2/3-26

Name	Mrs SANNAMANDA KAMALA KUMARI	**UHID**	HNH-00016451
Father/Guardian	Mr B SAI KUMAR	**Age/Gender**	30 Y 2 M 16 D/ Female
Address	SIDDARATHA MADHURAN APARTMENT 303 3RD FLOOR, Jamia Osmania, Hyderabad, Telangana, INDIA, 500061		
IP No	IP26-00006794	**Admission Date**	09-07-2026
Ref Doctor			
Discharge Date	12.07.2026		

DISCHARGE SUMMARY

Consultant:
Dr. SWAPNA SAMUDRALA
MBBS, MS (OBG)
69924

Diagnosis: PRIMI AT 34^{+2} WEEKS WITH SEVERE PRE-ECLAMPSIA WITH ABRUPTIO PLACENTA FOR EMERGENCY LOWER SEGMENT CAESAREAN SECTION

EMERGENCY LOWER SEGMENT CAESAREAN SECTION DONE ON 09.07.2026

History:
LMP: 15.10.2025 Obstetric formula: PRIMI

Name	Mrs SANNAMANDA KAMALA KUMARI	**UHID**	HNH-00016451
IP No	IP26-00006794	**Admission Date**	09-07-2026

EDD: 18.08.2026 Gestation at admission: 34^{+2} weeks

Obstetric History:
G1 -Present Pregnancy, Spontaneous conception.

Medical History: Nil **Family History:** Nil
Surgical History: Nil **Allergies:** Nil

Antenatal Details:
Mrs SANNAMANDA KAMALA KUMARI was booked to Rainbow hospital at 34^{+2} weeks of gestation. She had regular antenatal checkups and investigations as advised elsewhere. NT scan was normal. FTS- low risk. TIFFA was normal. Viability scan normal. Growth scan was normal. Fetal surveillance done by serial growth scans . She had H/o cough and cold since 2 weeks for which treatment was taken. She consulted elsewhere with C/o sudden painless bleeding p/v with increased BP recordings (150/106 mmhg) on 9/7/26. USG scan done (09.07.2026) showed at 34 weeks showed single live fetus with cephalic presentation placenta -posterior upper segment , with retroplacental clot near lower end of placenta AFI-11cm, EFW-2.2kg.Hence she was referred at 34^{+2} weeks with Abruptio placenta for EM-LSCS.

Investigations: Enclosed.
Blood group: "B" Positive

Management:
Course in hospital and Delivery Details:

Name	Mrs SANNAMANDA KAMALA KUMARI	**UHID**	HNH-00016451
IP No	IP26-00006794	**Admission Date**	09-07-2026

At admission on clinical examination the vitals were BP-150/110 mmHg ,PR-90bpm , uterus was relaxed, Fetal Heart rate was good, L/e Bleeding pv noted ,Urine protein was 3+, No imminent signs of preeclampsia noted. Preeclampsia profile was sent and was normal. Inj Betamethasone 12 mg I.M. was given for fetal lung maturity. NICU counselling was done. She was decided for emergency C- section in view of Severe Pre eclampsia with Abruption and was prepared with indwelling Foley's catheter and IV canula under aseptic conditions. Written informed consent for surgery taken. Preanesthetic check up done. Anesthetic premedication (IV Pantop and Perinorm) given. Patient shifted to theatre.

Surgery Notes:

Under general anesthesia she was painted and draped as per hospital protocol. Abdomen opened in layers. The parietal and visceral peritoneum carefully opened after identifying the urachus. Bladder was reflected. A lower segment curvilinear incision given on the uterus. Baby delivered. Cord clamped and cut and cord blood collected for blood grouping and Rh typing. Baby handed over to pediatrician. Placenta delivered with controlled cord traction. Uterus closed in layers. Hemostasis secured. Instruments and swab count checked. Rectus sheath closed. Subcutaneous fat approximated. Skin closed with subcuticular sutures. Wound dressing done. Vagina cleaned with Betadine solution after expelling clots. Misoprostol 800 mcg given per rectum as prophylaxis against Postpartum hemorrhage. Patient was shifted out of theatre to post operative recovery room.

* **LUS formed.**
* **Liquor- scanty.**

Name	Mrs SANNAMANDA KAMALA KUMARI	**UHID**	HNH-00016451
IP No	IP26-00006794	**Admission Date**	09-07-2026

***Retroplacental clot of 100 gm noted.**

Delivery Details :
Date : 09.07.2026
Time of Delivery: 03:16pm
Type of Delivery: Emergency lower segment caesarean section
Indication : Abruptio placenta with severe pre-eclampsia
Anaesthesia : Spinal

Baby Details:
Date : 09.07.2026
Time : 03:16pm
Sex : Female
Weight : 1.74kg
Apgar : 6,7
Gestational Age: 34^{+2} weeks
NICU Admission: Yes

Post-Operative Notes:
She was closely monitored. In immediate postoperative period, her BP recordings were high and was started on labetalol infusion in consultation with Axon /Physician. Uterus was well retracted with no Postpartum hemorrhage. Breast feeding initiated. Her BP recordings were high immediate post OP for which Inj.Labetolol infusion was started at 4ml/hr and increased to 10 ml/hr. On first post operative day Physician review done and antihypertensives revised (Tab. Labetalol 200 mg BD,Tab. Amlong 10 mg BD). She was shifted to room.

Name	Mrs SANNAMANDA KAMALA KUMARI	**UHID**	HNH-00016451
IP No	IP26-00006794	**Admission Date**	09-07-2026

On third postoperative day dressing was changed. On inspection wound was healthy. Physician opinion was sought and antihypertensive revised and advised review after 5 days. Her general condition was satisfactory and she was found to be fit for discharge. Wound care and medications were explained to patient supplemented by written information. She was given the postpartum book for further reference.

Advice:

1. Tab. Augmentin DUO 625 mg thrice daily after food till 15.07.2026 (9am-3pm -11pm) after food.
2. Tab. Calpol 500mg (Paracetamol 500mg) (2tabs) thrice daily till 13.07.2026(8am-2pm-10pm) after food.
3. Tab. Voveran 50 mg (Diclofenac 50mg) thrice daily till 13.07.2026 (9am-3pm-11pm) after food.
4. Tab. Pantop 40mg twice daily till 15.07.2026(7am-7pm) before food.
5. Tab. Livogen (Elemental Iron - 50mg, folic acid 1.5mg) once daily (7am) for three months before breakfast.
6. Tab. Shelcal (Elemental Calcium 500 mg, Vitamin D3 250 IU) once daily (2pm) till breast feeding for after food.
7. Tab Amlong 10mg twice daily (8am-8pm) till further advice.
8. Tab Labetalol 200mg twice daily (10am-10pm) till further advice.
9. Physician review after 5 days.
10. Nebasulf Powder for local application.

Home Blood pressure monitoring to be done **twice daily** for **two weeks**. Report to emergency if **BP >140/90mmHg**, presence of headache, vomitings,

Name	Mrs SANNAMANDA KAMALA KUMARI	UHID	HNH-00016451
IP No	IP26-00006794	Admission Date	09-07-2026

blurred vision, reduced urine output, epigastric pain, seizures.

* Suggest **PAP smear** and **HPV Vaccine** after **6 weeks**; Please discuss with your treating doctor regarding **HPV vaccination.**

Review with **Dr. SWAPNA SAMUDRALA** after **2 week** on **27.07.2026** at Rainbow Children's Hospital with prior appointment **(Review consultation will be charged).**

Review with **Dr. NISHANTH REDDY INAVOL**, after **5 days** on **16.07.2026** at rainbow children's hospital with prior appointment. **(Review consultation will be charged).**

For Women Who Have Had a Caesarean Section
Care of the wound:
1.You can bath and shower.
2.The wound can get wet during a bath or shower. Dry it thoroughly and gently by dabbing with a gauze piece. Do not rub the wound.
3.This gauze piece needs to be discarded after one use.
4.Prior to touching the wound clean hands thoroughly with Microshield solution and allow them to air dry or use disposable paper napkins.
5.Apply Nebasulf or Neomycin dusting powder on the wound after it is dry.
6.Do not touch the wound with unwashed hands.

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, when and how to obtain

Name	Mrs SANNAMANDA KAMALA KUMARI	**UHID**	HNH-00016451
IP No	IP26-00006794	**Admission Date**	09-07-2026

emergency care etc also have been explained by doctor ..... in a language that I can understand and I acknowledge.

Patient/ Attender

In case of emergency like bleeding, fever [please refer to postpartum book for further details - Chapter II page 6] kindly contact 9154865045 at Rainbow Children's Hospital Himayatnagar just dial one toll free number - 18002122. You can also take appointments at any time by going online to our website **www.rainbowhospitals.in**

Dr. Manish

Registrar/Resident/C.M.O

Consultant:
Dr. SWAPNA SAMUDRALA
MBBS, MS (OBG)
69924

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar ,Hyderabad ,Telangana, INDIA ,500029.
TEL NO :040-48873000
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006794 **Admit Date** : 09-Jul-2026 **Admit Time** : 02:47 PM **UHID** : HNH-00016451

Patient Details :

Patient Name	: Mrs SANNAMANDA KAMALA KUMARI	**Age**	: 30 Y 2 M 16 D
Guardian	: Mr B SAI KUMAR	**DOB**	: 23-04-1996
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: SIDDARATHA MADHURAN APARTMENT 303 3RD FLOOR Jamia Osmania Hyderabad Telangana INDIA 500061	**Phone No**	: 8801580040/ 9398535470
		E-mail	: KAMALAKUMARISANNAMANDA@GMAIL.COM

Admission Details :

Bed Type : TWIN SHARING **Bed No** : LDR-416 **Ward Name** : 4F -OT

Room No : LDR-416 **Admission Type** : First Visit

Contact Details :

Name : Mr B SAI KUMAR **Relationship** : Husband

Contact Address : SIDDARATHA MADHURAN APARTMENT 303 3RD FLOOR Jamia Osmania Hyderabad Telangana INDIA 500061 **Phone No** : 8801580040

Signature

Doctor Details :

Doctor Name : Dr. SWAPNA SAMUDRALA **Specialisation** : OBSTETRICS AND GYNECOLOGY

Referral Doctor : **Phone No** :

Co-Consultant :

Payment Details :

Deposit Amount : 10000.00

Payment Mode : DC/CC Card **Payor Name** : VIDAL HEALTH INSURANCE TPA PVT LTD

PATIENT TRANSFER FORM

Rainbow® Children's Hospital
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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016451 IP26-00006794 Mrs SANNAMANDA KAMALA KUMARI 23-04-1996 30 Y 2 M 17 D (F) Dr. SWAPNA SAMUDRALA	9/7/26	11/7/26 10:10 AM
	Transfer Ordered by Dr. Dua.	Reason for Transfer Obs
From Unit MICU	To Unit Room	Information to Attendant Yes ☐ No ☑
Number of Sheets in Clinical File 35	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	PI	
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sis. Monika.	Dr. Dua.

Patient & Clinical Records Received by : Mounika.

Date & Time of Patient Received : @10:30 AM. 11/7/26

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

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

HNH-00016451 IP26-00006794
Mrs SANNAMANDA KAMALA KUMARI
23-04-1996 30 Y 2 M 17 D (F)
Dr. SWAPNA SAMUDRALA

HNH-00016451 IP26-00006794
Mrs SANNAMANDA KAMALA KUMARI
23-04-1996 30 Y 2 M 16 D (F)
Dr. SWAPNA SAMUDRALA

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CROSS CONSULTATION FORM

Doctor Name: Dr. NISHANTH REDDY .I. Date: 9/7/26 Time: 5:15pm

Diagnosis: S/p LSCS - P.O.D - 5 : ? Seizure ; URTI

Hospital: STAR HOSPITAL

Type of Referral :
☐ Emergency
☐ Urgent
☐ Non Urgent

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

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

Signature:

Findings and Recommendations : → S/p LSCS - P.O.D - 5

- Cough: 2 week
  - Productive
  - Postural variation +
- Swelling over both feet +
- No Dizziness, Headache, Blurring of vision

PR - c/c/c
PR - 112/m
BP - 140/90 mmHg
CVS - S1, S2 +
RS - BAE +

B/L Pedal edema +

CVE-Tnt. 3+

Rx
1) Tab. LOBET 200mg - Advise B.P
1 - 1 - 1
2) Tab. MONTEK - LC x 5 days
1 - 0 - 0
FLOMIST NASAL spray x 5 days
1 - 1 - 1

Consultant :

Name: Dr. NISHANTH REDDY .I Signature: [signature] Date & Time: 9/7/26, 5:15pm

Doc. No. : RCH / FRM / CLINICAL / 049

HNH-00016451 IP26-00006794
Mrs SANNAMANDA KAMALA KUMARI
23-04-1996 30 Y 2 M 16 D (F)
Dr. SWAPNA SAMUDRALA

(2)

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CROSS CONSULTATION FORM

Doctor Name: Dr. NISHANTH REDDY. L Date: 10/7/26 Time: 4:30pm

Diagnosis: S/p LSCS - POD -(1) ; ? SGA ; VRS

Hospital: STAR HOSPITAL

Type of Referral :

☐ Emergency

☐ Urgent

☐ Non Urgent

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

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

Signature:

Findings and Recommendations :

- S/p LSCS - POD - 1

- Asymptomatic

PT - c/c/c
S1 - fair
PR - 80/min
BP - 138/80 mmHg
CVS - S1, S2 +
RS - BAE +

Rx

Tab. LOBET | 200mg
1 — 1 — 1

Inform BP

+ Tab. NICARDIA RETARD | 20mg
1 — 1 — 1

Consultant :

Name: Dr. NISHANTH REDDY. L Signature: [signature] Date & Time: 10/7/26 - 4:30pm

Doc. No. : RCH / FRM / CLINICAL / 049

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ACTIVITY RECORD FOR BILLING

Name :_____ HNH-00016451 IP26-00006794
Mrs SANNAMANDA KAMALA KUMARI
23-04-1996 30 Y 2 M 16 D (F)
Dr. SWAPNA SAMUDRALA

UHID No. : ____ Consultant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
9/7/26	3PM	pre-post	OT	Kamala
9/7/26	4:30pm	OT	NICU	
11/7/26	10:10 Am			

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	urine albumin	9/7/26	212190	Ankeb.
2	dipstick			
3	(3+)			
4	Dr. Tejaswi (NNC)	9/7/26	212189	dkw 9.
5	(Neonatal counseling)			
6	Dr. Nishanth reddy	9/7/26	2198	Ankeb
7	Dr. Nishanth reddy	10/7/26	12571	Ankeb
8	Dr. S. Tejaswi Reddy (Lactation)	11/7/26 Saturday	12783	
9				cross checked done by priyanka.
10				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
9/7/26	CBP. - ①	11342 ✓	[signature]
9/7/26	electrolytes, urea, uric acid		
	creatinine, LFT, PT / APTT	11341 ✓	[signature]
	LDH		
9/7/26	GRBS - 91 mg/dl	11350 ✓	[signature]
~~[illegible]~~	~~([illegible] - ①)~~	~~[illegible]~~ ✓	[signature]
10/7/26	CBP - ②	11392 ✓	[signature]

Cross checked done

ans by Re

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
9/7	Infusion pump	4:30pm	9:30 AM	212167	Akhila.
9/7	cardia monitor	4:30pm		212167	
9/7	syrange pump	9:54 PM	10 AM 10/7/26 stoped	212315	Anusha.
			Cross checked done		

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
	IV placement	(1)	2169	Akhila
9/7/26	catheterization	(1)	2169	
9/7/26	PAC	(1)	2170	Akhila
		Cross checked done		
11/7/26	NIA	(1)	12784	BE

Room checked properly done by

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00016451 IP26-00006794
Mrs SANNAMANDA KAMALA KUMARI
23-04-1996 30 Y 2 M 16 D (F)
Dr. SWAPNA SAMUDRALA

Patient

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IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

~~Pain~~ . For Emr LSCS i/v/o abruption

Obstetric Formula: Primi

Obstetric Hostory:
Viability scan ✓, NT (N)
FTS - Low risk.
AFFFA (N)

Present Pregnancy Record:
Growth (N)
H/O High BP ~~:~~ today

RISK FACTORS:

- High BP recordings (GHTN)
- Retroplacental clot

Height: ..... cm
Weight: ~~48~~ ..... kg
Allergies: Nil
Breast: ~~☐~~ Normal ☐ Abnormal
General Examination:
Consciousness: (+) Pallor: (-)
Icterus: (-) Edema: (-)
Temp: Afebrile PR: 90bpm
BP: 150/110mmHg. DTR: (N).
CVS: S_1S_2 (+) RS BL NVBS
Liver/Spleen: (N) Urine Output: (N)

LMP: 15/10/25. EDD:
Corrected EDD: 18/8/26. GA: 38+2wks

Menstrual History: Regular: ~~☐~~ Yes ☐ No

Obstetric Examination

Fundal Height: Uterm
Ut. Activity: ~~☐~~ Relaxed ☐ Mild ☐ Mod ☐ Severe
Liquor: ~~☐~~ Adequate ☐ Oligo ☐ Poly
PP: ~~☐~~ Cephalic ☐ Breech Others _____
Head Fifths Palpable: 5/5
FHS: ~~☐~~ Normal ☐ Tachy ☐ Brady ☐ Absent

Per Speculum Examination N/A

Draining: ☐ Present ☐ Absent ☐ Bleeding
Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination N/A

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

DIAGNOSIS

Primi / 38+2 wks ε Abruptio placenta for Emr LSCS.

HNH-00016451 IP26-00006794
Mrs SANNAMANDA KAMALA KUMARI
23-04-1996 30 Y 2 M 16 D (F)
Dr. SWAPNA SAMUDRALA

Family History:	Surgical History:
Nil	Nil
Medical History:	**Medication History:**
Nil	On T. Fe / T. Ca
Plan of Care:	**Investigations:**
Emergency LSCS - NBM - Informed consent - Reserve 2 ⓞ PRBC - Inform OT / Anesth H - shift to OT on call - RBP - PE profile - Urine dipstick GRBS → 91 mg% ultrumin dipstick 3+	Blood Group - 'B positive' Hb - 11.1 g/dl Plt - 3.65 lkh WBC - 11k. 16/5/26 HIV HbsAg RPR NR. USG (9/7/26) ~ 34 wks. SLUG ~ 34 wks. Pl - PUS. c Retroplacental clot near lower end of Placenta. AFI - 11 cm, EFW - 2.2 kg.

Dr. SWAPNA SAMUDRALA
Reg. No: 69824

Doctor Name: Dr. G. Veena
Signature:
Date & Time: 9/7/26 @ 2pm.

Consultant Name: Dr. Swapna Samudrala
Signature:
Date & Time: 9/7/26 @ 2pm.

HNH-00016451 IP26-00006794
Mrs SANNAMANDA KAMALA KUMARI
23-04-1996 30 Y 2 M 16 D (F)
Dr. SWAPNA SAMUDRALA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

09/7/26
2.30pm

Counselling

Mother Name :- Kamala

H/o abruption

34wks , EFW → 2kg (± 200 g).

3 weeks early delivery.

2 days → Steroid injections → lung, heart, stomach (Maternity)

Prelem

1) lung : Breathing difficulty

CPAP → DR

lungs open

NICU → NIV

→ Ventilator → Surfactant

lungs

RCH /FRM / CLINICAL / 088

(P.T.O)

HNH-00016451 IP26-00006794
Mrs SANNAMANDA KAMALA KUMARI
23-04-1996 30 Y 2 M 16 D (F)
Dr. SWAPNA SAMUDRALA

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2)	feeding →	15 to 20ml ×.
	2ml → 4ml → 6ml	
	Mother milk.	
	↓	
	preterm formula.	
3)	Infection →.	Antibiotic → ~~Inf~~ test ↓ neg.
	24hrs → Conformatory → neg	
		stop
4)	Heart | Brain stem	at 24hrs
	Duration of stay →	Resp. support 5-7 days. Ventilator > 1wks
		feeding 3 days

Dr. S. TEJASWI REDDY
Registration No: 94068

HNH-00016451 IP26-00006794
Mrs SANNAMANDA KAMALA KUMARI
23-04-1996 30 Y 2 M 16 D (F)
Dr. SWAPNA SAMUDRALA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/3/26 2pm	Primi / 34+2 wks / Sev. PE / Abruptio placenta	
	c/o Bleeding P/V - 1 episode (? frank bleeding) @ 9:30 AM f/b another episode	
	& low back	
	c/o Bleeding P/V / cough. On & off ...	
	No Eminent Symptoms	
	App. fm well	
		Adv
	O/E - G.c fair	- NBM
	Afebrile	- PAC
	O_2 sat - 99% RA	- RBS, ...
	R.S - Cl - clear, Occ. fever	- Reserve 2 U PRBC
	PR - 92 b/m' Cephalic +	- Drugs as charted
	B.P - 152/110 mmHg	- NNS
U. Alb (3+)	P/A - UV ~ 32 wks relaxed	- Drugs as charted
		- TPR / BP / FHR monitoring
	Ceph ↓, FHR - 140 b/m'	- Foleys Catheterisation
		- Shift to O.T on call
	Scan → SLF, Ceph ↓, PL - post. ? RP clot (+)	

Dr. SWAPNA SAMUDRALA
Reg. No: 69924

(Dr. ...)

IP26-00006794
...ANDA KAMALA KUMARI
30 Y 2 M 16 D (F)
SAMUDR...

HNH-00016451 IP26-00006794
Mrs SANNAMANDA KAMALA KUMARI
23-04-1996 30 Y 2 M 16 D (F)
Dr. SWAPNA SAMUDRALA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	→ Couple & attender counselled regarding present maternal condition – 34+ wks / Sev PE / Abruptio placenta – → Explained regarding need for Emergency LSCS & probable complications – Eclampsia / Acute Renal failure / HELLP / haemorrhage / IUFD. – Explained regarding need for transfusion of blood & blood products / multi organ failure / need for ventilatory support / shift of care to multidisciplinary hospital site. – Explained regarding complications of prematurity & prolonged NICU care. – Understanding the above, we give our willful consent for management as per obstetrician / anaesthetist / neonatologist advice & will not hold any doctor / hospital staff responsible for untoward consequences including maternal / fetal death.	

(signature)

Dr. SWAPNA SAMUDRALA
Reg. No: 69924

HNH-00016
Mrs SANN
-04-199
Dr. SWAP

HNH-00016451 IP26-00006794
Mrs SANNAMANDA KAMALA KUMARI
23-04-1996 30 Y 2 M 16 D (F)
Dr. SWAPNA SAMUDRALA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7/26	POD 0	(P.L.L | Sev. PE | Sterilisation)
	No comp	
	O/E - G/c fair	Adv
	afebrile	- NBM till further order
	O_2 sat - 99% RA	- IVF / Analgesic /
	PR - 80bpm.	Antihypertensive /
Baby - NICU	B.P - 150/112 mmHg.	thromboprophylaxis - AXON
	R.S - B/L clear	- Drugs as charted
V.O.S	P/A - UT well retracted	- TPR / BP / I/O
(clear)	L/E - NAB.	chart
		- W/F excessive P/V
		bleeding
		- Physician opinion
		(Dr. Nishanth)
		- Dayan Sir
		(Dr. Swapna)
		Dr. SWAPNA SAMUDRALA Reg. No: 69924

HNH-00016451 IP26-00006794
Mrs SANNAMANDA KAMALA KUMARI
23-04-1996 30 Y 2 M 16 D (F)
Dr. SWAPNA SAMUDRALA

Rainbow® Children's Hospital
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/s/B Dr. Dna	
9/7/26 7pm.	POD-O P1L1 / Sev PE / Abruptio.	
	C/C Fair	Adv.
	Afebrile	- NBM till further order
Baby at NICU	BP: 153/96 mmHg	- IV fluids
	PR: 102/min	- Drugs as charted
	SpO2: 98% on RA	- I/O charting
	P/A Uterus Retracted well.	- BP Monitoring 2nd hourly
		- W/f excessive P.V bleed
U/O - clear · 100ml/hr.	Bowel sound sluggish	- Analgesics, Thromboprophylaxis
Stamp!	P/V - P/v bleed WNL.	as per AKON.
		- Monitor vitals
		- Inform SOS
	[signature]	
	S/B Dr Swapna MV	
9/7/2026 10pm	- POD-O. P1L1 / Scar @ PE / Abruptio -	
	- TAB NICARDIA + 10mg given @ 9pm	
	O/E: vitals:	Adv
	P - 80/m	- @ vitals
	BP - 150/106 mmHg	
U/O N 40cc/hr.		Start drinking water
	PA: Soft, Ut well (R)	+ Inform AKON
	Pulses, BS +/+	team regarding

Docu. No. : RCH /FRM / CLINICAL / 088

LPS: Bleed WNL

↑ BP readings

HNH-00016451 IP26-00006794
Mrs SANNAMANDA KAMALA KUMARI
23-04-1996 30 Y 2 M 16 D (F)
Dr. SWAPNA SAMUDRALA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Started on Inj LABETALOL infusion as per Anaesthesia orders	
		- Strict BP @ hrly.
		- To watch for premonitory symptoms
	[signature] Dr. Swathi H V, Consultant Obstetrics and Gynecology, Reg. No: 15501	
	V/B Dr SWATHI.HV	
10/7/2026 7:00AM	- POD-0 / P1L1 / Severe PE / Abruption	
	- pt comfortable, no premonitory symptoms	
Baby in NICU	O/E: GC fair	Advice:
	P = 88 bpm	- Regular diet
	BP - 140/100.	- TAB NICARDIA-R 10mg BD.
O/P ↓ 500cc clear	Can Inj Labetalol infusion @ 7ml (hr)	- Continue Inj Labetalol infusion
	PA: soft, uterus (R)	- BP @ hrly
	BS+, D dry	- Strict I/O charting
CBP Awaited	L/E: NAD	- Inj Tranexamic acid if bleeding
	No Bleed (+)	- Follow SOS.
I/1500ml O/1350	[signature] Dr. Swathi H V, Consultant Obstetrics and Gynecology, Reg. No: 15501	-

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)GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/2026 9:00am	c/s/by Dr. Naveena	
	Pt is on POD 1 foll. Em PTLSCS. c̄ Severe PE on.	
	Inj. labetolol. Infusion @ 7ml/hr	
		Adv
	o/E GC fair	
	Afebrile SpO2 - 99% on RA.	
	PR: 69 mmHg	
	BP: 148/98 mmHg	
	CVS/RS: NAD	
	PA: ut. retracted well. Soft, NT	
	Dressing: dry & clean	
	L/E: P/V bleeding WNL.	
	U/O: adequate & clean	
	Baby: NICU	
	c/o/w Dr. Nishanth	
		Adv
		- T. Amlodipine 10mg PO stat
		- strict BP monitoring 2hrly
		- w/f Imminent sign
		- Urine I/O charting.

Docu. No. : RCH /FRM / CLINICAL / 088

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/2026 9AM	C/S / By Aron anaesthesia,	
	POD1 of emergency Caesarean section	
	C/O of peripheral edema (pedal edema) high BP	
	was started at night on Labetalol infusion 1mg/mL @ 5ml.	
	P :- 97	
	BP :- 161/100 increased to 7ml/hr as per BP reading	
	SPO2 : 98 on RA	
	Last urine output 250ml - -	
	Labetalol infusion increased to 10ml/hr.	
	On TNi cardic retard 10mg -	
	W/H ORAL Labetalol	Advice
	Physician reference done	→ Monitor blood pressure
	~~Labetalol~~ T Amlodipine 10mg added	→ Taper Labetalol as per BP reading
		→ Physician reference SOS
		→ W/F urine output

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/9/26	POD - 0 (P1L1) Em LSCS / Sev PE / Abruptio)	
11:00 AM		
	No comp.	On Calchelol Infusion
	Pt comfortable.	
	O/E - G.C. fair	Adv
	Afebrile	- Oral liquids f/b
	O_2 Sat - 99% RA	Soft Diet
Baby - NICU	PR - 90 b/m	- Oral hydration
	B.P - 142/98 mmHg	- Ambulation
V.O → clear	P/A - Ut well retracted	- Drugs as charted
Adeq	Chest: BS +	- monitor vitals 4th hrly
	L/E - NAD	- I/O chart
		- Physician Review -
		- Inform Sos.
10/7/26	c/s/B Dr. Veena	
4:30PM	Dr. SWAPNA ... Reg. No. ...	
	POD-01 / P1L1 / Em. LSCS / Abruptio placenta. Imp: Severe PE	
	No complaints, Pt is stable.	
	No imminent signs.	Adv
Baby @ NICU	O/E G.C fair, Pedal edema (+)(+)	- Soft diet
	Afebrile, Pallor (-)	- Ambulation
	BP - 138/89 mmHg	- Adequate hydration
	PR - 90 bpm	- Drugs as charted
	P/A - Ut well retracted	- Vital monitoring
	BS (+)	- Inform SOS.
	L/E - NAD	- I/O charting

U/O - (A)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S/B Dr. Nishanth (Physician review)	
	Adv :- - T. Labetalol 200mg TID	
	- T. Nicardia - Retard 20mg TID	
		(signature)
10/7/26 9pm	C/S/B Dr. Dhg	
	POD-1 P1L1 / sev PE / Abruption.	
	No complaints	Adv
Baby at NICU.	G C fair	- Soft diet
	Afebrile	- Ambulation
	BP: 133/96 mmHg	- Adequate hydration.
	PR: 90 bpm.	- Drugs as charted
urine - passed	P/A Uterus Retracted	- Vital Monitoring
flatus - not passed	well	- W/F PV bleed
	L/E: NAB.	- W/F Imminent signs
		- Inform SOS.
		- BP Monitoring 2nd hrly
	(signature)	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S/B Dr. Dug	
11/7/26 6:30AM	POD-2, P1L1/sev PE/Abruption	
	C/C fair	Adv
	Afebrile	- Soft diet
Baby at NICU	BP: 132/95 mmHg	- Adequate hydration
	PR: 83 bpm.	- Ambulation.
	P/A Uterus Retracted	- Drugs as charted
Urine passed	well	- Monitor vitals
Flatus not passed	BS (+)	- BP Monitoring 2nd hrly
	L/E NAB.	- w/f PV bleed
		- w/f [illegible] signs
		- Inform SOS
Pt can be shifted to room		
11/7/26 11:30 AM	POD - 3	Adv
	No comp	- Reg Diet
	O/E - G/C fair	- Oral hydration
	Afebrile	- Ambulation
Baby - NICU	Vitals - Stable	- Drugs as charted
	B.P. - 135/95 mmHg	- Monitor vitals
	P/A - Ut well Retracted	- Dulcolax supp
Urine ✓ Flatus ✓	Supr. BS +	2 tab, P/R, Stat
Stools	L/E - NAD	- Inform SOS

Dr. SWAPNA SAMUDRALA
Reg. No: 69924

Docu. No. : RCH /FRM / CLINICAL / 088

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/7/2026 6:30pm	c/s/b/y	Dr. Naveena.
	POD- 2.	
	o/E GC-fair	Adv
	Afebrile	~~Regular diet~~
	PR: 87bpm	~~Adequate hydration~~
V-✓	BP: 138/92bpm.	~~drugs as charted~~
F-✓	c/s/RS: NAD	~~w/f PV bleeding~~
S-✓	PA: ut retracted well	~~Ambulation~~
	S/NT.	~~Monitor Vitals~~
	Dressing: dry & clean	~~Inform SOS~~
	I/E: PV bleeding WNL.	
	Baby: ~~Mother~~ NICU	
		Dr. Naveena.
		N.B. Anusha @ 7:30pm
12/07/2026 7:00am	c/s/b/y Dr Naveena.	
	o/E GC-fair	Adv
	Afebrile.	- Regular diet
	Vitals - stable BP-128/89	- Adequate hydration
V-✓	c/s/RS: NAD	- drugs as charted
F-✓	PA: ut retracted well	- STERIZONE DRESSING
S-✓	S/NT.	- w/f PV bleeding
	Dressing: dry & clean.	- Ambulation
	I/E: PV bleeding WNL.	- MVE & ILSOS
	Baby: NICU	Dr. Naveena.

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/7/26		
11 AM	Can be discharged after antihypertensive advice	

Dr. RAMYA THOTA VADIYALA
Reg. No: 01458

HNH-00016451 IP26-00006794
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016451 IP26-00006794 Mrs SANNAMANDA KAMALA KUMARI 23-04-1996 30 Y 2 M 16 D (F) Dr. SWAPNA SAMUDRALA	9/7/26 @	9/7/26 @
	Transfer Ordered by DR.	Reason for Transfer TCA EM-LSCS
From Unit Pre-post	To Unit OT	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	RL - 500ml	(1)
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Ses.	DR.

Patient & Clinical Records Received by :

Date & Time of Patient Received :

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

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

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DP

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RESULT SHEET

Date	9/4/26					
Time						
Hb	11.1					
PCV	32.0					
RBC	4.14					
WBC	16.28					
N/L						
Platelets	299					
CRP						
ESR						
PCT						
RBS						
Na	131					
K	4.3					
Cl	107					
Ca/Mg						
Phosphate						
Urea	19					
Creatinine	0.6					
ALP						
SGPT	19					
SGOT	29					
T.Bill/Conj	~~0.4~~ 0.2					
T.Protein	5.7					
S.Albumin	2.6					
S.Globulin	3.1					
A/G Ratio	0.8					
Uric Acid	5.7					
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
~~N/L~~ LDH	297					

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Blood group = B+ve						
HIV						
HbsAg } NR.						
HCV						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

Others (ECG, Contrast Studies etc.,) : .....

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☑ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.
(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ..... Shifted to: .....

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Dna

Date & Time : 9/7/26. 2pm.

Nurse Name & Signature: AKW 9/7/26

Date & Time : 9/7/26

Docu. No. : RCH / FRM / GENERAL / 090

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DRUG CHART

Date of Admission: 9/7/26 Drug Allergies: .... ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

GENERAL - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.

DOCTOR
- Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line / through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES
- Nurses must follow strictly the FIVE RIGHTS before administration of medication.
  1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name .... Signature ....

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23-04-1996 30 Y 2 M 16 D (F)
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REGULAR PRESCRIPTIONS

Weight. 84kgs Ward. ....

DRUG : CEFOTAXIME

Dose	Route	Frequency	Start Date
1g	IV	BD	9/7/26

Date: 9/7 — 8 AM ✗; 8 PM (signed); Stop Dr. ...

Name & Signature of the Doctor Starting the Drugs: Dr. ...

Additional Instructions: After test dose.

Daily Doctor's Endorsement by a Sign

DRUG : Inj. PARACETAMOL

Dose	Route	Frequency	Start Date
1gm	IV	TID	9/7/26

Date: 9/7, 10/7, 11/7 — 6 AM, 2 PM, 10 PM; STOP Dr. ...

Name & Signature of the Doctor Starting the Drugs: Dr. Ayesha

Additional Instructions: To be converted to Oral after 24 hrs.

Daily Doctor's Endorsement by a Sign

DRUG : Inj. TRAMADOL

Dose	Route	Frequency	Start Date
100mg	IV	TID	9/7/26

Date: 9/7, 10/7 — 6 AM, 2 PM, 10 PM; STOP 10/7/26

Name & Signature of the Doctor Starting the Drugs: Dr. Ayesha

Additional Instructions: To be converted to Oral after 24 hrs.

Daily Doctor's Endorsement by a Sign

DRUG : Neb c̄ LEVOLIN

Dose	Route	Frequency	Start Date
0.63 mg	PN	TID	9/7/26

Date: 9/7, 10/7, 11/7, 12/7 — 7 AM, 3 PM, 11 PM

Name & Signature of the Doctor Starting the Drugs: Dr. Ayesha

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Verified by Dr. Dhakshayani

Verified by Dr. Dhakshayani

Verified by Dr. Dhakshayani

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REGULAR PRESCRIPTIONS

Sheet No: .... Weight 84 kg Ward ....

Verified by Dr. Dhakshayani

				Date / Time	9/7	10/7		
DRUG : TRANEXAMIC ACID				6 AM	X	[illegible]		
Dose 500mg	Route IV	Frequency TID	Start Dt. 9/7	2 PM	X	[illegible]	STOP	
Name & Signature of the Doctor Starting the Drugs: Dr Dva				10 PM	[illegible]			
Additional Instructions: x24 hrs								
Daily Doctor's Endorsement by a Sign					[sign]	[sign]		

STOP [signature] 10/7/26.

				Date / Time	9/7	10/7	11/7
DRUG : T LABETALOL				6 AM	X	X	[illegible]
Dose 200mg	Route PO	Frequency TID	Start Dt. 9/7/26	2 PM	X	[illegible]	[illegible]
Name & Signature of the Doctor Starting the Drugs: Dr. Dva				10 PM	2 PM given	[illegible]	
Additional Instructions:							
Daily Doctor's Endorsement by a Sign					[sign]	[sign]	

STOP Dr. Naveena.

				Date / Time	10/7	11/7	12/7
DRUG : FLUTICASONE PROPIONATE.				8 AM	[illegible]	[illegible]	[illegible]
Dose 50mg	Route intra Nasal	Frequency BD	Start Dt. 10/7/26				
Name & Signature of the Doctor Starting the Drugs: Dr. Dva.				8 PM	[illegible]	[illegible]	
Additional Instructions: Intranasal. (Nasal spray) x 5 days							
Daily Doctor's Endorsement by a Sign					[sign]		

				Date / Time			
DRUG : Levocetirizine + Montelukast							
Dose 5mg/10mg	Route PO	Frequency OD	Start Dt. 9/7/26.				
Name & Signature of the Doctor Starting the Drugs: Dr Dva							
Additional Instructions: 8pm at bed time. x 5days.							
Daily Doctor's Endorsement by a Sign							

Stop Dr. Dva

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

(P.T.O.)

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REGULAR PRESCRIPTIONS

Sheet No: .... Weight 84kgs Ward ....

DRUG: Inj. ENOXAPARIN				Date ▸ Time ▾	10/7	11/7	12/7
Dose	Route	Frequency	Start Dt.				
40mg	S/C	OD	10/7/26				
Name & Signature of the Doctor Starting the Drugs: Dr. Ayesha [signature]			8:00AM	8AM	[signature]	[signature]	[signature]
Additional Instructions: After Obg team review For 3days							
Daily Doctor's Endorsement by a Sign					[signature]	[signature]	

DRUG: Inj. METRONIDAZOLE				Date ▸ Time ▾	9/7	10/7	11/7
Dose	Route	Frequency	Start Dt.				
500mg	IV	TID	9/7/26	7AM	X	[signature]	[signature]
Name & Signature of the Doctor Starting the Drugs: Dr. Ayesha [signature]				3PM	X	[signature]	Made
Additional Instructions:				11PM	[signature]	[signature]	
Daily Doctor's Endorsement by a Sign					[signature]	[signature]	

STOP [signature] Dr. Naveena

DRUG: Inj. AMOXICILLIN				Date ▸ Time ▾	9/7	10/7	11/7
Dose	Route	Frequency	Start Dt.				
1.2gm	IV	TID	9/7/26	7AM	X	[signature]	Made
Name & Signature of the Doctor Starting the Drugs: Dr. Ayesha [signature]				3PM	X	[signature]	Made
Additional Instructions:				11PM	[signature]	[signature]	
Daily Doctor's Endorsement by a Sign					[signature]	[signature]	

STOP [signature] Dr. Naveena

DRUG: PANTOPRAZOLE				Date ▸ Time ▾	10/7	11/7
Dose	Route	Frequency	Start Dt.			
40mg	IV	OD	9/7/26	8AM	[signature]	[signature]
Name & Signature of the Doctor Starting the Drugs: Dr. Dra [signature]						
Additional Instructions:						
Daily Doctor's Endorsement by a Sign					[signature]	

STOP [signature] Dr. Naveena

Verified by Dr. Dhakshayani

Verified by Dr. Dhakshayani

Verified by Dr. Dhakshayani

Verified by Dr. Dhakshayani

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Verified by Dr. Dhakshayani

REGULAR PRESCRIPTIONS

Sheet No: .... Weight 84 kg Ward ....

				Date/Time			
DRUG: MONTEK-LC.				Date	9/7	10/7	11/7
Dose	Route	Frequency	Start Dt.				
10mg	PO.	OD	9/7/26.	8pm			
Name & Signature of the Doctor Starting the Drugs: Dr. Dura.							
Additional Instructions: 8pm x 5day.							
Daily Doctor's Endorsement by a Sign							
DRUG: TAB NICARDIA-R				Date	9/7	10/7	
Dose	Route	Frequency	Start Dt.				
10mg	P/O	BD.	9/7	9am	X		
Name & Signature of the Doctor Starting the Drugs:				9pm			
Additional Instructions:							
Daily Doctor's Endorsement by a Sign							
DRUG: TAB. NICARDIA RETARD.				Date	10/7	11/7	
Dose	Route	Frequency	Start Dt.				
20mg	P/O.	TID	10/7/26	1 AM	X		
Name & Signature of the Doctor Starting the Drugs:				9 AM	X		
Additional Instructions:				5 pm			
Daily Doctor's Endorsement by a Sign							
DRUG: INJ-TRAMADOL				Date	10/7		
Dose	Route	Frequency	Start Dt.				
100mg.	IV	BD.	10/7/26	12 AM			
Name & Signature of the Doctor Starting the Drugs:							
Additional Instructions:				12 pm			
Daily Doctor's Endorsement by a Sign							

STOP. 10/7/26.

STOP Dr. Naveena

STOP Dr. Naveena

HNH-00016451 IP26-00006794
Mrs SANNAMANDA KAMALA KUMARI
23-04-1996 30 Y 2 M 16 D (F)
Dr. SWAPNA SAMUDRALA

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Sheet No: .....

REGULAR PRESCRIPTIONS

Weight ..... Ward .....

DRUG : TAB. AUGMENTIN 625

Dose	Route	Frequency	Start Dt.
625mg	PO	TID	11/7

Name & Signature of the Doctor Starting the Drugs: Dr. Naveena

Additional Instructions: AFTER FOOD

Date ▸ / Time	11/7	11/7
7AM	✓	✓
3PM	✓	
11PM	✓	✓

Daily Doctor's Endorsement by a Sign

DRUG : T. LABETALOL

Dose	Route	Frequency	Start Dt.
200mg	PO	BD.	11/7

Name & Signature of the Doctor Starting the Drugs: Dr. Naveena.

Additional Instructions: AFTER FOOD

Date ▸ / Time	11/7	12/7
6AM	✓	✓
6PM	✓ 2PM	

Daily Doctor's Endorsement by a Sign

DRUG : T. AMLONG.

Dose	Route	Frequency	Start Dt.
10mg	PO	BD	11/7

Name & Signature of the Doctor Starting the Drugs: Dr. Naveena.

Additional Instructions:

Date ▸ / Time	11/7	12/7
9AM	X	(NB)
9PM	✓	

Daily Doctor's Endorsement by a Sign

DRUG : T. CALPOL 500MG

Dose	Route	Frequency	Start Dt.
2TAB	PO	TID	11/7

Name & Signature of the Doctor Starting the Drugs: Dr. Naveena.

Additional Instructions:

Date ▸ / Time	11/7	12/7
8AM	✓	✓
2PM	✓	
10PM	✓	

Daily Doctor's Endorsement by a Sign

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Sheet No: .....

REGULAR PRESCRIPTIONS

Weight ..... Ward .....

DRUG : TAB. VOVERAN

Dose	Route	Frequency	Start Dt.
75mg	PO	BTID	11/7

Name & Signature of the Doctor Starting the Drugs: Dr. Naveena.

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸	11/7	12/7
Time ▾		
7AM	X	
3PM	X	
11PM		

DRUG : T. PANTOPRAZOLE

Dose	Route	Frequency	Start Dt.
40mg	PO	BD	11/7

Name & Signature of the Doctor Starting the Drugs: Dr. Naveena.

Additional Instructions: 8pm

Daily Doctor's Endorsement by a Sign

Date ▸	11/7	12/7
Time ▾		
6AM	X	
8PM	✓	

DRUG : SYP ASCORYL LS

Dose	Route	Frequency	Start Dt.
10ML	PO	TID	11/7

Name & Signature of the Doctor Starting the Drugs: Dr. Naveena

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸	11/7	12/7
Time ▾		
7AM	X	
3PM	X	
11PM		

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸
Time ▾

VERIFIED BY : Name ..... Signature

Patient Sticker

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

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

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

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

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

Patient Sticker

Weight. 84 Ward. .....

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
9/7/26	2pm	PANTOPRAZOLE	40mg	IV		Ary
9/7/26	2pm	METOCLOPROMIDE	10mg	IV		Ary
9/7/26	2pm	BETAMETHASONE	12 mg	IM		Anita
9/7/26	2:30 pm	INJ. TRANEXAMIC ACID	1g (in 100ml NS)	IV		Ary
9/7/26	3:16pm	Inj. OXYTOCIN	3IU	IV		Nursing Natasha
9/7/26	3:18pm	Inj. OXYTOCIN	6IU in 500ml RL	IV		Nursing Natasha
9/7/26	3:40pm	Inj. METRONIDAZOLE	500mg	IV		Pallavi Natasha
9/7/26	3:20pm	Inj. AMOXICILLIN	1.2gm	IV		Pallavi Natasha
9/7/26	4:00pm	TRAMADOL Suppository	100mg	PR		

Verified by Dr. Dhakshayani

VERIFIED BY : Name ..... Signature .....

Mrs SANNAMANDA KAMALA KUMARI
23-04-1996 30 Y 2 M 16 D (F)
Dr. SWAPNA SAMUDRALA

I.V. FLUIDS CHART

Weight. 84 kgs Ward. .....

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
9/7	2pm	RINGER LACTATE	IV	17			9/7		
9/7/26	3:00pm	RINGER LACTATE	IV	500 ml/hr			9/7		
9/7/26	9.57	INJ LABETELOL 1mg/mL	iv	@ 5ml/hr			10/7/26		
9/7/26	10:30PM	RINGER LACTATE	iv	75 ml/hr			10/7		
10/7/26	6:20 AM	RINGER LACTATE	iv	75 ml/hr			10/7/26		
10/7/26	2.45 AM	INJ LABETELOL 1mg/mL	IV	1 ml/hr			10/7/26		
10/7/26	9.45 AM	INJ LABETELO 1mg/mL	IV	1 ml/hr			10/7/26		
		STOP 10/7/26							

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STAT / ONCE ONLY DRUGS

Weight: 84 kgs

Sheet No: ....

Name: ....

DATE	TIME	MEDICATION	DOSAGE & OTHER INSTRUCTIONS	ROUTE	SIGNATURE: Doctor	SIGNATURE: Nurse-1	SIGNATURE: Nurse-2
9/7/26	4:50pm	Inj. LABETALOL	10 mg	IV	[signature]	Pallavi	Puja.
10/7	9:45AM	T. AMLODIPINE	10mg	PO	[signature]	[signature]	[signature]
11/7	3:30pm	TAB DULCOLAX SUPPOSITORY	20mg	P/R	[signature]	[signature]	[signature]

Verified by Dr. Dhakshayani

HNH-00016451 IP26-00006794
Mrs SANNAMANDA KAMALA KUMARI
23-04-1996 30 Y 2 M 16 D (F)
Dr. SWAPNA SAMUDRALA

3B

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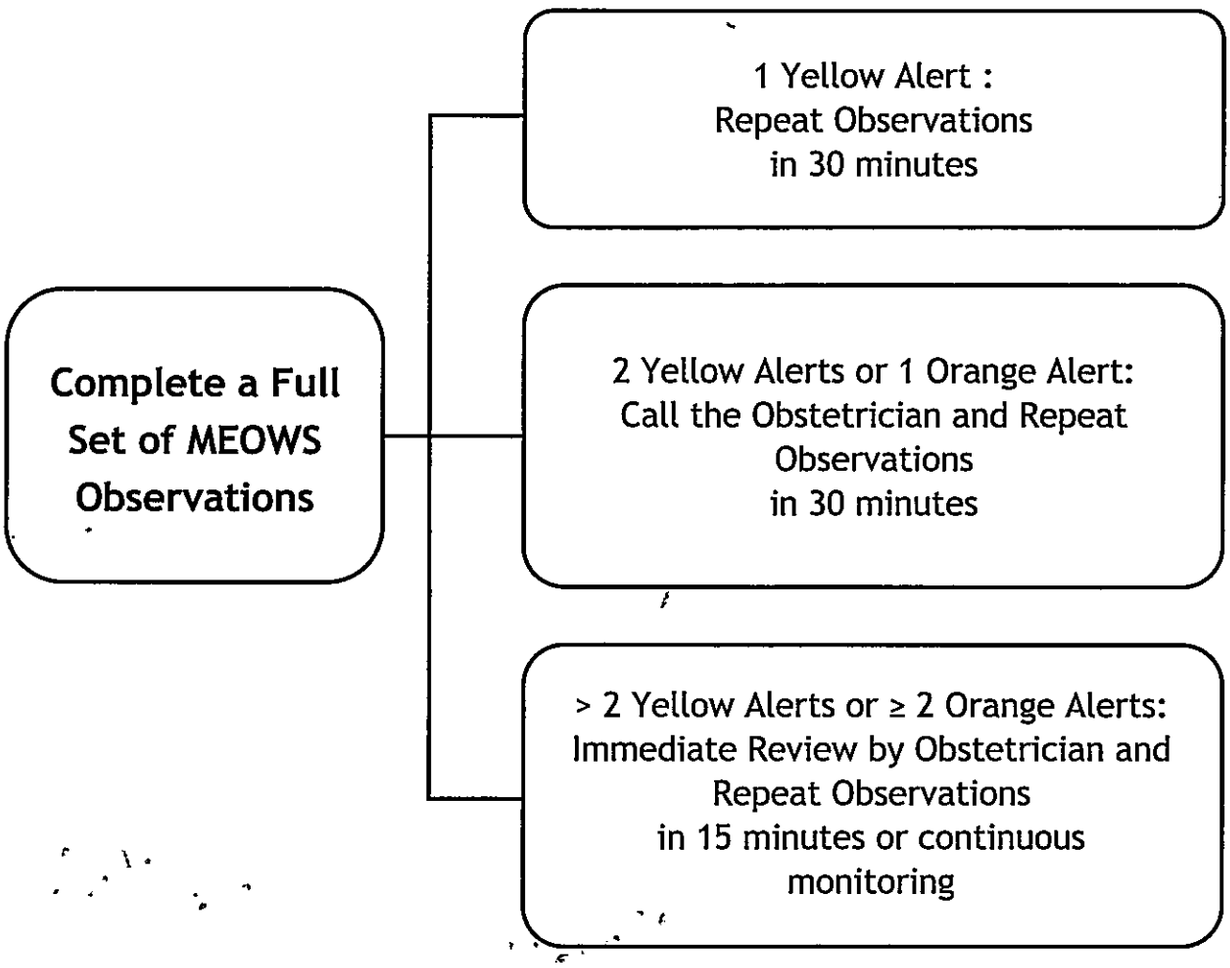
Early Warning Observation Score Chart - Obstetrics

9/7/26

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								20		20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20
	0 - 10																									
Saturations	94 - 100 %								96		99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99
	< 94 %																									
Administered O_2 (L/min.)											-	-	-													
Temp°c	40																									
	39																									
	38																									
	37																									
	36								98.4		-	-	-	-												
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90								75		90	90	89	80	74	90	84	86	82	74	80	76	71	85	79	
	80																									
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150										150	160	150	163	155	157	153	149	146	153	147	158	144	150	149	149
	140																									
	130																									
	120																									
	110																									
	100																									
	90								140																	
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90								95		112	110	97	103	107	103	105	100	95	100	103	90	107	100	98	101
	80																									
	70																									
	60																									
	50																									
	40																									
NEURO RESPONSE [✓]	Alert								-		-	-	-	-												
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30																									
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal																									
	Heavy / Foul																									
Liquor	Clear / Pink																									
	Green																									
TOTAL YELLOW SCORES									0		2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL ORANGE SCORES																										
Nurse Initial																										

Obstetrics and Gynaecology Early Warning Signs



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

HNH-00016451 IP26-00006794
Mrs SANNAMANDA KAMALA KUMARI
23-04-1996 30 Y 2 M 16 D (F)
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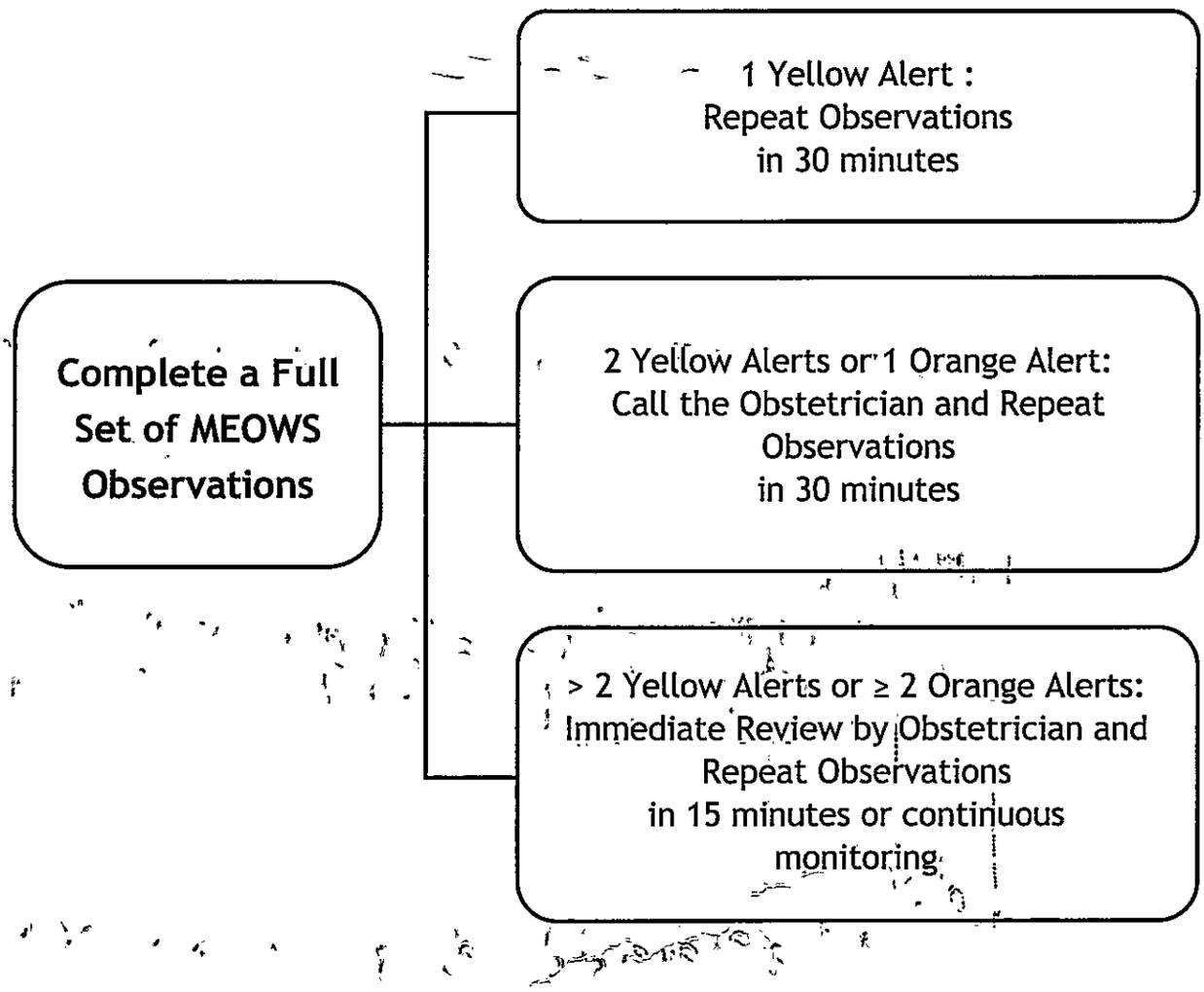
Early Warning Observation Score Chart - Obstetrics

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

		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	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20
	0 - 10																									
Saturations	94 - 100 %	100	100	100	100	99	99	100	99	99	99	99	99	99	98	99	99	98	99	99	98	99	98	99	98	
	< 94 %																									
Administered O_2 (L/min.)																										
Temp °c	40																									
	39																									
	38																									
	37																									
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70	63	73	88	90	89	80	90	91	88	90	84	89	90	76	83	84	86			84	80		76	83	84
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160				160																					
	150	134	140			150	134																			
	140							139	135	135	133	134	132		133	136	130	134	133		130	131	133	132	133	
	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90	94	90	100	90	94	98	94	94	90	84	88			96	89	90	93	85		90	96		93	95	90
	80																									
	70																									
	60																									
	50																									
	40																									
NEURO RESPONSE [✓]	Alert																									
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30																									
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal																									
	Heavy / Foul																									
Liquor	Clear / Pink																									
	Green																									
TOTAL YELLOW SCORES																										
TOTAL ORANGE SCORES																										
Nurse Initial																										

Obstetrics and Gynaecology Early Warning Signs



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

HNH-00016451 IP26-00006794
Mrs SANNAMANDA KAMALA KUMARI
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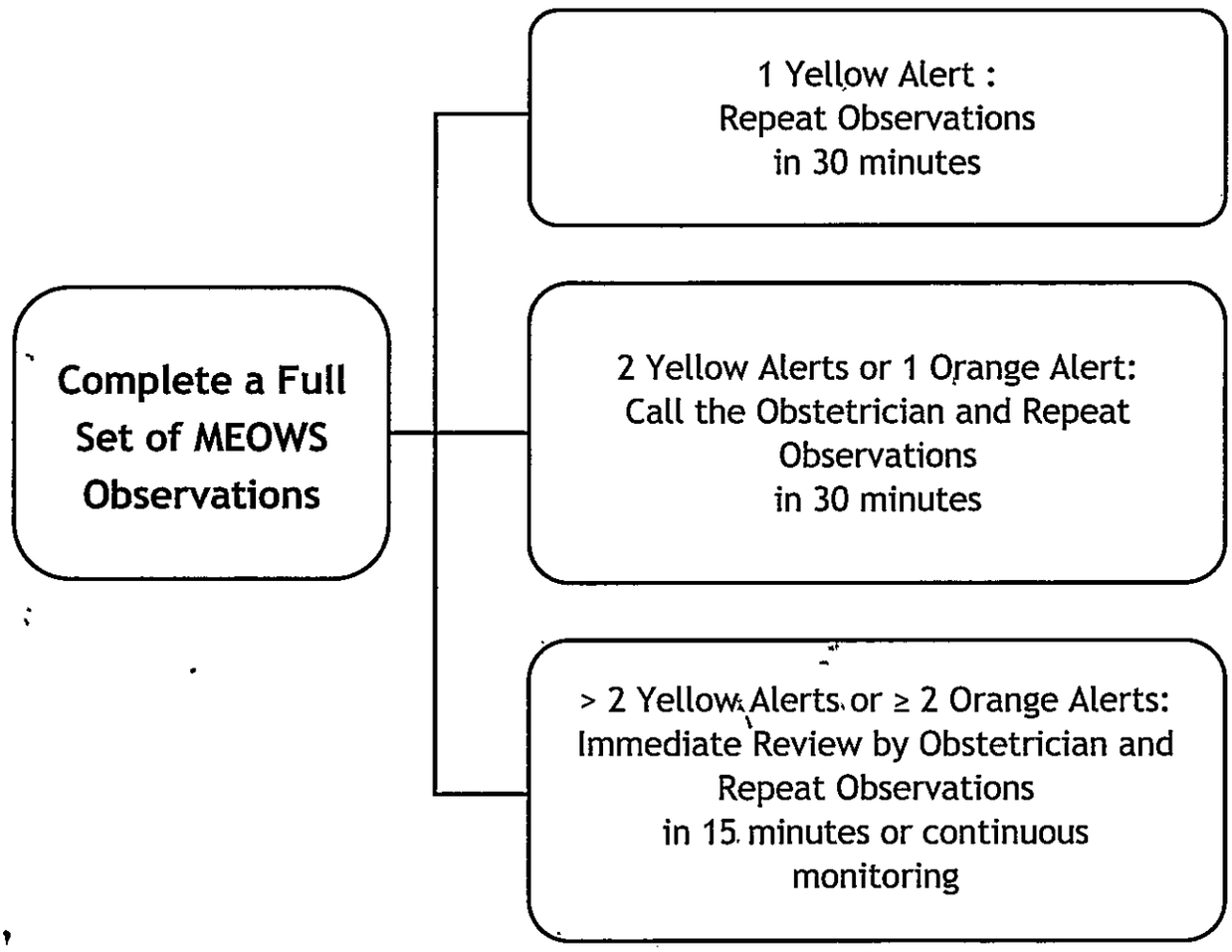
Early Warning Observation Score Chart - Obstetrics

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

		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		20	20			20		20		23		22		22		20				20				26	
	0 - 10																									
Saturations	94 - 100 %		99%				99%		99%		99%		99%		99%		98%				98%				99%	
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37																									
	36						36		34		36°C		36°C		36°C		97.2°C				97.3°F				97.3°F	
	35																									
	< 35		36																							
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80			80			99		87		92		87		99		86				79				80	
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130			112			126		134		133		131		131		125				121				123	
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50										(102)		(103)													
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90										83		82		84		93									
	80																									
	70			81																	76				89	
	60																									
	50																									
	40						96		94																	
NEURO RESPONSE [✓]	Alert			–			✓		✓		–		–		–		–				✓				–	
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30			–			✓		–		–		–		–		–				–				–	
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal						✓		–		–		–		–		–				–				–	
	Heavy / Foul																									
Liquor	Clear / Pink						✓		–		–		–		–		–				–				–	
	Green																									
TOTAL YELLOW SCORES				1			0		0		0		0		0		1				0				0	
TOTAL ORANGE SCORES				0			0		0		0		0		0		0				0				0	
Nurse Initial																										

Obstetrics and Gynaecology Early Warning Signs



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

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FLUID CHART

Sheet No. : (c)

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						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			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 :**						
9/7	02:00 pm	P	N	100ml								
	03:00 pm	2	B	100ml								
	04:00 pm	P	M	100ml								
	05:00 pm	2	N	100ml			NA			100ml	0	Empty
	06:00 pm	R	B	100ml								
	07:00 pm	2	M	100ml								
Total Intake :		600ml.				**Total Output :**						
9/7	08:00 pm	RL		100						650ml		Empty 8:40pm
	09:00 pm	RL		100								
	10:00 pm	RL	SIPS	75							0	
	11:00 pm	RL	NIL	75								(d)
	12:00 am	RL	NIL	75								
	01:00 am	RL		75								
Total Intake :						**Total Output :**						
9/7	02:00 am	RL	NIL	75						250ml		Empty
	03:00 am	RL	NIL	75							1	
	04:00 am	RL		75							0	
	05:00 am	RL		75								Urine
	06:00 am	RL	NIL	75								
	07:00 am	RL		75						450ml		
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

Patient Sticker

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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						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
20/12/20	08:00 am	RL	H_2O	75ml							1	
	09:00 am	RL		75ml								
	10:00 am	RL	H_2O	75ml							0	CS
	11:00 am	RL		75ml		NA						
	12:00 pm	RL	H_2O	75ml							1	
	01:00 pm	RL		75ml						150ml		Emt
Total Intake :						**Total Output :**						
	02:00 pm	RL	Idly	100ml							1	
	03:00 pm	RL		75ml			NA					
	04:00 pm	RL		75ml						600ml	0	
	05:00 pm		H_2O									
	06:00 pm										1	
	07:00 pm		Soup									
Total Intake :		Taken				**Total Output :**				passed		
	08:00 pm		100								1	
	09:00 pm		VKing									
	10:00 pm		150								0	Sneha
	11:00 pm		150									
	12:00 am											
	01:00 am		100									
Total Intake :		Taken				**Total Output :**				passed		
	02:00 am		100								1	
	03:00 am											
	04:00 am		100								0	Sneha
	05:00 am											
	06:00 am		100								1	
	07:00 am											
Total Intake :		Nil				**Total Output :**				passed		

Total 24 hrs. Intake		Total 24 hrs. Output	

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Mrs SANNAMANDA KAMALA KUMARI
23-04-1996 30 Y 2 M 16 D (F)
Dr. SWAPNA SAMUDRALA

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BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
11/7/26	08:00 am									✓	1	
	09:00 am		Idly									
	10:00 am					NA					2	
	11:00 am		+							✓		
	12:00 pm											
	01:00 pm											
Total Intake :								**Total Output :** U - 2 M -				
11/7/26	02:00 pm	✓						✓				
	03:00 pm											
	04:00 pm		Idly				✓			✓	0	
	05:00 pm	0	+		NA			NA				
	06:00 pm	✓	H2O								✓	
	07:00 pm									✓		
Total Intake :								**Total Output :** U - 2 M - 1				
11/7/26	08:00 pm	✓				✓						
	09:00 pm		Idli					✓				
	10:00 pm		+							✓		
	11:00 pm	0	H2O		NA			NA			0	
	12:00 am	✓										
	01:00 am										✓	
Total Intake : Taken								**Total Output :**				
12/7/26	02:00 am	✓				✓						
	03:00 am		H2O					✓				
	04:00 am	0			NA			NA		✓		
	05:00 am	✓									✓	
	06:00 am									✓		
	07:00 am											
Total Intake : Taken								**Total Output :**				

Total 24 hrs. Intake		Total 24 hrs. Output	

Patient Sticker

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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						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			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	

HNH-00016451 IP26-00006794
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NURSING CARE RECORD

Rainbow® Children's Hospital
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Your Right to a Safe Delivery

Date: 9/7/26

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	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon	2pm 8pm	→ plan for vitals → plan for Admission → plan for medication → maintain Flowchart & Fluid	2pm 8pm	→ Assessed the pt condition → monitored the vitals & Fluid → Administered medication as per doctor order → maintained Flowchart	Pt is stable	Maintain I/O chart & Fluid.	Akhils
Night	8pm 6am	→ Assess the pt condition → Check the Vital's → I/O chart Maintain → Plan for Medication	8pm 6am	→ Assessed pt condition → checked Vital's & Recorded → Maintained I/O chart → given Medication as per doctor's order	pt is stable	Vital's is Normal	

Patient Sticker

NURSING CARE RECORD

Rainbow® Children's Hospital
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BirthRight
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Date: 10/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am to 2pm	=> Assess the patient condition => maintain vitel => maintain Flochart	8Am to 2pm.	=> Assess the patient condition => maintain vitel & Record => maintain Flochart	patient is stable	vitel is Norm	[signature]
Afternoon	2pm | 8pm	=> plan for vitals => plan for I/O chart => plan for medication => plan for Ambulation	2pm | 8pm	=> vitals Normal => I/O chart maintained => medication given as per chart	stable	Normal	[signature]
Night	2pm to 8pm	-> Assess pt condition -> monitor the vitals -> maintain I/O chart -> Administer medication as per drug chart	2pm to 8pm	-> Assessed pt condition -> monitore the vitals -> maintained I/O chart -> Administered medication as per drug chart	Patient is stable	Recheck vitals	[signature]

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NURSING CARE RECORD

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Date: 11/7/26

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	Re-Assessment	Nurse Name & Signature
Morning	8pm to 2pm	→ Assessed the pt condition → monitor vitals → maintain I/O	8Am to 2pm	→ Assessed the pt condition → monitor vitals → maintain I/O	→ Now pt is stable	Re-check vitals	Medh
Afternoon	2pm to 8pm	→ Assess pt condition → monitor the vitals → Maintain I/O chart → Administer medication as per drug chart	2pm to 8pm	→ Assessed pt condition → monitored vitals → maintained I/O chart → Administered medication as per drug chart	Patient is stable	Re-checked vitals	
Night	8pm to 8Am	Assess the pt. condition - Monitor vitals & records - Maintain I/O chart - Give medications as prescribed by doctor	8pm to 8am	Assessed pt. condition - monitor vitals & records - Maintained I/O chart - Given medication as prescribed by doctor	patient is stable.	Re-checked vitals	

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NURSING CARE RECORD

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Date: .....

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							

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CHECKLIST FOR THROMBOPHLEBITIS

9/1/26 10/1/26 11/1/26

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0		0	—	—	—		—	—	—	
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		—	—	—	—		NA	NA	NA	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2		—	—	—	—		NA	NA	NA	
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		—	—	—	—		NA	NA	NA	
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		—	—	—	—		NA	NA	NA	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5		—	—	—	—		NA	NA	NA	
		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 : .....

Patient Sticker

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CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	9/4/26	10/4/26	10/4
		Score		MK	E
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0	0	0	0
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0			
IV / Heparin Lock or Saline	Yes	20	20	20	20
	No	0			
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0			
Mental Status	Forgets limitations	15			
	Oriented to own ability	0			
Total Morse Fall Scale Score:			20	20	20
		Signature			

Fall Risk Grading		
Risk Level	**Morse Fall Score (MFS)**	**Action**
Low Risk	0 - 24	Standard Fall Precaution
Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
High Risk	≥ 51	Implement High Risk Fall Prevention Intervention

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

Choose Highest Applicable Score from each Category		Date / Time	11/2	17		Fall Risk Grading		
		Score	45	01				
History of Falling (immediately or w/in 3 months)	Yes	25				Risk Level	Morse Fall Score (MFS)	Action
	No	0						
Secondary Diagnosis (more than one diagnosis)	Yes	15						
	No	0				Low Risk	0 - 24	Standard Fall Precaution
Ambulatory Aid	Furniture	30						
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0	0				
IV / Heparin Lock or Saline	Yes	20	20	20		Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20						
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
Mental Status	Forgets limitations	15						
	Oriented to own ability	0						
Total Morse Fall Scale Score:			20	20				
		Signature						

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

- ☐ Ensure patients use their prescribed eye glasses if any, in the hospital
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BRADEN 'Q' SCALE

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					Date :	9/7	10/7/26	10/7	11/7
					Time :	12	2PM	E	1PM
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.		4	4	4	4
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4	4	4	4
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4	4	4	4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4	4	4	4
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	4	4
					TOTAL SCORE	28	28	28	28
					Evaluator's Name				

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

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

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

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BRADEN 'Q' SCALE

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It takes a lot to treat the little.

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				Date :	11/7			
				Time :	21			
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4			
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4			
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 mean 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			
				TOTAL SCORE	28			
				Evaluator's Name				

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

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

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PAIN ASSESSMENT FORM

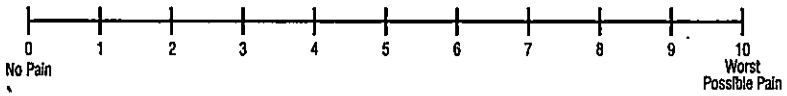
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
9/7/26	4pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
9/7/26	8pm.	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
10/7/26.	10AM	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
10/7/26	2pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
11/7/26	9pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	[signature]
11/7/26	10pm	0/10	-	☐ Continuous ☐ Intermittent	☑ Acute ☐ Chronic	☑ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	[signature]
12/7	6Am	0/10	-	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☑ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	NA	[signature]
				☐ 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:

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 pain-relieving intervention.
   d) Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

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, SaO_2	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

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NURSING SHIFT HAND OVER FORM - WARD

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

SITUATION

Diagnosis: EM- LSCS (preterm)

Any Infection: ☐ Yes ☐ No ☐ Not Known
If Yes Specify: .....

BACKGROUND / ASSESSMENT / Recommendations	Area / Shift Time	E2	9/7 M6	10/7 M6	10/7 E	11/7 M6	11/7 E2
BACKGROUND	Medical Condition (Any special condition to be noted):	NA	–	NA	NA	–	–
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.1°F	98°F	98°F	97.8	98.	97.5°F
	Res:	20 bmt	20	20	20	20	22 bpm
	SpO_2:	99%	99%	99%	99%	99%	100%
	Pulse:	87 bmt	87	86	89	80	85
	BP:	140/90	140/80	160/100	130/88	120/74	112/76
	Fall Risk Score:	0/10	0/10	0/10	0/10		–
	Pain Score:	–			–		–
Recommendations	Safety Needs:	Yes	Yes	Yes	Yes		–
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	–	–	–	–	–	–
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	NA	–	–	–	–	–
Post Operative Procedure Special Orders:		NA	–	–	–	–	–
Handed Over By Name :		AKGils	AKGils	Claude	–	MLV	Anusha
Signature :							
Date:		9/7/26	9/7/26	10/7/26	10/7/26	11/7/26	11/7/26
Time:		8pm	8pm		8AM	2p	8PM
Taken Over By Name :		AKGils	Claude	Anusha		Anusha	Priyanka
Signature :							
Date:		9/7/26	9/7/26	10/7/26		11/7/26	11/7/26
Time:		2pm				2pm	8pm

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NURSING SHIFT HAND OVER FORM - WARD

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

SITUATION	Diagnosis: LSCS	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area / Shift Time	11/7 N1					
	Medical Condition (Any special condition to be noted):	–					
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	97.8°F					
	Res:	20/hr					
	SpO_2:	100%					
	Pulse:	86/hr					
	BP:	119/72					
	Fall Risk Score:	–					
	Pain Score:	–					
Recommendations	Safety Needs:	–					
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	–					
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	–					
Post Operative Procedure Special Orders:		–					
Handed Over By Name :		Priyanka R					
Signature :							
Date:		12/7					
Time:		8pm					
Taken Over By Name :							
Signature :							
Date:							
Time:							

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CAESAREAN SECTION OPERATIVE NOTES

Surgeon's Name:	Dr. Swapna.	Date of Delivery:	9/7/26.
Assistant Surgeon:	Dr. Dna	Time of Delivery:	3:16 pm.
Anaesthetist's Name:	Dr. Ayesha.	Gender of Baby:	FEMALE.
Type of Anaesthesia:	Spinal.	Weight of Baby:	1.74 kg.
Neonatologist:	Dr. Spandana, Dr Pranav.	AGPAR Score:	6, 7.
Scrub Nurse:	Susheela.	NICU Admission:	☑ Yes ☐ No

Pre-Operative Diagnosis: Primi | 34+2 week | ~~Obstr~~ Sev PE | ~~Abruptio placenta~~

☐ Elective ☑ Emergency Indication: ~~Abruptio placenta~~

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:

Emergency Lower Segment Cesarean Section.

Post Operative Diagnosis:

Peri-Operative Complications:

Amount of Blood Loss:	Blood Transfused (in ML):

Name and Number of Surgical Specimen sent for examination:

Examination Findings when Appropriate:

Presentation: ☑ Cephalic ☐ Breech ☐ Other ..... Cervical Dilatation: ..... cm

5th Palpable: ..... Fetal Position: .....

Station: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2 Moulding: ☐ None ☐ + ☐ ++ ☐ +++

Caput: ☐ + ☐ ++ ☐ +++ Meconium: ☐ None ☐ + ☐ ++ ☐ +++

Bladder Catheterized : ☑ Yes ☐ No Urine: ☑ Clear ☐ Blood Stained

---

Skin Incision: ☑ Pfannensteil ☐ Transverse ☐ Midline ☐ Other .....

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

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

Incision Through Placenta: ☐ Yes ☑ No

Delivery of head: ☑ Manual ☐ Forceps

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

Delivery of Placenta: ☐ Manual ☑ CCT ..... ☑ Complete ☐ Incomplete ☐ Piecemeal

Cord Appearance: Normal. Cord around the neck ☐ Yes ☑ No

Appearance of placenta: Retroplacental Clot – 100gm. Cavity explored ☑ Yes ☐ No

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

USG – Not formed.
Liquor – Scanty

Uterine Closure: ☐ One Layer ☑ Two Layers ..... Vicryl No-1 ..... Suture

Peritoneal Closure: ☑ Pelvic ☐ Abdominal ☐ None ..... Vicryl No-1 ..... Suture

Sheath Closure: ..... Vicryl No-1 ..... Suture

Fat Closure: ☑ Yes ☐ No ..... Vicryl No-1 ..... Suture

Skin Closure: ☑ Subcuticular ☐ Mattress ..... Monocryl No-1 ..... Suture

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: .....

- NBM till further orders.
- IV fluids, Anti°HTN drugs.
- I.V. Antibiotics.
- Analgesics & theomboprophylaxis as per AXOM.
- Drugs as charted.
- I/O charting
- Strict BP Monitoring 1/2 hourly.
- Monitor vitals, Inform SOs

Doctor Name: Dr. Swapna. Doctor Signature: .....

Date & Time: 9/7/26.

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OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 9/7/26 Time of Arrival: 2pm Time Seen by Nurse: 2pm

1) **Level of Consciousness:** ☐ Conscious ☐ Semi-Conscious ☐ UnConscious

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

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

3) **Vital Signs:** Temperature: 97°f Pulse: 82bmt RR: 20bmt SpO_2: 99% BP: 130/98 Weight: .....

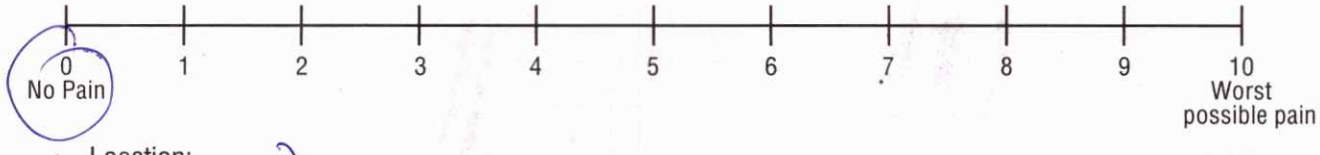
4) **Gestational Criteria:**

Gravida:	G	P	L	A

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

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

5) **Pain Screening:** **Numerical Pain Scale (NPS)**



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

.....

6) **Past History:**

a) Surgeries: ..... NIL

b) Medical: ..... NIL

Patient Sticker

7) **Allergy:** ☐ Yes ☐ No, If Yes : .....

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

9) **Prenatal Medical History:**

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

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: 10pm.

Nurse Name : Akuils Nurse Signature: .....

Date: 9/4/26 Time: .....

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OBSTETRICS / GYNECOLOGY
NURSING INITIAL ASSESSMENT FORM

Date of Admission: 9/7/26

Baseline Information:

Admission From: ☐ ER ☐ OPD ☑ Admission Desk ☐ Others, specify .....

Primary Language: ☑ Telugu ☐ English ☐ Hindi ☐ Others, specify .....

Do you require an interpreter? ☐ Yes ☑ No if Yes specify .....

Source of Information: ☑ Patient ☐ Family ☐ Others, specify .....

Allergies: ☐ Yes ☑ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: .....

If yes , identify .....

Chief Complaints: .....

Come for delivery.

Doctor Notified on Admission: ☑ Yes ☐ No

Name of the Doctor: Dr. Vareena.

Time Notified: 1PM

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

Past Medical History	Past Surgical History	Previous Hospital Admission
-	-	-

Gynecology Assessment: ☐ Not Applicable

Menstrual History: .....

Regular

Onset of Menarche: .....

Menstrual Cycle: ☐ Regular ☐ Irregular

Last Menstrual Period: .....

Gynecology Surgical History:

Caesarean Section: ☑ No ☐ Yes

Cervical Cerclage: ☑ No ☐ Yes

Ectopic Pregnancy: ☑ No ☐ Yes

Myomectomy: ☑ No ☐ Yes

Others: _____

Gynecological History:

Contraceptives: ☑ No ☐ Yes

Vaginal Discharge: ☑ No ☐ Yes

Post-Coital Bleeding: ☑ No ☐ Yes

Infertility: ☐ No ☑ Yes

If Yes Type: ☐ Primary ☐ Secondary

Obstetric History: G ..... P ..... L ..... A .....

Previous LSCS: .....

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: 97.1°F HR: 87 bpm RR: .....

BP: 110/70 Weight: ..... Height: ..... BMI: .....

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

Patient Sticker

PHYSICAL ASSESSMENT

General Appearance: ☑ Healthy ☐ ill looking ☐ Anxious ☐ Agitated ☐ Others: .....

Fall Assessment: ☐ Yes ☑ No Score .....0..... (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore: ☐ Yes ☑ No Score ...0..... (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

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 .....family member.....

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 .....PT.....

Name of Person Orientation was given to: .....HSA Kamala Kumari.....

Orientation not given Reason: .....

Nurse Signature: .....

Nurse Name: .....Akula.....

Date & Time: .....9/7/26.....

SURGICAL SAFETY CHECKLIST

Surgeon : Dr Swapna
Asst. Surgeon : Dr. Durga
Anaesthetist : Dr. Ayesha
Scrub Nurse : Sr. Sreshella

HNH-00016451 IP/26-00006794
Mrs SANNAMANDA KAMALA KUMARI
23-04-1996 30 Y 2 M 15 D (F)
Dr. SWAPNA SAMUDRALA

Patient Name ..... Gender : .....
UHID No. : .....
Date : 9/7/26 In-time : ..... Out-time : .....

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Before Induction of Anaesthesia ➤ ➤

SIGN IN Time: 3:00pm

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. Sk. Ayesha

Before Skin Incision ➤ ➤

TIME OUT Time: 3:10 Pm

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? Bleeding, 1hour, 500ml ☐ Yes ☐ No ☐ NA

Anaesthesia Team Reviews:
- Are There Any Patient-specific Concerns? Hypertension, Bleeding ☐ 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 : Karuna 3:10pm

Before Patient Leaves Operating Room

SIGN OUT Time: 4:00pm

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. Swapna S

PATIENT TRANSFER FORM

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HNH-00016451 IP26-00006794
Mrs SANNAMANDA KAMALA KUMARI
23-04-1996 30 Y 2 M 16 D (F)
Dr. SWAPNA SAMUDRALA

	Date & Time of Admission	Date & Time of Transfer Order
	9/7/26 @	9/7/26 @ 4:15pm
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr. Swapna	Dr. Ayesha	Observation.
From Unit	**To Unit**	**Information to Attendant**
OT	Pre Post	Yes ☐ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant** Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	RL	1
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☑ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Karuna	Dr. Ayesha

Patient & Clinical Records Received by : akhila @

Date & Time of Patient Received : 9/7/26 @

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

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

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: Mrs. KAMALA KUMARI Age: 30 y Sex: F UHID.No: HNH-00016451

Date: 9/7/26 Time: 9:00 pm Proposed Operation: Emergency Lower Segment Cesarean Section

Diagnosis: Primi / 34 wks / Severe PE +2 / CHTN c̄ Abruptio Placenta

B.P / CRT: 152/110 mm Hg H.R: 92/min Weight: 84 kg ASA Physical Status: ☐ 1 ☑ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 11.1 gm%	Glucose:	Protein:	HIV: NR	X-Ray:
PCV: 32	Urea:	Alb:	HBS Ag: NR	ECG:
WBC: 16280	Creat:	Total Bill:	HCV: NR	2D Echo:
Plate: 2.91 lakhs	Na:	Dir. Bill:	Blood group: B+ve	Stress/Anglo:
PT:	K:	LDH:	T3	Other:
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH	
	Cl -:	SGOT/SGPT:	**Allergies:** NIL	

Medical History: CVS / RESP / CNS / Renal / Hepatic / GE / Others: → Cold & cough :: 1 week, LRTI on medication; NIL SIGNIFICANT

Diabetes:

Physical Activity: METS > 4

Past Anaesthetic History:

Physical Exam:

Airway: MP 1 2 ③ 4 Mouth Opening: Adequate Mentohyoid Distance: (N) Neck: (N) Teeth: (N) Alignment

Lungs: B/L AE (+)

Heart: S1S2 (+)

CNS: NAD

Pregnant: ☑ Yes ☐ No ☐ NA | Venous Access Site: Peripheral (+) | Spine Exam for regional: Midline palpable

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours; → Others 6 Hours ✓
3. Informed Consent: ☑ Standard ☑ High Risk
4. Post Operative Pain Management: ☑ Discussed with Patient
5. Other Instructions:
   ① CBC, Coagulation profile
   ② 2 PRBC / 2 FFP, Reserve & Cross match

Signature: [signature] Name: Dr. SK Ayesha

Docu. No.: RCH /FRM / CLINICAL / 044

HNH-00016451 IP26-00006794
Mrs SANNAMANDA KAMALA KUMARI
23-04-1996 30 Y 2 M 16 D (F)
Dr. SWAPNA SAMUDRALA

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition:	☐ Yes ☑ No	Fasting Status:	Adequate
Physical Status:	☑ Patient Identified	☑ Consent Present	☑ Chart Reviewed

H.R: 110/min | B.P / CRT: 160/110 | SpO_2: 98/ c RA | R.R: 18/ min | Last Feed: > 6hrs

Pre-OP Diagnosis: Primi, 34+2 wks, Abruptio placenta? Operation: Emergency LSCS Date: 9/7/26

Surgeon: Dr. Swapna Anaesthesiologist: Dr. Ayesha Technician: Pallavi

TIME	3:00	3:10	3:20	3:30	3:40	3:50	4:00
N_2O /AIR /O_2 LPM							
HALO /SO /SEVO							
Drugs:	Inj. OXYTOCIN 3IU IV	Inj. OXYTOCIN 6IU IN 500ml RL IV					
FIO_2 / SaO_2	100/100	100/100	100/100	100/100	100/100	100/100	100/100
$ETCO_2$							
ECG	SR	SR	SR	SR	SR	SR	SR
Temperature	36.3C						
Urine Output							
Fluids							
Blood							

Antibiotic: Inj. Amoxicillin 1.2gm IV; Inj. METRONIDAZOLE 500mg IV

Suppository: TRAMADOL 100mg PR

Blood Loss: 450ml

NOTES

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

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

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

LAB Values: ABG; GRBS; Others

- ☑ Equipment Checked and Functional
- ☐ BP
- ☑ Cuff Site: (Rt) UL
- ☑ Art Site: 3 lead
- ☑ EKG Lead
- ☑ Temp Site: (Rt) axilla
- ☐ FIO_2 Monitor
- ☐ Agent Monitor
- ☑ Pulse Oximeter
- ☐ Capnograph
- ☐ Ventilator
- ☐ Nerve Stimulator

Position: .....
- ☑ 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: 3:00pm
- OP Start: 3:06pm
- OP End: 4:00pm
- Leave OR: 4:04pm

Anaesthesia:
- ☐ GA
- ☐ Monitored Anaesthesia Care
- ☑ Regional

Line (Size & Location)
- ☐ CVP: .....
- ☐ ART: .....
- ☑ IV: 18G on (Rt) UL
- ☑ IV: 16G on (Rt) UL
- ☐ IV: .....

Induction
- ☐ IV ☐ Inhal
- ☐ Pre O_2 ☐ RSI
- ☐ Others

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

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

Blade# ..... Attempts: .....
Difficulty Why? .....

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

Regional:
Extremity Specify: .....
- ☑ Spinal ☐ Epidural ☐ Caudal

Others: .....
Position: Sitting
Site: L3-L4
Needle Size: 25G Depth: .....
Parasthesia ☐ Yes ☑ No
Catheter at skin ..... cm
Drug Name & Conc: 0.5% Heavy BUPIVACAINE
Bolus: 2ml + 25mcg FENTANYL
Infusion: .....
Block Level: T6 - T4
Comments: .....

Transportation to
☐ PACU ☑ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☐ NA

Name of the Doctor: Dr. Ayesha
Signature of the Doctor: .....

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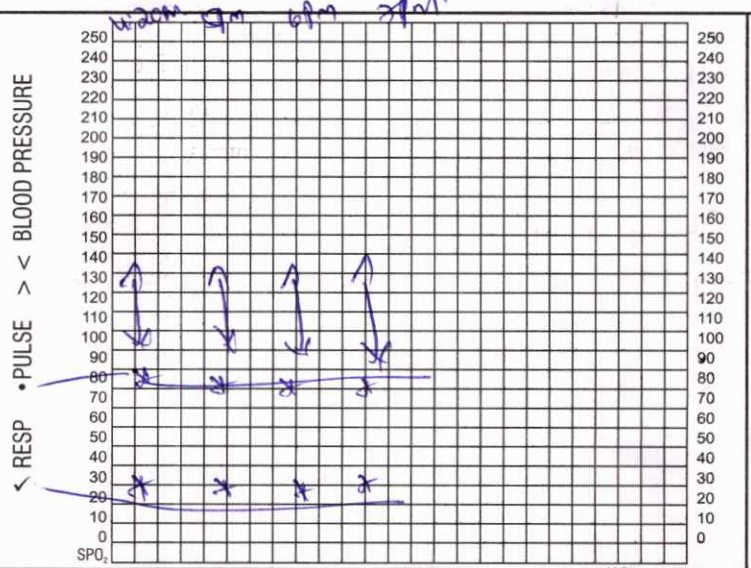
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Sis. Akhila Time Received : 4:30pm Time Discharged : 10:10Am



IV Cannula Site : Lt. side

- ☐ O_2 Mask
- ☐ Nasal Prongs
- ☐ Tracheostomy
- ☐ T-Piece
- ☐ Oral Airway
- ☐ Nasal Airway

Vomiting : ☐ Yes ☐ No Drug: Inj Zofer

NG Tube : ☐ Yes ☐ No

Drain: ☐ Yes ☐ No

Urinary Catheter: ☑ Yes ☐ No

Chest Tube: ☐ Yes ☐ No

Nil Oral ☐ Yes ☐ No

IV Fluids: DL

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
9/7	4:20pm	0/10	NA	
9/7	5:20pm	0/10	NA	
9/7	6:20pm	0/10	NA	
9/7	6:29pm	0/10	NP	

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

Reassessment Frequency:

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

Anaesthesiologist Name : Ayesha

Anaesthesiologist Signature:

Date & Time:

PACU Nurse Name : Mounika

PACU Nurse Signature:

Date & Time: 9/7/26

Transferred to Unit by (PACU): 3rd floor (313)

Date & Time: 11/7/26

Patient Sticker

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EPIDURAL ANALGESIA RECORD

Date: ..... Time: ..... Procedure done by .....

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

Depth: ..... Catheter at Skin: ..... Attempts : .....

Parasthesia : Yes/No if yes details : .....

Solution Composition : .....

Any other issues :

a) .....

b) .....

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

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

Catheter Removed by and Tip Inspected : .....

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

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NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 11/7/26 Time: 10:00 am

Origin: Indian Height: 154 cms. Weight: 80 kg BMI: ☐ ~ 26 kg/m² ☐ ~ 28 kg/m² ☐ ~ 30 kg/m²
29.8 kg/m²

Food Allergies: N.D

Diagnosis: LSCS

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

Diet Advised:

Liquid Diet – ORS/ Coconut Water / Butter Milk / Barley Water / Soups

Normal Diet – Rice, Rotis, Dal and Soft Cooked Vegetables and Curd

Soft Diet – Soft Rice, Dal and Vegetable Curries Soft Cooked, Curd

Diabetic Diet – Brown Rice / Oats/ Dahlia/ Rotis, Dal and Vegetables and Curd (Avoid Roots / Tubers)

Patient's / Attendant's
Signature: Kamala

Name: Kamala

Date & Time: 11/7/26 ; 11:00am

Dietician's
Signature: Satvika

Name: Satvika

Date & Time: 11/7/26 ; 11:00am

DIETARY NOTES

Date	Time	Notes	Sign

HNH-00016451 IP26-00006794
Mrs SANNAMANDA KAMALA KUMARI
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CROSS CONSULTATION FORM

Doctor Name : Dr: Swapna Date : 11/7/26 Time : 12pm

Diagnosis : LSCS

Hospital : RCH – HMNR

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

Type of Referral :
☐ Emergency
☐ Urgent
☐ Non Urgent

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

Signature:

Findings and Recommendations :

Lactation care plan

- Well formed Breast & Nipple's
- colostrum seen, Primi, baby at NICU
- Advised Expressed Breast milk every 2–2½ hours on each side 15–20 mints.
- Can use electrical Breast pump
- Advised spoon feeds to baby.

Consultant :

Name : Sathwika.G Signature : Date & Time : 11/7/26 ; 12pm

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : Mrs: KAMALA KUMARI Age : 30y Gender : Male ☐ Female ☑

UHID NO: ..... Surgeon Name: Dr: SWAPNA

Anaesthesiologist : Dr: AYESHA

Operative procedure planned : EMERGENCY LOWER SEGMENT CESAREAN SECTION

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 without numbness can be achieved by infusing weak solutions of local anesthetics arid 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 mellitus ☐ Renal failure

☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma / Renal Tubular Aacidosis

☐ Incapacitating Cronic Obstructive Pulmonary Disease

☑ Others : Hypotension, Bleeding, Need for transfusion, Need for

Comments : ICU Care, post op mechanical Ventilation

- Doctor to document in medical record also if necessary (Cross-out if not applicable)

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient Mrs: KAMALA KUMARI the above mentioned operation / Diagnostic / Therapeutic procedures EMERGENCY LOWER SEGMENT CESAREAN SECTION

I authorize and give consent for anaesthesia (☐ Regional / ☐ General Anesthesia / ☐ Monitored Anesthesia Care as considered appropriate by the anaesthetic team.

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, risk, benefits and alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anesthesia.

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, asthmatic reactions, headaches.

I authorize the anaesthetic team to perform any additional procedures (for example, Central Venous Pressure line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I 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 in need arises.

I understand that the above mentioned consultant anesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

- Pregnant : ☑ Yes ☐ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

I declare that I have explained the nature of General Anaesthesia / Regional Anaesthesia / Monitored Anesthesia Care to be given and discussed the risks that particularly concern this patient.

I have given the patient an opportunity to ask questions and I have answered these.

Patient / Patient Attendant :

Signature : Kamala

Name : Kamala

Relationship with Patient: Self

Date & Time : 9/7/26 @ 2pm

Witness :

Signature : S. Kamal

Name : S. Kamal.

Date & Time : .....

Doctor (who is taking the consent) :

Signature : Ayesha

Name : Dr. Sk Ayesha

Date & Time : 9/7/26

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : Mrs Kamala kumari Gender: ☐ Male ☑ Female Age : 30yr.

UHID No : HNH-0001645 Date : 9/7/26

Instruction:

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

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

EMERGENCY LOWER SEGMENT CESAREAN SECTION

upon

Mrs Kamala kumari (Name of the Patient)

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

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

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

excessive bleeding, wound infection, injury to adjacent organs like bowel, bladder, blood vessel, risk of eclampsia Need for blood & blood product transfusion, risk of multiorgan in Risk of fetal distress, Need for ventilatory support

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. Swapna

Consentee :

Signature : Kamala

Name : Mrs Kamala kumari

Date & Time : 9/7/26. 2pm

Witness :

Signature :

Name :

Date & Time :

Patient Attendant :

Signature : Sai kumar

Name : Sai kumar

Relationship with Patient: Husband.

Date & Time : 9/7/26 2:25pm

Doctor (who is taking the consent) :

Signature :

Name : Dr. Dna.

Date & Time : 9/7/26. 2pm.

INFORMED CONSENT FOR HIGH RISK PROCEDURE / SURGERY

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Name: Mrs Kamala kumari Age: 30yr. Gender: ☐ Male ☑ ~~Female~~

UHID.No : HNH-0001645 Date: 9/7/26

I / We Mr. Sai kumar have been explained by Dr. Swapna about the medical condition and the proposed procedure.

I / We have been told that our patient Mrs Kamala kumari has the following Medical Conditions / Diagnosis:

Primi / 34+2 week / Abruptio placenta / GHTN.

Proposed Treatment / Procedure / Operation: Emergency Lower Segment Cesarean Section

I / legal guardian, have been explained in the language understood by me / us, about the medical condition mentioned above and that our patient has following risks involved during the hospital stay

excessive bleeding, risk of eclampsia, AKI, Liver failure, multiorgan involvement, Need for ventilatory support.

I / We have been explained risk, benefits and alternatives of the procedure.

I / We have been informed that the ongoing treatment in the Intensive Care Unit involves the risk of unsuccessful results, complications, temporary or permanent injury or disability and even fatality from known or unforeseen causes and no guarantee or promises have been made to me / us concerning the results of the procedure or treatment.

I / We have understood the consequences of not undergoing the proposed treatment.

I / We hereby give (my / our) full consent for the above – mentioned treatment.

I / We also indemnify the hospital, the concerned Doctors and the hospital staff in case of any adverse consequences arising from the treatment.

Patient (Or Patient Relative / Guardian):

Signature: Sai Kumar

Name: Sai Kumar.

Date & Time 9/7/26. 2:25pm

Doctor (Who is talking the consent)

Signature:

Name: Dr. Swapna

Date & Time 9/7/26 2:25 pm.

Witness

Signature: Name:

Relative / Legal Guardian: (Relationship with Patient)

Address:

Date & Time

HNH-00016451 IP26-00006794
Mrs SANNAMANDA KAMALA KUMARI
23-04-1996 30 Y 2 M 16 D (F)
Dr. SWAPNA SAMUDRALA

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URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 09/7/2026 Date of Removal: .....

Parameters / Date / Shift Time	9/7/26 E						
Need for the Catheter	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hand Hygiene	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Usage of Sterile Equipment	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the Collection bag below the level of bladder	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Check the Tube for Obstruction (Free of Kinking)	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Catheter dated as policy	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Collecting bag is been emptied regularly?	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Maintenance of closed system for the catheter	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing clean and dry?	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the line removed as Policy?	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Performance of Perineal Care	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Onset of New Fever	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Asses for the leakage at the site of insertion	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Nurse	Anu						
Signature of the Nurse							

26-0000212172

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NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name: Mrs. Sannamanda Kamala Kumari		Age: 30 Yrs.	Gender: Female
UHID No: HNH-0001645	IP No: 26-00006796	Date: 9/7/26	Time:
Diagnosis: EM LSCS			OT

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	100mcg	01
2.	Morphine Sulphate Inj. 15mg/Ml		
3.	Remifentanil Hydrochloride Inj. 2MG		
4.	Remifentanil Hydrochloride inj. 1MG		

Doctor Name: Dr. Sk. Ayesha

Doctor Registration No: TSMC/FMR/07725

Signature:

NARCOTIC DISPENSING FORM
APPENDIX 4 – FORM NO. 3E
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: 26-00006796 **Date:** 9/7/26

Aadhaar No. of the Patient (Optional): .....

1.	**Name :** Mrs Sannamanda Kamala Kumari	**Remarks**
2.	Complete postal address (with contact number, if any)	Jamaosmaia + Hyderabad.
3.	Brief description of the illness	EM LSCS
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	No
5.	Details of essential Narcotic drug dispensed	Fentanyl

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
9/7/26	Fentanyl	01		

Dispensed by (Name & ID No.): ..... Signature: .....

Received by (Name & ID No.): U. Pallavi 017921 Signature: U. Pallavi

Time: .....