

KUH-00177234 IP5-00176155  
Mrs J SWARNA SREE  
05-01-1990 35 Y 6 M 6 D (F)  
Dr. SASIKALA KOLA



## SURGERY DETAILS

Date : 10/7/26

Patient Name: Mrs J Swarna Sree Date of Birth: 5/1/1990 Age: 36 yrs

Gender: Female Ward : UHID No: KUH-00177234

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

Name of the Surgery: EMERGENCY LOWER SEGMENT CESAREAN SECTION  
↓ SPINAL

Time in : 12:10 pm

Time Out : 1:10 pm

### NAME

### AMOUNT

- Surgeon : Dr. Sasikala
- Anaesthetist : Dr. Shilpa / Dr. Ramya
- Assistant Surgeon : Dr. Maithri
- OT Technician : Kuliam
- Circulating Nurse : Sis. Rebecca
- Assistant Nurse : Sis. Pritha

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

Dr. Sasikala Kola

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9698532

Order by: Sis. Deepa





# CONSUMABLES OF OT

Circulating staff : ..... Technician : Kulsum Date : 10/7 Time : .....

| Anaesthesia Disposables            | Qty    |      | Surgical Disposables         | Qty    |      | Disposables (Baby Side)     | Qty    |      |
|------------------------------------|--------|------|------------------------------|--------|------|-----------------------------|--------|------|
|                                    | Issued | Used |                              | Issued | Used |                             | Issued | Used |
| ET tube                            |        |      | Major Pack <u>Leei Drape</u> | ✓      | 1    | Inj Vit.K                   | ✓      | 2    |
| LMA                                |        |      | Sutures <u>2347 DA 1804</u>  | ✓      | 1    | Cord Clamp                  | ✓      | 1    |
| ECG leads : <u>A / P / N</u>       | ✓      | 3    |                              | ✓      | 1    | Suction Catheter <u>6no</u> |        | 0    |
| HME filter : A / P / N             |        |      | <u>2762</u>                  | ✓      | 1    | Feeding Tube                |        |      |
| Syringes : 10 cc                   |        |      |                              |        |      | Vacuum Suction Set          | ✓      | 1    |
| 05 cc                              | ✓      | 04   | Gloves <u>G.6 1/2 17</u>     | ✓      | 04   | Surgical Gloves <u>A</u>    | ✓      | 2    |
| 02 cc                              | ✓      | 04   | <u>P.F 6 1/2</u>             | ✓      | 2    | Gauze Pack                  | ✓      | 1    |
| 01 cc                              |        |      |                              |        |      | Syringe 1ml / 2ml           | ✓      | 2    |
| Cautery plate <u>A / P / N</u>     |        | 00   | Surgical blade <u>22</u>     | ✓      | 1    | Surgical Blade # 20         | ✓      | 1    |
| IV set                             |        |      | NG tube                      |        |      | Koochies (S) <u>1's</u>     | ✓      | 1    |
| RL                                 | ✓      | 02   | Cautery pencil               | ✓      | 1    |                             |        |      |
| NS : 10ml / 100ml / 500ml / 1000ml | ✓      | 01   | Koochies <u>xc</u>           | ✓      | 1    |                             |        |      |
| <u>10x 2 1/2</u>                   | ✓      | 00   | Ointments                    |        |      |                             |        |      |
| <u>ephedrine</u>                   | ✓      | 01   | Suction Catheter             |        |      |                             |        |      |
| Fentanyl                           | ✓      | 01   | Cap, Mask                    |        |      |                             |        |      |
| Morphine                           |        |      | Gauze Pack                   | ✓      | 20   |                             |        |      |
| Ketamine                           |        |      | Mop Pack                     | ✓      | 1    |                             |        |      |
| Propofol                           |        |      | Steristrip <u>3002</u>       | ✓      | 1    |                             |        |      |
| Rocuronium                         |        |      | Underpad                     | ✓      | 1    |                             |        |      |
| Glycopyrolate                      | ✓      | 01   | Draw sheet <u>QuickSut</u>   | ✓      | 1    |                             |        |      |
| Myopyrolate                        |        |      | Abgel                        |        |      |                             |        |      |
| Ondansetron                        | ✓      | 00   | Foley's catheter             |        |      |                             |        |      |
| Pencan 25g / Spinal Needle 22      | ✓      | 01   | Urobag                       |        |      |                             |        |      |
| Bupivacaine 0.25%                  |        |      | Chest Drainage Catheter      |        |      |                             |        |      |
| Bupivacaine 0.25%(Heavy)           | ✓      | 01   | Romodrain bag                |        |      |                             |        |      |
| Antibiotics <u>Tranexa</u>         | ✓      | 02   | Bandage                      |        |      |                             |        |      |
|                                    |        |      | Tegaderm                     |        |      |                             |        |      |
| Suppositories                      |        |      | Ioban                        |        |      |                             |        |      |
| Amol : 80mg / 250mg / 170 mg       |        |      | Double J Stent               |        |      |                             |        |      |
| upridol : 100mg                    | ✓      | 01   | Vacuum Suction set           | ✓      | 1    |                             |        |      |
| Justin : 12.5 mg / 25mg / 100mg    | ✓      | 01   | Plastic Bed Sheet            | ✓      | 1    |                             |        |      |
| Tab. Misoprost : 200mg             | ✓      | 05   | Betadine Solution            | ✓      | 2    |                             |        |      |
| <u>Oxytocin</u>                    | ✓      | 01   | Microshield                  | ✓      | 2    |                             |        |      |
| <u>glove</u>                       | ✓      | 01   | Cotton Balls                 | ✓      | 10   |                             |        |      |
| <u>Gauze</u>                       | ✓      | 01   | Latex Gloves                 | ✓      | 10   |                             |        |      |
| <u>O2 mask</u>                     | ✓      | 01   | Ramdone Scrub                | ✓      | 1    |                             |        |      |
|                                    |        |      | Saral <u>DIA</u>             | ✓      | 1    |                             |        |      |

Surgeon ..... Anaesthesiologist ..... Nurse ..... OT Technician .....  
Order No. : 9698537538/539 Ordered by : SRP  
Doc. No. : RCH / FRM / GENERAL / 125



## ADMISSION SHEET



### Registration Details :

Admission No : IP5-00176155      Admit Date : 09-Jul-2026      Admit Time : 02:14 PM      UHID : KUH-00177234

### Patient Details :

|              |                                                                                                                  |                |                                 |
|--------------|------------------------------------------------------------------------------------------------------------------|----------------|---------------------------------|
| Patient Name | : Mrs J SWARNA SREE                                                                                              | Age            | : 36 Y 6 M 4 D                  |
| Guardian     | : Mr PALAPARTHI SUJESH RAJ                                                                                       | DOB            | : 05-01-1990                    |
| Gender       | : Female                                                                                                         | Religion       | :                               |
| Occupation   | :                                                                                                                | Marital Status | : Married                       |
| Address (H)  | : FLAT NO 511, RR TROPICANA, CATERPILLAR ROAD, NEAR SUB REGISTER ROAD Manikonda Hyderabad Telangana INDIA 500089 | Phone No       | : 9966889283/ 7337000770        |
|              |                                                                                                                  | E-mail         | : SUJESHRAJ.PALAPARTHI@GMAIL.CO |

### Admission Details :

Bed Type : DAY CARE      Bed No : BC DC 418      Ward Name : 4F-BIRTHING CENTRE  
Room No : BC DC 418      Admission Type : First Visit

### Contact Details :

Name : Mr PALAPARTHI SUJESH RAJ      Relationship : Husband  
Contact Address : FLAT NO 511, RR TROPICANA, CATERPILLAR ROAD, NEAR SUB REGISTER ROAD Manikonda Hyderabad Telangana INDIA 500089      Phone No : 9966889283

  
Signature

### Doctor Details :

Doctor Name : Dr. SASIKALA KOLA      Specialisation : OBSTETRICS AND GYNECOLOGY  
Referral Doctor : SELF      Phone No :  
Co-Consultant :

### Payment Details :

Payment Mode : Cash      Deposit Amount : 0.00  
Payor Name : VIDAL HEALTH INSURANCE TPAPVT LTD



# **ACTIVITY RECORD FOR BILLING**

Name : **KUH-00177234**  
**IP5-00176155**  
**Mrs J SWARNA SREE**  
**05-01-1990** **36 Y 6 M 4 D** (F)  
**Dr. SASIKALA KOLA**

UHID No



Consultant:

Dept :

Date of Admission:

Time :

Date of Discharge :

Time :

Room / Bed No :

Ward :

Suggested Billable bed type :

## **WARD TRANSFERS**

| Date    | Time    | From | To         | Signature of Nurse |
|---------|---------|------|------------|--------------------|
| 10/2/26 | 4:35 PM | OBS  | 301        | Sumande            |
| 10/2/26 | 6 PM    | OBS  | ROOM (301) | 2                  |
|         |         |      |            |                    |
|         |         |      |            |                    |
|         |         |      |            |                    |

## **Cross Consultation Visit**

|    | Doctors Name           | Date    | Order No. | Signature |
|----|------------------------|---------|-----------|-----------|
| 1  | Dr. Tuhena Sharma (PT) | 11/7/26 | 96988496  | Sargulth  |
| 2  |                        |         |           |           |
| 3  |                        |         |           |           |
| 4  |                        |         |           |           |
| 5  |                        |         |           |           |
| 6  |                        |         |           |           |
| 7  |                        |         |           |           |
| 8  |                        |         |           |           |
| 9  |                        |         |           |           |
| 10 |                        |         |           |           |



[illegible]

NST - 0

265084147

2

CBA

26068696

2

NST - 2

265034175

Snare

NSA - 8

Conclusion

NST ③

034188

5m4

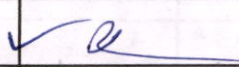
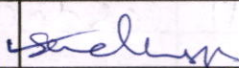
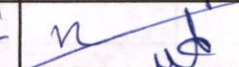
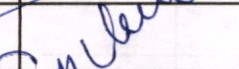
Cr



[illegible]



# PROCEDURE

| Date    | Procedure       | Quantity | Order No. | Signature                                                                           |
|---------|-----------------|----------|-----------|-------------------------------------------------------------------------------------|
| 9/2/10  | IV placement    | 1        | 9694868   |  |
| 9/2/10  | PAC             | 1        | 9695454   |  |
| 10/2/10 | Catheterization |          | 9696562   |  |
|         |                 |          |           |  |
|         |                 |          |           |                                                                                     |
|         |                 |          |           |                                                                                     |
|         |                 |          |           |                                                                                     |
|         |                 |          |           |                                                                                     |
|         |                 |          |           |                                                                                     |
|         |                 |          |           |                                                                                     |
|         |                 |          |           |                                                                                     |
|         |                 |          |           |                                                                                     |
|         |                 |          |           |                                                                                     |

## ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

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





## IP ADMISSION SHEET FOR OBSTETRICS

### Presenting Complaints

came for observation/delivery

LMP: 24/09/2025

EDD: 1/7/2026

Corrected EDD: 25/7/2026

GA: 37+4 wks

Obstetric Formula: primigravida

Menstrual History: Regular: ☐ Yes ☒ No

### Obstetric History:

1st-pp-sp. Conception:  
Early ANC checkups at Apollo  
Present Pregnancy Record: by Dr. Mythri Sharan.

Booked at 29+3 wks of GA

### Obstetric Examination

Fundal Height: ~7cm

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

Liquor: ☒ Adequate ☐ Oligo ☐ Poly

PP: ☒ Cephalic ☐ Breech Others \_\_\_\_\_

Head Fifts Palpable: SLR

FHS: ☒ Normal ☐ Tachy ☐ Brady ☐ Absent

### RISK FACTORS: HPLC-(N)

→ FGR since 28 weeks.  
on Lonopin since 29 wks.

### Per Speculum Examination

Draining: ☐ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

### Vaginal Examination

Cervix: ☒ Long ☐ Partially effaced ☐ Effaced

Os: Closed Dilated 1 finger

Membranes: ☒ Present ☐ Absent

Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Presenting Part: ☒ Vertex ☐ Breech ☐ Others

Sutton: ☒ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Pelvis: ☒ Adequate ☐ Doubtful

Height: 167 cm

Weight: 97 kg

Allergies: NKPA

Breast: ☒ Normal ☐ Abnormal

### General Examination:

Consciousness: c/c/c Pallor: } absent

Icterus: absent Edema: }

Temp: afebrile PR: 78 BPM

BP: 12/18 mmHg DTR: (+)

CVS: S1S2 RS BAE(7)

Liver/Spleen: not palpable Urine Output: equal

### DIAGNOSIS

primigravida / 37+4 wks / FGR / for observation / delivery





|                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                             |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Family History:</p> <p>Mother, grandmother } DM<br/>grand father</p>                                                                                               | <p>Surgical History:</p> <p>Nil.</p>                                                                                                                                                                                                                                                                                                                                                                                        |
| <p>Medical History:</p> <p>26/11/25 - cervical polyp.</p>                                                                                                             | <p>Medication History:</p> <p>fc, ca, megafem, Supost,<br/>inj. Lonopin 20mg</p>                                                                                                                                                                                                                                                                                                                                            |
| <p>Plan of Care:</p> <p>✓ Admission<br/>✓ IV cannulation<br/>✓ Part preparation<br/>✓ Send and. trace CBP.</p> <p>9/7/26<br/>Hb-12.1<br/>WBC-11.24k<br/>PLT-1.98L</p> | <p>Investigations:</p> <p>BCT- O+ve<br/>Vireo - NR</p> <p>23/06/26: Hb-11.6 / WBC-11,100 / 4.85<br/>1/7/26 (Gs):<br/>S10L, 36+3 wks, PL-ALM<br/>AFI-11.8cm, EFW-2538(177),<br/>AC-67., Doppler mean PI maintain</p> <p>6/5/26 S10L, 28+4 wks, EFW-1072g<br/>(167.) AC-57., CXL-3.1cm,<br/>AFI-11.2cm<br/>TIFFA - (N)<br/>↑ resistam flow<br/>CX-3.1cm - possibility of cervical polyp.<br/>NT-1.8mm<br/>NIP - low risk.</p> |

Doctor Name: Dr. Divya

Signature: [Signature]

Date & Time: 9/07/2026; 2:05 PM

Consultant Name: Dr. Sasikala man.

Signature: [Signature]

Date & Time: 10 AM 10/7/26



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05-01-1990 36 Y 6 M 6 D (F)  
Dr. SASIKALA KOLA



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



**BirthRight**  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

## DEFICIENCY CHECK LIST OF CASE SHEET

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

Doc. No. : RCHBH/ FRM / GENERAL / 126

**Signature and Date :**

(P.T.O)



## ERROR LOG

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

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE



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## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time   | Progress Notes                                                                  | Doctor's Order                                                                          |
|---------------|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| 9/7/20        | <u>adw</u> Dr. Mathr.                                                           |                                                                                         |
| 9pm           | adv. ① NST 5th h<br>② Vitals & FHR 5th h                                        |                                                                                         |
| NST. reactive | ② w/F spontaneous post & Inform<br>Dr. Mathr.                                   |                                                                                         |
|               | ③ If no met Progress, plan<br>C-section tomorrow.                               |                                                                                         |
|               |                                                                                 | Dr. Arshya                                                                              |
| 9/7/20        |                                                                                 |                                                                                         |
| 9pm           | Hb - 12.1<br>plt - 1.93<br>WBC - 11.24 K                                        | adv ① Consent<br>② PAE<br>③ Elbs - (12-1 Pm) 10/7/2021<br>(if No Progression of Labour) |
| 9/7/20        |                                                                                 |                                                                                         |
| 9:30pm        | No Complaints<br>Gest. -<br>apbale<br>Vital - stable<br>P/A - at Relaxed<br>P/A | Dr. Arshya<br>adv ① CS<br>② Monitor vital<br>③ Inform<br>④ NST 5th h<br>Dr. Arshya      |



## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time        | Progress Notes                                                                                                                   | Doctor's Order                                                                                                                                                                                                              |
|--------------------|----------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 10/7/20<br>1:45 PM | No complaint<br>patient is comfortable<br>Afebrile<br>HR 82/min.<br>BP 127/87 mmHg.<br>SpO2 98% @ RA<br>P/A ut released<br>FHR ⊕ | ① No feeds from 6 AM<br>② No leged from 8 AM<br>③ Early breakfast 11 AM<br>④ No 1st try<br>⑤ vitals & FHR ⊕<br>⑥ w/ spontaneous<br>PBL<br>⑦ Consent }<br>PAC }<br>for elin.<br>⑧ Shift to 4th floor.<br>at 10 AM. (10/7/20) |
|                    | Shift to room now.                                                                                                               | Dr. Arun                                                                                                                                                                                                                    |
| 10/7/20<br>9 AM    | Primi / 37th w / FGR / Decel                                                                                                     | NB<br>Success                                                                                                                                                                                                               |
| FHR ⊕              | Gc: per<br>Vitals: stable<br>P/A: ut 37w<br>released<br>FHR                                                                      | Re<br>1) NBM<br>2) prepone pain<br>3) PAC<br>4) consent<br>5) Foley's catheter<br>6) Monitor vitals FHR<br>7) Techs                                                                                                         |
|                    | Shift to 4th floor<br>at 10 AM                                                                                                   | Dr. Arun                                                                                                                                                                                                                    |



103

KUH-00177234  
Mrs J SWARNA SREE  
03-01-1990 38 Y 6 M 5 D  
Dr. SASIKALA KOLA (F)



PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time          | Progress Notes                                                                                                                                                 | Doctor's Order                                                                                                                                                                                                                                                                       |
|----------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 10/7/26<br>1:45pm    | <p>POD-0/EL-WG/PLI</p> <p>O/E</p> <p>Pt comfortable</p> <p>Bp- 97/62 (74)mmHg</p> <p>PR- 66 Bpm.</p> <p>SPO2- 98% TRA</p> <p>RA- ut @ well</p> <p>LE- BWNL</p> | <p>Adv</p> <p>1. NBM for 5-6 hrs</p> <p>2. IVF @ 100ml/hr</p> <p>3. Drugs cu charted</p> <p>4. monitor vital every 30 min</p> <p>5. No charting</p> <p>6. Ambulation on bed</p> <p>7. No active bleeding per vaginal</p> <p>8. tachycardia</p> <p>9. Inform sos</p> <p>Dr. Dings</p> |
| 10/7/2026<br>11:30pm | <p>POD-0/EL-WG/PLI</p> <p>O/E</p> <p>Pt comfortable</p> <p>Bp 116/69 (74)mmHg</p> <p>PR 96 Bpm</p> <p>SPO2- 98% TRA</p> <p>RA- ut @ well</p> <p>LE- BWNL</p>   | <p>Adv</p> <p>1. Allow sips if wat</p> <p>2. liquid diet from 5:00pm</p> <p>3. soft diet from 8:00pm</p> <p>4. Drugs cu charted</p> <p>5. No charting</p> <p>6. No active bleeding</p> <p>7. Monitor vitals 4th heel</p> <p>8. Inform sos</p>                                        |



## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time         | Progress Notes                                                                                                                                                                                                                                                     | Doctor's Order                                                                                                                                                                                                    |
|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 10/7/2026<br>4:30pm | <p>POD-0 / EL-lyg</p> <p>O/F</p> <p>Ceftriaxone</p> <p>Vitals - Stable</p> <p>PLA - UT @ cell</p> <p>L/E - BUNL</p> <p>B - well</p> <p>(feeding)</p> <p>VO - adequate</p> <p>Consider inj. Ceftriaxone 1g</p> <p>from 11/7/26</p> <p>based on the indymon scan</p> | <p>Adv</p> <p>① Liquid diet</p> <p>② Soft diet from 8:00pm</p> <p>③ Drugs as charted</p> <p>④ I/O charting</p> <p>⑤ Monitor vitals till hrs</p> <p>⑥ Inform sos</p> <p>Dr. Drury</p> <p>noted by pnp/ra @ 8pm</p> |
| 11/7/2026<br>8:30pm | <p>POD-1 / EL-lyg</p> <p>O/F</p> <p>Ceftriaxone</p> <p>Vitals - Stable</p> <p>PLA - UT @ cell</p> <p>BS @</p> <p>L/E - BUNL</p> <p>B - well</p> <p>CV - dm.</p> <p>on inj. ceftriaxone</p> <p>inj. ceftriaxone</p>                                                 | <p>Adv soft diet</p> <p>① Liquids plenty</p> <p>② Drugs as charted</p> <p>③ W/O active bleeding</p> <p>④ Monitor vitals with hrs</p> <p>⑤ Inform sos</p> <p>⑥ Remove Foley's</p> <p>Dr. Drury</p>                 |





## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time                | Progress Notes                                                              | Doctor's Order                                                                                                                                |
|----------------------------|-----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|
| 10/2/2026<br>1:30pm        | POD-1   EL-Lms   P14                                                        |                                                                                                                                               |
| B-well.<br>V/<br>+<br>S(X) | GC: per<br>vitals: stable<br>P/A: UA (R) well<br>Soft<br>BS (+)<br>P/V: NAB | 1) Soft diet & plenty of oral fluids<br>2) Drug as charted<br>3) w/t Plw Bleeding<br>4) Ambulation<br>5) Monitor vitals - 4ty<br>6) Tufex sos |
| 1                          |                                                                             | Dr. Sravanti<br>noted by Surgeon 2607PM 6PM                                                                                                   |
| 11/2/2026<br>7:30pm        | POD-1   EL-Lms   P14                                                        |                                                                                                                                               |
| B-well<br>V/<br>+<br>S(X)  | GC: per<br>vitals: stable<br>P/A: UA (R) well<br>Soft 10.5 (+)<br>P/V: NAB  | 1) Soft diet & plenty of oral fluids<br>2) Drug as charted<br>3) w/t Plw Bleeding<br>4) Ambulation<br>5) Monitor vitals - 4ty<br>6) Tufex sos |







KUH-00177234 IP5-00176155  
Mrs J SWARNA SREE  
05-01-1990 36 Y 6 M 4 D (F)  
Dr. SASIKALA KOLA



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## RESULT SHEET

|                     |        |  |  |  |  |
|---------------------|--------|--|--|--|--|
| Date                | 9/7/20 |  |  |  |  |
| Time                |        |  |  |  |  |
| Hb                  | 12.1   |  |  |  |  |
| PCV                 | .      |  |  |  |  |
| RBC                 |        |  |  |  |  |
| WBC                 | 11.24  |  |  |  |  |
| N/L                 |        |  |  |  |  |
| Platelets           | 1.9    |  |  |  |  |
| CRP                 |        |  |  |  |  |
| ESR                 |        |  |  |  |  |
| PCT                 |        |  |  |  |  |
| RBS                 |        |  |  |  |  |
| Na                  |        |  |  |  |  |
| K                   |        |  |  |  |  |
| Cl                  |        |  |  |  |  |
| Ca/Mg               |        |  |  |  |  |
| Phosphate           |        |  |  |  |  |
| Urea                |        |  |  |  |  |
| Creatinine          |        |  |  |  |  |
| ALP                 |        |  |  |  |  |
| SGPT                |        |  |  |  |  |
| SGOT                |        |  |  |  |  |
| T.Bill/Conj         |        |  |  |  |  |
| T.Protein           |        |  |  |  |  |
| S.Albumin           |        |  |  |  |  |
| S.Globulin          |        |  |  |  |  |
| A/G Ratio           |        |  |  |  |  |
| Uric Acid           |        |  |  |  |  |
| S.Amylase           |        |  |  |  |  |
| Sr.Lipase           |        |  |  |  |  |
| Blood Lactate       |        |  |  |  |  |
| S.Cholesterol       |        |  |  |  |  |
| PT/INR              |        |  |  |  |  |
| APTT                |        |  |  |  |  |
| CSF Protein / Sugar |        |  |  |  |  |
| Cells               |        |  |  |  |  |
| N/L                 |        |  |  |  |  |



|                            |  |  |  |  |  |  |
|----------------------------|--|--|--|--|--|--|
| Date                       |  |  |  |  |  |  |
| Time                       |  |  |  |  |  |  |
| CUE - Alb                  |  |  |  |  |  |  |
| CUE - Sugar                |  |  |  |  |  |  |
| CUE - Ketones              |  |  |  |  |  |  |
| CUE - PUS Cells            |  |  |  |  |  |  |
| CUE - RBC Cells            |  |  |  |  |  |  |
| CUE                        |  |  |  |  |  |  |
|                            |  |  |  |  |  |  |
|                            |  |  |  |  |  |  |
|                            |  |  |  |  |  |  |
| Stool Pus Cell             |  |  |  |  |  |  |
| OVA / Cyst                 |  |  |  |  |  |  |
| Occult Blood               |  |  |  |  |  |  |
| Blood group <sup>two</sup> |  |  |  |  |  |  |
|                            |  |  |  |  |  |  |
|                            |  |  |  |  |  |  |
|                            |  |  |  |  |  |  |
|                            |  |  |  |  |  |  |
|                            |  |  |  |  |  |  |
|                            |  |  |  |  |  |  |
|                            |  |  |  |  |  |  |

Culture and Sensitivities : .....

.....

.....

.....

Radiology :      USG : .....

                         X-Ray : .....

                         ECHO : .....

                         CT : .....

                         MRI : .....

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



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## MEDICATION RECONCILIATION FORM

Drug Allergies: NKA

☒ Not known any Drug Allergies

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

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

Shifting From: .....

Shifted to: .....

| S.No | MEDICATION NAME<br>(GENERIC NAME CAPITAL LETTERS) | DOSE<br>(mg, mcg) | ROUTE<br>(PO, NG, SC, IV) | FREQUENCY   | LAST DOSE<br>Date / Time | ON<br>ADMISSION<br>/ SHIFTING                                     |
|------|---------------------------------------------------|-------------------|---------------------------|-------------|--------------------------|-------------------------------------------------------------------|
| 1    | Tab. MEGAFERON                                    | 1 tab             | PO                        | OD<br>11 AM | 8/7/26                   | <input type="checkbox"/> C <input checked="" type="checkbox"/> DC |
| 2    | T. suport.                                        | 1 tab             | PO                        | OD          | 8/7/26                   | <input type="checkbox"/> C <input checked="" type="checkbox"/> DC |
| 3    | T. CORCIUM                                        | 1 tab             | PO                        | OD          | 8/7/26                   | <input type="checkbox"/> C <input checked="" type="checkbox"/> DC |
| 4    | inj. Lonopin                                      | 20mg              | SLC.                      | OD          | 8/7/26<br>7:20 PM        | <input type="checkbox"/> C <input checked="" 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: [Signature]

Date & Time: 9/7/26; 2:12 PM

Nurse Name & Signature: [Signature]

Date & Time: 9/7/26 @ 4 PM





103

## DRUG CHART

Date of Admission: 9/7/26 Drug Allergies: NKDA ☒ Not known any Drug Allergies

### FOR THE SAFETY OF THE PATIENT

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

### SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name Signature



## REGULAR PRESCRIPTIONS

Weight. 97.3 Ward. BC



|                                                                          |              |                  |                    |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--------------------------------------------------------------------------|--------------|------------------|--------------------|--------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| DRUG: TAB. PARACETMOL                                                    |              |                  |                    | Date<br>Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose<br>100                                                              | Route<br>PO  | Frequency<br>QID | Start Date<br>10/4 |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs:<br>Dr. K. M. RAMYA |              |                  |                    |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                                                 |              |                  |                    |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                     |              |                  |                    |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| DRUG: TAB. TRAMADOL                                                      |              |                  |                    | Date<br>Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose<br>100                                                              | Route<br>PO  | Frequency<br>TID | Start Date<br>10/4 |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs:<br>Dr. K. M. RAMYA |              |                  |                    |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                                                 |              |                  |                    |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                     |              |                  |                    |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| DRUG: TAB. DICLOFENAC                                                    |              |                  |                    | Date<br>Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose<br>50                                                               | Route<br>PO  | Frequency<br>TID | Start Date<br>10/4 |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs:<br>Dr. K. M. RAMYA |              |                  |                    |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                                                 |              |                  |                    |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                     |              |                  |                    |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| DRUG: Tab. Clonidine                                                     |              |                  |                    | Date<br>Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose<br>60                                                               | Route<br>SLC | Frequency<br>O.D | Start Date<br>10/4 |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs:<br>Dr. K. M. RAMYA |              |                  |                    |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:<br>On 11/7 if no bleeding at 9 AM               |              |                  |                    |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                     |              |                  |                    |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |



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

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

STAT / ONCE ONLY DRUGS

| Date | Time    | Medication               | Dosage & Other Instructions | Route | Signature | Nurses            |
|------|---------|--------------------------|-----------------------------|-------|-----------|-------------------|
| 10/7 | 11am    | Ty CEFOTAXIME            | 1gm                         | IV    | Dr        | Pudley<br>Bhoshli |
| 10/7 | 11:30am | Ty Pantoprazole          | 40mg                        | IV    | Dr        | Pudley<br>Bhoshli |
| 10/7 | 11:05am | Ty PERINORM              | 10mg                        | IV    | Dr        | Pudley<br>Bhoshli |
| 10/7 | 12:40PM | Sup. TRANAMAXIC<br>acid  | 1g                          | IV    | Dr        | Laxmi<br>Bhoshli  |
| 10/7 | 12:45PM | Sup. ONDANSATRON         | 4mg                         | IV    | Dr        | Pudley<br>Bhoshli |
| 10/7 | 1:20PM  | Sup. DICLOFENAC          | 100mg                       | PIR   | Dr        | Pudley<br>Bhoshli |
| 10/7 | 1:30PM  | Sup. TRAMADOL            | 100mg                       | PIR   | Dr        | Pudley<br>Bhoshli |
| 10/7 | 2:30PM  | Sup. T. PGE <sub>1</sub> | 400mg                       | PIR   | Dr        | Pudley<br>Bhoshli |
|      |         |                          |                             |       |           |                   |
|      |         |                          |                             |       |           |                   |





# I.V. FLUIDS CHART

Weight. 97.3 kg Ward. BC

Signature

VERIFIED BY : Name

| Date    | Time   | Composition of I.V. Fluid<br>(If infusion, mention ml/hr = Mcg/kg/min. etc) | Route | Flow Rate<br>ml/hr | Doctor<br>Sign | Nurse<br>Sign | Date of<br>Stopping | Doctor<br>Sign | Nurse<br>Sign |
|---------|--------|-----------------------------------------------------------------------------|-------|--------------------|----------------|---------------|---------------------|----------------|---------------|
| 9/7/26  | 2:00pm | RINGER LACTATE                                                              | IV    | 100ml              | Dr. Reddy      | Reddy         | 10/7                | Dr. Reddy      | Reddy         |
| 9/7/26  | 8am    | RINGER LACTATE                                                              | IV    | 100ml              | Dr. Reddy      | Reddy         | 10/7                | Dr. Reddy      | Reddy         |
| 10/7/26 | 8am    | RINGER LACTATE                                                              | IV    |                    | Dr. Reddy      | Reddy         | 10/7                | Dr. Reddy      | Reddy         |
| 10/7/26 | 11am   | RINGER LACTATE                                                              | IV    |                    | Dr. Reddy      | Reddy         | 10/7                | Dr. Reddy      | Reddy         |
| 10/7/26 | 12am   | RINGER LACTATE                                                              | IV    |                    | Dr. Reddy      | Reddy         | 10/7                | Dr. Reddy      | Reddy         |
| 10/7/26 | 3am    | RINGER LACTATE                                                              | IV    |                    | Dr. Reddy      | Reddy         | 10/7                | Dr. Reddy      | Reddy         |
| 10/7/26 | 4am    | RINGER LACTATE                                                              | IV    |                    | Dr. Reddy      | Reddy         | 10/7                | Dr. Reddy      | Reddy         |
| 10/7/26 | 6am    | Ringer Lactate                                                              | IV    | 100ml              | Dr. Reddy      | Reddy         |                     |                |               |
|         |        |                                                                             |       |                    |                |               |                     |                |               |
|         |        |                                                                             |       |                    |                |               |                     |                |               |



Sheet No: 2

REGULAR PRESCRIPTIONS

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

|                                                       |       |           |           |              |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
|-------------------------------------------------------|-------|-----------|-----------|--------------|------|------|------|--|--|--|--|--|--|--|--|--|--|--|--|--|
| DRUG : T. PARACETAMOL                                 |       |           |           | Date<br>Time | 10/7 | 11/7 | 12/7 |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                  | Route | Frequency | Start Dt. |              |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 500mg                                                 | P/O   | TID       | 10/7      | 6am          | X    | 10am | 12pm |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs: |       |           |           |              |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dr. Swarnanthi                                        |       |           |           |              |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                              |       |           |           |              |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                  |       |           |           |              |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |

|                                                       |       |           |           |              |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
|-------------------------------------------------------|-------|-----------|-----------|--------------|------|------|------|--|--|--|--|--|--|--|--|--|--|--|--|--|
| DRUG : T. DICLOFENAC                                  |       |           |           | Date<br>Time | 10/7 | 11/7 | 12/7 |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                  | Route | Frequency | Start Dt. |              |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 50mg                                                  | P/O   | BD        | 10/7      | 9am          | X    | 10am | 12pm |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs: |       |           |           |              |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dr. Swarnanthi                                        |       |           |           |              |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                              |       |           |           |              |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                  |       |           |           |              |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |

|                                                       |       |           |           |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|-------------------------------------------------------|-------|-----------|-----------|--------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| DRUG : T. TRAMADOL                                    |       |           |           | Date<br>Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                  | Route | Frequency | Start Dt. |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 100mg                                                 | P/O   | BD        | 10/7      |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs: |       |           |           |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dr. Swarnanthi                                        |       |           |           |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                              |       |           |           |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                  |       |           |           |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

STOP  
man (2 WAITING)  
6pm 10/7/12

|                                                       |       |           |           |              |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
|-------------------------------------------------------|-------|-----------|-----------|--------------|------|------|------|--|--|--|--|--|--|--|--|--|--|--|--|--|
| DRUG : T. PANTOPRAZOLE                                |       |           |           | Date<br>Time | 10/7 | 11/7 | 12/7 |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                  | Route | Frequency | Start Dt. |              |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 40mg                                                  | P/O   | BD        | 10/7      | 6am          | X    | 10am | 12pm |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs: |       |           |           |              |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dr. Swarnanthi                                        |       |           |           |              |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                              |       |           |           |              |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                  |       |           |           |              |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |





Sheet No: 221

**REGULAR PRESCRIPTIONS**

Weight .....

Ward PJ

|                                                                         |           |           |             |              |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|-------------------------------------------------------------------------|-----------|-----------|-------------|--------------|----------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>DRUG :</b> <u>Cefixime</u>                                           |           |           |             | Date<br>Time | <u>10/2/17</u> |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                                    | Route     | Frequency | Start Dt.   |              |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <u>1gm</u>                                                              | <u>IV</u> | <u>Bd</u> | <u>10/2</u> |              |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor Starting the Drugs:<br><u>M D MATHEW</u> |           |           |             |              |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                                                |           |           |             |              |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                    |           |           |             |              |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>DRUG :</b> <u>Cefixime</u>                                           |           |           |             | Date<br>Time | <u>11/2</u>    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                                    | Route     | Frequency | Start Dt.   |              |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <u>200mg</u>                                                            | <u>PO</u> | <u>Bd</u> | <u>11/2</u> |              |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor Starting the Drugs:<br><u>M D MATHEW</u> |           |           |             |              |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                                                |           |           |             |              |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                    |           |           |             |              |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>DRUG :</b>                                                           |           |           |             | Date<br>Time |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                                    | Route     | Frequency | Start Dt.   |              |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                                                                         |           |           |             |              |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor Starting the Drugs:                      |           |           |             |              |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                                                |           |           |             |              |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                    |           |           |             |              |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>DRUG :</b>                                                           |           |           |             | Date<br>Time |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                                    | Route     | Frequency | Start Dt.   |              |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                                                                         |           |           |             |              |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor Starting the Drugs:                      |           |           |             |              |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                                                |           |           |             |              |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                    |           |           |             |              |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

VERIFIED BY : Name .....



7. SASIKALA KOLA



**BirthRight™**  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

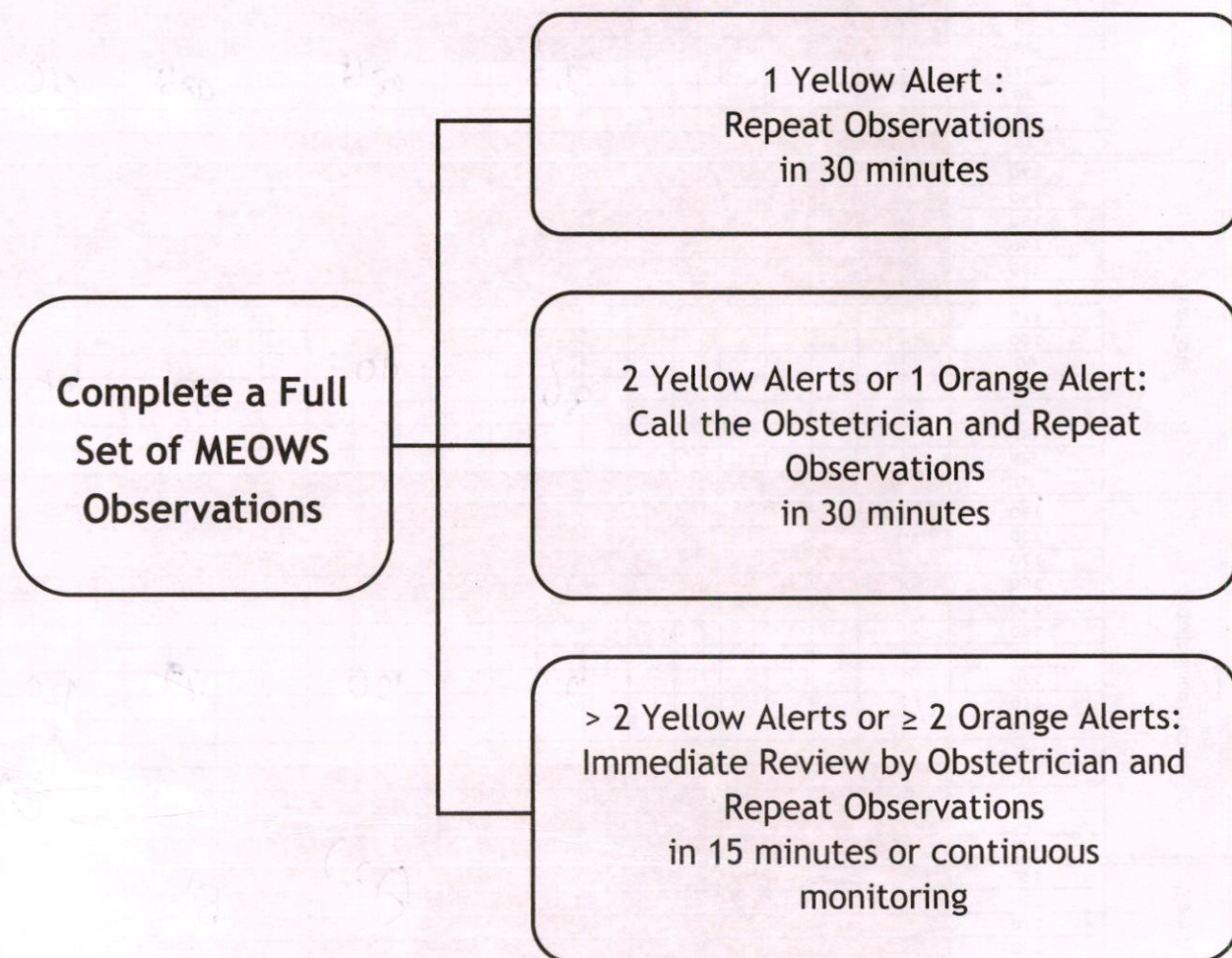
**CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME**

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



10/7/26  
5AM  
PST - 136 W

## Obstetrics and Gynaecology Early Warning Signs



\* The Modified Early Warning Score (MEOWS)



IP5-00176155

Mrs J SWARNA SREE  
05-01-1990 36 Y 6 M 5 D

05-01-1990

26 Y 6 M 3 D

(F)

Dr. SASIKALA KOLA



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



**BirthRight™**  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

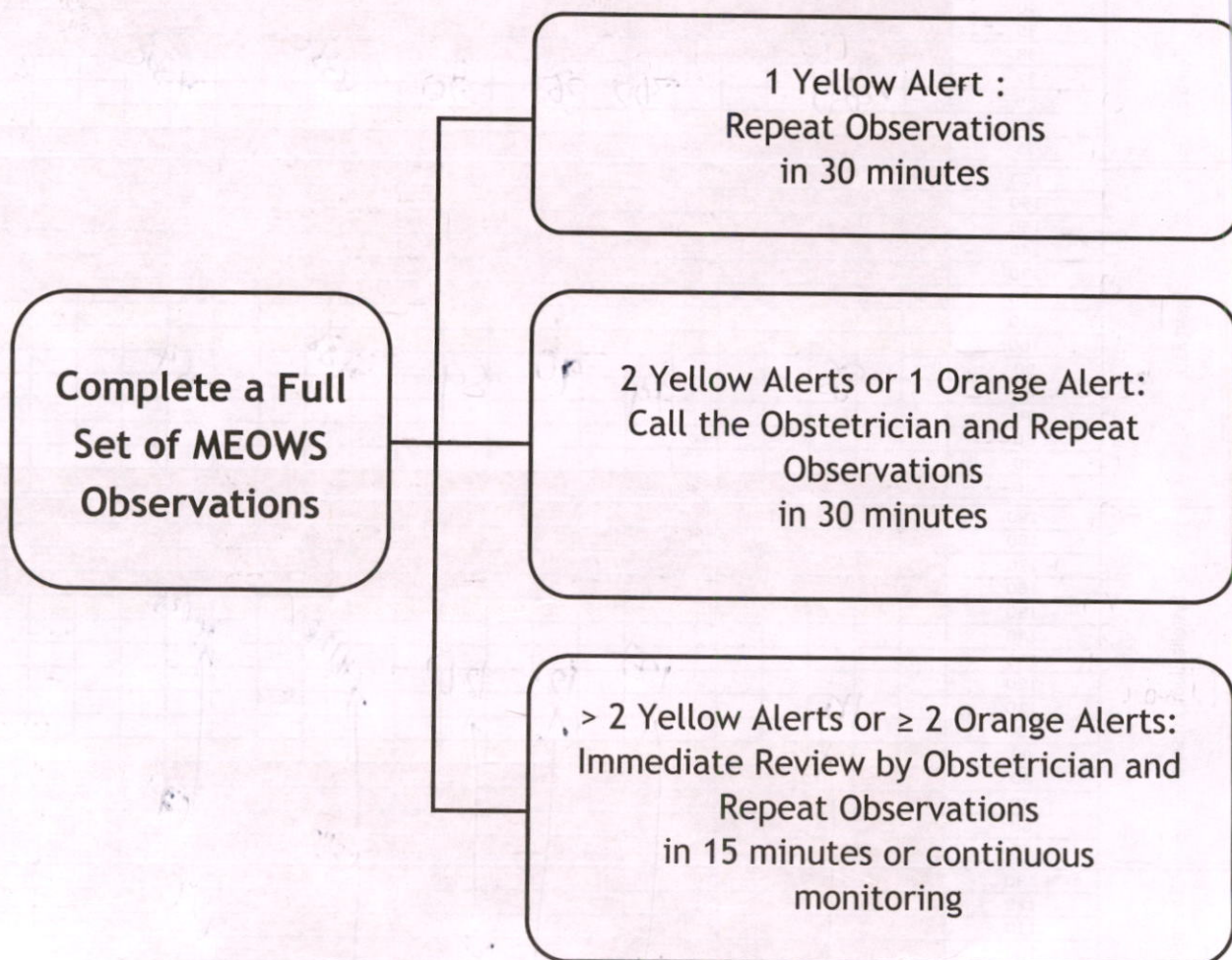
**Early warning Observation Score Chart - Obstetrics**

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

| TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME |                          |              |   |    |    |    |   |   |   |   |   |   |   |  |
|----------------------------------------------------------|--------------------------|--------------|---|----|----|----|---|---|---|---|---|---|---|--|
| Date                                                     |                          | 8            | 9 | 10 | 11 | 12 | 1 | 2 | 3 | 4 | 5 | 6 | 7 |  |
| Time                                                     |                          | 8            | 9 | 10 | 11 | 12 | 1 | 2 | 3 | 4 | 5 | 6 | 7 |  |
| RESP<br>(write rate in<br>corresp. box)                  | > 30                     |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 21 - 30                  |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 11 - 20                  |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 0 - 10                   |              |   |    |    |    |   |   |   |   |   |   |   |  |
| Saturations                                              | 94 - 100 %               |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | < 94 %                   |              |   |    |    |    |   |   |   |   |   |   |   |  |
| Administered O <sub>2</sub> (L/min.)                     |                          |              |   |    |    |    |   |   |   |   |   |   |   |  |
| Temp °C                                                  | 40                       |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 39                       |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 38                       |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 37                       |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 36                       |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 35                       |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | < 35                     |              |   |    |    |    |   |   |   |   |   |   |   |  |
| Heart Rate                                               | 170                      |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 160                      |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 150                      |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 140                      |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 130                      |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 120                      |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 110                      |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 100                      |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 90                       |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 80                       |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 70                       |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 60                       |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 50                       |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 40                       |              |   |    |    |    |   |   |   |   |   |   |   |  |
| Systolic Blood Pressure                                  | 190                      |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 180                      |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 170                      |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 160                      |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 150                      |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 140                      |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 130                      |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 120                      |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 110                      |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 100                      |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 90                       |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 80                       |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 70                       |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 60                       |              |   |    |    |    |   |   |   |   |   |   |   |  |
| 50                                                       |                          |              |   |    |    |    |   |   |   |   |   |   |   |  |
| Diastolic Blood Pressure                                 | 130                      |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 120                      |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 110                      |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 100                      |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 90                       |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 80                       |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 70                       |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 60                       |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 50                       |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | 40                       |              |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          | NEURO<br>RESPONSE<br>[✓] | Alert        |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          |                          | Voice        |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          |                          | Pain         |   |    |    |    |   |   |   |   |   |   |   |  |
|                                                          |                          | Unresponsive |   |    |    |    |   |   |   |   |   |   |   |  |
| URINE<br>mls / hour                                      | > 30                     |              |   |    |    |    |   |   |   |   |   |   |   |  |



## Obstetrics and Gynaecology Early Warning Signs



\* The Modified Early Warning Score (MEOWS)

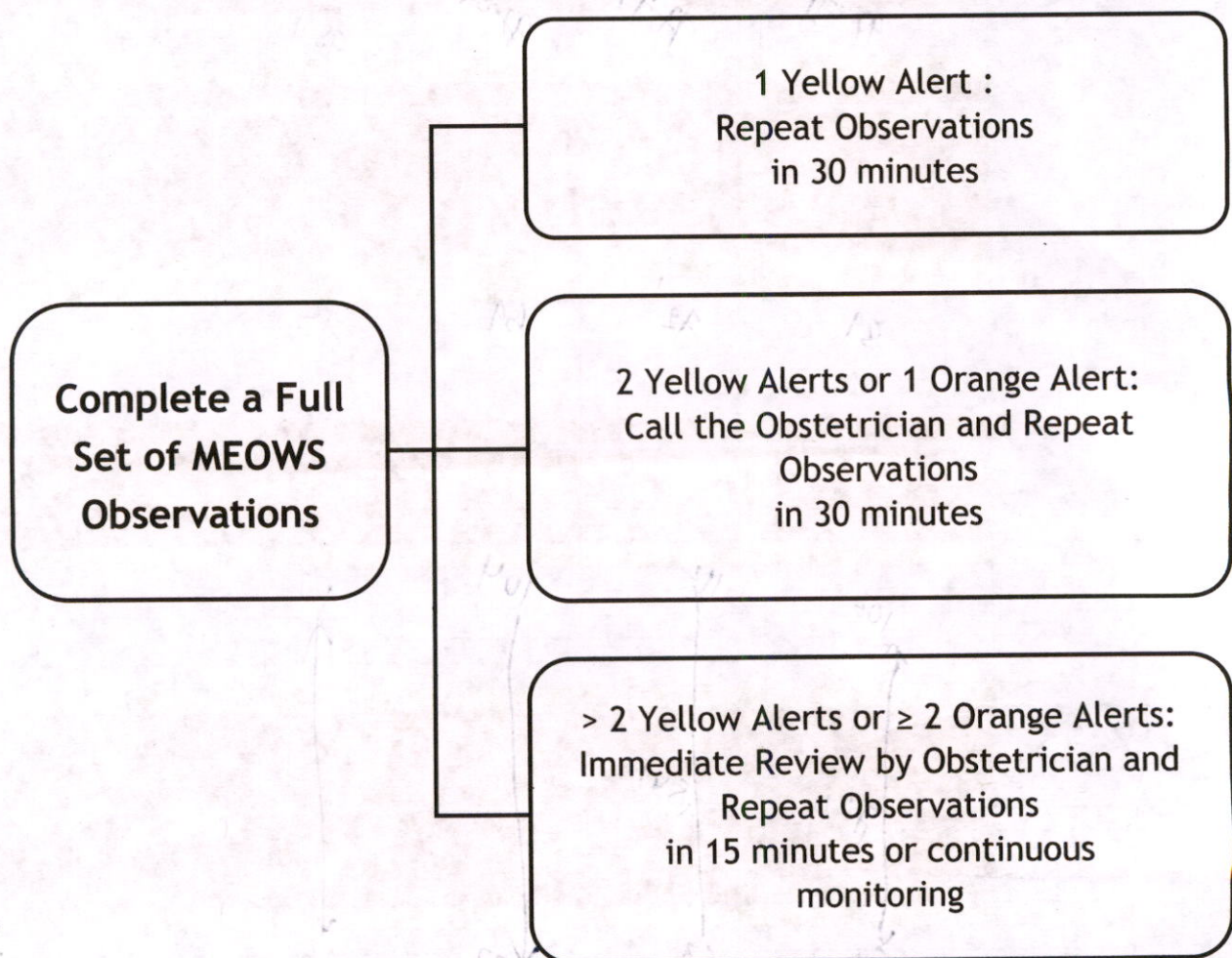


**CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME**

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



## Obstetrics and Gynaecology Early Warning Signs



\* The Modified Early Warning Score (MEOWS)



KUH-00177234 IP5-00176155  
 Mrs J SWARNA SREE  
 05-01-1990 36 Y 6 M 4 D (F)  
 Dr. SASIKALA KOLA



# FLUID CHART

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

BirthRight  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

Sheet No. : ①

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

| Date                 | Time     | Nature of Fluid | Intake |     |     | Output               |           |       |          |       |  | IV Site Thrombo-phlebitis Score | Sign. Nurse |
|----------------------|----------|-----------------|--------|-----|-----|----------------------|-----------|-------|----------|-------|--|---------------------------------|-------------|
|                      |          |                 | Mouth  | I.V | N.G | NG                   | Diarrhoea | Vomit | Drainage | Urine |  |                                 |             |
|                      | 08:00 am |                 |        |     |     |                      |           |       |          |       |  |                                 |             |
|                      | 09:00 am |                 |        |     |     |                      |           |       |          |       |  |                                 |             |
|                      | 10:00 am |                 |        |     |     |                      |           |       |          |       |  |                                 |             |
|                      | 11:00 am |                 |        |     |     |                      |           |       |          |       |  |                                 |             |
|                      | 12:00 pm |                 |        |     |     |                      |           |       |          |       |  |                                 |             |
|                      | 01:00 pm |                 |        |     |     |                      |           |       |          |       |  |                                 |             |
| Total Intake :       |          |                 |        |     |     | Total Output :       |           |       |          |       |  |                                 |             |
|                      | 02:00 pm |                 |        |     |     |                      |           |       |          |       |  |                                 |             |
|                      | 03:00 pm |                 |        |     |     |                      |           |       |          |       |  |                                 |             |
|                      | 04:00 pm | H2O             |        |     |     |                      |           |       |          |       |  |                                 |             |
|                      | 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 :       |           |       |          |       |  |                                 |             |
|                      | 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 |                 |        |     |     |                             |           |       |          |       |  |                                 |             |
| <b>Total Intake :</b>       |          |                 |        |     |     | <b>Total Output :</b>       |           |       |          |       |  |                                 |             |
|                             | 02:00 pm |                 |        |     |     |                             |           |       |          |       |  |                                 |             |
|                             | 03:00 pm |                 |        |     |     |                             |           |       |          |       |  |                                 |             |
|                             | 04:00 pm |                 |        |     |     |                             |           |       |          |       |  |                                 |             |
|                             | 05:00 pm |                 |        |     |     |                             |           |       |          |       |  |                                 |             |
|                             | 06:00 pm |                 |        |     |     |                             |           |       |          |       |  |                                 |             |
|                             | 07:00 pm |                 |        |     |     |                             |           |       |          |       |  |                                 |             |
| <b>Total Intake :</b>       |          |                 |        |     |     | <b>Total Output :</b>       |           |       |          |       |  |                                 |             |
|                             | 08:00 pm |                 |        |     |     |                             |           |       |          |       |  |                                 |             |
|                             | 09:00 pm |                 |        |     |     |                             |           |       |          |       |  |                                 |             |
|                             | 10:00 pm |                 |        |     |     |                             |           |       |          |       |  |                                 |             |
|                             | 11:00 pm |                 |        |     |     |                             |           |       |          |       |  |                                 |             |
|                             | 12:00 am |                 |        |     |     |                             |           |       |          |       |  |                                 |             |
|                             | 01:00 am |                 |        |     |     |                             |           |       |          |       |  |                                 |             |
| <b>Total Intake :</b>       |          |                 |        |     |     | <b>Total Output :</b>       |           |       |          |       |  |                                 |             |
|                             | 02:00 am |                 |        |     |     |                             |           |       |          |       |  |                                 |             |
|                             | 03:00 am |                 |        |     |     |                             |           |       |          |       |  |                                 |             |
|                             | 04:00 am |                 |        |     |     |                             |           |       |          |       |  |                                 |             |
|                             | 05:00 am |                 |        |     |     |                             |           |       |          |       |  |                                 |             |
|                             | 06:00 am |                 |        |     |     |                             |           |       |          |       |  |                                 |             |
|                             | 07:00 am |                 |        |     |     |                             |           |       |          |       |  |                                 |             |
| <b>Total Intake :</b>       |          |                 |        |     |     | <b>Total Output :</b>       |           |       |          |       |  |                                 |             |
| <b>Total 24 hrs. Intake</b> |          |                 |        |     |     | <b>Total 24 hrs. Output</b> |           |       |          |       |  |                                 |             |



## NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 9/2/26

Assessment: patient Camp for observation.

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         |
|--------------------|-------------------------|--------------------|---------------------------|--------------------|
| 3 <sup>30</sup> PM | Assess the Pt condition | 3 <sup>30</sup> PM | Assessed the Pt condition | pt is comfortable. |
| 4 <sup>00</sup> PM | monitoring. vital.      | 4 <sup>30</sup> PM | vital checked & noted.    |                    |
|                    | NST                     |                    | NST done.                 |                    |
| 5 <sup>00</sup> PM | soft diet               | 5 <sup>30</sup> PM | soft diet done.           |                    |
|                    | oral hydration          |                    | oral hydration done.      |                    |
| 6 <sup>00</sup> PM | observation             | 7 <sup>30</sup> PM | observation done          |                    |

Re-Assessment: Reassessment 4th NST

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Rudra

Date & Time: 9/2/26 8 PM



KUH-00177234  
 Mrs J SWARNA SREE  
 03-01-1990 36 Y 6 M 5 D (F)  
 Dr. SASIKALA KOLA

# NURSING CARE RECORD



Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 9/2/26

Assessment: patient do fear & Anxiety

Goals

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

| Time | Plan of Care            | Time     | Implementation           | Evaluation  |
|------|-------------------------|----------|--------------------------|-------------|
| 8PM  | Assesse to pt condition | 9PM      | assessed to pt condition | pt is       |
| 10PM | → DIO Hand              | 11:30 PM | → DIO Hand monitoring    | comfortable |
| 12AM | → NST                   | 1AM      | → GIST 16th hourly dose  |             |
| 4AM  | → 4th hour PSH          | 6AM      |                          |             |
| 8AM  | → NPO 6AM started       | 8AM      | → continue IV fluid      |             |

Re-Assessment:

Special Notes: NST 6th hourly, PSH 9th hourly, pt is stable

Nurse Signature: [Signature]

Nurse Name: sumana

Date & Time: 10/7/26 @ 8AM



KUH-00177234 IP5-00176155  
 Mrs J SWARNA SREE  
 05-01-1990 36 Y 6 M 5 D (F)  
 Dr. SASIKALA KOLA



## NURSING CARE RECORD

Rainbow®  
 Children's  
 Hospital  
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**BirthRight™**  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: 10/7/20

Assessment: .....

patient Gen. for. ch-hscl

Goals

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

| Time             | Plan of Care            | Time   | Implementation             | Evaluation        |
|------------------|-------------------------|--------|----------------------------|-------------------|
| 8am              | Assess the Pt condition | 9am    | Assessed the Pt condition. | Pt is comfortable |
| 10am             | Monitoring vitals.      | 11am   | vitals checked & stable.   |                   |
| 12 <sup>PM</sup> | D/o chest monitoring    | 2pm    | D/o chest monitoring       |                   |
| 4pm              | IV flushes              | 5pm    | Started IV flushes         |                   |
| 6pm              | Observation             | 7:30pm | Observation done.          |                   |

Re-Assessment: .....

Re-Assessment 6th hourly

Special Notes: .....

Nurse Signature: \_\_\_\_\_

Nurse Name: Reilly

Date & Time: 10/7/20 Jan



KUH-00177234 IP5-00176155  
 Mrs J SWARNA SREE  
 05-01-1990 38 Y 6 M 5 D (F)  
 Dr. SASIKALA KOLA



# NURSING CARE RECORD

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

**BirthRight**  
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 Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 10/7/26

Assessment: patient is having discomfort

Goals

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

| Time | Plan of Care                                    | Time     | Implementation                                      | Evaluation                        |
|------|-------------------------------------------------|----------|-----------------------------------------------------|-----------------------------------|
| 8pm  | * Assess the patient Condition and vitals check | 8:30 pm  | * Assessed the patient Condition and vitals checked | * now patient Condition is Stable |
| 10pm | * monitor the I/O chart                         | 10:30 pm | * monitored the I/O chart                           |                                   |
| 12am | * maintain personal hygiene                     | 12:30 AM | * maintained the personal hygiene                   |                                   |
| 3AM  | * provide comfortable position to the pt        | 3:30 AM  | * provided comfortable position to the pt           |                                   |
| 6AM  | * Administer medicine as per chart              | 6:30 AM  | * Administered medicine as per chart                |                                   |
| 7AM  | * ensure safety                                 | 7:30 AM  | * ensured safety                                    |                                   |

Re-Assessment: Assess the patient Condition now it is Stable

Special Notes: Nil

Nurse Signature: Sneh Nurse Name: Sneh 607635 Date & Time: 10/7/26 @ 8pm



# NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 11/9/28

Assessment:

patient is having discomfort

Goals

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

| Time | Plan of Care                          | Time    | Implementation                          | Evaluation    |
|------|---------------------------------------|---------|-----------------------------------------|---------------|
| 8Am  | → Assess the patient trend condition. | 8:30Am  | → Assessed the patient trend condition. | pt is stable. |
| 10Am | → monitor vitals                      | 10:30pm | → monitor vitals                        |               |
| 12pm | → Ilo chut maintained                 | 12:30pm | → ilo chut maintained                   |               |
| 3pm  | → Administer medication as per chart  | 3:30pm  | → administer medication as per chart    |               |
| 6pm  | → ensure safety                       | 6:30pm  | → ensure safety                         |               |

Re-Assessment:

patient is stable

Special Notes:

Nil

Nurse Signature:

Nurse Name:

Sangeetha @ 601228

Date & Time:

11/7/28 @ 8pm



KUH-00177234 IP5-00176155  
 Mrs J SWARNA SREE  
 05-01-1990 36 Y 6 M 6 D (F)  
 Dr. SASIKALA KOLA



## NURSING CARE RECORD

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

**BirthRight**  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 11/7/26

Assessment: patient is having discomfort

Goals

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

| Time | Plan of Care                           | Time    | Implementation                           | Evaluation            |
|------|----------------------------------------|---------|------------------------------------------|-----------------------|
| 8am  | Assess the patient's general condition | 8:30pm  | Assessed the patient's general condition | And patient is stable |
| 10pm | Administer medication as per chart     | 10:30pm | Administered medication as per chart     |                       |
| 12am | Maintain fluid balance                 | 12:30am | monitored fluid balance                  |                       |
| 3am  | monitor vital signs                    | 3:30am  | monitored vital signs                    |                       |
| 7am  | Ensure safety                          | 7:30am  | Ensure safety                            |                       |

Re-Assessment: Re-Assessment done every 3rd hourly

Special Notes: NM

Nurse Signature: [Signature]

Nurse Name: Yamuna @ 606222

Date & Time: 12/7/26 @ 8am



KUH-00177234 IP5-00176155  
 Mrs J SWARNA SREE  
 05-01-1990 36 Y 6 M 6 D (F)  
 Dr. SASIKALA KOLA



# NURSING CARE RECORD



Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: .....

Assessment: .....

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: .....

Special Notes: .....

Nurse Signature: .....

Nurse Name: .....

Date & Time: .....



Patient Sticker

NURSING CARE RECORD



Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: .....

Assessment: .....

- 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: .....

Special Notes: .....

Nurse Signature: ..... Nurse Name: ..... Date & Time: .....





## NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Sasikala Kola Department: BC Date of Admission: 9/12/20

| SITUATION                                |                                                                     | Diagnosis:                                                          |                                                                     | Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known |                                                                     |        |
|------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------|
| BACKGROUND                               |                                                                     | Area                                                                |                                                                     | If Yes Specify:                                                                                                       |                                                                     |        |
|                                          |                                                                     | Shift Time                                                          |                                                                     |                                                                                                                       |                                                                     |        |
| ASSESSMENT                               | Medical Condition<br>(Any special condition to be noted):           | 08:30-12:00                                                         | 12:00-02:00                                                         | 02:00-08:00                                                                                                           | 08:00-12:00                                                         |        |
|                                          |                                                                     | 02:00-08:00                                                         | 08:00-12:00                                                         | 12:00-02:00                                                                                                           | 02:00-08:00                                                         |        |
| RECOMMENDATIONS                          | Allergy:                                                            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                   | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |        |
|                                          | Tubes/Drains/Catheter:                                              | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                   | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |        |
|                                          | Vital Signs:                                                        | Temp:                                                               | 97.6                                                                | 98.6                                                                                                                  | 98.4                                                                | 98.4   |
|                                          |                                                                     | Res:                                                                | 20                                                                  | 19                                                                                                                    | 20                                                                  | 22     |
|                                          |                                                                     | SpO <sub>2</sub> :                                                  | 99%                                                                 | 99%                                                                                                                   | 100%                                                                | 99%    |
|                                          |                                                                     | Pulse:                                                              | 88                                                                  | 90                                                                                                                    | 87                                                                  | 86     |
|                                          |                                                                     | BP:                                                                 | 120/80                                                              | 128/72                                                                                                                | 120/78                                                              | 121/85 |
|                                          | Fall Risk Score:                                                    | 20                                                                  | 20                                                                  | 20                                                                                                                    | 25                                                                  |        |
|                                          | Pain Score:                                                         | 0                                                                   | 0                                                                   | 0                                                                                                                     | 0                                                                   |        |
|                                          | Safety Needs:                                                       | side rail                                                           | side rail                                                           | side rail                                                                                                             | side rail                                                           |        |
| Physiotherapy                            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                   |                                                                     |        |
| Others Specify:                          | NA                                                                  | NA                                                                  | NA                                                                  | NA                                                                                                                    |                                                                     |        |
| Special Diet:                            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                   |                                                                     |        |
| Other Special Orders / Medications:      | NA                                                                  | NA                                                                  | NA                                                                  | NA                                                                                                                    |                                                                     |        |
| Post Operative Procedure Special Orders: |                                                                     | NA                                                                  | NA                                                                  | NA                                                                                                                    | NA                                                                  |        |
| Handed Over By Name :                    |                                                                     | Palle                                                               | Suvarna                                                             | Palle                                                                                                                 | Suvarna                                                             |        |
| Signature :                              |                                                                     | [Signature]                                                         | [Signature]                                                         | [Signature]                                                                                                           | [Signature]                                                         |        |
| Date:                                    |                                                                     | 9/12/20                                                             | 10/12/20                                                            | 10/12/20                                                                                                              | 11/12/20                                                            |        |
| Time:                                    |                                                                     | 8PM                                                                 | 1:30                                                                | 8AM                                                                                                                   | 8PM                                                                 |        |
| Taken Over By Name :                     |                                                                     | Suvarna                                                             | Suvarna                                                             | Suvarna                                                                                                               | Suvarna                                                             |        |
| Signature :                              |                                                                     | [Signature]                                                         | [Signature]                                                         | [Signature]                                                                                                           | [Signature]                                                         |        |
| Date:                                    |                                                                     | 9/12                                                                | 10/12/20                                                            | 10/12/20                                                                                                              | 11/12                                                               |        |
| Time:                                    |                                                                     | 8PM                                                                 | 3AM                                                                 | 8AM                                                                                                                   | 8PM                                                                 |        |



## NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. SK Department: 3<sup>rd</sup> floor Date of Admission: 9/7

|                                          |                                                           |                                                                     |                                                                                                                                     |                                                                     |                                                                     |                                                                     |  |
|------------------------------------------|-----------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|--|
| SITUATION                                | Diagnosis: <u>prim 34<sup>th</sup> week</u>               |                                                                     | Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known<br>If Yes Specify: ..... |                                                                     |                                                                     |                                                                     |  |
|                                          |                                                           |                                                                     |                                                                                                                                     |                                                                     |                                                                     |                                                                     |  |
| BACKGROUND                               | Area                                                      | Shift Time                                                          |                                                                                                                                     |                                                                     |                                                                     |                                                                     |  |
|                                          | Medical Condition<br>(Any special condition to be noted): | <u>3<sup>rd</sup> floor<br/>4pm to 8pm<br/>NA</u>                   |                                                                                                                                     |                                                                     |                                                                     |                                                                     |  |
| ASSESSMENT                               | Allergy:                                                  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|                                          | Tubes/Drains/Catheter:                                    | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|                                          | Vital Signs:                                              | Temp:                                                               | <u>98.9</u>                                                                                                                         |                                                                     |                                                                     |                                                                     |  |
|                                          |                                                           | Res:                                                                | <u>24bpm</u>                                                                                                                        |                                                                     |                                                                     |                                                                     |  |
|                                          |                                                           | SpO <sub>2</sub> :                                                  | <u>100</u>                                                                                                                          |                                                                     |                                                                     |                                                                     |  |
|                                          |                                                           | Pulse:                                                              | <u>78bpm</u>                                                                                                                        |                                                                     |                                                                     |                                                                     |  |
|                                          |                                                           | BP:                                                                 | <u>107/72</u>                                                                                                                       |                                                                     |                                                                     |                                                                     |  |
|                                          |                                                           | Fall Risk Score:                                                    | <u>D60</u>                                                                                                                          |                                                                     |                                                                     |                                                                     |  |
| Pain Score:                              | <u>0/10</u>                                               |                                                                     |                                                                                                                                     |                                                                     |                                                                     |                                                                     |  |
| Recommendations                          | Safety Needs:                                             | <u>Y4</u>                                                           |                                                                                                                                     |                                                                     |                                                                     |                                                                     |  |
|                                          | Physiotherapy                                             | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|                                          | Others Specify:                                           | <u>NA</u>                                                           |                                                                                                                                     |                                                                     |                                                                     |                                                                     |  |
|                                          | Special Diet:                                             | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|                                          | Other Special Orders / Medications:                       | <u>NA</u>                                                           |                                                                                                                                     |                                                                     |                                                                     |                                                                     |  |
| Post Operative Procedure Special Orders: |                                                           | <u>NA</u>                                                           |                                                                                                                                     |                                                                     |                                                                     |                                                                     |  |
| Handed Over By Name :                    |                                                           | <u>Yanika</u>                                                       |                                                                                                                                     |                                                                     |                                                                     |                                                                     |  |
| Signature :                              |                                                           | <u>[Signature]</u>                                                  |                                                                                                                                     |                                                                     |                                                                     |                                                                     |  |
| Date:                                    |                                                           | <u>12/7</u>                                                         |                                                                                                                                     |                                                                     |                                                                     |                                                                     |  |
| Time:                                    |                                                           | <u>8am</u>                                                          |                                                                                                                                     |                                                                     |                                                                     |                                                                     |  |
| Taken Over By Name :                     |                                                           | <u>marvita</u>                                                      |                                                                                                                                     |                                                                     |                                                                     |                                                                     |  |
| Signature :                              |                                                           | <u>[Signature]</u>                                                  |                                                                                                                                     |                                                                     |                                                                     |                                                                     |  |
| Date:                                    |                                                           | <u>12/7</u>                                                         |                                                                                                                                     |                                                                     |                                                                     |                                                                     |  |
| Time:                                    |                                                           | <u>8am</u>                                                          |                                                                                                                                     |                                                                     |                                                                     |                                                                     |  |



KUJ-00177234

IP5-00176155

Mrs J SWARNA SREE

05-01-1990

38 Y 6 M 5 D

(F)

Dr. SASIKALA KOLA



## BRADEN 'Q' SCALE

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

**BirthRight**  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

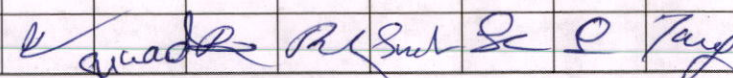
|                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Date :                  | 10/15/2020 | 12/9 |      |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------|------|------|
|                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Time :                  | 8 AM       | 4 PM | 1 PM |
| Mobility                                                                                                                                                                    | <b>1. Completely immobile:</b><br>Does not make even slight changes in body or extremity position without assistance.                                                                                                                                                                                                                    | <b>2. Very limited:</b><br>Makes occasional slight changes in body or extremity position but unable to completely turn self independently.                                                                                                                                                                                                                   | <b>3. Slightly limited:</b><br>Makes frequent through slight changes in body or e.tremity position independently.                                                                                                                                                                               | <b>4. No limitations:</b><br>Makes major and frequent changes in position without assistance.                                                                                                                                                                                          |                         | 4          | 4    | 4    |
| "Activity The degree of physical activity"                                                                                                                                  | <b>1. Bedfast :</b><br>Confined to bed                                                                                                                                                                                                                                                                                                   | <b>2. Chairfast :</b><br>Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."                                                                                                                                                                                                         | <b>3. Walks occasionally:</b><br>Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.                                                                                                                        | <b>4. All patients too young to ambulate; OR walks frequently:</b><br>Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.                                                                                                    |                         | 4          | 4    | 4    |
| Sensory Perception                                                                                                                                                          | <b>1. Completely limited:</b><br>Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.                                                                                                                  | <b>2. Very limited:</b><br>responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.                                                                                                                               | <b>3. Slightly limited:</b><br>Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.                                                           | <b>4. No impairment:</b><br>Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.                                                                                                                                    |                         | 4          | 4    | 4    |
| Moisture Degree to which skin is exposed to moisture                                                                                                                        | <b>1. Constantly moist:</b><br>Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.                                                                                                                                                                   | <b>2. Very moist:</b><br>Skin is often, but not always, moist. Linen must be changed at least every 8 hours.                                                                                                                                                                                                                                                 | <b>3. Occasionally moist:</b><br>Skin is occasionally moist, requiring linen change every 12 hours.                                                                                                                                                                                             | <b>4. Rarely moist:</b><br>Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.                                                                                                                                                                   |                         | 4          | 4    | 4    |
| <b>FRICION-SHEAR</b><br><b>Friction</b> Occurs when Skin moves against support surfaces<br><b>Shear</b> Occurs when skin and adjacent bony surface slide across one another | <b>1. Significant problem:</b><br>Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.                                                                                                                                                                                                        | <b>2. Problem:</b><br>Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.                                                                                                                    | <b>3. Potential problem:</b><br>Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.            | <b>4. No apparent problem:</b><br>Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."                         |                         | 4          | 4    | 4    |
| Nutritional Usual food intake pattern                                                                                                                                       | <b>1. Very Poor:</b><br>NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement. | <b>2. Inadequate:</b><br>Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. | <b>3. Adequate:</b><br>Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered. | <b>4. Excellent:</b><br>Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation. |                         | 4          | 4    | 4    |
| Tissue Perfusion & Oxygenation                                                                                                                                              | <b>1. Extremely compromised:</b><br>Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.                                                                                                                                                                                   | <b>2. Compromised:</b><br>Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.                                                                                                                                                                                                | <b>3. Adequate:</b><br>Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.                                                                                                                                        | <b>4. Excellent:</b><br>Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.                                                                                                                                                                               |                         | 4          | 4    | 4    |
| <b>Severe Risk : less than 9   High Risk : 10-12   Moderate Risk : 13-14   Mild Risk : 15-18   Not at Risk: 19-23</b>                                                       |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | <b>TOTAL SCORE</b>      | 28         | 28   | 28   |
| Docu. No. : RCHBH /FRM / CLINICAL / 119                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | <b>Evaluator's Name</b> | Sush       | Sush | Gm   |



| Risk Score  | Category      | Action                                                                                                                                                                                                                                                                                                                                       | <b>Support Surfaces</b><br><b>(Please Note:</b> Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice |
|-------------|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 15-18       | At Risk       | <ul style="list-style-type: none"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul> | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                        |
| 13-14       | Moderate Risk | <ul style="list-style-type: none"> <li>• Use the Same Protocol as for “<b>At Risk</b>” Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>                                                                                                                                                        | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                        |
| 10-12       | High Risk     | <ul style="list-style-type: none"> <li>• Follow the same protocol as for “<b>Moderate Risk</b>” Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>                                                                                                             | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                        |
| Less than 9 | Severe Risk   | <ul style="list-style-type: none"> <li>• Use same protocol as for “<b>High Risk</b>” Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>                                                                                                                     | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                        |

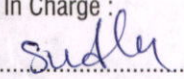
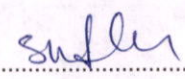


## CHECKLIST FOR THROMBOPHLEBITIS

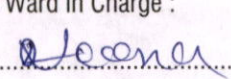
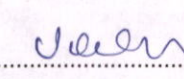
| S. No.                 | SITE OBSERVATION                                                                                                                                     | STAGE / ACTION                                                                                          | SCORE | DAY-1   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

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

Signature of Shift In Charge :

Signature :  Name : 

Signature of Ward In Charge :

Signature :  Name : 





## PAIN ASSESSMENT FORM

| Date   | Time             | Pain Score (0/10) | Location | Duration                                                                     | Acuity                                                             | Character                                                                                                                        | Modifying Factors                                                          | Patient / Family Educated                                   | Intervention | Sign   |
|--------|------------------|-------------------|----------|------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------|--------------|--------|
| 9/7/20 | 4 <sup>pm</sup>  | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Pudley |
| 9/7/20 | 4 <sup>pm</sup>  | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Pudley |
| 9/7    | 9 <sup>pm</sup>  | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Suanda |
| 10/7   | 12 <sup>pm</sup> | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Suanda |
| 10/7   | 8 <sup>am</sup>  | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Pudley |
| 10/7   | 10 <sup>am</sup> | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Pudley |
| 10/7   | 12 <sup>pm</sup> | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Pudley |
| 10/7   | 2 <sup>pm</sup>  | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Pudley |
| 10/7   | 4 <sup>pm</sup>  | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Pudley |
| 10/7   | 6 <sup>pm</sup>  | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Pudley |

**Re-assessment Frequency:**

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

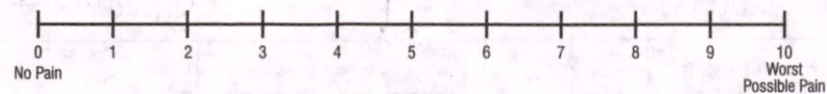


# PAIN ASSESSMENT TOOLS

## FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

| CATEGORY      | SCORING                                      |                                                                             |                                                          |
|---------------|----------------------------------------------|-----------------------------------------------------------------------------|----------------------------------------------------------|
|               | 0                                            | 1                                                                           | 2                                                        |
| Face          | No Particular expression or smile            | Occasional Grimace or Frown, withdraw, Disoriented                          | Frequent to constant frown, quivering chin, clenched jaw |
| Legs          | Normal Position or Relaxed                   | Uneasy, restless, tense                                                     | Kicking, or legs brawn up                                |
| Activity      | Laying quietly normal position, moves easily | Squirming shifting back and forth, tense                                    | Arched, right, or Jerking                                |
| Cry           | No Cry (Awake or asleep)                     | Moans or whimpers occasional complaint                                      | Crying steadily, screams of sobs, frequent complaints    |
| Consolability | Content, relaxed                             | Reassured by occasional touching, hugging, or being talked to, distractible | Difficult to console or comfort                          |

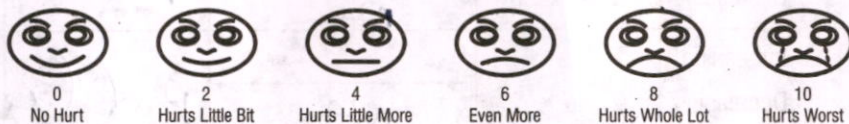
## Numerical Pain Scale (Obstetric and Gynecology)



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

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

## Wong - Baker (Pediatrics) Above 7 Years







## PAIN ASSESSMENT FORM

| Date    | Time | Score (0/10) | Location | Duration                                                                     | Acuity                                                             | Character                                                                                                                        | Modifying Factors                                                          | Patient / Family Educated                                   | Intervention | Sign |
|---------|------|--------------|----------|------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------|--------------|------|
| 10/7/26 | 9pm  | 0/10         | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Such |
| 11/7/26 | 12Am | 0/10         | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Such |
| 11/7/26 | 3Am  | 0/10         | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Such |
| 11/7/26 | 6Am  | 0/10         | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Such |
| 11/7    | 12pm | 0/10         | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Such |
| 11/7    | 6pm  | 0/10         | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Such |
| 11/7    | 11pm | 0/10         | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Such |
| 12/7    | 6am  | 0/10         | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Such |
|         |      |              |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |              |      |
|         |      |              |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |              |      |

**Re-assessment Frequency:**

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

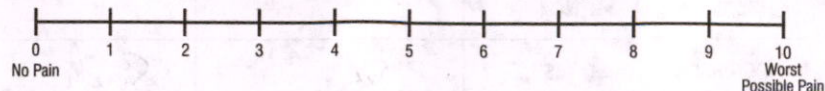


# PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

| CATEGORY      | SCORING                                      |                                                                             |                                                          |
|---------------|----------------------------------------------|-----------------------------------------------------------------------------|----------------------------------------------------------|
|               | 0                                            | 1                                                                           | 2                                                        |
| Face          | No Particular expression or smile            | Occasional Grimace or Frown, withdraw, Disoriented                          | Frequent to constant frown, quivering chin, clenched jaw |
| Legs          | Normal Position or Relaxed                   | Uneasy, restless, tense                                                     | Kicking, or legs brawn up                                |
| Activity      | Laying quietly normal position, moves easily | Squirming shifting back and forth, tense                                    | Arched, right, or Jerking                                |
| Cry           | No Cry (Awake or asleep)                     | Moans or whimpers occasional complaint                                      | Crying steadily, screams of sobs, frequent complaints    |
| Consolability | Content, relaxed                             | Reassured by occasional touching, hugging, or being talked to, distractible | Difficult to console or comfort                          |

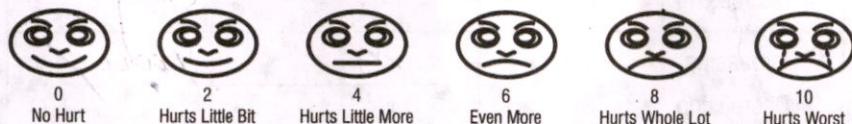
Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years





## Morse Fall Risk Assessment Form

| Choose Highest Applicable Score from each Category   |                               | Date / Time | Fall Risk Grading |                           |                                                           |
|------------------------------------------------------|-------------------------------|-------------|-------------------|---------------------------|-----------------------------------------------------------|
|                                                      |                               | Score       |                   |                           |                                                           |
| History of Falling<br>(immediately or w/in 3 months) | Yes                           | 25          | Risk Level        | Morse Fall Score<br>(MFS) | Action                                                    |
|                                                      | No                            | 0           |                   |                           |                                                           |
| Secondary Diagnosis<br>(more than one diagnosis)     | Yes                           | 15          | Low Risk          | 0 - 24                    | Standard Fall<br>Precaution                               |
|                                                      | No                            | 0           |                   |                           |                                                           |
| Ambulatory Aid                                       | Furniture                     | 30          | Moderate Risk     | 25 - 50                   | Implement<br>Moderate Fall<br>Prevention<br>Intervention  |
|                                                      | Crutches, Cane(S), Walker     | 15          |                   |                           |                                                           |
|                                                      | None /Bed Rest /Nurse Assist  | 0           |                   |                           |                                                           |
| IV / Heparin Lock or Saline                          | Yes                           | 20          | High Risk         | ≥ 51                      | Implement High<br>Risk Fall<br>Prevention<br>Intervention |
|                                                      | 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                | 38                        |                                                           |
| Signature                                            |                               | Swarna Sree |                   |                           |                                                           |

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



KUH-00177234 IP5-00176155  
Mrs J SWARNA SREE  
05-01-1990 36 Y 6 M 4 D (F)  
Dr. SASIKALA KOLA



## Morse Fall Risk Assessment Form

| Choose Highest Applicable Score from each Category   |                               | Date / Time | Fall Risk Grading |    |  |
|------------------------------------------------------|-------------------------------|-------------|-------------------|----|--|
|                                                      |                               | Score       |                   |    |  |
| History of Falling<br>(immediately or w/in 3 months) | Yes                           | 25          | 11/7/20           | 1' |  |
|                                                      | No                            | 0           | 8 AM to 8 PM      |    |  |
| Secondary Diagnosis<br>(more than one diagnosis)     | Yes                           | 15          | 18                |    |  |
|                                                      | No                            | 0           |                   |    |  |
| Ambulatory Aid                                       | Furniture                     | 30          |                   |    |  |
|                                                      | Crutches, Cane(S), Walker     | 15          |                   |    |  |
|                                                      | None /Bed Rest /Nurse Assist  | 0           | 0                 |    |  |
| IV / Heparin Lock or Saline                          | Yes                           | 20          | 20                |    |  |
|                                                      | No                            | 0           |                   |    |  |
| GAIT / Transferring                                  | Impaired                      | 20          |                   |    |  |
|                                                      | Weak (uses touch for balance) | 10          |                   |    |  |
|                                                      | Normal /On Bed Rest /Immobile | 0           | 0                 |    |  |
| Mental Status                                        | Forgets limitations           | 15          |                   |    |  |
|                                                      | Oriented to own ability       | 0           |                   |    |  |
| Total Morse Fall Scale Score:                        |                               |             | 20                |    |  |
| Signature                                            |                               |             | Such              |    |  |

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



KUH-00177234 IP5-00176155  
Mrs J SWARNA SREE  
05-01-1990 36 Y 6 M 5 D (F)  
Dr. SASIKALA KOLA



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

  
**BirthRight™**  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

## POST – PARTUM ASSESSMENT FORM – IN-PATIENT

Date: 11/7/26

Chief Complaint : Pain at the suture site

Obstetric/ Birthing History : P1L1, LSCS, POD -1

Previous Surgical/Medical History : -

### Assessment :

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

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

Iv line ☒ / -

Catheter ☒ + / -

Postural alignment -

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

**On Examination :** Breathing pattern – abdominal/ ☒ apical/ diaphragmatic

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

Able to initiate Pelvic Floor Activation – ☒ Yes ☐ No

### Spl Notes -

#### Treatment Plan :

☒ Lateral Breathing

☒ Pelvic Floor Activation

☒ Transversus Abdominis Activation

☒ Gluteus Activation

☒ Active Motion for Limbs

☒ Transfer Training & Mobility

☒ Sit to Stand

☒ Monitored Walk

☒ Posture & Ergonomic Education

Signature : T.S.

Name : Dr. Tuhena Sharma (PT)

Date & Time: 11/7/26 3:45 pm





## MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: primi / 37+4 wks / FGR / for observation / deliver

| Date Time         | Discipline                                                                                                                        | Type                                                                                                                                                    | Patient Needs / Problem List | Goal                 | Plan / Intervention                        | Signature          | Team Verification                                                                                                   |
|-------------------|-----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|----------------------|--------------------------------------------|--------------------|---------------------------------------------------------------------------------------------------------------------|
| 9/7/26<br>3pm     | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others:                          | <input checked="" type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input type="checkbox"/> Per-Op<br><input type="checkbox"/> Post Op | → FGR                        | → safe delivery      | → observation / delivery                   | <i>[Signature]</i> | <input type="checkbox"/> Nursing<br><input type="checkbox"/> Others:                                                |
| 9/7/26<br>C. SR   | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others:                          | <input checked="" type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input type="checkbox"/> Per-Op<br><input type="checkbox"/> Post Op | Primi 37+4                   | safe delivery.       | ① observation                              | <i>[Signature]</i> | <input type="checkbox"/> Medical<br><input type="checkbox"/> Others:                                                |
| 11/7/26<br>6am    | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input checked="" type="checkbox"/> Others: <i>breast</i> | <input type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input type="checkbox"/> Per-Op<br><input checked="" type="checkbox"/> Post Op | pon-1/LSU                    | soft diet            | soft high protein diet                     | <i>[Signature]</i> | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input checked="" type="checkbox"/> Others: |
| 11/7/26<br>3:45pm | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input checked="" type="checkbox"/> Others:               | <input type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input type="checkbox"/> Per-Op<br><input checked="" type="checkbox"/> Post Op | Post LSCS                    | Post partum recovery | Deep core retraining & functional training | <i>T.S</i>         | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others:            |
|                   | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others:                          | <input type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input type="checkbox"/> Per-Op<br><input type="checkbox"/> Post Op            |                              |                      |                                            |                    | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others:            |



## INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

### Part - I.

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

### Identified Education Needs:

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

### Part - II

| Date    | Time    | Need Identified | Information Taught                                                  | Use codes from the list in part III |                   |                |                                   |               | Comments | Designation / Signature |
|---------|---------|-----------------|---------------------------------------------------------------------|-------------------------------------|-------------------|----------------|-----------------------------------|---------------|----------|-------------------------|
|         |         |                 |                                                                     | Person Taught                       | Learning Barriers | Teaching Tools | Mechanism/s to overcome barrier/s | Understanding |          |                         |
| 9/7/26  | 2:10 PM | 1, 2, 3, 4      | Diagnosis, treatment & care plan<br>Pain management, Informed cons. | PT/M                                | 1                 | 0              | 1                                 | 1             |          | Wheya                   |
| 9/8/26  | 3 PM    | 7               | Infection control measures                                          | PT/S                                | 1                 | 0              | 1                                 | 1             |          |                         |
| 11/7/26 | 8 AM    | 9               | Safe sex                                                            | PT                                  | 1                 | 0              | 1                                 | 1             |          | Raine                   |
|         |         |                 |                                                                     |                                     |                   |                |                                   |               |          |                         |

### Part - III: CODES

|                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                   |                                 |                                |            |             |              |                          |                             |                               |                                                   |                            |                                |                          |                                           |                             |                        |                            |                       |                               |                         |                                 |  |
|-------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|---------------------------------|--------------------------------|------------|-------------|--------------|--------------------------|-----------------------------|-------------------------------|---------------------------------------------------|----------------------------|--------------------------------|--------------------------|-------------------------------------------|-----------------------------|------------------------|----------------------------|-----------------------|-------------------------------|-------------------------|---------------------------------|--|
| <b>Who was taught:</b>                    | PT: Patient                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | F: Father                                         | M: Mother                       | S: Spouse                      | Sn: Son    | D: Daughter | C: Caregiver | O: Other (Specify) ..... |                             |                               |                                                   |                            |                                |                          |                                           |                             |                        |                            |                       |                               |                         |                                 |  |
| <b>Learning Barriers:</b>                 | <table border="0"> <tr> <td>1. No Learning Barriers</td> <td>4. Language Barrier</td> <td>7. Impaired Thought Process/Cognitive Limitations</td> <td>10. Financial Difficulties</td> <td>13. Cultural/Religion Practice</td> </tr> <tr> <td>2. Physical Impairment</td> <td>5. Educational Level</td> <td>8. Responsibilities at Home</td> <td>11. Beliefs and Values</td> <td>14. Others (Specify) .....</td> </tr> <tr> <td>3. Emotional Barriers</td> <td>6. Desire / Motivate to Learn</td> <td>9. Cultural Differences</td> <td>12. Impaired Vision/ or Hearing</td> <td></td> </tr> </table> |                                                   |                                 |                                |            |             |              |                          | 1. No Learning Barriers     | 4. Language Barrier           | 7. Impaired Thought Process/Cognitive Limitations | 10. Financial Difficulties | 13. Cultural/Religion Practice | 2. Physical Impairment   | 5. Educational Level                      | 8. Responsibilities at Home | 11. Beliefs and Values | 14. Others (Specify) ..... | 3. Emotional Barriers | 6. Desire / Motivate to Learn | 9. Cultural Differences | 12. Impaired Vision/ or Hearing |  |
| 1. No Learning Barriers                   | 4. Language Barrier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 7. Impaired Thought Process/Cognitive Limitations | 10. Financial Difficulties      | 13. Cultural/Religion Practice |            |             |              |                          |                             |                               |                                                   |                            |                                |                          |                                           |                             |                        |                            |                       |                               |                         |                                 |  |
| 2. Physical Impairment                    | 5. Educational Level                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 8. Responsibilities at Home                       | 11. Beliefs and Values          | 14. Others (Specify) .....     |            |             |              |                          |                             |                               |                                                   |                            |                                |                          |                                           |                             |                        |                            |                       |                               |                         |                                 |  |
| 3. Emotional Barriers                     | 6. Desire / Motivate to Learn                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 9. Cultural Differences                           | 12. Impaired Vision/ or Hearing |                                |            |             |              |                          |                             |                               |                                                   |                            |                                |                          |                                           |                             |                        |                            |                       |                               |                         |                                 |  |
| <b>Teaching Tools Used:</b>               | A: Audio                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | D: Demonstration                                  | V: Video                        | O: Oral                        | P: Printed |             |              |                          |                             |                               |                                                   |                            |                                |                          |                                           |                             |                        |                            |                       |                               |                         |                                 |  |
| <b>Mechanism/s to overcome barrier/s:</b> | <table border="0"> <tr> <td>1. None</td> <td>3. Reassurance &amp; Support</td> <td>5. Respect values &amp; beliefs</td> <td>7. Other, Specify .....</td> </tr> <tr> <td>2. Obtain translator</td> <td>4. Teach Family / Others</td> <td>6. Respect Cultural / Religion Preference</td> <td></td> </tr> </table>                                                                                                                                                                                                                                                                                    |                                                   |                                 |                                |            |             |              |                          | 1. None                     | 3. Reassurance & Support      | 5. Respect values & beliefs                       | 7. Other, Specify .....    | 2. Obtain translator           | 4. Teach Family / Others | 6. Respect Cultural / Religion Preference |                             |                        |                            |                       |                               |                         |                                 |  |
| 1. None                                   | 3. Reassurance & Support                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Respect values & beliefs                       | 7. Other, Specify .....         |                                |            |             |              |                          |                             |                               |                                                   |                            |                                |                          |                                           |                             |                        |                            |                       |                               |                         |                                 |  |
| 2. Obtain translator                      | 4. Teach Family / Others                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 6. Respect Cultural / Religion Preference         |                                 |                                |            |             |              |                          |                             |                               |                                                   |                            |                                |                          |                                           |                             |                        |                            |                       |                               |                         |                                 |  |
| <b>Understanding:</b>                     | <table border="0"> <tr> <td>1. Verbalizes Understanding</td> <td>2. Demonstrates Understanding</td> <td>3. Needs Review</td> </tr> </table>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                   |                                 |                                |            |             |              |                          | 1. Verbalizes Understanding | 2. Demonstrates Understanding | 3. Needs Review                                   |                            |                                |                          |                                           |                             |                        |                            |                       |                               |                         |                                 |  |
| 1. Verbalizes Understanding               | 2. Demonstrates Understanding                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 3. Needs Review                                   |                                 |                                |            |             |              |                          |                             |                               |                                                   |                            |                                |                          |                                           |                             |                        |                            |                       |                               |                         |                                 |  |



# PATIENT TRANSFER FORM

|                                                                                                                                                                                                                               |                                           |                                                                                                                                                                        |                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|
| <b>Patient Name &amp; UHID No.</b><br>KUH-00177234 IP5-00176155<br>Mrs J SWARNA SREE (F)<br>05-01-1990 36 Y 6 M 5 D<br>Dr. SASIKALA KOLA<br> |                                           | <b>Date &amp; Time of Admission</b><br>10/7/2024 @ 11:14 pm                                                                                                            | <b>Date &amp; Time of Transfer Order</b><br>10/7/20 @ 6 pm |
|                                                                                                                                                                                                                               |                                           | <b>Transfer Ordered by</b><br>Dr. Swarnalatha                                                                                                                          | <b>Reason for Transfer</b><br>POST OP                      |
| <b>From Unit</b><br>OBS                                                                                                                                                                                                       | <b>To Unit</b><br>ROOM (301)              | <b>Information to Attendant</b><br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                 |                                                            |
| <b>Number of Sheets in Clinical File</b><br>35                                                                                                                                                                                | <b>Number of Imaging Films</b><br>NST (4) | <b>Personal belongings including clinical documents. If any handed over to attendant</b><br>Yes <input type="checkbox"/> No <input type="checkbox"/><br>If yes, what ? |                                                            |
| <b>Medications / Consumables / Surgicals / Hand over</b>                                                                                                                                                                      |                                           |                                                                                                                                                                        |                                                            |
| Sl.No.                                                                                                                                                                                                                        | Item Name                                 | Quantity                                                                                                                                                               |                                                            |
| 1.                                                                                                                                                                                                                            |                                           |                                                                                                                                                                        |                                                            |
| 2.                                                                                                                                                                                                                            |                                           |                                                                                                                                                                        |                                                            |
| 3.                                                                                                                                                                                                                            |                                           |                                                                                                                                                                        |                                                            |
| 4.                                                                                                                                                                                                                            |                                           |                                                                                                                                                                        |                                                            |
| 5.                                                                                                                                                                                                                            |                                           |                                                                                                                                                                        |                                                            |
| <b>Shifting Summary / Notes Written by Doctor :</b> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                                                       |                                           |                                                                                                                                                                        |                                                            |
| <b>Name &amp; Signature of Person who is Transferring</b><br>Sis. Reddy                                                                                                                                                       |                                           | <b>Name of Person Ordered Transfer</b><br>Dr. Swarnalatha                                                                                                              |                                                            |
| <b>Patient &amp; Clinical Records Received by :</b><br>Pooja                                                                                                                                                                  |                                           |                                                                                                                                                                        |                                                            |
| <b>Date &amp; Time of Patient Received :</b><br>10/7/26 @ 6:10 pm                                                                                                                                                             |                                           |                                                                                                                                                                        |                                                            |

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





## OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 9/7/16 Time of Arrival: 2:00 pm Time Seen by Nurse: 2:05 pm

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

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

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

3) **Vital Signs:** Temperature: 98.2 Pulse: 88 RR: 20 SpO<sub>2</sub>: 100 BP: 128/85 Weight:

4) **Gestational Criteria:**

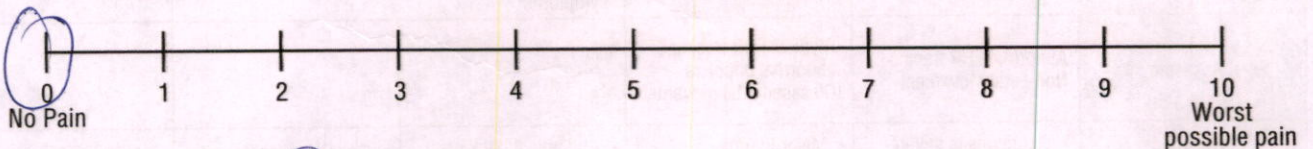
|          |   |   |          |   |   |
|----------|---|---|----------|---|---|
| Gravida: | G | P | <u>2</u> | L | A |
|----------|---|---|----------|---|---|

LMP: 24/9/15 EDD: 25/9/16 Gestational Age: 37+4 w

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

5) **Pain Screening:**

**Numerical Pain Scale (NPS)**



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

6) **Past History:**

- a) Surgeries: Nil  
b) Medical: 26/11/16 - cervical polyp





1) Allergy: ☐ Yes ☒ No, If Yes : .....

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

9) Prenatal Medical History:

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

**Triage Category:** (Please tick on the category)

**Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)**

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

**OCBU Obstetrical Triage Acuity Scale (OTAS)**

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

Time seen by Doctor: 2:30 pm

Nurse Name : Randle Nurse Signature:

Date: 9/7/20 Time: 3 pm





## OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 9/2/20

### Baseline Information:

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

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

Chief Complaints: obstruction Doctor Notified on Admission: ☐ Yes ☒ No  
Name of the Doctor: Dr. Divya  
Time Notified: 4pm

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

| Past Medical History           | Past Surgical History | Previous Hospital Admission |
|--------------------------------|-----------------------|-----------------------------|
| 26/11/20 - Cervical<br>ripping | Nil                   | no.                         |

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

Obstetric History: G ..... P 2/1/20 L ..... A .....

Previous LSCS: NO

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

Family History: ☒ No Abnormalities Detected

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

Vital Signs / Measurements: Temp: 98.2 HR: 88 RR: 22  
BP: 123/88 Weight: ..... Height: ..... BMI: .....

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





### PHYSICAL ASSESSMENT

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

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

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

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

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

Inform consultant for positive criteria

**NUTRITIONAL SCREENING:** ☒ No Abnormality Detected

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

Inform consultant for positive criteria

**PSYCHOLOGICAL SCREENING:**

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

Inform consultant for positive criteria

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

**SOCIAL SCREENING:**

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

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

**Social History:** Lives With .....

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

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

Above information given to .....

Name of Person Orientation was given to: patient (Swarma Sree)

Orientation not given Reason: .....

Nurse Signature: [Signature]

Nurse Name: Pdilly

Date & Time: 9/21/2024



# INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

Patient Name : SWARNA SREE Gender: ☐ Male ☒ Female Age : 36  
UHID No : KUH-0047234 Date : 10/1/20

## Instruction:

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

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

ELECTIVE LOWER SEGMENT CESAREAN SECTION  
upon SWARNASREE  
(Name of the Patient)

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

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

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

Bleeding and blood Blood transfusion Infection Injury to bowel loops

## 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. Sankar

Consentee : Swarna Sree  
Signature : Swarna Sree  
Name : Swarna Sree  
Date & Time : 9/1/20 9:30 PM

Witness : Dr. Arun  
Signature : Dr. Arun  
Name : Dr. Arun  
Date & Time : 10/1/20 9:30 PM

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

Patient Attendant : P. Sujesh Raj  
Signature : P. Sujesh Raj  
Name : P. Sujesh Raj  
Relationship with Patient : Husband  
Date & Time : 9/1/20 9:30 PM

Doctor (who is taking the consent) : Dr. Arun  
Signature : Dr. Arun  
Name : Dr. Arun  
Date & Time : 9/1/20 9 PM



KUH-00177234  
Mrs J SWARNA SREE  
05-01-1990 36 Y 6 M 4 D (F)  
Dr. SASIKALA KOLA

## CONSENT FOR ANAESTHESIA

Authorization By: ☒ Patient ☐ Patient Attendant

Operative Procedure: Electric lower segment

Anaesthesiologist: Dr. Subhramanyam. Surgeon: Dr. Sankala

### Please read this before you consent for Anaesthesia

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

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

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

☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease

☒ Others Post dural puncture headache, shivering, itching

### Declaration by Patient Attendant

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

### Patient / Patient Attendant:

Signature: Swarna Sree

Name: J. Swarna Sree

Relationship with patient: self

Date & Time: 9/7/26 - 8:11 PM

### Witness:

Signature: P. Suresh Raj

Name: P. SURESH RAJ

Date & Time: 9/7/26 - 8:12 PM

### Doctor (who is taking consent):

Signature: Dr. K. Sankala Name: Dr. K. Sankala Date: 9/7/26 Time: 8:11 pm



## అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స: .....

అనస్థీషియా వైద్యుడు: ..... శస్త్రచికిత్స నిపుణుడు: .....

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

సాధారణ అనస్థీషియా అనేది శస్త్రచికిత్స ముందు రోగిని పూర్తిగా అవస్థాపక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్థాపన ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు. రీజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్కోటిక్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై రిస్క్:

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

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

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

☐ ఇతరవి: .....

రోగి / రోగి అటెండెంట్

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

రోగి / రోగి అటెండెంట్:

సంతకం: .....

పేరు: .....

రోగితో సంబంధం: .....

తేదీ & సమయం: .....

సాక్షి:

సంతకం: .....

పేరు: .....

తేదీ & సమయం: .....

డాక్టర్ :

సంతకం: ..... పేరు: ..... తేదీ & సమయం: .....



Department of Anaesthesiology  
PRE-ANAESTHETIC EVALUATION

KUH-00177234 IP5-00176155  
Mrs J SWARNA SREE  
05-01-1990 36 Y 6 M 4 D (F)  
Dr. SASIKALA KOLA



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

BirthRight™  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

Name: J. Swarna Sree Age: 36y Sex: F UHID.No: KUH-00177234  
Date: 9/7/26 Time: 8:00pm Proposed Operation: Elective lower segment cesarean section,  
Diagnosis: primigravida 37+4 weeks / FGR  
B.P / CRT: ..... H.R: ..... Weight: 94kg , ASA Physical Status: ☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 12.1 Glucose: ..... Protein: ..... HIV: ..... X-Ray: .....  
PCV: ..... Urea: ..... Alb: ..... HBS Ag: 1.12 ECG: .....  
WBC: 11.240 Creat: ..... Total Bill: ..... HCV: 1.12 2D Echo: .....  
Plate: 1.98 lakh Na: ..... Dir. Bill: ..... Blood group: O positive Stress/Anglo: .....  
PT: ..... K: ..... LDH: ..... T3 ..... Other: .....  
PTT: ..... Ca++: ..... Alk phos: ..... T4 .....  
INR: ..... Mg++: ..... Amylase: ..... TSH .....  
Cl -: ..... SGOT/SGPT: .....

Allergies: NADA

Medical History: CVS:

RESP: Not Significant. Diabetes: Nil  
CNS: .....  
Renal: .....  
Hepatic / GE: ..... Physical Activity: METS 24  
Others: .....

Past Anaesthetic History: H/o Meniscus tear, ACL reconstruction - 2017 JGA (unsuccessful)

Physical Exam: High BMI

Airway: MP 1 2 3 4 Mouth Opening: >3cm Mento-hyoid Distance: (N) Neck: (N) Teeth: 4 - Artificial fixed caps, 1 missing tooth  
Lungs: BAE+, clear  
Heart: S1 S2+  
CNS: Grossly Intact.

Pregnant: ☐ Yes ☐ No ☐ NA Venous Access Site: 18G RT hand. Spine Exam for regional: (N)

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

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

| CURRENT MEDICATIONS | DOSAGE |
|---------------------|--------|
|                     |        |
|                     |        |
|                     |        |
|                     |        |

Pre-Operative Instructions:

- DVT Prophylaxis : Explained
- 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: Dr. K. S. Somp.



|                                             |                      |                                                        |                                                     |                                                    |  |
|---------------------------------------------|----------------------|--------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------|--|
| <b>Change in Patient Condition:</b>         |                      | <input type="checkbox"/> Yes                           | <input checked="" type="checkbox"/> No              | <b>Fasting Status:</b> Confirmed                   |  |
| <b>Physical Status:</b>                     |                      | <input checked="" type="checkbox"/> Patient Identified | <input checked="" type="checkbox"/> Consent Present | <input checked="" type="checkbox"/> Chart Reviewed |  |
| H.R.: 98 BPM                                | B.P / CRT: 110/70/16 | SpO <sub>2</sub> : 98%                                 | R.R.: 16                                            | Last Feed: 16h                                     |  |
| Pre-OP Diagnosis: primary biliary cirrhosis |                      | Operation: GUS                                         |                                                     | Date: 9/7/2016                                     |  |
| Surgeon: Dr. K. Ramya                       |                      | Anaesthesiologist: Dr. K. Ramya                        | Technician: Ramesh                                  |                                                    |  |

| TIME                                                                                                                                                                                | N <sub>2</sub> O / AIR / O <sub>2</sub> LPM | HALO / SO / SEVO | Drugs: | Antibiotic | Suppository | Blood Loss | NOTES |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|------------------|--------|------------|-------------|------------|-------|
| 12:15 x 45                                                                                                                                                                          |                                             |                  |        |            |             |            |       |
| 1:00 x 1:30                                                                                                                                                                         |                                             |                  |        |            |             |            |       |
| <p>DRUGS GIVEN 30 + 30 mg.</p> <p>DRUG ON ANAESTHETIC - 4mg</p> <p>DRUG TRANAXAMIC acid - 1g</p> <p>PAINKILLER (PCE) → 300mg + 100mg + 100mg</p>                                    |                                             |                  |        |            |             |            |       |
| <p>FI<sub>O</sub><sub>2</sub> / SaO<sub>2</sub></p> <p>ETCO<sub>2</sub></p> <p>ECG</p> <p>Temperature</p> <p>Urine Output</p>                                                       |                                             |                  |        |            |             |            |       |
| <p>Fluids</p> <p>Blood</p>                                                                                                                                                          |                                             |                  |        |            |             |            |       |
| <p>B.P</p> <p>V Systolic</p> <p>A Diastolic</p> <p>X Mean</p> <p>• Heart Rate</p> <p>Tourniquet on Time</p> <p>Tourniquet off Time</p> <p>Throat Pack In</p> <p>Throat Pack Out</p> |                                             |                  |        |            |             |            |       |
| <p>LAB Values</p> <p>ABG</p> <p>GRBS</p> <p>Others</p>                                                                                                                              |                                             |                  |        |            |             |            |       |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Equipment Checked and Functional<br><input checked="" type="checkbox"/> BP<br><input checked="" type="checkbox"/> Cuff Site: Right Arm<br><input checked="" type="checkbox"/> Art Site: Radial<br><input checked="" type="checkbox"/> EKG Lead: Leads I, II, III, aVR, aVL, aVF, V1, V2, V3, V4, V5, V6<br><input checked="" type="checkbox"/> Temp Site: Axilla<br><input type="checkbox"/> FIO <sub>2</sub> Monitor<br><input type="checkbox"/> Agent Monitor<br><input checked="" type="checkbox"/> Pulse Oximeter<br><input type="checkbox"/> Capnograph<br><input type="checkbox"/> Ventilator<br><input type="checkbox"/> Nerve Stimulator<br><br><b>Position:</b> supine<br><input checked="" type="checkbox"/> Pressure Points Checked                                        | <b>Temp:</b><br><input type="checkbox"/> HME <input type="checkbox"/> Fluid Warmer<br><input type="checkbox"/> Cling Film <input type="checkbox"/> OH Warmer<br><input type="checkbox"/> Hugger's <input type="checkbox"/> Cotton Wool<br><input type="checkbox"/> Other:<br><br><b>Times:</b><br>Anaes Start: 12:15 PM<br>OP Start: 1:15 PM<br>OP End: 1:35 PM<br>Leave OR: 1:35 PM<br><br><b>Anaesthesia:</b><br><input type="checkbox"/> GA<br><input type="checkbox"/> Monitored Anaesthesia Care<br><input checked="" type="checkbox"/> Regional<br><br><b>Line (Size &amp; Location)</b><br><input type="checkbox"/> CVP:<br><input type="checkbox"/> ART:<br><input checked="" type="checkbox"/> IV: @ forearm<br><input type="checkbox"/> IV:<br><input type="checkbox"/> IV: | <b>Induction</b><br><input type="checkbox"/> IV <input type="checkbox"/> Inhal<br><input type="checkbox"/> Pre O <sub>2</sub> <input type="checkbox"/> RSI<br><input type="checkbox"/> Others:<br><br><input type="checkbox"/> Mask <input type="checkbox"/> SGA<br><input type="checkbox"/> Airway <input type="checkbox"/> Oral <input type="checkbox"/> Nasal<br>ETT# _____ at _____ cm<br><input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Cuff<br><input type="checkbox"/> Tracheostomy <input type="checkbox"/> Topical<br><input type="checkbox"/> Drug:<br><br><input type="checkbox"/> Awake <input type="checkbox"/> Direct Vision<br><input type="checkbox"/> Video Laryngoscopy <input type="checkbox"/> Stylette / Bougie<br><input type="checkbox"/> Fiberoptic<br>Blade # _____ Attempts: _____<br>Difficulty Why? _____ |
| <b>Regional:</b><br><input checked="" type="checkbox"/> Spinal    Specify: _____<br><input type="checkbox"/> Epidural <input type="checkbox"/> Caudal<br>Others: _____<br>Position: _____<br><b>Site:</b> right thigh<br>Needle Size: 25    Depth: _____<br>Parasthesia <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>Catheter at skin _____ cm<br>Drug Name & Conc: 0.5% Bupivacaine<br>Bolus: 2ml + 10ml infusion<br>Infusion: _____<br>Block Level: T4-T5<br>Comments: _____<br><br><b>Transportation to</b><br><input type="checkbox"/> PACU <input type="checkbox"/> ICU <input type="checkbox"/> Other<br>Relaxant Reversed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA<br>Name of the Doctor: DR. K. Sri Ramya<br>Signature of the Doctor: _____ |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

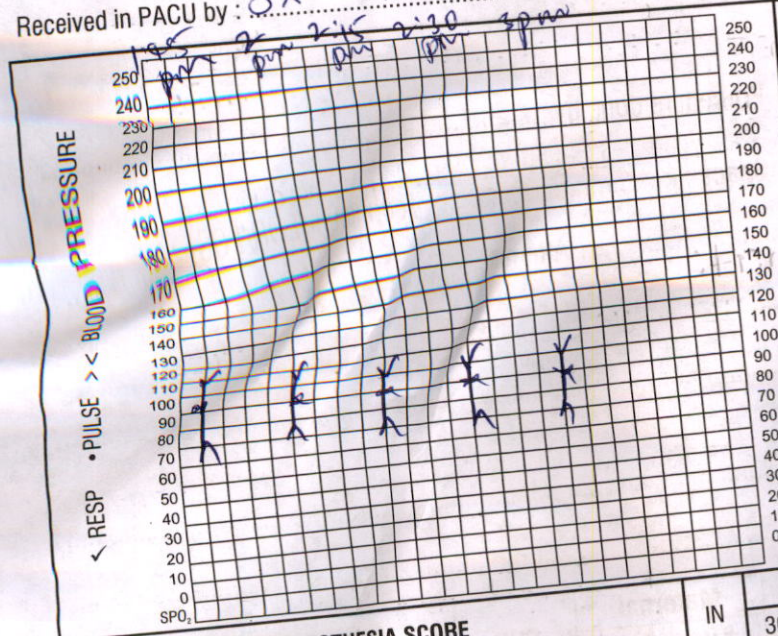


POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: Dr. Kerdher

Time Received: 1:45pm

Time Discharged: .....



IV Cannula Site: lt side

☐ O<sub>2</sub> Mask ☐ Nasal Prongs  
☐ Tracheostomy ☐ T-Piece  
☐ Oral Airway ☐ Nasal Airway

Vomiting: ☐ Yes ☒ No  
NG Tube: ☐ Yes ☒ No  
Drain: ☐ Yes ☒ No  
Urinary Catheter: ☐ Yes ☒ No  
Chest Tube: ☐ Yes ☒ No  
Nil Oral: ☒ Yes ☐ No  
IV Fluids: .....  
Oral Feeds: .....

POST ANAESTHESIA SCORE  
(Modified Aldrete Score)

|                                                    | IN | 30 | 60 | 90 | OUT |
|----------------------------------------------------|----|----|----|----|-----|
| Able to move 4 extremities voluntary or on command | 1  | 2  | 2  | 2  | 2   |
| Able to move 2 extremities voluntary or on command | 2  | 2  | 2  | 2  | 2   |
| Able to move 0 extremities voluntary or on command | 2  | 2  | 2  | 2  | 2   |
| Able to deep breathe & cough freely                | 2  | 2  | 2  | 2  | 2   |
| Dyspnea or limited breathing                       | 2  | 2  | 2  | 2  | 2   |
| Apneic                                             | 2  | 2  | 2  | 2  | 2   |
| BP $\pm$ 20 of Pre Anaesthetic level               | 2  | 2  | 2  | 2  | 2   |
| BP $\pm$ 20-50 of Pre Anaesthetic level            | 2  | 2  | 2  | 2  | 2   |
| BP $\pm$ 50 of Pre Anaesthetic level               | 2  | 2  | 2  | 2  | 2   |
| Fully awake                                        | 2  | 2  | 2  | 2  | 2   |
| Arousable on calling                               | 2  | 2  | 2  | 2  | 2   |
| Not responding                                     | 2  | 2  | 2  | 2  | 2   |
| Pink                                               | 2  | 2  | 2  | 2  | 2   |
| Pale, dusky, blotchy, jaundiced, other             | 2  | 2  | 2  | 2  | 2   |
| Cyanotic                                           | 2  | 2  | 2  | 2  | 2   |
| TOTAL                                              | 9  | 10 | 10 | 10 | 10  |

SCORING INTERPRETATION

A Minimum Total Score of 8 is Required for Discharge

Exceptions to this, are to be explained in the space below by the Discharging Physician:

PAIN ASSESSMENT AND MANAGEMENT FORM

| Date | Time | Pain Score | Intervention | Signature |
|------|------|------------|--------------|-----------|
| 10/7 | 4pm  | 0/10       | na           | RKp       |
|      |      |            |              |           |
|      |      |            |              |           |
|      |      |            |              |           |

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

Anaesthesiologist Name: Dr. Kerdher  
Anaesthesiologist Signature: [Signature]  
Date & Time: 10/7/2006  
PACU Nurse Name: [Signature]  
PACU Nurse Signature: [Signature]

- 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): .....  
Date & Time: .....



## Department of Anaesthesiology

CSE /Spinal /Epidural

Parasthesia : Yes/No if yes details :

Any other issues :

b)

### Time

Catheter Removed by and Tip Inspected :

APGAR:

SVD / Instrumental / LSCS (if LSCS Details)

Doctor Signature: \_\_\_\_\_

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

Date and Time : .....



# SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Sankarale  
 Asst. Surgeon : Dr. Marathe  
 Anaesthetist : Dr. Anitha  
 Scrub Nurse : Sh. Laxmi

Mrs J SWARNA SREE  
 05-01-1990 36 Y 6 M 5 D (F)  
 Dr. S ALA KOLA

Patient Name : .....

UHID No. : .....

Date : ..... In-time : ..... Out-time : .....

ender : .....

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## Before Induction of Anaesthesia >>

## Before Skin Incision >>

## Before Patient Leaves Operating Room

| SIGN IN                                                                  |                                                                                                 | Time: <u>12pm</u> |
|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------|
| <b>Patient Has Confirmed</b>                                             |                                                                                                 |                   |
| Identity                                                                 | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                   |
| Site                                                                     | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                             |                   |
| Procedure                                                                | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                   |
| Consent                                                                  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                   |
| <b>Site Marked</b>                                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA |                   |
| <b>Anaesthesia Safety Check Completed</b>                                | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                   |
| <b>Pulse Oximeter on Patient &amp; Functioning</b>                       | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                   |
| <b>Does Patient have a:</b>                                              |                                                                                                 |                   |
| Known Allergy?                                                           | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                             |                   |
| <b>Difficult Airway / Aspiration Risk?</b>                               |                                                                                                 |                   |
| Yes, & Equipment / Assistance Available                                  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                   |
| <b>Risk of &gt; 500ml Blood Loss (7ml/kg In Children)?</b>               |                                                                                                 |                   |
| Yes, and Adequate Intravenous Access and Fluids Planned                  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                   |
| Blood Units Reserved                                                     | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA |                   |
| <b>Has Antibiotic Prophylaxis been given within the last 60 minutes?</b> |                                                                                                 |                   |
|                                                                          | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                   |
| Signature : <u>[Signature]</u>                                           |                                                                                                 |                   |
| Name : <u>Dr. Sumanth</u>                                                |                                                                                                 |                   |

| TIME OUT                                                                                                                                        |                                                                     | Time: <u>12:10pm</u> |
|-------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------|
| <b>Confirm all team members have introduced themselves by Name and Role</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                                     |                      |
| <b>Surgeon, Anaesthesia Professional and Nurse Verbally Confirm</b>                                                                             |                                                                     |                      |
| Correct Patient (Check ID Band)                                                                                                                 | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                      |
| Correct Site                                                                                                                                    | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                      |
| Correct Procedure                                                                                                                               | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                      |
| <b>Anticipated Critical Events</b>                                                                                                              |                                                                     |                      |
| <b>Surgeon Reviews:</b>                                                                                                                         |                                                                     |                      |
| What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? <u>1 hour 200-300ml</u>                                  |                                                                     |                      |
| <b>Anaesthesia Team Reviews:</b>                                                                                                                |                                                                     |                      |
| Are There Any Patient-specific Concerns? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA        |                                                                     |                      |
| <b>Nursing Team Reviews:</b>                                                                                                                    |                                                                     |                      |
| Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? <u>no issues</u>                        |                                                                     |                      |
| <b>Is Essential Imaging Displayed?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA                     |                                                                     |                      |
| Power Supply, Earthing, Power Backup and functioning of equipment checked. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |                                                                     |                      |
| Signature : <u>[Signature]</u>                                                                                                                  |                                                                     |                      |
| Name : <u>Shaf</u>                                                                                                                              |                                                                     |                      |

| SIGN OUT                                                                                                                                   |                                                                                                 | Time: <u>1:pm</u> |
|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------|
| <b>Nurse Verbally Confirms with the Team:</b>                                                                                              |                                                                                                 |                   |
| The Name of the Procedure Recorded                                                                                                         | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                   |
| That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)                                                                  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                   |
| The Specimen is Labelled (including patient name)                                                                                          | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA |                   |
| Whether there are any Equipment Problems to be addressed                                                                                   | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA |                   |
| <b>To Surgeon, Anaesthetist and Nurse:</b>                                                                                                 |                                                                                                 |                   |
| What are the key concerns for recovery and management of this patient? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                 |                   |
| Signature : <u>[Signature]</u>                                                                                                             |                                                                                                 |                   |
| Name : <u>Dr. Praveen</u>                                                                                                                  |                                                                                                 |                   |



# SURGICAL SAFETY CHECKLIST

Surgeon : .....  
Asst. Surgeon : .....  
Anaesthetist : .....  
Scrub Nurse : .....

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

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## Before Induction of Anaesthesia ➤ ➤

## Before Skin Incision ➤ ➤

## Before Patient Leaves Operating Room

| SIGN IN                                                                  |                                                                                      | Time:..... |
|--------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------|
| <b>Patient Has Confirmed</b>                                             |                                                                                      |            |
| Identity                                                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No                             |            |
| Site                                                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No                             |            |
| Procedure                                                                | <input type="checkbox"/> Yes <input type="checkbox"/> No                             |            |
| Consent                                                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No                             |            |
| <b>Site Marked</b>                                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |            |
| <b>Anaesthesia Safety Check Completed</b>                                | <input type="checkbox"/> Yes <input type="checkbox"/> No                             |            |
| <b>Pulse Oximeter on Patient &amp; Functioning</b>                       | <input type="checkbox"/> Yes <input type="checkbox"/> No                             |            |
| <b>Does Patient have a:</b>                                              |                                                                                      |            |
| Known Allergy?                                                           | <input type="checkbox"/> Yes <input type="checkbox"/> No                             |            |
| <b>Difficult Airway / Aspiration Risk?</b>                               |                                                                                      |            |
| Yes, & Equipment / Assistance Available                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No                             |            |
| <b>Risk of &gt; 500ml Blood Loss (7ml/kg In Children)?</b>               |                                                                                      |            |
| Yes, and Adequate Intravenous Access and Fluids Planned                  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |            |
| Blood Units Reserved                                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |            |
| <b>Has Antibiotic Prophylaxis been given within the last 60 minutes?</b> |                                                                                      |            |
|                                                                          | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |            |
| Signature : .....                                                        |                                                                                      |            |
| Name : .....                                                             |                                                                                      |            |

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

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





## CAESAREAN SECTION OPERATIVE NOTES

|                                        |                                                                          |
|----------------------------------------|--------------------------------------------------------------------------|
| Surgeon's Name: <u>Dr. Sasikala</u>    | Date of Delivery: <u>10/7/20</u>                                         |
| Assistant Surgeon: <u>Dr. Maitri</u>   | Time of Delivery: <u>12:35 pm.</u>                                       |
| Anaesthetist's Name: <u>Dr. Ranmya</u> | Gender of Baby: <u>Male</u>                                              |
| Type of Anaesthesia: <u>LSA</u>        | Weight of Baby: <u>3.096</u>                                             |
| Neonatologist:                         | AGPAR Score:                                                             |
| Scrub Nurse: <u>Laxmi</u>              | NICU Admission: <input type="checkbox"/> Yes <input type="checkbox"/> No |

Pre-Operative Diagnosis: Primigravida @ 37<sup>th</sup> wks @ FGR @ Delivery

☒ Elective ☐ Emergency Indication: FGR @ Maternal request

Urgency

☐ Immediate Threat to life of woman or fetus

☐ Maternal or fetal compromise not immediately life threatening

☒ No maternal or fetal compromise but needs early delivery

☐ Delivery timed to suit woman and staff

Decision time: ..... Knife to rectus: 2 min.

CTG Description: .....

If there was a delay give the reasons: .....

Surgical Procedure: Elective Lower segment caesarean section + hysterectomy done.

Post Operative Diagnosis: POD-0 / P.L.L.

Peri-Operative Complications: Small fibroid 2x2cm in the Right meso  
Salpinx -  
Corneal implantation of placenta.

- Manual Removal of placenta.

- Small hematoma at Right angle, hemostatic suture applied

Amount of Blood Loss: 700ml Blood Transfused (in ML): -

Name and Number of Surgical Specimen sent for examination:

-



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: ☒ Pfannenstiel ☐ Transverse ☐ Midline ☐ Other .....

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

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

Incision Through Placenta: ☐ Yes ☒ No

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: ..... *normal.* ..... Cavity explored ☒ Yes ☐ No

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

|                                    |                                                  |                                                |                                               |                                                                     |
|------------------------------------|--------------------------------------------------|------------------------------------------------|-----------------------------------------------|---------------------------------------------------------------------|
| Uterine Closure:                   | <input type="checkbox"/> One Layer               | <input checked="" type="checkbox"/> Two Layers | .....                                         | Suture                                                              |
| Peritoneal Closure:                | <input type="checkbox"/> Pelvic                  | <input checked="" type="checkbox"/> Abdominal  | <input type="checkbox"/> None                 | .....                                                               |
| Sheath Closure:                    |                                                  |                                                |                                               | .....                                                               |
| Fat Closure:                       | <input checked="" type="checkbox"/> Yes          | <input type="checkbox"/> No                    | .....                                         |                                                                     |
| Skin Closure:                      | <input checked="" type="checkbox"/> Subcuticular | <input type="checkbox"/> Mattress              | .....                                         |                                                                     |
| Vaginal Evacuated                  | <input checked="" type="checkbox"/> Yes          | <input type="checkbox"/> No                    | .....                                         |                                                                     |
| Drain:                             | <input type="checkbox"/> Yes                     | <input checked="" type="checkbox"/> No         | <input type="checkbox"/> Remove in ..... days | <input type="checkbox"/> Await instructions                         |
| Catheter                           | <input checked="" type="checkbox"/> Yes          | <input type="checkbox"/> No                    | <input type="checkbox"/> Remove in ..... days | <input type="checkbox"/> Await instructions                         |
| Swap & Instruments count correct?  | <input checked="" type="checkbox"/> Yes          | <input type="checkbox"/> No                    | <input type="checkbox"/> Post-op Antibiotics  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| Intra-Operative Antibiotics Cover: | <input checked="" type="checkbox"/> Yes          | <input type="checkbox"/> No                    | <input type="checkbox"/> Thromboprophylaxis   | <input type="checkbox"/> Yes <input type="checkbox"/> No            |

Post-Operative Notes:

- \* NBM for 4-6 hrs
- \* Flv fluids - 100ml/hr
- Dmg as charted
- I/O charting
- w/f. Plv Bleeding
- Ambulation
- Monitor vitals - 1x every 2 hrs

Doctor Name: Dr. Sravanthi

Doctor Signature: \_\_\_\_\_

Date & Time: 10/7/2026, 5pm



KUH-00177234 IP5-00176155  
Mrs J SWARNA SREE  
05-01-1990 36 Y 6 M 5 D (F)  
Dr. SASIKALA KOLA



## POST-SURGICAL CARE PLAN FORM

Procedure Done: Elective. lower segment cesarean section #

Post-Surgical Diagnosis: POD-0

Post-Operative Monitoring Parameters /Frequency:

→ Monitor vitals  $\frac{1}{2}$  hourly x 2 hrs

Wound Care:

→ w/lt flw bleeding

Drain /Special Lines/Catheters:

→ Foley x 24 hrs

Special Patient Positioning and Requirements:

→ can move side to side in bed

Nutritional Instructions:

→ NBM for 4-6 hrs

When to Start Mobilization:

→ walk after removal of foley

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. Sasikala Kola  
Treating Surgeon  
(Signature & Stamp)

Date: 10/8/2018 Time: 5pm

Note: Plan of care will be readjusted if necessary.





## RISK ASSESSMENT TOOL FOR DEEP VEIN THROMBOSIS

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

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

Signature of the Doctor: Qui Date: 10/2/2020 Time: 5 PM

Action Plan: Thromboprophylaxis x 10 days

### Risk Assessment Tool for Deep Vein Thrombosis

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



Patient Sticker

KUH-00177234 IP5-00176155  
 Mrs J SWARNA SREE  
 05-01-1990 36 Y 6 M 5 D (F)  
 Dr. SASIKALA KOLA



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## BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 10/7/26

Department : OBG TO Duration of Procedure : .....

Name of Surgeon : Dr. Sasikala Date of Admission : 10/7/26

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

|    |                                                                                                                                                                                                                                                                                                                                                                                                           | Staff Signature |
|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|
| 1. | Antibiotic given prior to surgery ? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br><input checked="" type="checkbox"/> Single Dose Antibiotic or Long Antibiotic Regime<br>Antibiotic administered within 60 minutes prior to incision ? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>Name of the Antibiotic : Inf-Taxime                               | Sandey          |
| 2. | Hair Removal <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No if Yes : Surgical Clipper<br>Department where Hair Removed : <input checked="" type="checkbox"/> Ward <input type="checkbox"/> Operating Room<br><input type="checkbox"/> Other : .....<br>Skin preparation done (cleanse surgical area with antiseptic agent)? <input type="checkbox"/> Yes <input type="checkbox"/> No | Sandey          |
| 3. | Patient's body temperature immediately post operation (Recovery Room) 98.6 °C<br><input type="checkbox"/> Oral Or <input checked="" type="checkbox"/> Axilla (Goal : 36-37 °C)                                                                                                                                                                                                                            | Sandey          |
| 4. | Name of doctor or staff administering the antibiotic : Dr. Sandey<br>Date & Time of antibiotic administration : 10/7/26 @ 3p.m.<br>Date & Time procedure started : 10/7/26 @ 3.10pm                                                                                                                                                                                                                       | Sandey          |

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

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





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# UNITED STATES DEPARTMENT OF AGRICULTURE

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# PATIENT TRANSFER FORM

|                                                                                                                                                                                                                    |                                                                                                                                                                        |                                                                                                                      |                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| Patient Name & UHID No.<br>KUH-00177234 IP5-00176155<br>Mrs J SWARNA SREE<br>05-01-1990 36 Y 6 M 5 D (F)<br>Dr. SASIKALA KOLA<br> |                                                                                                                                                                        | Date & Time of Admission<br>10/7/20 9AM                                                                              | Date & Time of Transfer Order<br>10/7/20 3:45PM |
|                                                                                                                                                                                                                    |                                                                                                                                                                        | Transfer Ordered by<br>Dr. Sasikala                                                                                  | Reason for Transfer<br>Observation              |
| From Unit<br>OBG OT                                                                                                                                                                                                | To Unit<br>OBG                                                                                                                                                         | Information to Attendant<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                      |                                                 |
| Number of Sheets in Clinical File<br>3                                                                                                                                                                             | Personal belongings including clinical documents. If any handed over to attendant<br>Yes <input type="checkbox"/> / No <input type="checkbox"/><br>If Yes, what? ..... | Patient shifted with ID band:<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/><br>If No: ..... |                                                 |
| Number of Imaging Films<br>2                                                                                                                                                                                       |                                                                                                                                                                        |                                                                                                                      |                                                 |
| Medications / Consumables / Surgicals / Hand over                                                                                                                                                                  |                                                                                                                                                                        |                                                                                                                      |                                                 |
| Sl.No.                                                                                                                                                                                                             | Item Name                                                                                                                                                              | Quantity                                                                                                             |                                                 |
| 1.                                                                                                                                                                                                                 |                                                                                                                                                                        |                                                                                                                      |                                                 |
| 2.                                                                                                                                                                                                                 |                                                                                                                                                                        |                                                                                                                      |                                                 |
| 3.                                                                                                                                                                                                                 |                                                                                                                                                                        |                                                                                                                      |                                                 |
| 4.                                                                                                                                                                                                                 |                                                                                                                                                                        |                                                                                                                      |                                                 |
| 5.                                                                                                                                                                                                                 |                                                                                                                                                                        |                                                                                                                      |                                                 |
| Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                                                   |                                                                                                                                                                        |                                                                                                                      |                                                 |
| Name & Signature of Person who is Transferring<br>Sangeetha                                                                                                                                                        |                                                                                                                                                                        | Name of Person Ordered Transfer<br>Dr. Sasikala                                                                      |                                                 |
| Patient & Clinical Records Received by: <i>[Signature]</i><br>10/7/20                                                                                                                                              |                                                                                                                                                                        |                                                                                                                      |                                                 |
| 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



# PATIENT TRANSFER FORM

|                                                                                                                                                                                                                                   |                                                                                                                                                                                 |                                                                                                                      |                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| Patient Name & UHID No.<br><br>KUJH-00177234      IP5-00176155<br>Mrs J SWARNA SREE<br>05-01-1990      36 Y 6 M 5 D (F)<br>Dr. SASIKALA KOLA<br> |                                                                                                                                                                                 | Date & Time of Admission<br><br>07/7/26 P 2:19PM                                                                     | Date & Time of Transfer Order<br><br>10/7/26 |
|                                                                                                                                                                                                                                   |                                                                                                                                                                                 | Transfer Ordered by<br><br>DR.                                                                                       | Reason for Transfer<br><br>observation       |
| From Unit<br><br>301                                                                                                                                                                                                              | To Unit<br><br>OB U                                                                                                                                                             | Information to Attendant<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                      |                                              |
| Number of Sheets in Clinical File<br><br>26                                                                                                                                                                                       | Personal belongings including clinical documents. If any handed over to attendant<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/><br>If Yes, what? ..... | Patient shifted with ID band:<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/><br>If No: ..... |                                              |
| Number of Imaging Films<br><br>2                                                                                                                                                                                                  |                                                                                                                                                                                 |                                                                                                                      |                                              |
| Medications / Consumables / Surgicals / Hand over                                                                                                                                                                                 |                                                                                                                                                                                 |                                                                                                                      |                                              |
| Sl.No.                                                                                                                                                                                                                            | Item Name                                                                                                                                                                       | Quantity                                                                                                             |                                              |
| 1.                                                                                                                                                                                                                                |                                                                                                                                                                                 |                                                                                                                      |                                              |
| 2.                                                                                                                                                                                                                                |                                                                                                                                                                                 |                                                                                                                      |                                              |
| 3.                                                                                                                                                                                                                                |                                                                                                                                                                                 |                                                                                                                      |                                              |
| 4.                                                                                                                                                                                                                                |                                                                                                                                                                                 |                                                                                                                      |                                              |
| 5.                                                                                                                                                                                                                                |                                                                                                                                                                                 |                                                                                                                      |                                              |
| Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                             |                                                                                                                                                                                 |                                                                                                                      |                                              |
| Name & Signature of Person who is Transferring                                                                                                                                                                                    |                                                                                                                                                                                 | Name of Person Ordered Transfer                                                                                      |                                              |
| 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 re