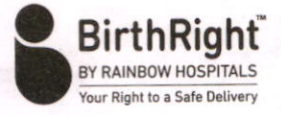


BAH-00448476 IP5-00174680
 Mrs MALIKREDDY ALEKHYA
 28-08-1994 31 Y 9 M 6 D (F)
 Dr. SHRUTHI REDDY/Dr. LAVANYA



SURGERY DETAILS

8049A

Date : 3/6/26

Patient Name: Mrs. M. ALEKHYA Date of Birth: Age: F

Gender: F Ward : PED-OT UHID No.: BAH - 00 7 48 4 76

Date of Surgery: 3/6/26 OT -1 OT -2 OT -3 OT -4 OBG OT-1 OBG OT-2

Name of the Surgery : Laparoscopic Bilateral tubectomy + Mirena removal.

Time in : 10:15 AM

Time Out : 11:15 AM

	<u>NAME</u>	<u>AMOUNT</u>
1. Surgeon	..... DR. SHRUTHI Reddy .....	.....
2. Anaesthetist	..... DR. NEENA .....	.....
3. Assistant Surgeon	..... - .....	.....
4. OT Technician	..... BR. Renuka .....	.....
5. Circulating Nurse	..... Sr. A. Mayra .....	.....
6. Assistant Nurse	..... Sr. Ruma Devi .....	.....

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

(Signature)
 Signature of the Surgeon

(Signature)
 Signature of Circulating Nurse

Order No: 1640802/

Order by: Bobi

ADMISSION SHEET

Registration Details :



Admission No : IP5-00174680

Admit Date : 03-Jun-2026

Admit Time : 08:58 AM UHID : BAH-00448476

Patient Details :

Patient Name : Mrs MALIKREDDY ALEKHYA

Age : 31 Y 9 M 6 D

Guardian : MR PUNNAPUREDDY VENKATA SIVA REDDY

DOB : 28-08-1994

Gender : Female

Religion :

Occupation :

Marital Status : Married

Address (H) : FLAT NO 201, D BLOCK ,SKY HIGH, HARSHA
DEVELOPERS, SHIAKPET Dargah Hussain
Shah Wali Hyderabad Telangana INDIA
500008

Phone No : 9573888875/ 9866456363

E-mail : M.ALEKHYA76@GMAIL.COM

Admission Details :

Bed Type : DAY CARE

Bed No : POST OP 411

Ward Name : 4F-OT COMPLEX

Room No : POST OP 411

Admission Type : First Visit

Contact Details :

Name : MR PUNNAPUREDDY VENKATA SIVA Relationship : Husband

Contact Address : FLAT NO 201, D BLOCK ,SKY HIGH, HARSHA
DEVELOPERS, SHIAKPET Dargah Hussain
Shah Wali Hyderabad Telangana INDIA 500008

Phone No : / 9573888875


Signature

Doctor Details :

Doctor Name : Dr. SHRUTHI REDDY/Dr.LAVANYA
JANAGAMA

Specialisation : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY

DR. MALIKREDDY ALEKHYA
 28-08-1994
 Dr. SHRUTHI REDDY/Dr. LAVANYA (F)

lap Tubectomy
CONSUMABLES OF OT

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Circulating staff: *[Signature]* Technician: *[Signature]* Date: *3/6/26* Time: *10:30am*

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube <i>2.0 7.5</i>	11	1	Major Pack <i>Hexamers</i>	12	2	Inj Vit.K		
LMA <i>3.4</i>	11	-	Sutures			Cord Clamp		
ECG leads: A/P/N	5	3	<i>Small prep</i>	1	1	Suction Catheter		
HME filter: A/P/N	1	1				Feeding Tube		
Syringes : 10 cc	10	3				Vaccum Suction Set		
05 cc	10	2	Gloves <i>6/6/2/2/2/2/2/2/2/2</i>	12	12	Surgical Gloves		
02 cc	10	0	<i>6/6/2/2/2/2/2/2/2/2</i>			Gauze Pack		
01 cc	2	-	<i>Gloves</i>	2	2	Syringe 1ml / 2ml		
Cautery plate: A/P/N	1	-	Surgical blade <i>11</i>	1	1	Surgical Blade # 20		
IV set	1	-	NG tube			Koochies (S)		
RL	1	1	Cautery pencil			<i>500ml NS</i>	2	1
NS : 10ml / 100ml / 500ml / 1000ml	12	2	Koochies			<i>Jug</i>	1	1
<i>02 Mask (A)</i>	1	-	Ointments			<i>10cc. Sec. 2cc 2cc</i>		
<i>Alprax 2.3</i>	11	1	Suction Catheter <i>10</i>	1	1	<i>Tubal bag</i>	2	2
Fentanyl	1	1	Cap, Mask	55	3/0	<i>0.25% Amwin</i>	1	1
Morphine			Gauze Pack <i>N42</i>	32	0			
Ketamine			Mop Pack	12	-			
Propofol	3	2	Steristrip <i>one lining</i>	31	31	<i>airways</i>		
Rocuronium	1	0	Underpad	1	11	<i>Tramadol 200B</i>	11	11
Glycopyrolate	1	0	Draw sheet	1	1	<i>Dexa</i>	1	-
Myopyrolate	1	0	Abgel			<i>Tramexa</i>	2	1
Ondansetron	1	0	Foleys catheter <i>14/16</i>	11	-	<i>Minispi</i>	2	2
Pencan (25g) Spinal Needle 22			Urobag	1	-	<i>Ephedrine</i>	1	0
Bupivacaine 0.25%	1	1	Chest Drainage Catheter			<i>Fronein</i>	1	1
Bupivacaine 0.25%(Heavy)			Romodrain bag			<i>Pylestube 14/16</i>	11	11
Antibiotics			Bandage			<i>Mida 2</i>	1	2
Suppositories			Tegaderm			<i>Nasal Alprax 2.3</i>	11	-
Anamol : 80mg / 250mg / 170 mg			Joban <i>TRP 3cc</i>	1	-	<i>2y: Dostin</i>	1	1
Supridol : 100mg	1	1	Double J Stent			<i>phenylees</i>	1	0
Justin : 12.5 mg / 25mg / 100mg	1	1	Vaccum Suction set	1	0	<i>Loli (ad)</i>	1	1
Tab. Misoprost : 200mg	2	1	Plastic Bed Sheet	1	0			
<i>Vaccum set</i>	1	1	Betadine Solution	2	1			
<i>Gauze</i>	3	0	Microshield	1	0			
<i>Gloves all</i>	4	-	Cotton Balls	2	1			
<i>IV p.cm</i>	1	1	Latex Gloves	108	108			
<i>3-way 100x10cm</i>	11	-	Ramdione Scrub	1	1			
			Saral					

Surgeon: *[Signature]* Anaesthesiologist: *[Signature]* Nurse: *[Signature]* OT Technician: *[Signature]*
 Order No.: *960088* Ordered by: *[Signature]*
 Doc. No.: RCH / FRM / GENERAL / 125

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP No. : _____ Dept : _____

BAH-00448476 IP5-00174680
Mrs MALIKREDDY ALEKHYA
28-08-1994 31 Y 9 M 6 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
3/6/26	10 AM	CUM	OT	reep
3/6/26	11:15 AM	OT	CUM	reep
3/6/26	2 PM	CUM	BPLing	reep

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

BAH-00448476 IP5-00174680
 Mrs MALIKREDDY ALEKHYA
 28-08-1994 31 Y 9 M 6 D (F)
 Dr. SHRUTHI REDDY/Dr. LAVANYA



OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 3/6/26

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: P.L. come to lap. Tubectomy Doctor Notified on Admission: Yes No
 Name of the Doctor: Dr. Dinger
 Time Notified: 9 AM

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>Nil</u>	<u>LCS</u>	<u>Nil</u>

<p>Gynecology Assessment: <input type="checkbox"/> Not Applicable</p> <p>Menstrual History:</p> <p>Onset of Menarche:</p> <p>Menstrual Cycle: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular</p> <p>Last Menstrual Period: <u>1/20/26</u></p>	<p>Gynecology Surgical History:</p> <p>Caesarean Section: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes</p> <p>Cervical Cerclage: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Ectopic Pregnancy: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Myomectomy: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Others:</p>	<p>Gynecological History:</p> <p>Contraceptives: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Vaginal Discharge: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Post-Coital Bleeding: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Infertility: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If Yes Type: <input type="checkbox"/> Primary <input type="checkbox"/> Secondary</p>
--	--	---

Obstetric History: G P 1 L 2 A

Previous LCS: 1 ces

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

Family History: No Abnormalities Detected

Heart Disease Hypertension Diabetes Stroke Seizures Kidney disease
 Liver disease Other

Vital Signs / Measurements: Temp: 98.6 F HR: 76 mt RR: 20 mt
 BP: 113/76 mt Weight: 78 kg Height: BMI:

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

PHYSICAL ASSESSMENT

General Appearance: Healthy ill looking Anxious Agitated Others:

Fall Assessment: Yes No Score 20 (complete the Morse Fall Risk Assessment Sheet)

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

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

Mobility problem Walking Problem No Abnormality Detected

Developmental Delay Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: No Abnormality Detected

Overweight Poor Appetite > 3 Days Needs Therapeutic Diet.

Under Weight Diabetes Mellitus Hyperemesis Gravidarum

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

Calm & Cooperative Restless Depressed Agitated Confused

Others

Inform consultant for positive criteria

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

Orientation has been given regarding the following aspects:

Call Bell in Reach : Yes No Waste Disposal Explained: Yes No

Infusion Pump : Yes No Hand Hygiene Explained: Yes No Others

Above information given to patient

Name of Person Orientation was given to: Mrs. Alekhya

Orientation not given Reason:

Nurse Signature: [Signature]

Nurse Name: [Name]

Date & Time: 03/06/26

BAH-00448476 IP5-00174680
Mrs MALIKREDDY ALEKHYA
28-08-1994 31 Y 9 M 6 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA



I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 3/6/26 Time of Admission :

Allergies: N/A Not know any drug allergies

PRESENTING COMPLAINTS :

+ P2L2 came for laproscopic sterilization.
→ Mirena insert - 2025 @ RCH by Dr. Shruith; Reddy.

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : 2018, NCM	Parity : P2L2
Previous Periods : Regular / 28 days	Mode of Delivery : LSCS - (IND-DCOA twin)
LMP : Jan, 2026	Last Child Birth : 2021 @ RCH
Contraception : Nil	Dr. Shruith; Reddy.

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
Nil Mirena insert - 2025	LSCS - 2021

FAMILY HISTORY:

Both parents - DM

MEDICATION HISTORY:

Nil

INITIAL ASSESSMENT :

Date <u>3/6/26</u> Ht. _____ Wt. _____ BMI _____ B.P. <u>113/83 mmHg</u> Pallor <u>absent</u> CVR <u>S2 (+)</u> Respiratory System <u>BAE (+)</u> Thyroid <u>(N)</u>	Breasts <u>(N)</u>	Local/Speculum Examination _____
	Abdominal Examination <u>Soft</u>	Bimanual Pelvic Examination _____

PROVISIONAL DIAGNOSIS :

P1b2 / previous lscs / for Lap. tubectomy.
Mirena IUD.

INVESTIGATIONS ORDERED

PLAN OF MANAGEMENT

1/6/26
 → Bct - O+ve.
 → Vitals - NR
 → CBP - Hb - 13.1 / PLT - 2.31L
 RBS - 84
 CR - 0.62
 TSH - 0.372

- 1) Admission
- 2) PAC
- 3) IV cannulation
- 4) IVF - @ 700ml/hr RL/L
- 5) Drugs as charted
- 6) part preparation
- 7) shift to OT on call.

Name of the Doctor : Dr. Divya

Signature of Doctor [Signature]

Date & Time : 3/6/26 ; 8:30 AM

BAH-00448476 IP5-00174680
Mrs MALIKREDDY ALEKHYA
28-08-1994 31 Y 9 M 6 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA



OPERATION THEATER NOTES

Patient's Name : Mrs. M. ALEKHYA Age : 31Y Gender : Male Female

UHID No.: BAH-00448476 Weight : 78.2 kg Height :

Surgeon : DR SHRUTHI Reddy Asst. Surgeon :

Anesthetist : DR NIMH OT Nurse : Renalini OT Technician: Rakesh.

Pre-Operative Diagnosis: P.L.2 / Prev. LSC for lap. tubectomy + Mirena removal

Surgical Procedure : lap. tubectomy + Mirena removal

Indications for Surgery : Permanent Sterilization.

Date : 3/6/26

Start Time : 10:20 AM

End Time : 11 AM.

Pre Operative Preparations:

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes: ↓ GA, ~~the~~ patient kept in lithotomy position.

↓ Asp, ports painted and ~~the~~ draped.

- Bladder Catheterized.

- 15mm - infraumbilical port.

- Pneumoperitoneum created.

- 15mm left lateral port.

- uterus normal in size.

- Bilateral ovaries and fallopian tubes - normal.

- 1 Oriental adhesion seen to anterior abdominal wall at umbilicus. (P.T.O.)

- Bilateral tubectomy tubal occlusion was performed using falope rings
- Hemostasis was confirmed.
- Pneumoperitoneum released.
- sterile dressing applied.
- Mirena removal done

Amount of Blood Loss: Minimal

Blood Transfused (in ML) Nil

Name and Number of Surgical Specimen sent for examination:

Peri-Operative Complications:

- Tab. TAXIM-0 - 200mg BD x 5 days.
- Tab. Dolo 650mg (CoS)

Name of the Surgeon: Dr. Shreetha Reddy

Signature of the Surgeon: For her (Dr. Lavon)

Date & Time: 3/6/26 11 AM

BAH-00448476 IP5-00174680
 Mrs MALIKREDDY ALEKHYA (F)
 28-08-1994 31 Y 9 M 6 D
 Dr. SHRUTHI REDDY/Dr. LAVANYA

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/6/26 11:15 AM.	POD-0 / P/L2 / Lap. tubectomy + Mirena removal. / previous lcy	
3/6/26	O/F GC-fair BP-110/70 mmHg PR-72 bpm SpO ₂ -98% RA PLA-soft	Adv 1) NBM for 4-6 hours 2) IVF - RL @ 100ml/hr 3) w/f active bleeding. 4) Monitor vitals 5) Drugs as charted 6) Encourage voiding 7) Inform SUS Dr. Divya
3/6/26 2:20 pm	POD-0 O/F GC-fair Vital-stable PLA-soft BS-(+)	Adv 1) Allow sips of water ↓ flb liquid diet 2) IVF - RL @ 100ml/hr 3) CST 4) Inform SUS
check voiding done. Can be discharged.		Dr. Divya



Date Time	Nurse Sig.	Nurse Sig.	Nurse Sig.	Nurse Sig.
DRUG :	Dose	Dose	Dose	Dose
	Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.
Route	Dose	Dose	Dose	Dose
Start Date	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.

Date Time	Nurse Sig.	Nurse Sig.	Nurse Sig.	Nurse Sig.
DRUG :	Dose	Dose	Dose	Dose
	Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.
Route	Dose	Dose	Dose	Dose
Start Date	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
3/6/26	9:45AM	INJ: CEFOTAXIM	1gm	IV	Dr. Diga	my Lena
3/6/26	11AM	INJ. PARACETANOL	1gm	IV	Am	my Lena
3/6/26	11:AM	Sup. DICLOFENAC	100mg	P/R	Am	my Lena
3/6/26	11AM	sup. TRAMADOL	100mg	P/R	Am	my Lena
3/6/26	11:15AM	INJ. DROTIN	40 mg	IV	Am	my Lena
3/6/26	12pm	INJ. ONDANSETRON	4mg	IV	Am	my Lena
3/6/26	12:30pm	INJ. PANTOPRAZOLE	40mg	IV	Am	my Lena

VERIFIED BY : Signature

BAH-00448476 IP5-00174680
 Mrs MALIKREDDY ALEKHYA
 28-08-1994 31 Y 9 M 6 D (F)
 Dr. SHRUTHI REDDY/Dr. LAVANYA



o +ve
Blood group



RESULT SHEET

Date	1/6/26				
Time					
Hb	13.1				
PCV					
RBC	4.28				
WBC	7.7				
N/L					
Platelets	231				
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

BAH-00448476 IP5-00174680
 Mrs MALIKREDDY ALEKHYA
 28-08-1994 31 Y 9 M 6 D (F)
 Dr. SHRUTHI REDDY/Dr.LAVANYA



MEDICATION RECONCILIATION FORM

Drug Allergies: N.K.O.A.

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						<input type="checkbox"/> C <input type="checkbox"/> DC
2						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Divya

Date & Time : 3/6/20 9:4 AM

Nurse Name & Signature: Keyra Key

Date & Time : 3/6/20 at 9 AM

BAH-00448476 IP5-00174680
Mrs MALIKREDDY ALEKHYA
28-08-1994 31 Y 9 M 6 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA



POST-SURGICAL CARE PLAN FORM

Procedure Done: Lap - Bilateral tubectomy + Mirena removal

Post-Surgical Diagnosis: POD-01

Post-Operative Monitoring Parameters /Frequency:

- Monitor vitals hourly

Wound Care:

- check for wound Soakage

Drain /Special Lines/Catheters:

- IV cannula

Special Patient Positioning and Requirements:

-

Nutritional Instructions:

- NBM x 2 hrs
- followed by liquids

When to Start Mobilization:

- After 2 hrs

Special Referrals:

-

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

Yes No

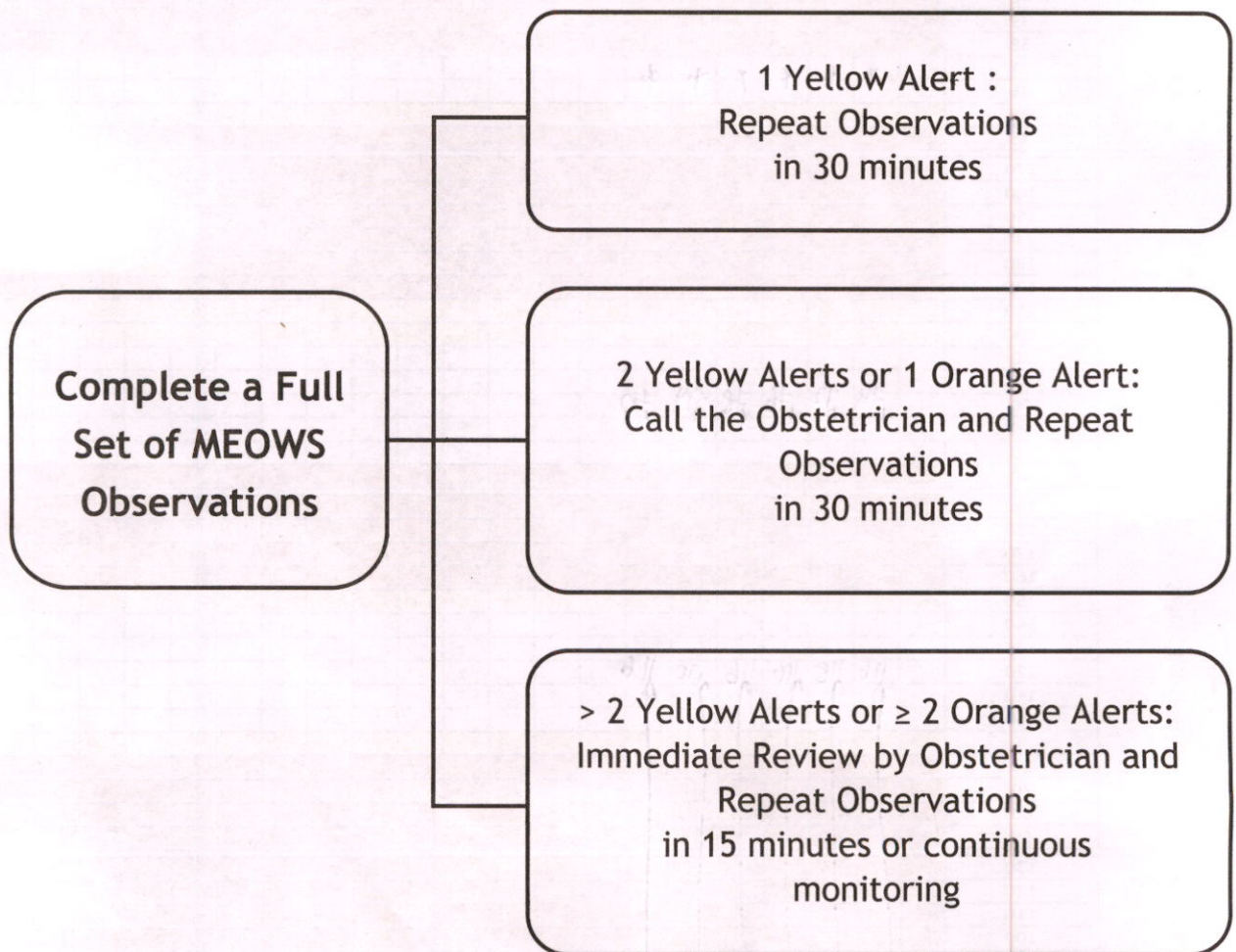
Any Other Post-Operative Care Needed including Required Follow Up

Dr. Lavanya
Treating Surgeon
(Signature & Stamp)

Date: 3/6/26 Time: 4 AM

Note: Plan of care will be readjusted if necessary.

**Obstetrics and Gynaecology
Early Warning Signs**



* The Modified Early Warning Score (MEOWS)

BAH-00448476 IP5-00174680
 Mrs MALIKREDDY ALEKHYA
 28-08-1994 31 Y 9 M 6 D (F)
 Dr. SHRUTHI REDDY/Dr. LAVANYA



FLUID CHART



Sheet No. : ①

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
9/6	08:00 am												
	09:00 am	RL	8	100ml									
	10:00 am		8	100ml									
	11:00 am		0	100ml									
	12:00 pm		water	100ml									
	01:00 pm				100ml								
Total Intake :						Total Output :							
9/6	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

Patient Sticker

FLUID CHART

Sheet No. :

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

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

Total 24 hrs. Intake

Total 24 hrs. Output

**Department of Anaesthesiology
 PRE-ANAESTHETIC EVALUATION**

Name: malik Reddy Alekhy Age: 31 Sex: Female UHID.No: BAH 00448476
 Date: 3/6/2026 Time: 9:10am Proposed Operation: Laparoscopic Bilateral tubectomy
 Diagnosis: P2L2
 B.P/CRT: 112/83 (96) H.R: 72wt Weight: 78.2kg ASA Physical Status: 1 2 3 4 5

Laboratory Data:

1/6/2026
 Hgb: 13.1 Glucose: Protein: HIV: X-Ray:
 PCV: 38.1 Urea: Alb: HBS Ag: ECG:
 WBC: Creat: Total Bill: HCV: 2D Echo:
 Plate: 2.31lak Na: Dir. Bill: Blood group: Oposh Stress/Anglo:
 PT: K: LDH: T3: Other:
 PTT: Ca++: Alk phos: T4:
 INR: Mg++: Amylase: TSH:
 Cl-: SGOT/SGPT:
 Allergies: nil

Medical History: CVS: Diabetes:
 RESP:
 CNS:
 Renal:
 Hepatic/GE:
 Others:
 Physical Activity: active

Past Anaesthetic History: LSCS + SAB → 2021 → OIL

Physical Exam:
 Airway: MP 1 2 3 4 Mouth Opening: nl Mentohyoid Distance: nl Neck: nl Teeth: nl loose
 Lungs: clear clear
 Heart: S1S2nl
 CNS: Gcs Full

Pregnant: Yes No NA Venous Access Site: Spine Exam for regional:

Anaesthetic Plan: MAC REGIONAL GA-ETT LMA

Peri-Operative Plan Explained to the Patient: Yes No

CURRENT MEDICATIONS	DOSAGE

Pre-Operative instructions:

- DVT Prophylaxis :
- NIL ORAL $\left\{ \begin{array}{l} \text{Water / ORS 2 Hours} \\ \text{Others 6 Hours} \end{array} \right.$
- Informed Consent: Standard High Risk
- Post Operative Pain Management: Discussed with Patient
- Other Instructions:

Signature: [Signature] Name: [Name]

Pre Induction Assessment:

Change in Patient Condition: Yes No

Physical Status: Patient Identified Consent Present

Fasting Status: Adipet

H.R.: 92/mnt B.P./CRT: 120/80mm SpO₂: 100% R.R.: 28/mnt Chart Reviewed

Pre-OP Diagnosis: P2.L2 Operation: Laparoscopic Tubectomy Last Feed: > 6hr

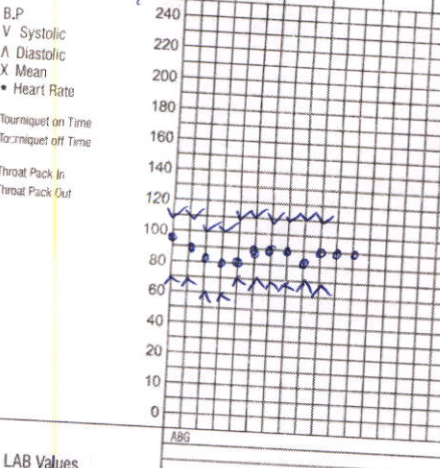
Surgeon: Dr. Shanthi Reddy / Dr. Levey Anaesthesiologist: Dr. NM/Dr. Annes Date:

Technician: Gowtham

TIME	10:15	10:45	11:15
N ₂ (AIR/O ₂) LPM	100	100	100
HALO/SO ₂ SEVO	34	34	34
Drugs:			
MIDAZOLAM	1mg		
FENTANYL	100µg		
PROPOFOL	120mg		
ROCURONIUM	30mg		
PARACETAMOL	1gm		
FiO ₂ / SaO ₂	100 / 100	100 / 100	100 / 100
ETCO ₂	34	34	34
ECG	SR	SR	SR
Temperature	37.1	37.1	37.1
Urine Output	34ml	35ml	35ml

Ramesh
Antibiotic
Suppository
SUPRAMADOL P/R
DILUPENTAC P/R
Blood Loss

Fluids
Blood
Ringer Lactate @ 150ml/hr



LAB Values
ABG
GRBS
Others

Equipment Checked and Functional

BP

Cuff Site: RA

Art Site:

EKG Lead

Temp Site - 3electrode

FIO₂ Monitor

Agent Monitor

Pulse Oximeter

Capnograph

Ventilator

Nerv Stimulator

Position: Supine

Pressure Points Checked

Eye Care:
 Oint
 Tape
 Padding
 Awake

Temp:
 FIME
 Cling Film
 Hugger's
 Other

Fluid Warmer
 OH Warmer
 Cotton Wool

Times:
Anaes Start: 10:15AM
OP Start: 10:30AM
OP End:

Anaesthesia:
 GA
 Monitored Anaesthesia Care
 Regional

Line (Size & Location)
 CVP:

Induction
 IV
 Inhal
 Pre O₂
 RSI
 Others

Mask
 Airway
 ETT# 7mm at 18 cm
 Oral
 Nasal
 Cuff
 Tracheostomy
 Topical
 Drug: Rocuronium

Awake
 Video Laryngoscopy
 Fiberoptic
Blade# 3 Attempts: 1
Difficulty Why?

Bilat = BS
 Semi-Closed Circle
 Closed Circle
 Other

Regional:
Extremity
 Spinal
Specify:

Epidural
 Caudal

Position:

Site:

Needle Size: Depth:

Parasthesia Yes No

Catheter at skin cm

Drug Name & Conc:

Bolus:

Infusion:

Block Level:

Comments:

Transportation to
 PACU
 ICU
 Other
Relaxant Reversed Yes No NA

Name of the Doctor: Dr. Annes

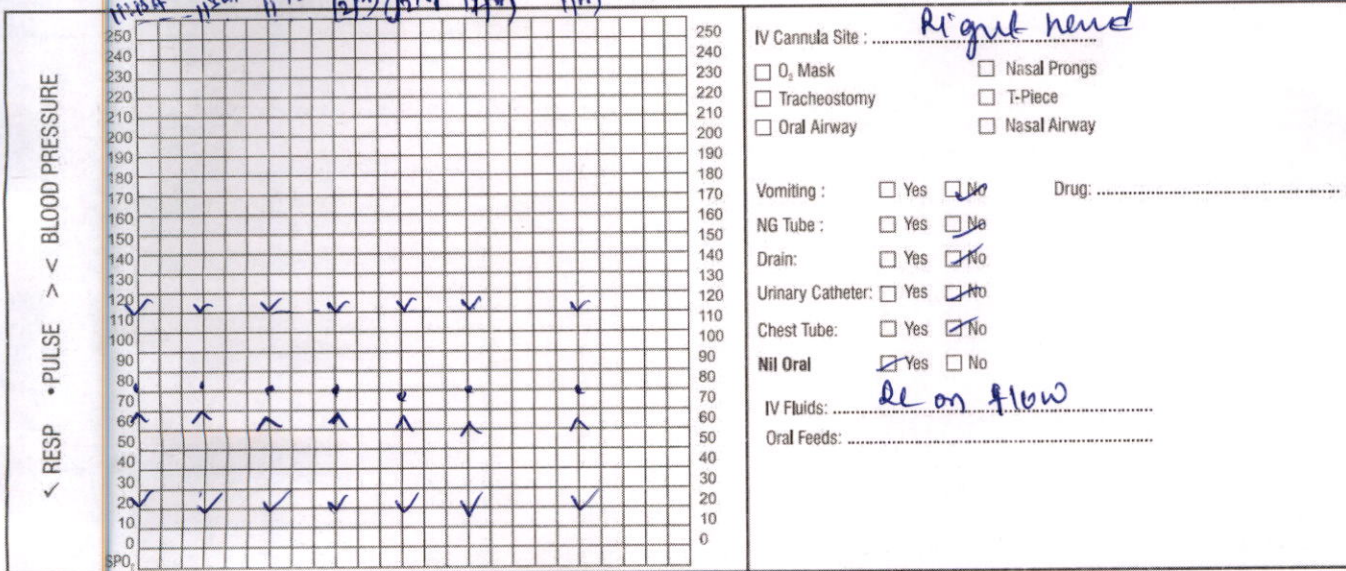
Signature of the Doctor: [Signature]

NOTES



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: Sy. Meyni Time Received: 11:15 AM Time Discharged: 2pm



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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
3/6	11:15 AM	8/10	24' DORTIN 4mg IV given	Meyni
3/6	12:20 pm	4/10	provided hot applicator	Meyni
	2pm	2/10	provided combi pain	Meyni

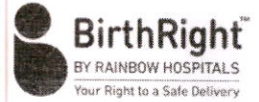
Pain Tool Used: N PASS FLACC Wong Baker NPS

Anaesthesiologist Name: Dr. Jayashankar
 Anaesthesiologist Signature: _____
 Date & Time: 3/6/20 at 2pm
 PACU Nurse Name: Meyni
 PACU Nurse Signature: _____
 Date & Time: 3/6/20 at 11:15 AM

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

Transferred to Unit by (PACU): 2pm
 Date & Time: 3/6/20 at 2pm

Patient Sticker



Department of Anaesthesiology EPIDURAL ANALGESIA RECORD

Date: Time: Procedure done by

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

Depth: Catheter at Skin: Attempts :

Parasthesia : Yes/No if yes details :

Solution Composition :

Any other issues :

a)

b)

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

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

Catheter Removed by and Tip Inspected :

Patient Satisfaction :

Discharge /Shifting ordered by

Doctor Signature:

Doctor Name:

Date and Time :

