



ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____

Date of Admission : _____

Room / Bed No : _____

IP5-00175775
BAH-00517966
Mrs NITYA BANSAL
29 Y 0 M 10 D (F)
20-06-1997
Dr. SHRUTHI REDDY/Dr. LAVANYA

Attendant : _____ Dept : _____

Time of Discharge : _____ Time : _____

Ward : _____ Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Shreya (Consultant)	1/7/26	09683542	[Signature]
2	NHA	1/7	9685925	[Signature]
3	Dr. Brundawani	1/7	9684042	[Signature]
4	Dr. Tuheena	3/7	9685926	[Signature]
5				
6				
7				
8				
9				
10				

[illegible][illegible]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
30/6	IV Placent	1	9681402	Freno
30/6	PAC	1	9681401	Freno
1/7	catheterization	1	09682038	Lusale

ANY OTHER INFORMATION

.....

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.....

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.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

ADMISSION SHEET


Registration Details :

Admission No : IP5-00175775 Admit Date : 30-Jun-2026 Admit Time : 02:41 PM UHID : BAH-00517966

Patient Details :

Patient Name	: Mrs NITYA BANSAL	Age	: 29 Y 0 M 10 D
Guardian	: Mr SHREYANS	DOB	: 20-06-1997
Gender	: Female	Religion	:
Occupation	:	Marital Status	: Married
Address (H)	: ~ Banjara Hills Hyderabad Telangana INDIA 500034	Phone No	: 9642733602
		E-mail	: NITYAGEMINI@GMAIL.COM

Admission Details :

Bed Type : PRESIDENTIAL SUITE Bed No : PRESIDENTIAL SUITE 2 (423) Ward Name : 4F-BIRTHRIGHT PREMIUM
Room No : PRESIDENTIAL SUITE 2 (423) Admission Type : First Visit

Contact Details :

Name : Mr SHREYANS Relationship : Husband
Contact Address : ~ Banjara Hills Hyderabad Telangana INDIA 500034 Phone No : / 9642733602


Signature
Doctor Details :

Doctor Name : Dr. SHRUTHI REDDY/Dr.LAVANYA JANAGAMA Specialisation : OBSTETRICS AND GYNECOLOGY
Referral Doctor : Self Phone No :
Co-Consultant :

Payment Details :

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

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IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

for IOL

Obstetric Formula:

Primigravida

Obstetric History:

Present Pregnancy Record:

Primigravida - spontaneous conception

RISK FACTORS:

- Booked @ 6 weeks

- Gestational Hypothyroid

LMP: 10-10-25

EDD:

Corrected EDD: 17-7-26

GA: 37^W 4

Menstrual History: Regular: ☒ Yes ☐ No

Obstetric Examination

Fundal Height: Term

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

Liquor: ☒ Adequate ☐ Oligo ☐ Poly

PP: ☒ Cephalic ☐ Breech Others _____

Head Fifts Palpable: _____

FHS: ☒ Normal ☐ Tachy ☐ Brady ☐ Absent

Per Speculum Examination

not done

Draining: ☐ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination

1 finger

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: 152 cm

Weight: 68.2 kg

Allergies: NICKA

Breast: ☒ Normal ☐ Abnormal

General Examination: fair

Consciousness: yes Pallor: absent

Icterus: absent Edema: absent

Temp: apyrexia PR: Normal

BP: DTR: Normal

CVS: S1S2 RS BLNVS

Liver/Spleen: not palpable Urine Output: normal, 300 ml

DIAGNOSIS

Primigravida / 37^W 4 / Gestational hypothyroid

for IOL

BAH-00517966

IP5-00175775

Mrs NITYA BANSAL

20-06-1997

29 Y 0 M 10 D

(F)

Dr. SHRUTHI REDDY/Dr. LAVANYA



Family History: Mother - Hypothyroid	Surgical History: Nic/
Medical History: Nic/	Medication History: Nic Medical reconciliation form.
Plan of Care: - Admission - NST now + bloodwork - Send CBP & trace - w/ vitals qnhly - consents $\begin{cases} \text{LOL} \\ \text{vaginal birth} \end{cases}$ to be taken - w/ LOL & fetal's & M25 qnhly - w/ progression of labour - Early epidural sitting	Investigations: - B positive $\frac{26/12/26}{\text{CBP-10.4/12/490/2.1aL.}}$ - urab - NR. $\frac{26/12/26}{\text{37wks, cephalic, 3373gms}}$ 80%. AC 97%. - AFI 9.9cm, placenta posterior high, (N) doppler. - TFFA - (N) - NT scan - (N), - FTS low risk

Doctor Name: Dr. Shreenu

Signature: [Signature]

Date & Time: 30/6/26 @ 3pm

Consultant Name: Dr. Shruthi Reddy

Signature: [Signature]

Date & Time:

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6/26		
4:20pm.	Pt comfortable O/E AC-fair PR - 89gms BP - 114/75mmHg common SPy - 99% / min P/A uterus Relaxed FHR ⊕	Adv - w/f POC - Trace CBP - LTC - 3rd hely - vitals okay - Inform h/s
	↓ aseptic precaution Foley's catheter inserted intra-uterine & bulb inflated 230cc distilled water	P/V - exiculated /unclearing soft, mumb ⊕ w- 25 talon
30/6/2026 6pm	Pt comfortable epidural sited Vitals stable P/A Relaxed NST on going Foleys P/V inserted	

Dr. Y. Suresh

BAH-00517966 IP5-00175775
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6/2026 9pm	PR: 98bmt BP: 12/77 (86) SpO ₂ : 100% P/A: Irritable Foley's Intitu NST Reactive Epidural sited	- soft diet - plenty of oral fluids - NST 3hly - vitals FHR hly - w/ POc - vent @ 1 AM (TPGE, D ₂ 25mg stat)
30/6/2026 11:30pm	C/o leaking PV P/A: Irritable P/V: Cu 50% Affected OS 2cm PPV _N - 2 memb (+) Sp. Expulsion of foley (+)	DR. Y. Suresh DR. Y. Suresh

17966 IP5-00175775
YA BANSAL
997 29 Y 0 M 10 D (F)
RUTHI REDDY/Dr.LAVANYA

PROGRESS NOTES AND DOCTOR'S ORDER

me	Progress Notes	Doctor's Order
17/2026 30/2026 4AM	Pt comfortable on Epidural Vitals stable.	Dr Y. Suresh
1/7/2026 6AM	P/A: mild Action P/V: Cu tffaced 80%. os 4cm PPVn -1 memb E SROM, clear Kate on Epidural	✓ NST now. ✓ OXYTOCIN @ 7AM Dr Y. Suresh
		Dr Y. Suresh 1/7/26 6:05AM

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Mrs NITYA BANSAL

20-06-1997

29 Y 0 M 11 D

(F)

Dr. SHRUTHI REDDY/Dr. LAVANYA



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>1/7/2016</u>	<u>Axon Anaesthesia Department</u>	
	o/b primigravida 137th w. / Gestational Hypertension ↳ on labour analgesia ↳ Epidural PC EA → Subarachnoid Relax Gal lockout ~20 min <u>Vitals</u> Called for itching around abdomen PR - 100 BP PP - 115/80 mmHg SpO₂ - 100% o/t WING - RAC @ day LVS - SLS @	
		<u>Advi</u> 1) INTRAVEN 2 & up stat 2) Monitor vital strictly 3) Subarachnoid
		Dr. Lavanya
		NB Susha 1/7/26 @ 6:10 AM

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/7/20 1pm	PR - 90/min BP - 125/80mm (92) SpO₂ - 98% @ RA P/A - ut (R) well P/A - ut (R) well	adv - (R) dul - vital 6th - Drug charted - w/ active bleeding - Remove Foley 5pm (1/7/20) - Informers
1/7/20 6pm	PR - 90/min BP - 125/80mm SpO₂ - 98% @ RA P/A - ut (R) well P/A - ut (R) well	adv - (R) dul - vital 6th - Drug charted - w/ active bleed - Informers

Date & Time	Progress Notes	Doctor's Order
2/9/20	<u>PND-1</u> 8AM Gutai akbroule PR - 86/min BP - 121/70 mmHg SpO2 - 98% @ RA P/A - ut (P) 6/4 P/A - norm	ad - (P) dub - vitals 5th hr - Onup an charte - w/ p. f. p. r. s. d. - 2mm (w) cord
		Dr. Ashy
		noted by Freeman
1/1/2026	<u>PND-1/P.14/SVD.</u> Comfortable Gutai/akbroule vitals - stable P/A - vitals improving well VRE - 10 chia & healthy	<u>Advice</u> ✓ Oral hydration ✓ Regular diet ✓ Monitor vitals ✓ Drugs as charted ✓ Ambulation ✓ Inform S/S
1:45 PM		by Mr. Deepika
by well		
Vv		
Pv		
Ln		



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/7/26 6:50pm	Pt comfortable	Adv - Regular diet, plenty of oral fluids
u x w	o/e ac: fair vital: stable P/A: uterine retracted well.	- drugs as per charted
Baby well	Yo lochia healthy	- vitals clinically - Ambulate - Inform of
		<i>[Signature]</i> Dr. Lavanya
3/7/2026 7:30 AM	Dr. PND Go - Diet Ac: fair vital: stable. P/A: uterine Retracted well. P/O: normal	NB Smaller 2/7/26 @ 7:30pm Adv ① Regular Diet. ② Uterine Monitoring. ③ W/Lt P/A: uterine. ④ Ambulate
	Baby well. - for Discharge	<i>[Signature]</i> Dr. Lavanya

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7/26. 1:00 PM	PND-2 PT is stable No c/o BP- 110/78(SI) PR- 80bpm SpO₂- 98% on PR PIA- ut well @/retracted He Bwana.	<u>Advice</u> ① Soft diet ② Hydrate & ambulate ③ Drugs as charted ④ Vitals 4th hly ⑤ W/p heavy bleeding ph ⑥ Fyerm 80s <u>Stable</u> <u>Noted by Nurse</u>
3/7/24 3pm	PND-2 PT is stable No c/o Vitals stable PIA- ut well retracted He- locked @	<u>Advice</u> ① Continue Same treatment <u>Stable</u> <u>Noted by Nurse</u>

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

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CROSS CONSULTATION FORM

Doctor Name : Shreya Proddutur Date : 1/7/2026 Time : 8pm

Diagnosis :

Hospital :

Type of Referral :

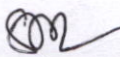
☐ Emergency

☐ Urgent

☐ Non Urgent

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

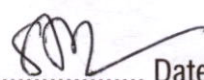
Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:


Signature:

Findings and Recommendations :

Breastfeeding amenment done.

Consultant :

Name : Shreya Signature :  Date & Time : 8pm 1/7



RESULT SHEET

Date	30-6					
Time	4.1 PM					
Hb	11.8					
PCV	35.7					
RBC	3.97					
WBC	12.33					
N/L						
Platelets	186					
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						

Culture and Sensitivities :

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.....

Radiology : USG :

X-Ray :

ECHO :

CT :

MRI

Others (ECG, Contrast Studies etc.) :



OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 30-6-26 Time of Arrival: 8:PM Time Seen by Nurse: 2:5PM

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: ToC

3) **Vital Signs:** Temperature: 98.6 Pulse: 80 RR: 17 SpO₂: 100% BP: 115/88 Weight: 68.2

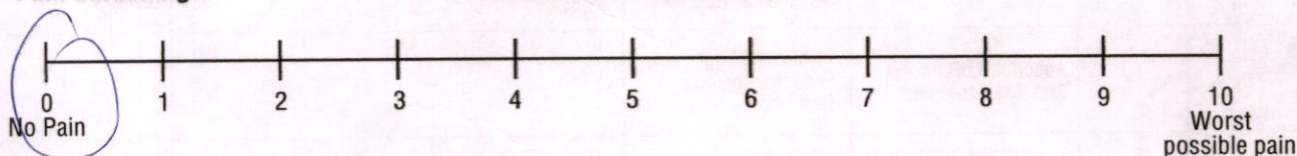
4) **Gestational Criteria:**

Gravida:	<u>G primi</u>	P	L	A
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LMP: 10-10-25 EDD: 17-7-26 Gestational Age: 37+4

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

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



- Location:
- Duration: Days / Weeks/ Months (Strike out which is not applicable)
- Character: NA
- Frequency: 1
- Interventions:

6) **Past History:**

- a) Surgeries: Ni U
b) Medical: Ni U



7) 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: ≤ 15 minutes & Reassessment: Every 15 minutes)
☐ **Category III:** Urgent (Time to Physician: ≤ 30 minutes & Reassessment: Every 15 minutes)
☐ **Category IV:** Less Urgent (Time to Physician: ≤ 60 minutes & Reassessment: Every 30 minutes)
☒ **Category V:** Non Urgent (Time to Physician: ≤ 120 minutes & Reassessment: Every 60 minutes)

OBCU Obstetrical Triage Acuity Scale (OTAS)

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

Time seen by Doctor: 2:40 PM

Nurse Name : Nurse Signature:

Date: 30-6-20 Time: 2:40 PM

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OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 30-6-26

Baseline Information:

Admission From: ☐ ER ☐ OPD ☒ Admission Desk ☐ Others, specify

Primary Language: ☒ Telugu ☒ English ☒ Hindi ☐ Others, specify

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

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

Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other:

If yes, identify

Chief Complaints: JOL Doctor Notified on Admission: ☐ Yes ☐ No

Name of the Doctor: Dr. Amena

Time Notified: 2:40 PM

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Nil	Nil	NA

Gynecology Assessment: ☐ Not Applicable	Gynecology Surgical History:	Gynecological History:
Menstrual History: <u>Regular</u>	Caesarean Section: ☐ No ☐ Yes	Contraceptives: ☒ No ☐ Yes
Onset of Menarche: <u>12y</u>	Cervical Cerclage: ☒ No ☐ Yes	Vaginal Discharge: ☒ No ☐ Yes
Menstrual Cycle: ☒ Regular ☐ Irregular	Ectopic Pregnancy: ☒ No ☐ Yes	Post-Coital Bleeding: ☒ No ☐ Yes
Last Menstrual Period: <u>25/6/26</u>	Myomectomy: ☐ No ☐ Yes	Infertility: ☐ No ☐ Yes
	Others: <u>Mother Hx Pathological</u>	If Yes Type: ☐ Primary ☒ Secondary

Obstetric History: G Prim P L A

Previous LSCS: Nil

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

Family History: ☐ No Abnormalities Detected
☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Stroke ☐ Seizures ☐ Kidney disease
☐ Liver disease ☐ Other: Mother Hx Pathological

Vital Signs / Measurements: Temp: 98.6 HR: 84 RR: 17
 BP: 115/68 Weight: 62.2 Height: 152 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 25 (complete the Morse Fall Risk Assessment Sheet)

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

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

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☒ No Abnormality Detected

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

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

Inform consultant for positive criteria

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

SOCIAL SCREENING:

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

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

Social History: Lives With husband

Orientation has been given regarding the following aspects:

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

Above information given to Patient

Name of Person Orientation was given to:

Orientation not given Reason:

Nurse Signature: P

Nurse Name: Preema

Date & Time: 30-6-2020 @ 2:40pm

Y PATIENT / FAMILY EDUCATION RECORD

Identified Education Needs : *Andi, English* Patient / Learner Literacy : ☐ Read ☒ Write ☒ Speak Willingness to Learn ☒ Yes ☐ No Healthcare Literacy ☒ Yes ☐ No

Identified Education Needs :

- | | | | |
|----------------------------|---|--|---|
| 1. Diagnosis | 5. Medication / Trerapy (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 Barries	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
30/6/26	3pm	1,2,3,4	Diagnosis. Treatment & care plan, Pain management, Informed consent	PT, S	1	0	1	1	-	<i>[Signature]</i>
30/6	3pm	7	Infection Control Measures	PT	1	0	1	1	-	<i>[Signature]</i>
27/7/26	9:30 am	9	Lactation diet	PT	1	0	1	1	-	<i>Saima</i>

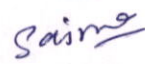
Part - III : CODES

Who was taught : PT : Patient F : Father M : Mother S : Spouse Sn : Son D : Daughter C : Caregiver O : Other (Specify).....							
Learning Barriers : 1. No Learning Barries 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 Barries 6. Desire / Motivate to Learn 9. Cultural Difference 12. Impaired Vision / or Hearing							
Teaching Tools Used : A : Audio D : Demonstration V : Video O : Oral P : Printed							
Mechanism/s to overcome barrier/s : 1. None 3. Reassurance & Support 5. Respect values & beliefs 7. Other, Specify..... 2. Obtain translator 4. Teach Family / others 6. Respect Cultural / Religion Preference							
Understanding : 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review							

MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis:

Primie / 37+4 wks / Gest. Hypothyroid for 10c

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
30/6/26 @ 3pm	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Primie / 37+4 wks / gest. Hypothyroid	for safe delivery	10c		☒ Nursing ☐ Others:
30/6 3pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Patient is having fear and anxiety related to 10c	to reduce anxiety	Psychological support so she can		☒ Medical ☐ Others:
2/7/26 9:30 am	☐ Medical ☐ Nursing ☒ Others: dietician	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	PND-1 SVD	Normal diet	Normal High protein diet		☐ Medical ☐ Nursing ☒ Others:
3/7/26 2:30pm	☐ Medical ☐ Nursing ☒ Others:	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	PND, SVD	post partum recovery	deep core & pelvic floor retraining		☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:



MEDICATION RECONCILIATION FORM

Drug Allergies: N/A ☒ Not known any Drug Allergies

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

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

Shifting From: NA Shifted to: NA

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Tab. THYRONORM	50mcg	PO	OD	30/6	☐ C ☒ DC
2	Tab. IRON	R	PO	OD	30/6	☐ C ☒ DC
3	Tab. CALCIUM		PO	OD	30/6	☐ C ☒ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Lameena

Date & Time: 30/6/26 @ 3pm

Nurse Name & Signature: Preema

Date & Time: 30-6-26 3pm

Weight 65 208 Ward 514

DRUG : TAB. THYRONORM				Date
Dose	Route	Frequency	Start Dt.	Time
5mg	PO	OD	2/7/26	7:30 AM
Name & Signature of the Doctor Starting the Drugs: By Ch. Pappas				2/7
				2/8
				2/9
Additional Instructions:				2/10
				2/11
				2/12
Daily Doctor's Endorsement by a Sign				2/13
				2/14
				2/15

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

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

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

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

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

VERIFIED BY : Name Signature



DRUG CHART

Date of Admission: 30/6/26 Drug Allergies: N/CDA ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name Signature



Weight. 68-204 Ward

Weight. 68-204 Ward

BFA

Page: 2/4



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
30/6/26	6 PM	1ij CEFOTAXIM	1gm	IV	[Signature]	Preena 6:05 PM
30/6/26	5 PM	Tab. PGE ₁	25mcg	PO	[Signature]	Preena 5:05 PM
30/6/26	9 PM	Tab PGE ₁	25mcg	PO	[Signature]	Swarna 9:02 PM
1/7/26	1 AM	T. PGE ₁	25mcg	PO	[Signature]	Swarna 1:03 AM
1/7/26	5 AM	T. PGE ₁	25mcg	PO	[Signature]	NOT GIVEN
1/7/26	6 AM	2ij CEFOTAXIM	1gm	IV	[Signature]	Swarna 6:10 AM
1/7/26	1 AM	Enema	100ml	PR	[Signature]	Swarna 2:05 PM
1/7/26	6 AM	INTAVIL	275	IV	[Signature]	Swarna 6:02 AM
1/7	10:40 AM	INT. GYTOCIN	100	IM	[Signature]	Preena 10:45 AM

1/7 10:50 AM TAB. MISOPROSTOL 400mcg PIR [Signature] Page: 3/4 (P.T.O) 10:55 AM

[illegible]

STAFF & ONCE ONLY GROUPS

STAFF & ONCE ONLY GROUPS

STAFF & ONCE ONLY GROUPS

STAFF & ONCE ONLY GROUPS

BAH-00517966

IP5-00175775

Mrs NITYA BANSAL

20-06-1997 29 Y 0 M 10 D (F)

Dr. SHRUTHI REDDY/Dr. LAVANYA



CHECKLIST FOR THROMBOPHLEBITIS

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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

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

Signature of Shift In Charge :

Signature : Name :

Signature of Ward In Charge :

Signature : Name :

CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
30/6	2:PM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Per
20/6	4 PM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Per
30/6	6 PM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Per
30/6	8 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Smaller
1/7	2 AM	3/10	Abdomen pain	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Epidural on going	Smaller
1/7	3 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Smaller
1/7	6 AM	1/10	Abdomen pain	☐ Continuous ☒ Intermittent	☒ Acute ☒ Chronic	☐ Sharp ☐ Dull ☒ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Epidural on going	Smaller
1/7	8 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Smaller
1/7	10 AM	1/10	Abdomen pain	☒ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Epidural Bolus	Per
1/7	10:30 PM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Per

Re-assessment Frequency:

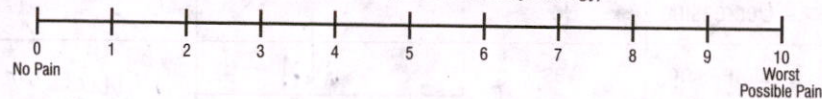
1. Every eight hours for all hospitalized patients.

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

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



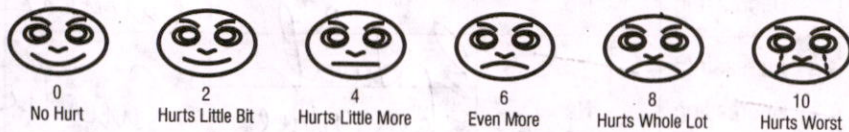
FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

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

Wong - Baker (Pediatrics) Above 7 Years





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
1/7	12:30 pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Pain
1/7	4pm	0/10	Severe pain site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Bucapron
1/7	8pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Bucapron
2/7	12am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Smile
2/7	8am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Smile
2/7	12PM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Pain
2/7	4pm	0	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Bucapron
2/7	8pm	0	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Bucapron
3/7	8AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Smile
3/7	12pm	0	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Pain

Re-assessment Frequency:

1. Every eight hours for all hospitalized patients.

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

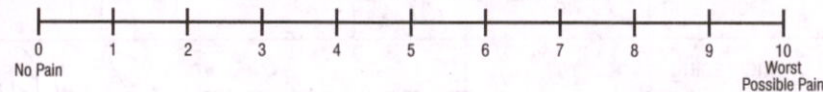
- At least every 2 hours for the first 24 hours
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- Prior to pain pain-relieving intervention.
- Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
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Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
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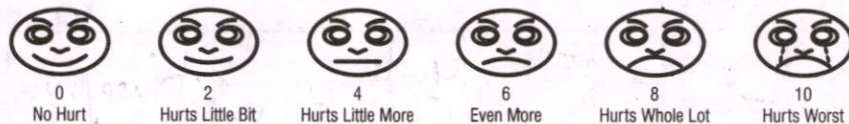
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Wong - Baker (Pediatrics) Above 7 Years



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
3/7/26	8pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	NA
3/7/26	9pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Smile
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

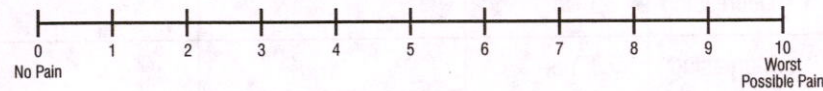
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- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
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PAIN ASSESSMENT TOOLS

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

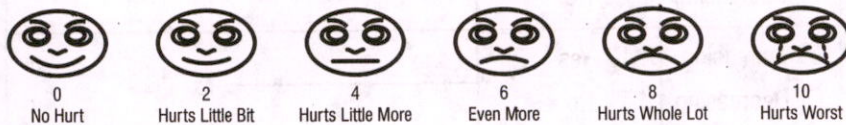
Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



PAIN ASSESSMENT FORM

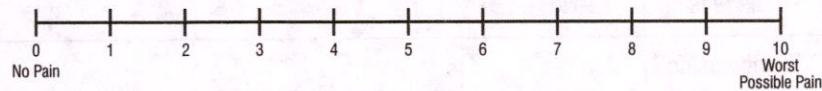
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

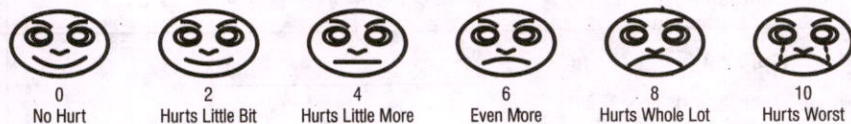
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 - a) At least every 2 hours for the first 24 hours
 - b) Then every 4 hours.
 - c) Prior to pain pain-relieving intervention.
 - d) Within 30 – 60 minutes after pain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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years



FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

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Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	30/6/24	30/6/26	1/7/26	Fall Risk Grading		
		Score		8pm				
History of Falling (immediately or w/in 3 months)	Yes	25				Risk Level	Morse Fall Score (MFS)	Action
	No	0						
Secondary Diagnosis (more than one diagnosis)	Yes	15	15	15	15	Low Risk	0 - 24	Standard Fall Precaution
	No	0						
Ambulatory Aid	Furniture	30				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0						
IV / Heparin Lock or Saline	Yes	20	20	20	20	High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0						
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0						
Total Morse Fall Scale Score:			35	35	35			
Signature			han	Shruthi	Pr.			

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

BAH-005179 IP5-00175775
Mrs NITYA BAL
20-06-1997 29 Y 0 M 11 D (F)
Dr. SHRUTHI DY/Dr. LAVANYA



Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	Fall Risk Grading		
		Score			
History of Falling (immediately or w/in 3 months)	Yes	25	2/2/26	1/7/26	2/2/26
	No	0	4pm-5pm	8pm	4pm-5pm
Secondary Diagnosis (more than one diagnosis)	Yes	15	15	15	15
	No	0			
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0			
IV / Heparin Lock or Saline	Yes	20	20	20	20
	No	0			0
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0			
Mental Status	Forgets limitations	15			
	Oriented to own ability	0		0	0
Total Morse Fall Scale Score:			35	35	35
Signature			Raeesha	Smilee	Raeesha

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	2/7/26 8:00 AM	3/2 8:00 AM	3/2/26 8:00 AM	Fall Risk Grading		
		Score				Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25				Low Risk	0 - 24	Standard Fall Precaution
	No	0	0	0	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0	0	0	0			
Ambulatory Aid	Furniture	30				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0	0	0			
IV / Heparin Lock or Saline	Yes	20				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0	0	0	0			
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0	0					
Total Morse Fall Scale Score:			0	0	0			
Signature			Smilee R	Smilee R	Smilee R			

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

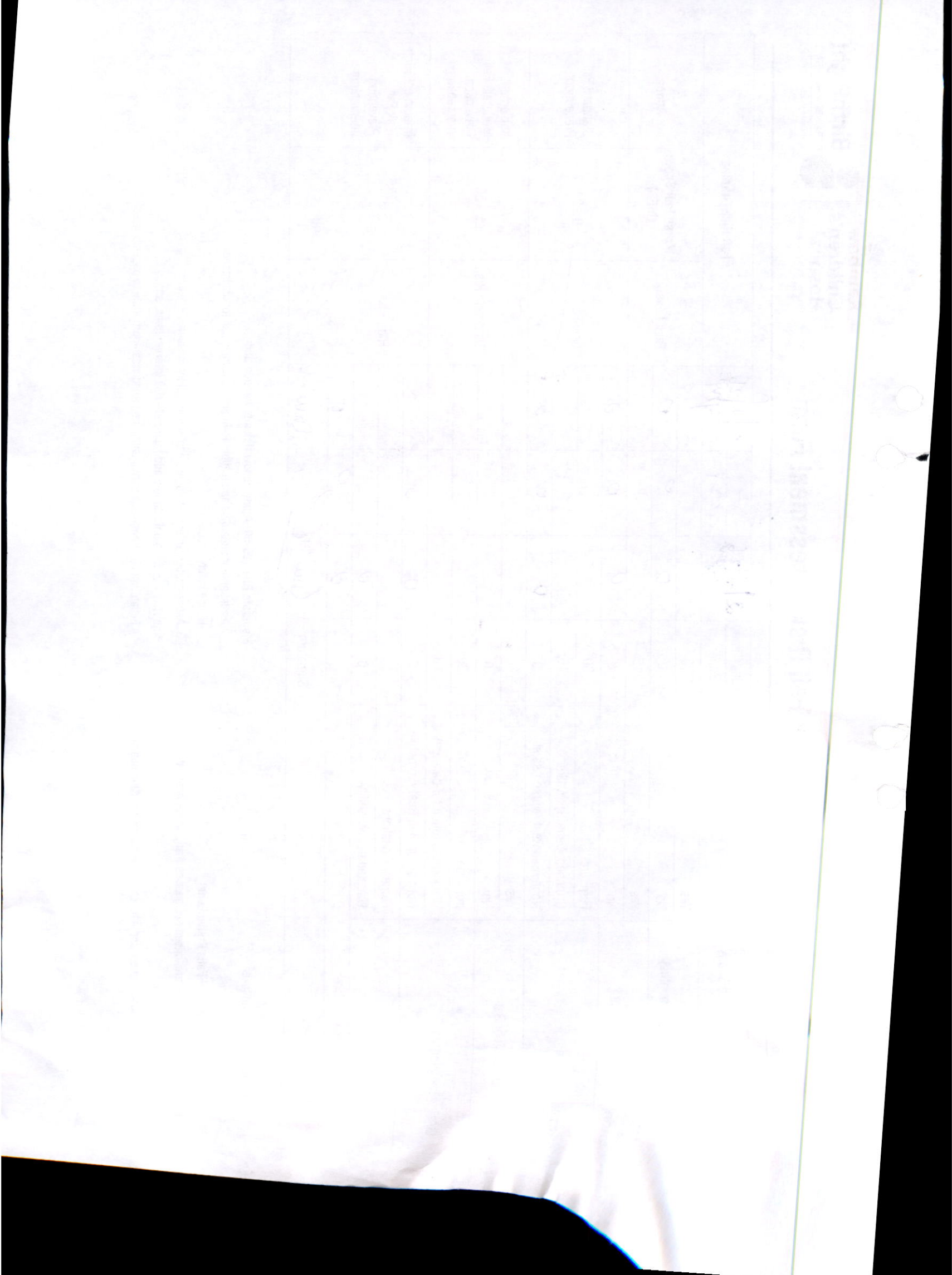
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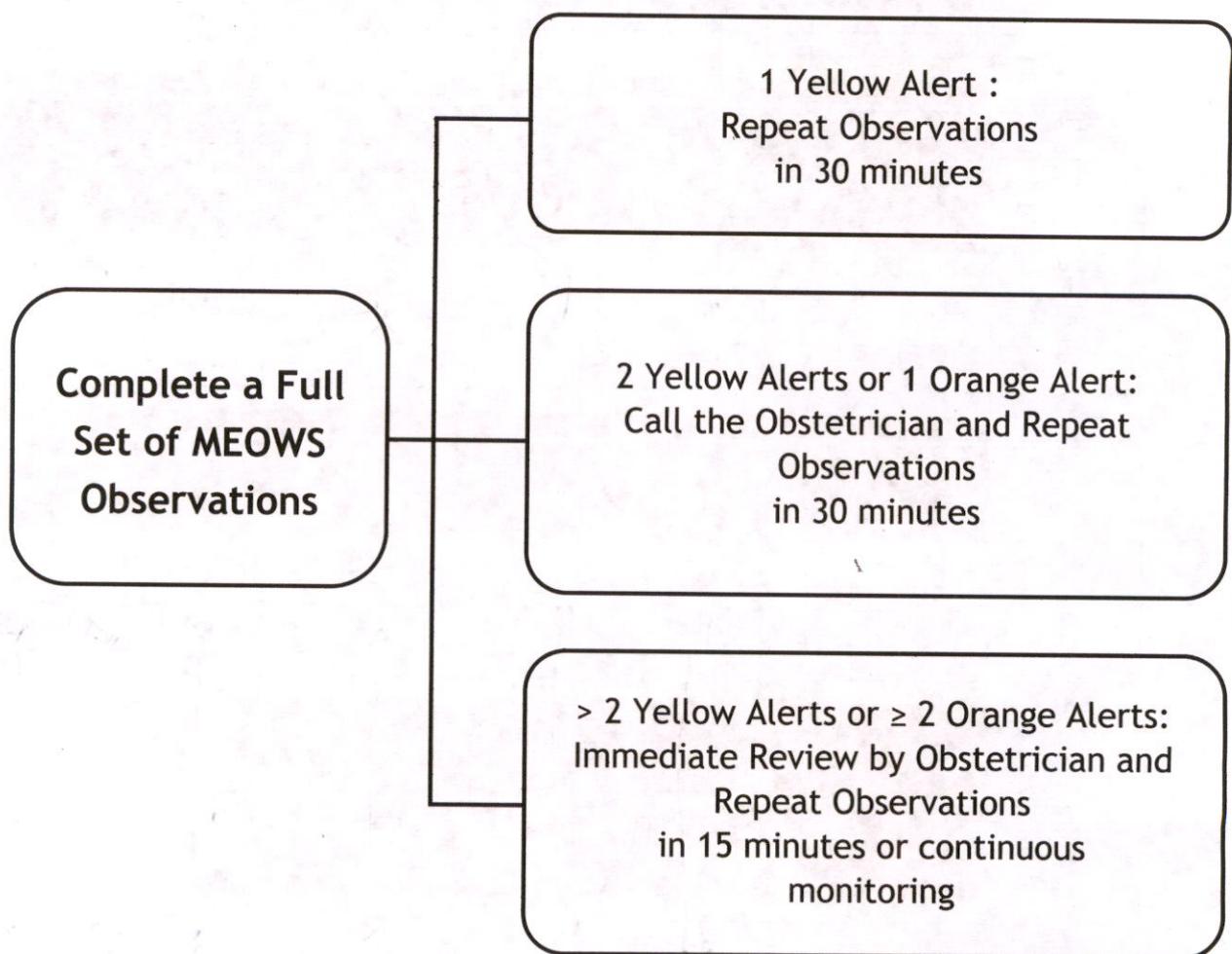


CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

2/7/26

[illegible]

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

IP5-00175775

BAH-00517900
Mrs NITYA BANSAL

20-06-1997

Mrs NITYA BANSAL
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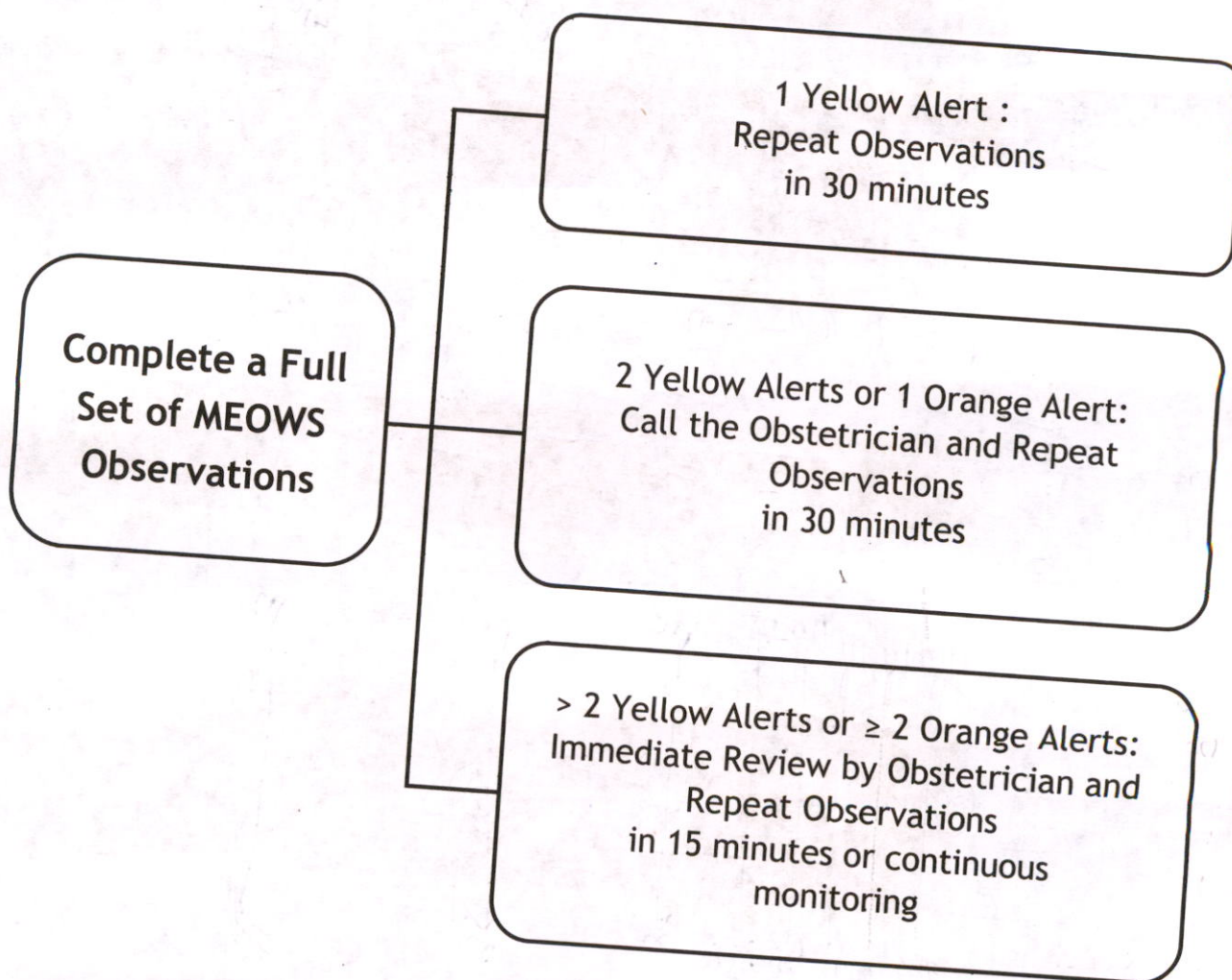
Early Warning Observation Score Chart - Obstetrics

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

2/7/26

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

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

IP5-00175775

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20-06-1997

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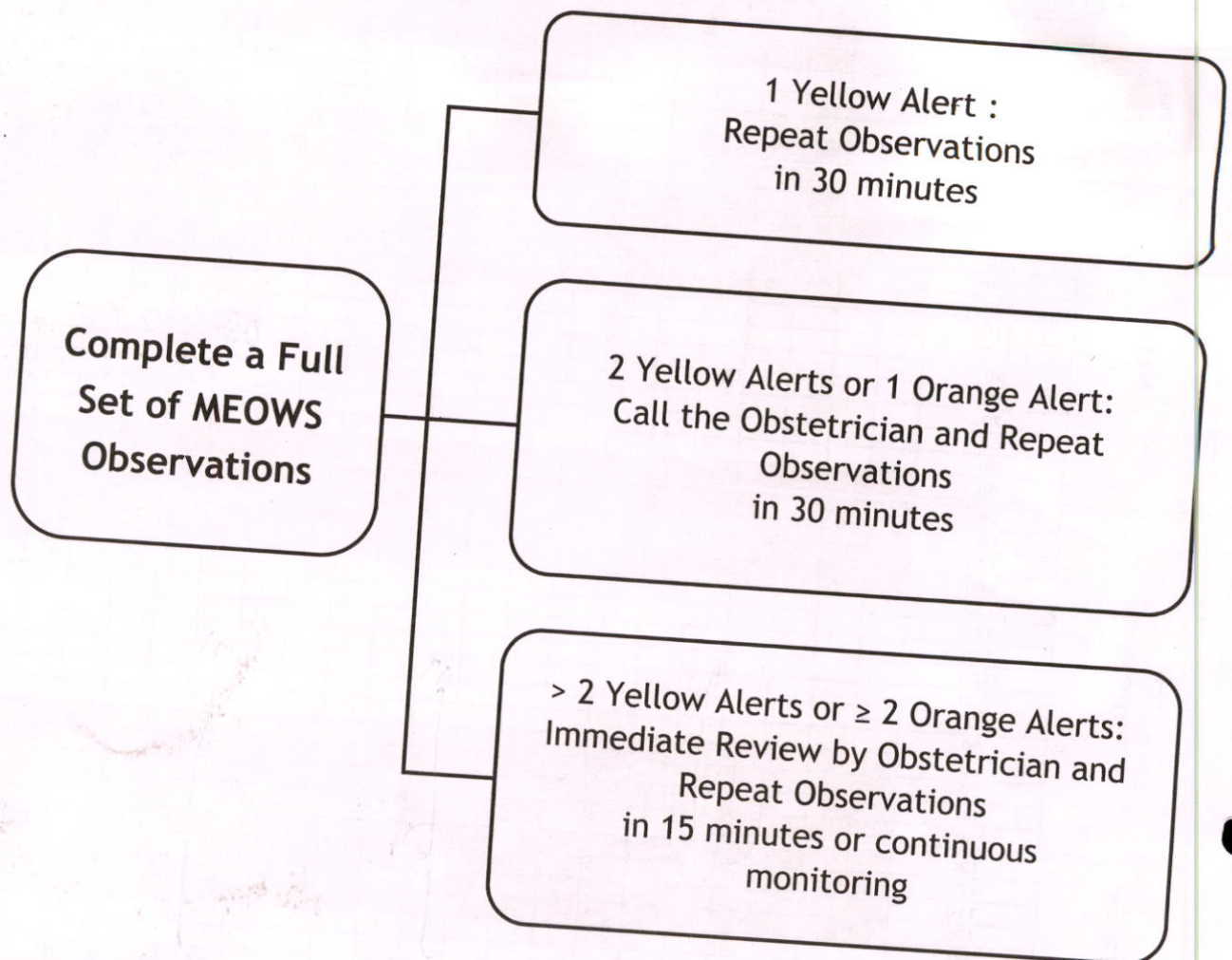
Early Warning Observation Score Chart - Obstetrics

Warning Observation Score Chart

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

[illegible]

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

s NITYA BANSAL
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 SHRUTHI REDDY/Dr.LAVANYA

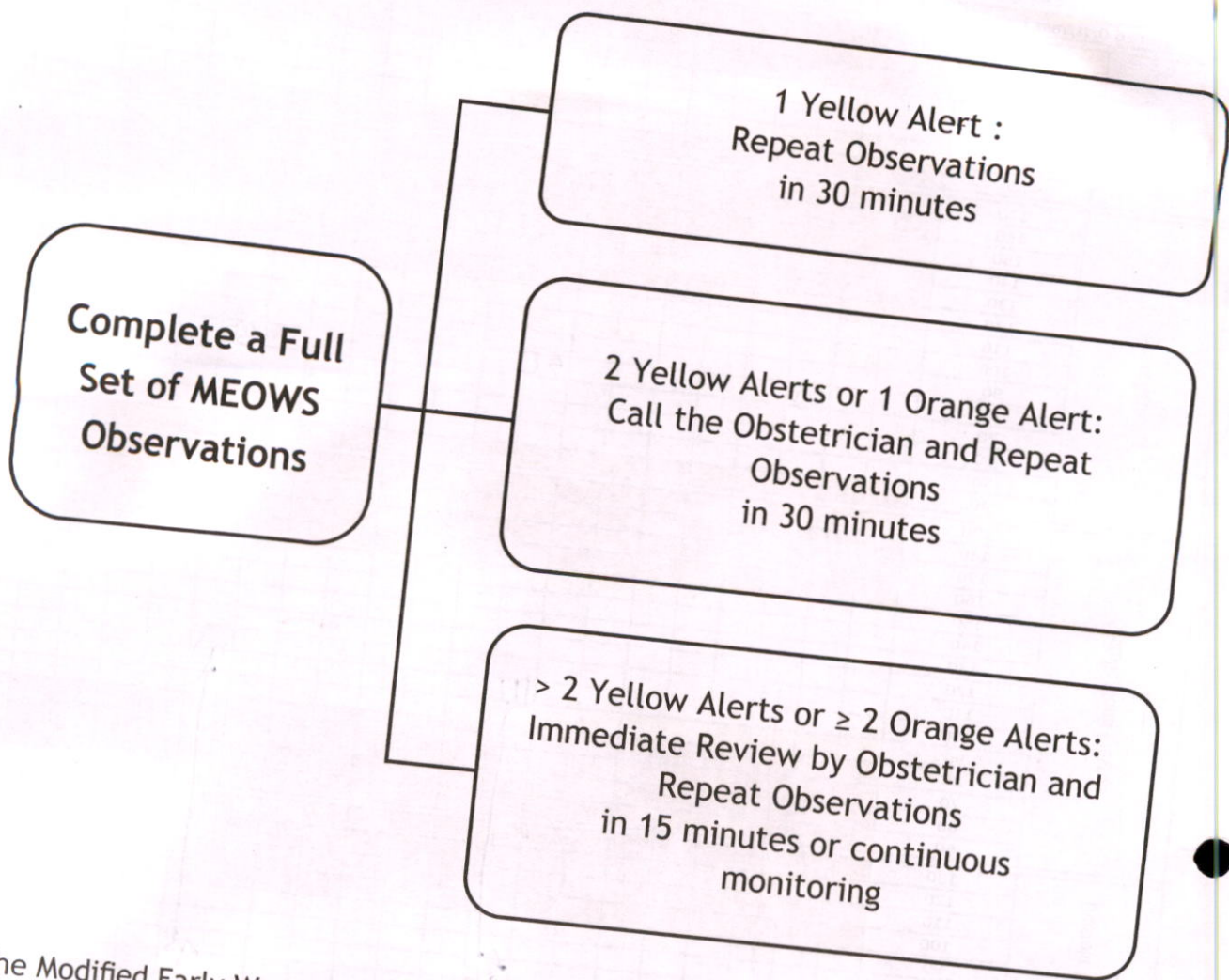


Early Warning Observation Score Chart - Obstetrics

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

[illegible]

**Obstetrics and Gynaecology
Early Warning Signs**



* The Modified Early Warning Score (MEOWS)

FLUID CHART

Sheet No. : 0

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm	water								✓	0	free
	03:00 pm	water								✓	0	free
	04:00 pm									✓	0	free
	05:00 pm									✓	0	free
	06:00 pm									✓	0	free
	07:00 pm	water								✓	0	free
Total Intake : 100ml						Total Output : 100ml						
	08:00 pm									✓	0	free
	09:00 pm	water								✓	0	free
	10:00 pm									✓	0	free
	11:00 pm									✓	0	free
	12:00 am	water								✓	0	free
	01:00 am									✓	0	free
Total Intake : 100ml						Total Output : 100ml						
	02:00 am	water								✓	0	free
	03:00 am									✓	0	free
	04:00 am									✓	0	free
	05:00 am	water								✓	0	free
	06:00 am									✓	0	free
	07:00 am	water								✓	0	free
Total Intake : 100ml						Total Output : 1100ml						
Total 24 hrs. Intake		100ml										
Total 24 hrs. Output		1100ml										



FLUID CHART

Sheet No. : 2

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

Intake						Output						IV Site Thrombo-phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
1/7/26	08:00 am	PC water		100ml						0	Phu		
	09:00 am	PC		100ml			NOT			0	h		
	10:00 am	PC		100ml						0	Phu		
	11:00 am	PC water		100ml			part		500ml	0	Phu		
	12:00 pm	PC		100ml						0	Phu		
	01:00 pm		water							0	Phu		
Total Intake : 500ml						Total Output : 500ml							
	02:00 pm		tho							0	Buy		
	03:00 pm									0	Buy		
	04:00 pm		tho						200ml	0	Buy		
	05:00 pm									0	Buy		
	06:00 pm		tho							0	Buy		
	07:00 pm		tho							0	Buy		
Total Intake : 200ml						Total Output : 0-1 M-0							
2/7	08:00 pm									0	Buy		
	09:00 pm		tho							0	Buy		
	10:00 pm									0	Buy		
	11:00 pm									0	Buy		
	12:00 am		tho							0	Buy		
	01:00 am									0	Buy		
Total Intake :						Total Output :							
	02:00 am									0	Buy		
	03:00 am		tho							0	Buy		
	04:00 am									0	Buy		
	05:00 am									0	Buy		
	06:00 am		tho							0	Buy		
	07:00 am									0	Buy		
Total Intake : 200ml						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

M - 1
 U - 1,800ml + 15ml

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FLUID CHART

Sheet No. : 3

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	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombophlebitis Score	Sign. Nurse
				Mouth	I.V	N.G							
		08:00 am	water					✓			✓	No	Prem
		09:00 am										IV	
		10:00 am	water										
		11:00 am											
		12:00 pm	water							✓			
		01:00 pm											
Total Intake : Taken				Total Output : pulled									
		02:00 pm						↑			✓	↓	Sweep
		03:00 pm	thru								✓	no	
		04:00 pm						↑			✓	IV	
		05:00 pm	thru								✓		
		06:00 pm									✓	↓	
		07:00 pm	thru								✓		
Total Intake : Taken				Total Output : 0-3 M-0									
		08:00 pm									✓	↓	Smile
		09:00 pm	thru									↓	
		10:00 pm										NO	
		11:00 pm									✓	IV	
		12:00 am	thru								✓		
		01:00 am									✓	↓	
Total Intake :				Total Output :									
		02:00 am						↑			✓	↓	Smile
		03:00 am	thru									↓	
		04:00 am						↑				NO	
		05:00 am									✓	IV	
		06:00 am	thru					↑				↓	
		07:00 am									✓		
Total Intake : Taken				Total Output : Taken									
Total 24 hrs. Intake													
Total 24 hrs. Output													



FLUID CHART

Sheet No. : 20

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

3726		Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am	Idly								✓	no	from
	09:00 am	Water										
	10:00 am											
	11:00 am	Water								✓	IV	
	12:00 pm											
	01:00 pm	Water									Cancel	
Total Intake :			Total			Total Output :			Total			
	02:00 pm											from
	03:00 pm	Water								✓	1	
	04:00 pm											
	05:00 pm	Water									10	
	06:00 pm									✓	16	
	07:00 pm										1	
Total Intake :			Total			Total Output :			Total			
up	08:00 pm									✓	1	Smile
	09:00 pm	tho									no	
	10:00 pm											
	11:00 pm									✓	IV	
	12:00 am	tho								✓	1	
	01:00 am									✓	1	
Total Intake :			Total			Total Output :			Total			
	02:00 am		tho							✓	1	Smile
	03:00 am											
	04:00 am									✓	no	
	05:00 am										IV	
	06:00 am	tho								✓	1	
	07:00 am									✓	1	
Total Intake :			Total			Total Output :			Total			
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.

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

Total 24 hrs. Intake

Total 24 hrs. Output

Patient Sticker

FLUID CHART

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Sheet No. :

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

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

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.

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

Patient Sticker

FLUID CHART

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

Sheet No. :

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

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

BAH-00517966

IP5-00175775

Mrs NITYA BANSAL

20-06-1997 29 Y 0 M 10 D (F)

Dr. SHRUTHI REDDY/Dr. LAVANYA



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: 30-6-26

Assessment: Patient is having Fear and Anxiety related to B.C

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
2pm	Monitor vitals	2:30pm	Assessed the patient general condition	Patient is stable
3pm	Assess the patient general condition		Monitor vitals and keep up on	
5pm	Administer the medication as per order	6pm	Administered the medication as per order	
7pm	Maintain the chart	8pm	Maintaining No chart	
	NSR 3rd hour		NSR 3rd hour	

Re-Assessment:

Special Notes: NSR 3rd hour

Nurse Signature:

Nurse Name: Preena

Date & Time: 30-6-26 2:30pm

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NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 30/6/26

Assessment: Patient cb pain abdomen.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the general condition of the patient.	8pm	Assessed the general condition of the patient.	pt is stable.
10pm	NST	10pm	NST 3rd July baby	
12am	Administer the Mediation	12am	Administered the Mediation as per doctor's order.	
2am	Relieve pain & discomfort	2am	Relieve pain & discomfort after Epidural	
4am	Prevent infection	4am	Preventing infection by using hand rub.	
7am	Ensure Safety	7am	Ensured safety needs.	

Re-Assessment: Pt is comfortable.

Special Notes: NST

Nurse Signature: [Signature]

Nurse Name: Surekha

Date & Time: 1/7/26 @ 8am

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 1/7/26

Assessment: Patient is having abdominal pain

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8AM	u Assess the patient's general condition	9AM	u Assessed the patient's general condition	Patient is stable
10AM	u Monitor vitals and recorded	11AM	u Monitored vitals and recorded	
12PM	u Administered the medication as per order	1PM	u Administered the medication as per order	
13PM	u NST 3rd hour u Assess the patient's pain level	2PM	u NST 3rd hour u Assessed the patient's pain level	

Re-Assessment: Patient is stable

Special Notes: NST 3rd hour

Nurse Signature: [Signature]

Nurse Name: Priya

Date & Time: 1/7/26 @ 2PM

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NURSING CARE RECORD

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BirthRight
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 Your Right to a Safe Delivery

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 1/2/26

Assessment: patient complains on fever & Anxiety

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ Assess the pt condition	2:10pm	→ Assessed the patient condition	→ pt is stable
3pm	→ Monitor vitals	3:10pm	→ vitals checked and ruled	
4pm	→ SpO2 checked	4:10pm	→ SpO2 checked maintained	
5pm	→ Administer medications	5:10pm	→ Administered IV medication	
6pm	→ Baby	6:10pm	→ Ensured baby	
7pm	→ Side rails	7:10pm	→ Side rails provided	
8pm	→ Comfort	8:10pm	→ provided comfortable position	

Re-Assessment: vitals checked and ruled

Special Notes: plan for Remove Foley cath 1/2/26 Removed

Nurse Signature: Sweeper Nurse Name: Sweeper Date & Time: 1/2/26 @ 8pm

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NURSING CARE RECORD

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BirthRight
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Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 1/7/26

Assessment: Patient cb fear & Anxiety.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the general condition of the patient.	8pm	Assessed the general condition of the patient.	Pt is stable.
11pm	Administer the medication	30 11pm	Administered the medication as per doctor's order.	
2am	Prevent infection	10 2AM	Preventing infection by using hand sub.	
5am	10 chat.	30 5am	Maintained 10 chat	
7am	Health Education.	30 7am	Health Education given about breast feeding	

Re-Assessment: Pt feels comfortable.

Special Notes:

Nurse Signature: \$

Nurse Name: Surekha

Date & Time: 2/6/26 2PM

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NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 2-7-26

Assessment: Patient is having Stitches Pain in episiotomy

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
8AM	1) Assess the Patient general condition	9AM	1) Assessed the Patient general Condition	Patient is stable
10AM	2) Monitor vitals and Record	11AM	2) Monitoring vitals and Recorded	
12PM	3) Administer the medication as doctor advice	12:30PM	3) Administered the medication as doctor advice	
1PM	4) Ambulation	1:30PM	4) Ambulation	
	5) Watch for bleeding PV	2PM	5) Watched for bleeding PV	

Re-Assessment: Patient is fine

Special Notes: Ambulation

Nurse Signature:  Nurse Name: Preema Date & Time: 2-7-26 2PM

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 2/7/26

Assessment: patient complaints on pt. & Anky

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ Assess the pt condition	2:10pm	→ Assessed the pt condition	→ patient's stable.
3pm	→ Monitor vitals	3:10pm	→ vitals checked and ruled	
4pm	→ No chest	4:10pm	→ No chest maintained	
5pm	→ Administer medications	5:10pm	→ Administered medications	
6pm	→ Regular diet	6:10pm	→ Regular diet provided	
7pm	→ Comfort position	7:10pm	→ provided comfortable position	
8pm	→ Ambulation	8:10pm	→ Ambulation done	

Re-Assessment:

Vitals checked and ruled

Special Notes:

Nurse Signature:

Sneha

Nurse Name:

Sneha

Date & Time:

2/7/26 @ 8pm

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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 2/7/26

Assessment: Patient clo fear of 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	Assess the general Condition of the Patient.	8pm	Assessed the general Condition of the Patient.	Pt is stable -
11pm	Administer the Medication	11pm	Administered the Medication as per doctor's order.	
2am	Prevent Infection	2am	Preventing Infection by using hand rub	
4am	No chat.	4am	Maintained No chat.	
7am	Health Education	7am	Health Education given about breast feeding.	

Re-Assessment: Pt is comfortable.

Special Notes: NIL Significant.

Nurse Signature: [Signature]

Nurse Name: Surebha

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



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NURSING CARE RECORD

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BirthRight
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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 3-7-26

Assessment: Patient is having stitch pain in episiotomy site

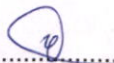
Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8AM	⇒ Assess the patient general condition	9AM	⇒ assessed the patient general condition	Patient is stable
10AM	⇒ Monitor vitals and recorded	11AM	⇒ monitoring vitals and recorded	
12PM	⇒ Administer the medication as doctor advice	1PM	⇒ Administered the medication as doctor advice	
4PM	⇒ Provide regular diet ⇒ Ambulation	5PM	⇒ provided regular diet ⇒ Ambulation Done	

Re-Assessment: recent lax

Special Notes: Ambulation Done

Nurse Signature: 

Nurse Name: Preethi

Date & Time: 3-7-26 @ 8PM

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NURSING CARE RECORD

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BirthRight
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 Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 3/7/26

Assessment: Patient ch 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	Asses the general condition condition of the patient	10 8pm	Assessed the general condition of the patient.	patient is stable
8am	1/0 chat.	30 12am	Maintained 1/0 chat	
8am	Prevent infection	30 1am	Preventing infection by as per doctor using handgub.	
7am	Soft diet.	30 7am	Provided soft diet.	
	Prevent infection		Prevent	

Re-Assessment: Patient is sleeping.

Special Notes: NPL Significant.

Nurse Signature: \$

Nurse Name: Kusikha

Date & Time: 1/7/26 @ 8AM

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Shrutti Department: R&P Date of Admission: 30/6/26

SITUATION		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:						
Diagnosis: <u>Primie @ 37⁺4 wky</u>								
BACKGROUND	Area	<u>R&P</u> <u>8pm</u>	<u>B&P</u> <u>8AM-2PM</u>	<u>B&P</u> <u>2PM-8PM</u>	<u>R&P</u> <u>8pm</u>	<u>B&P</u> <u>8AM-2PM</u>	<u>B&P</u> <u>2PM-8PM</u>	
	Shift Time							
ASSESSMENT	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Allergy:	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	
ASSESSMENT	Tubes/Drains/Catheter:	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	
	Vital Signs:	Temp:	<u>98.2°F</u>	<u>98.6°F</u>	<u>98.5°F</u>	<u>98.2°F</u>	<u>98.6°F</u>	<u>98.5°F</u>
		Res:	<u>18b/m</u>	<u>17</u>	<u>19b/m</u>	<u>18b/m</u>	<u>17</u>	<u>18b/m</u>
		SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>
		Pulse:	<u>98b/m</u>	<u>74</u>	<u>82b/m</u>	<u>88b/m</u>	<u>80</u>	<u>85b/m</u>
		BP:	<u>121/68</u>	<u>121/80</u>	<u>110/80</u>	<u>112/70</u>	<u>111/70</u>	<u>116/65</u>
		Fall Risk Score:	<u>35</u>	<u>35</u>	<u>35</u>	<u>35</u>	<u>35</u>	<u>35</u>
	Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	
Recommendations	Safety Needs:	<u>Side rails</u>	<u>NA</u>	<u>Side rails</u>	<u>Side rails</u>	<u>NA</u>	<u>Yes</u>	
	Physiotherapy	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Special Diet:	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Shrutti</u>	<u>Pran</u>	<u>Shrutti</u>	<u>Shrutti</u>	<u>Pran</u>	<u>Shrutti</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>1/7/26</u>	<u>1/7</u>	<u>1/7</u>	<u>1/7/26</u>	<u>2/7</u>	<u>2/7</u>	
Time:		<u>8AM</u>	<u>2PM</u>	<u>8PM</u>	<u>8AM</u>	<u>2PM</u>	<u>8PM</u>	
Taken Over By Name :		<u>Pran</u>	<u>Shrutti</u>	<u>Shrutti</u>	<u>Pran</u>	<u>Shrutti</u>	<u>Shrutti</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>1/7</u>	<u>1/7</u>	<u>1/7/26</u>	<u>2/7</u>	<u>2/7</u>	<u>2/7/26</u>	
Time:		<u>8AM</u>	<u>2PM</u>	<u>8PM</u>	<u>8AM</u>	<u>2PM</u>	<u>8PM</u>	

Bansal

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Shruthi Department: BLR Date of Admission: 30/6/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known			
	<u>Pain - 2</u>		If Yes Specify: _____			
BACKGROUND	Area	Shift Time	<u>BLR</u> <u>8pm</u>	<u>BLR</u> <u>8pm-8am</u>	<u>BLR</u> <u>8pm</u>	
	Medical Condition (Any special condition to be noted):		<u>hypotensive</u>	<u>Hypotensive</u>	<u>hypotensive</u>	
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	<u>98.2</u>	<u>98.6</u>	<u>98.2</u>	
		Res:	<u>18</u>	<u>17</u>	<u>18</u>	
		SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>99%</u>	
		Pulse:	<u>88</u>	<u>80</u>	<u>86</u>	
		BP:	<u>112/80</u>	<u>112/70</u>	<u>121/70</u>	
		Fall Risk Score:	<u>0</u>	<u>0</u>	<u>0</u>	
Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>			
Recommendations	Safety Needs:	<u>Side rails</u>	<u>nil</u>	<u>Side rails</u>		
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>		
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>		
Post Operative Procedure Special Orders:		<u>Discharge</u>	<u>Discharge</u>	<u>NA</u>		
Handed Over By Name :		<u>Shruthi</u>	<u>Ravi</u>	<u>Shruthi</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>3/7/26</u>	<u>3/7</u>	<u>3/7/26</u>		
Time:		<u>8PM</u>	<u>8PM</u>	<u>8AM</u>		
Taken Over By Name :		<u>Ravi</u>	<u>Shruthi</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>3/7</u>	<u>3/7/26</u>			
Time:		<u>8AM</u>	<u>8PM</u>			

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

BAH-00517966
Mrs NITYA BANSAL
20-06-1997 29 Y 0 M 10 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: Nitya Bansal Age: 28y Sex: F UHID.No:
Date: 30/6/26 Time: 3:30 pm Proposed Operation: Epidural Analgesia
Diagnosis: Hypothyroid
B.P / CRT: 115/68 H.R: 120 Weight: 68.2kg ASA Physical Status: ☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: Glucose: 91 Protein: HIV: X-Ray:
PCV: Urea: Alb: HBS Ag: NR ECG:
WBC: Creat: Total Bill: HCV: 2D Echo:
Plate: Na: Dir. Bill: Blood group: B+ve Stress/Angio:
PT: K: LDH: T3: Other:
PTT: Ca++: Alk phos: 21/4 T4:
INR: Mg++: Amylase: TSH: 5.9
Cl -: SGOT/SGPT:

Allergies:

Medical History: CVS:

RESP:

Diabetes:

CNS:

Renal:

Hepatic / GE:

Physical Activity: Active

Others: Hypothyroid - on 50 ug Thyronorm

Past Anaesthetic History:

Physical Exam:

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

Lungs: Clear

Heart: 88b +

CNS: NAD

Pregnant: ☒ Yes ☐ No ☐ NA

Venous Access Site: (7) Spine Exam for regional: (N)

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

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

CURRENT MEDICATIONS	DOSAGE
<u>Thyronorm</u>	<u>50 ug od</u>

Pre-Operative Instructions:

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

Signature: Dr. Sundhara Name: Dr. Sundhara

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

Patient Sticker

ANAESTHESIA CHART

Pre Induction Assessment:

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

H.R:	B.P / CRT:	SpO ₂ :	R.R:	Last Feed:
Pre-OP Diagnosis:		Operation:		Date :
Surgeon:		Anaesthesiologist:		Technician:

[illegible]

☐ Equipment Checked and Functional ☐ BP ☐ Cuff Site: ☐ Art Site: ☐ EKG Lead ☐ Temp Site ☐ FIO ₂ Monitor ☐ Agent Monitor ☐ Pulse Oximeter ☐ Capnograph ☐ Ventilator ☐ Nerve Stimulator Position: ☐ Pressure Points Checked Eye Care: ☐ Oint ☐ Tape ☐ Padding ☐ Awake	Temp: ☐ HME ☐ Fluid Warmer ☐ Cling Film ☐ OH Warmer ☐ Hugger's ☐ Cotton Wool ☐ Other Times: Anaes Start: OP Start: OP End: Leave OR: Anaesthesia: ☐ GA ☐ Monitored Anaesthesia Care ☐ Regional Line (Size & Location) ☐ CVP: ☐ ART: ☐ IV: ☐ IV: ☐ IV: ☐ IV:	Induction ☐ IV ☐ Inhal ☐ Pre O ₂ ☐ RSI ☐ Others ☐ Mask ☐ SGA ☐ Airway ☐ Oral ☐ Nasal ETT# at cm ☐ Oral ☐ Nasal ☐ Cuff ☐ Tracheostomy ☐ Topical ☐ Drug: ☐ Awake ☐ Direct Vision ☐ Video Laryngoscopy ☐ Stylette / Bougie ☐ Fiberoptic Blade# Attempts: Difficulty Why? ☐ Bilat = BS ☐ Semi-Closed Circle ☐ Closed Circle ☐ Other	Regional: Extremity Specify: ☐ Spinal ☐ Epidural ☐ Caudal Others: Position: Site: Needle Size: Depth: Parasthesia ☐ Yes ☐ No Catheter at skin cm Drug Name & Conc: Bolus: Infusion: Block Level: Comments: Transportation to ☐ PACU ☐ ICU ☐ Other Relaxant Reversed ☐ Yes ☐ No ☐ NA Name of the Doctor : Signature of the Doctor :
---	---	--	--

Patient Sticker

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Time Received : Time Discharged :

< RESP • PULSE > BLOOD PRESSURE		IV Cannula Site : ☐ O ₂ Mask ☐ Nasal Prongs ☐ Tracheostomy ☐ T-Piece ☐ Oral Airway ☐ Nasal Airway Vomiting : ☐ Yes ☐ No Drug: NG Tube : ☐ Yes ☐ No Drain: ☐ Yes ☐ No Urinary Catheter: ☐ Yes ☐ No Chest Tube: ☐ Yes ☐ No Nil Oral ☐ Yes ☐ No IV Fluids: Oral Feeds:
---------------------------------	--	--

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature

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

Anaesthesiologist Name :

Anaesthesiologist Signature:

Date & Time:

PACU Nurse Name :

PACU Nurse Signature:

Date & Time:

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

EPIDURAL ANALGESIA RECORD

Date: 30/6/26. Time: 3:45 PM Procedure done by Dr. Smidhara
CSE/Spinal/Epidural Position: L4/5 Space: L4/5 Technique (LOR/LOS) (LOS)
Depth: 4 cm Catheter at Skin: 9 cm Attempts: 1

Parasthesia: Yes/No If yes details:

Solution Composition: 0.0625% Bup + 2.5 ug/cc Fentanyl

Any other issues: PCEA - 6 ml bolus, 4 ml/hr - Infusion

- a) Only sited the Epidural catheter
b)

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level		Maternal		FHR	Comments
			Left	Right	BP	Pulse		
3:45 PM	—	3cc 2% lidocaine + 0.8% ropivacaine Test dose			110/74	99	136	
1:45 AM	4 ml/hr	10cc 0.8% ropivacaine + 0.8% lidocaine Test dose	T8-T8		117/75	99	135	Com Fortably
2:10	4 ml/hr		T8-T8		118/80	99	130	Com Fortably
8:55	4 ml/hr	Chirocin bolus 10ml P7.			118/80	102	135	CTO of pain of left side 4-6 Right T10 T11 before
11:4								

Delivery Details: Time: 10:37 APGAR: 8-9 SVD / Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected: Dr. Aditi N CRTF done

Patient Satisfaction:

Discharge /Shifting ordered by
Doctor Signature: Dr. Aditi N
Doctor Name: Dr. Aditi N
Date and Time: 1/7/26



PROCEDURE SAFETY CHECK LIST (TIMEOUT OUTSIDE OT)

Procedure Name: Epidural Analgesia Date: 30/6/26 In-Time: 3:30 pm Out-Time: 3:45 PM
Doctor Performing Procedure: Dr. Sundhara Doctor Giving Sedation: - Assisting Nurse: Freema

SIGN IN	Time: <u>3:30 pm</u>
Patient is verified using two identifiers (Name & UHID)	Yes ☒ No ☐ NA ☐
All required documents, images, studies are available	Yes ☒ No ☐ NA ☐
NPO Status Checked from Patient / Patient Attendant	Yes ☒ No ☐ NA ☐
Consent is Signed	Yes ☒ No ☐ NA ☐
Any need for blood products	Yes ☐ No ☒ NA ☐
If Yes Comment:	
Any Risk of Hemodynamic Compromise	Yes ☒ No ☐ NA ☐
If Yes Comment: <u>Monitored</u>	
Any drug or food allergy	Yes ☐ No ☒ NA ☐
If Yes Comment:	
Correct Site of Procedure Marked	Yes ☒ No ☐ NA ☐
All resources required are correct, available and functioning	Yes ☒ No ☐ NA ☐
Signature of the Doctor: <u>Sundhara</u>	
Name of the Doctor: <u>Dr. Sundhara</u>	

TIME OUT	Time: <u>3:40 PM</u>
Correct Patient	Yes ☒ No ☐ NA ☐
Correct Site	Yes ☒ No ☐ NA ☐
Correct Procedure	Yes ☒ No ☐ NA ☐
All the team members introduced	Yes ☐ No ☐ NA ☐
Signature of the Nurse: <u>Freema</u>	
Name of the Nurse: <u>Freema</u>	

SIGN OUT	Time: <u>3:45 PM</u>
Name of the Surgical / Invasive Procedure is recorded	Yes ☒ No ☐ NA ☐
Instrument, Sponge and Needle Count Completed	Yes ☐ No ☒ NA ☐
Specimens are labeled	Yes ☒ No ☐ NA ☐
Any equipment problems are addressed	Yes ☐ No ☒ NA ☐
Signature of the Nurse: <u>Freema</u>	
Name of the Nurse: <u>Freema</u>	

Any Adverse / Unexpected Events



CONSENT FOR LABOUR ANALGESIA

Authorization By: ☒ Patient ☐ Patient Attendant

I, the undersigned do hereby acknowledge the following:

- I have been made aware by the doctors in language known to me the details of the procedure as follows:

☒ Epidural Analgesia ☐ Intravenous Analgesia (Remifentanyl)

- I have been made aware of the possible complications from the procedures as follows:

For Epidural: Fall in blood Pressure, Numbness, Itching, Headache, Shivering, Occasional incomplete pain relief, Need for Re-Siting the epidural.

For Remifentanyl: Drowsiness, nausea, vomiting, need for oxygen supplementation, itching, fall in blood pressure, heart rate and Respiratory Rate.

- I understand that labour analgesia is offered to reduce labour pain and make the birthing process more comfortable, by reducing pain and stress and promoting better cooperation during childbirth.
- I have been clearly explained about the benefits, risk, and alternative of the procedures.
- I authorize Dr. Sundhara and his / her team to perform the above procedure(s) upon the patient / myself.
- 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: Nitya Bansal

Name: NITYA BANSAL

Relationship with patient: Self

Date & Time: 30/6/26, 3:30 pm

Witness:

Signature: Shreyas

Name: Shreyas

Date & Time: 30/6/26 3:30 pm

Doctor (who is taking consent):

Signature: Dr. Sundhara Name: Dr. Sundhara Date: 30/6/26 Time: 3:30 pm

ప్రసవ నొప్పి నివారణ కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అబ్సెండ్

వైద్యులు నాకు తెలిసిన భాషలో క్రింది విధానాల గురించి సమగ్రంగా వివరించారు:

- ☐ ఎపిడ్యూరల్ అనాల్జీసియా
☐ శిరస్రావం ద్వారా నొప్పి నివారణ (రెమిఫెంటానిల్)

- ఈ విధానాల వల్ల సంభవించగలిగే సమస్యలను కూడా నాకు వివరించారు:

ఎపిడ్యూరల్ సంబంధించినవి:

రక్తపోటు తగ్గడం, మందత్వం/ స్పర్శలేమి, దద్దుర్లు/ దురద, తలనొప్పి, వణుకు, అప్పుడప్పుడు పూర్తిగా నొప్పి తగ్గకపోవడం, ఎపిడ్యూరల్ మళ్లీ పెట్టాల్సిన అవసరం.

రెమిఫెంటానిల్ సంబంధించినవి:

నిద్రమత్తు, వాంతి భావం, వాంతులు, ఆక్సిజన్ అవసరం పెరగడం, దద్దుర్లు/ దురద, రక్తపోటు తగ్గడం, గుండె వేగం తగ్గడం, శ్వాస రేటు తగ్గడం.

- ప్రసవ నొప్పిని తగ్గించడం, ప్రసవ ప్రక్రియను సాకర్వచంతంగా చేయడం, 'నొప్పి మరియు ఒత్తిడిని తగ్గించడం, ప్రసవ సమయంలో సహకారం మెరుగు పరచడం కోసం లేబర్ అనాల్జీసియా అందించబడుతుందని నేను అర్థం చేసుకున్నాను.
- ఈ విధానాల ప్రయోజనాలు, ప్రమాదాలు మరియు ప్రత్యామ్నాయాల గురించి నాకు స్పష్టంగా వివరించబడింది.
- డాక్టర్ _____ గారికి మరియు వారి బృందానికి, పై విధానం(లు)ను నాకు / రోగికి నిర్వహించడానికి నేను అనుమతి ఇస్తున్నాను.
- పై సమాచారాన్ని నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు ఆ ప్రశ్నలకు నాకు అర్థమయ్యే భాషలో సంతృప్తికరంగా సమాధానాలు అందాయి. ఈ అనుమతి నేను పూర్తిగా స్వచ్ఛమైన చిత్తంతో ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అబ్సెండ్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

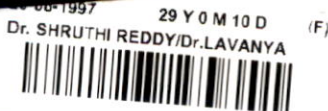
సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:



INFORMED CONSENT FOR VAGINAL BIRTH

Patient Name : Nitya Bansal UHID No : BAH-00517966
Gender: ☐ Male ☒ Female Date : 30/6/20 Time : 3pm

I hereby authorized the performance of the following procedure:

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

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

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

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

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

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

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

Name of the Doctor performing the procedure: Dr. Shrutthi Reddy

Consentee :

Signature : Nitya

Name : Nitya

Date & Time : 30-6-20 @ 3PM

Witness :

Signature : [Signature]

Name : Freemur

Date & Time : 30-6-20 @ 3PM

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

Patient Attendant :

Signature : [Signature]

Name : Shreyas Jain

Relationship with Patient: Husband

Date & Time : 30-6-20 @ 3PM

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Bansal

Date & Time : 30/6/20 @ 3pm

సహజ ప్రసవం కొరకు సమ్మతి పత్రము

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

రోగి పేరు : వయస్సు లింగం పు స్త్రీ
యు.హెచ్.ఐ.డి. విభాగము
తేదీ

ఈ ప్రక్రియ యొక్క వివరములను నేను ఆమోదించాను:

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

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

సహజ ప్రసవం విజయవంతం కాకపోతే, తగిన అనస్థీషియా ఇచ్చి పాత్తికడుపు కోతతో సిజేరియన్ ద్వారా డెలివరీ చేయవలసిన అవసరం కలగవచ్చు

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

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

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

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

ఈ ప్రక్రియను నిర్వహించే డాక్టరు పేరు:

సహాయకుడు(అటెండెంట్)

సాక్షి

సంతకము

సంతకము

పేరు

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

తేదీ మరియు సమయము

సంతకము

పేరు

INDUCTION OF LABOR CONSENT

Name: Nitya Bansal Age: 28 Gender: Male ☐ Female ☒
UHID.No : BAH-00517966 Date: 30/6/26

You are scheduled for an induction of labor on 30/6/26 (date) at 37th (weeks of gestation).

The reason for your induction is Tam

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

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

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

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

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

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

Patient
Signature: [Signature]
Name: Nitya
Date & Time: 30-6-26 @ 3 PM

Patient Attendant: [Signature]
Signature: [Signature]
Name: Shreyans
Relationship with Patient: Husband
Date & Time: 30-6-26 @ 3 PM

Doctor:
Signature: [Signature]
Name: Dr. Ananya
Date & Time: 30/6/26 @ 3 PM

Witness
Signature: [Signature]
Name: Freema
Date & Time: 30-6-26 @ 3 PM

PS - II

NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 2/7/26

Time: 9:30am

Origin: Indian Height: 152cm Weight: 68.2kg BMI: 29.5kg/m²

Food Allergies: NO

Diagnosis: PND-1/SVD (spontaneous vaginal delivery)

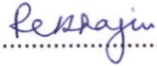
Type of Diet: ☐ Liquid ☐ Soft ☒ Normal ☐ Diabetic
☒ Vegetarian ☐ Non-Vegetarian ☐ Vegan

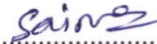
Diet Advised:

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

Patient's / Attendant's

Dietician's

Signature: 

Signature: 

Name: Nitya

Name: Saini

Date & Time: 2/7/26
9:30am

Date & Time: 2/7/26
9:30am

DIETARY NOTES[illegible]