషియా విధానం, ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయ చికిత్సల గురించి అనస్థీషియా వైద్యులు నాకు వివరించినట్లు నేను అంగీకరిస్తున్నాను.
- పై సమాచారం అంతా నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో వాటికి సమాధానాలు ఇచ్చారు. ఈ అనుమతి నేను పూర్తిగా స్వచ్ఛమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Age: Sex: UHID.No:

Date: 1/7/21 Time: 530 Proposed Operation: elective cesarean section

Diagnosis: G2P1 L1 / 36+6 wks, previous LSCS, MCDP 10

B.P / CRT: 120/77 H.R: 90 Weight: 106.6 ASA Physical Status: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 12.5 Glucose: Protein: HIV: X-Ray:
PCV: Urea: 6.1 Alb: 7 HBS Ag: ECG:
WBC: 5450 Creat: 0.1 Total Bill: 7 HCV: 2D Echo:
Plate: 2.04L Na: Dir. Bill: 7 Blood group: O free Stress/Anglo:
PT: K: LDH: 7 T3 Other:
PTT: Ca++: Alk phos: T4
INR: Mg++: Amylase: TSH
Cl-: SGOT/SGPT:

Allergies: NKDA

Medical History: CVS: ✓

RESP: ✓

Diabetes: ✓

CNS: ✓

Renal: ✓

Hepatic / GE: ✓

Physical Activity: ✓

Others: ✓

Past Anaesthetic History: 2018 → LSCS

Physical Exam:

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

Lungs: AEBE, clear

Heart: S1S2

CNS: NKDA

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

Pre-Operative Instructions:

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

Signature: Dr. Satish N Name: Dr. Satish N



ANAESTHESIA CHART



Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☒ No

Fasting Status: > 6hr

Physical Status: ☒ Patient Identified

☒ Consent Present

☐ Chart Reviewed

H.R: 141

B.P / CRT: 123/92

SpO₂: 96%

R.R: 16

Last Feed: 26hr

Pre-OP Diagnosis: Gr. Peli. 0. Pw. LSC. DUCATION

Operation: Elective Caesarean Section

Date: 1/12/21

Surgeon: Dr. Prathyusha

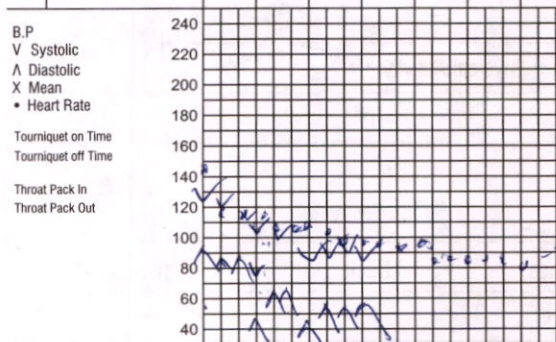
Anaesthesiologist: Dr. Aditya

Technician: Amritha

TIME
N₂O / AIR / O₂ LPM
HALO / SO / SEVO
Drugs:
INT OXIDIN 30+30+30+30
INT METHER GEN 0.2 MCT 5M

FiO₂ / SaO₂: 95 94 95 95
ETCO₂: 5R 5R 5R 5R
ECG
Temperature
Urine Output

Fluids
Blood LTE RLV - R2



LAB Values

- ☒ Equipment Checked and Functional
- ☒ BP LVL
- ☒ Cuff Site: LVL
- ☒ Art Site: 36ad
- ☒ EKG Lead
- ☒ Temp Site
- ☒ FIO₂ 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: 5:45
OP Start:
OP End:
Leave OR:

Anaesthesia:

- ☐ GA
- ☐ Monitored Anaesthesia Care
- ☐ Regional

Line (Size & Location)

- ☐ CVP:
- ☐ ART:
- ☐ IV: LVL 185
- ☐ IV:
- ☐ IV:

Induction

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

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

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

Blade# Attempts:
Difficulty Why?

- ☐ Bilal = BS
- ☐ Semi-Closed Circle
- ☐ Closed Circle
- ☐ Other

Regional:

- Extremity ☒ Spinal ☐ Epidural ☐ Caudal

Others:

Position: Supine

Site: L3-4

Needle Size: 25G Depth:

Paresthesia ☐ Yes ☐ No

Catheter at skin cm

Drug Name & Conc: 0.5%

Bolus: Bupivacaine 25mg

Infusion: 25mg

Block Level: T1

Comments:

Transportation to ☒ PACU ☐ ICU ☐ Other

Relaxant Reversed ☐ Yes ☐ No ☐ NA

Name of the Doctor: Dr. Aditya

Signature of the Doctor: Aditya

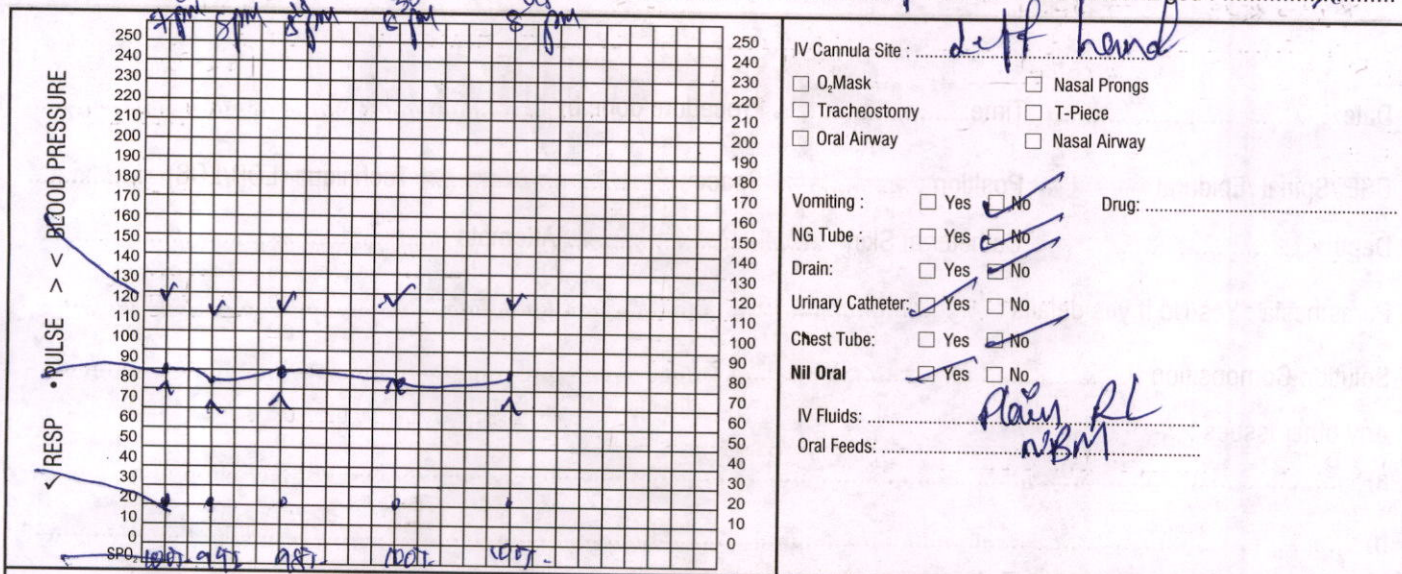


POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Dr. Adithi

Time Received : 7:30 PM

Time Discharged : 2 AM



IV Cannula Site : Left hand

☐ O₂ Mask ☐ Nasal Prongs
☐ Tracheostomy ☐ T-Piece
☐ Oral Airway ☐ Nasal Airway

Vomiting : ☐ Yes ☒ No

Drug :

NG Tube : ☐ Yes ☒ No

Drain : ☐ Yes ☒ No

Urinary Catheter : ☐ Yes ☒ No

Chest Tube : ☐ Yes ☒ No

Nil Oral : ☒ Yes ☐ No

IV Fluids : Plain RL

Oral Feeds : NBM

POST ANAESTHESIA SCORE (Modified Aldrete Score)

IN MINUTES
30 60 90 OUT

SCORING INTERPRETATION

Able to move 4 extremities voluntary or on command = 2	ACTIVITY	1	2	2	2	
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	2	
Arousable on calling = 1						
Not responding = 0						
Pink = 2	COLOR	2	2	2	2	
Pale, dusky, blotchy, jaundiced, other = 1						
Cyanotic = 0						
TOTAL		9	10	10	10	

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:

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
1/11/26	9 PM	0/10	NA	Dr. Adithi

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

Anaesthesiologist Name : Dr. ADITHI

Anaesthesiologist Signature : [Signature]

Date & Time : 2/11/26 @ 1 AM

PACU Nurse Name : Dr. Adithi

PACU Nurse Signature : [Signature]

Date & Time : 1/11/26 @ 9 PM

Reassessment Frequency:

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

Transferred to Unit by (PACU): DRS

Date & Time : 1/11/26 @ 9 PM

Patient Sticker

Department of Anaesthesiology
EPIDURAL ANALGESIA RECORD

b)

[illegible]

Date and Time :

BAH-00322855 IP5-00175830
Mrs SANDHYA REDDY MALLADI
23-11-1986 39 Y 7 M 8 D (F)
Dr. DR.M PRATHYUSHA REDDY

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

DISCHARGE PLANNING FORM

Nationality: Indo

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

1. Anticipated Date of Discharge: 31/10/16

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

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

☐ Needs Assistance In:

Remarks

☐ Medication ☐ Yes ☐ No

☐ Bathing ☐ Yes ☐ No

☐ Eating ☐ Yes ☐ No

☐ Walking ☐ Yes ☐ No

☐ Dressing ☐ Yes ☐ No

☐ Toileting ☐ Yes ☐ No

Not Applicable

Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: Hand Hygiene

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

☒ Patient ☐ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: Becky

Date and Time: 1/11/16 12:20pm

BAH-00322855 IP5-00175830
Mrs SANDHYA REDDY MALLADI
23-11-1986 39 Y 7 M 8 D (F)
Dr. DR.M PRATHYUSHA REDDY



URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 1/7/26

Date of Removal: 2/7/26 at 12pm

Parameters	Date	Shift Time						
Need for the Catheter	1/7/26	11:30 AM	☒ Yes ☐ No	1/7/26	11:30 AM	☒ Yes ☐ No	2/7/26	6 AM
Hand Hygiene			☒ Yes ☐ No			☒ Yes ☐ No		
Usage of Sterile Equipment			☒ Yes ☐ No			☒ Yes ☐ No		
Is the Collection bag below the level of bladder			☒ Yes ☐ No			☒ Yes ☐ No		
Check the Tube for Obstruction (Free of Kinking)			☒ Yes ☐ No			☒ Yes ☐ No		
Is Catheter dated as policy			☒ Yes ☐ No			☒ Yes ☐ No		
Collecting bag is been emptied regularly?			☒ Yes ☐ No			☒ Yes ☐ No	Removed	
Maintenance of closed system for the catheter			☒ Yes ☐ No			☒ Yes ☐ No		
Dressing clean and dry?			☒ Yes ☐ No			☒ Yes ☐ No		
Is the line removed as Policy?			☐ Yes ☒ No			☐ Yes ☒ No		
Performance of Perineal Care			☒ Yes ☐ No			☒ Yes ☐ No		
Onset of New Fever			☐ Yes ☒ No			☐ Yes ☒ No		
Asses for the leakage at the site of insertion			☐ Yes ☐ No			☐ Yes ☐ No		
Name of the Nurse			Heela Reddy			seema		
Signature of the Nurse								



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NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 2/7/26

Time: 8:40am

Origin: Indian

Height: 157cm

Weight: 106.6kg's

BMI: 43.49kg/m²

Food Allergies: No

Diagnosis: POD-1 / EL. LSCS (Lower Segment Cesarean 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 food

Patient's / Attendant's

Signature: K. Anitha

Name: Anitha

Date & Time: 2/7/26
8:40am

Dietician's

Signature: Saima

Name: SAIMA

Date & Time: 2/7/26
8:40am

DIETARY NOTES[illegible]