Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Banjara Hills

8-2-120/103/1,2,3,4 and 5,Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad ,Telangana, India ,500034.
TEL NO :+91-40-4466 5555
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP5-00175971 **Admit Date** : 04-Jul-2026 **Admit Time** : 02:21 PM **UHID** : CUV-00119388

Patient Details :

Patient Name	: Mrs PATAN RESHMA BEGUM	**Age**	: 31 Y 6 M 26 D
Guardian	: Mr MOHAMMED DUBER HASAN KHAN	**DOB**	: 08-12-1994
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Married
Address (H)	: KHAN'S PLAZA , 4TH FLOOR, BENZ CIRCLE Patamata Vijayawada Andhra Pradesh INDIA 520010	**Phone No**	: 8099887786/ 9153996786
		E-mail	: DUBERKHAN@GMAIL.COM

Admission Details :

Bed Type : DAY CARE **Bed No** : BC DC 418 **Ward Name** : 4F-BIRTHING CENTRE

Room No : BC DC 418 **Admission Type** : First Visit

Contact Details :

Name : Mr MOHAMMED DUBER HASAN KHAN **Relationship** : Husband

Contact Address : KHAN'S PLAZA , 4TH FLOOR, BENZ CIRCLE Patamata Vijayawada Andhra Pradesh INDIA 520010 **Phone No** : 8099887786

Signature

CUV-00119388 Mrs PATAN RESHMA BEGUM 08-12-1994 Dr. DR.M PRATHYUSHA REDDY 31 Y 6 M 26 D IP5-00175971 (F)

Doctor Details :

Doctor Name : Dr. DR.M PRATHYUSHA REDDY **Specialisation** ND GYNECOLOGY

Referral Doctor : Self **Phone No**

Co-Consultant :

Payment Details :

Payment Mode : Cash **Deposit Amount** : 0.00

Payor Name : SELFPAY

CUV-00119388 IP5-00175971
Mrs PATAN RESHMA BEGUM
08-12-1994 31 Y 6 M 26 D (F)
Dr. DR.M PRATHYUSHA REDDY

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ACTIVITY RECORD FOR BILLING

Name :_____

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

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
4/7/26	2:30pm	OBS	OT	Tunny
4/7/26	4:10pm	OT	OBS	Srilatha

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
4/7	Cardiac monitor	4pm	6:38	9687872	

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
4/7/26	IV placement	1	9687709	Dunno
	PAC	1	9687708	Dunno

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 4/7/26 Time of Admission : 1:34pm

Allergies: NKDA ☒ Not know any drug allergies

PRESENTING COMPLAINTS :

- $G_3P_2L_2$ - 2NVD @ 6+5wks
- failed contraception.
- Unplanned pregnancy.
- Wants termination.
- USG on 2/7/26 - Oral report.
  SLIUG - 6wks

→ Patient given option of MTRPC vs SURGICAL

→ opted for SURGICAL.

Surgical evacuation of products of conception

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage :	Parity : $G_3P_2L_2$
Previous Periods : Irregular.	Mode of Delivery : NVD.
LMP : LMP: 18/5/26	Last Child Birth : C_1 4-2020 - FTNVD ; C_2 -
Contraception : EDD = 25/2/27	C_2 + 2025, ♀ FTNVD ; ♂ - ALIVE
POG = 6+5wks	C_3 - IUD - spontaneous abortion.

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
Nil	Nil.

Mrs PATAN RESHMA BEGUM
08-12-1994 31 Y 6 M 26 D (F)
Dr. DR.M PRATHYUSHA REDDY

FAMILY HISTORY:

Father - K/c/o DM & CAD.
Father - K/c/o hypothyroid & DM.

MEDICATION HISTORY:

See reconciliation form.

INITIAL ASSESSMENT :

Date 5/7/26.
Ht. _____ Wt. _____
BMI _____
B.P 110/70 ; PR 84 bpm
Pallor — absent
CVR — N
Respiratory System — N
Thyroid _____

Breasts — N

Abdominal Examination — N

Local/Speculum Examination

Bimanual Pelvic Examination

PROVISIONAL DIAGNOSIS : $G_3P_2L_2$ @ G+5wks c previous NVD c/c termination of pregnancy c/c

INVESTIGATIONS ORDERED

B positive.

30/6/26
Hb = 13.2
Tc = 8.17k
Plt = 2.28L
TSH = 1.05
BNEG - 163G
LBS - 79.2.
HIV
HBsAg
HCV
} NR.

PLAN OF MANAGEMENT

Surgical abortion/ products of conception

1. Admission.
2. NBM
3. IVF
4. Prepare parts
5. Drugs as charted
6. Consents.
7. Shift to OT on call.

Name of the Doctor : Dr. Prathyusha Reddy Signature of Doctor Sruthi for Dr Prathyusha

Date & Time : 4/7/26 ; 1:30pm.

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/2/2026 4:30pm	POD-0/SFKPC	
	O/E Certain BP- 98/54(67)mmHg PR- 58Bpm SpO2 - 98% RA CP/A- Soft.	Adv ① NBM ② IVF @ 100ml/hr ③ Drugs as chart ④ monitor vitals ⑤ if active bleeding. ⑥ Inform SVS ~~⑦ Dr. Divya~~

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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OPERATION THEATER NOTES

Patient's Name : ..... Age : ..... Gender : ☐ Male ☐ Female

UHID No.: ..... Weight : ..... Height : .....

Surgeon :	Asst. Surgeon :	
Anesthetist :	OT Nurse:	OT Technician:
Pre-Operative Diagnosis:		
Surgical Procedure : Suction and Evacuation of Retained products of Conception		
Indications for Surgery : Termination of Failed contraception		
Date :	Start Time :	End Time :
Pre Operative Preparations:		
Post Operative Diagnosis: PoD-0.		
Peri-Operative Complications: Nil		
Operation Notes: ↓ asptic precautions, perineum cleaned & draped.		
(1) fibro cervical length. 3½ inch		
(2) gentle curettage done.		
(3) Suction evacuation of products of Conception done.		
(4) pbt procedure was done - showed No RPOC.		
(5) Hemostasis secured.		
(6) procedure uneventful.		

Amount of Blood Loss:	Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

Peri-Operative Complications:

adv (1) T. Cefixime 200mg BD x 5 days.

(2) T. pantop 40mg OD x 5 days.

(3) T. Paracetamol 1gm TID. x 3 days.

(4) T. Zincovit OD x 1 month.

Name of the Surgeon: Dr Akshaya for Dr Satyasha.

Signature of the Surgeon: .....

Date & Time: 4/7/25, 4pm.

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POST-SURGICAL CARE PLAN FORM

Procedure Done: Suction & Evacuation.

Post-Surgical Diagnosis: POD-0

Post-Operative Monitoring Parameters /Frequency:

Temp, PR, BP, Spo2 Every 2nd hr.

Wound Care:

(-)

Drain /Special Lines/Catheters:

(IV) Canula

Special Patient Positioning and Requirements:

Supine 4-6 hr

Nutritional Instructions:

NBM 4-6 hr.

When to Start Mobilization:

(-)

Special Referrals:

(-)

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

☑ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

Dr. prathyusha.

Treating Surgeon
(Signature & Stamp)

Date: 4/7/20. Time: 4pm

Note: Plan of care will be readjusted if necessary.

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date : 4/7/26

To Be Filled In By Assigned Nurse :

Department : OBG - OT Duration of Procedure : 1hr

Name of Surgeon : Dr Prathyusha Reddy Date of Admission : 4/7/26

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

		Staff Signature
1.	Antibiotic given prior to surgery ? ☑ Yes ☐ No ☑ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☑ Yes ☐ No Name of the Antibiotic : Inj: Cefaim	Sudath
2.	Hair Removal ☐ Yes ☑ No if Yes : ☑ Surgical Clipper Department where Hair Removed : ☑ Ward ☐ Operating Room ☐ Other : ..... Skin preparation done (cleanse surgical area with antiseptic agent)? ☑ Yes ☐ No	Sudath
3.	Patient's body temperature immediately post operation (Recovery Room) 36.4 °C ☐ Oral Or ☐ Axilla (Goal : 36-37 °C)	Sudath
4.	Name of doctor or staff administering the antibiotic : Dr Laxmi Date & Time of antibiotic administration : 4/7/26 @ 2pm Date & Time procedure started : 4/7/26 @ 3pm.	Sudath

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

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
CUV-00119388 IP5-00175971 Mrs PATAN RESHMA BEGUM 08-12-1994 31 Y 6 M 26 D (F) Dr. DR.M PRATHYUSHA REDDY	4/7/26 @ 2pm	4/7/26 @ 4p
	Transfer Ordered by Dr. Prathyusha	Reason for Transfer SEPSIS POS/O
From Unit OT	To Unit OBS	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 5	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☑ If Yes, what?	Patient shifted with ID band: Yes ☑ No ☐ If No: .....
Number of Imaging Films —		

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sr. Sitalthe	Dr. prathyusha

Patient & Clinical Records Received by :
Sr. Lavanya

Date & Time of Patient Received : 4/7/26 @ 4pm.

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

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

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RESULT SHEET

Date						
Time						
Hb						
PCV						
RBC						
WBC						
N/L						
Platelets						
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 : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

CUV-00119388 IP5-00175971
Mrs PATAN RESHMA BEGUM
08-12-1994 31 Y 6 M 26 D (F)
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INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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Part - I.

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
4/7/26	1:32 PM	1,2,3, 4	Dx, Rx & Care Plan, Pain management, PT, s Expected course.	1		O	1	1		Safi
4/8/26	3p	3	Pain Management	PTs		O	1	1	—	Kanan

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C Caregiver O: Other (Specify) .....

Learning Barriers:

1. No Learning Barriers
2. Physical Impairment
3. Emotional Barriers
4. Language Barrier
5. Educational Level
6. Desire / Motivate to Learn
7. Impaired Thought Process/Cognitive limitations
8. Responsibilities at Home
9. Cultural Differences
10. Financial Difficulties
11. Beliefs and Values
12. Impaired Vision/ or Hearing
13. Cultural/Religion Practice
14. Others (Specify .....

Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed

Mechanism/s to overcome barrier/s:

1. None
2. Obtain translator
3. Reassurance & Support
4. Teach Family / Others
5. Respect values & beliefs
6. Respect Cultural / Religion Preference
7. Other, Specify .....

Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review

Patient Sticker

MULTI-DISCIPLINARY PLAN OF CARE FORM

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Diagnosis: $G_3P_2L_2$ | 2 NVD + 6 Hrs for MTP. — SERPC for TOP.

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
2/7/26 1:30pm	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Unwanted pregnancy	Safe mother conditions	SERPC	Smita	☐ Nursing ☐ Others:
4/7/26 2p	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Partial hair fear & Anxiety	* Reduce the fear & Anxiety	* plan for SOP	Kaur	☐ Medical ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☑ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... NKDA ..... ☐ Not known any Drug Allergies

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

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

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Sruthi, Sruthi.

Date & Time : 4/7/20 ; 1:34 PM.

Nurse Name & Signature: Hanna

Date & Time : 4/7/20 2p

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DRUG CHART

Date of Admission: 4/7/26 Drug Allergies: N.K.D.A ☐ ~~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 ..... Sign. .....

Patient Sticker

REGULAR PRESCRIPTIONS

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

DRUG : T. PARACETAMOL				Date▸ Time▾
Dose	Route	Frequency	Start Date	
1gm	P/O	QID	04/07	
Name & Signature of the Doctor Starting the Drugs: DR SHINY [signature]				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

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

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

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

Patient Sticker

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

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

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

Signature .....

VERIFIED BY : Name .....

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
4/7	2:00pm	INJ CEFOTAXIM	1g	IV	Sruthi	Shobha Kanmani
4/7	2:10pm	INJ PANTOPRAZOLE	40mg	IV	Sruthi	Shobha Kanmani
04/07/26	2:55pm	INJ TRAMADOL	30mg	IV	Suraj	Rajesri
04/07/26	3:00pm	INJ ONDANSETRON	4mg	IV	Suraj	Rajesri
04/07/26	3:15pm	INJ METHERGIN	0.2mg	IM	Suraj	Rajesri
04/07/26	3:55pm	SUP TRAMADOL	100mg	P/R	Suraj	Rajesri
04/07/26	3:55pm	SUP DICLOFENAC	100mg	P/R	Suraj	Rajesri

Patient Sticker

I.V. FLUIDS CHART

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

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
04/07/24	2:15pm	RINGER LACTATE	IV	FF					

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

CUV-00119388 IP5-00175971
Mrs PATAN RESHMA BEGUM (F)
08-12-1994 31 Y 6 M 26 D
Dr. DR.M PRATHYUSHA REDDY

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OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 4/3/26 Time of Arrival: 2'20pm Time Seen by Nurse: 2'30pm

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

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

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

3) **Vital Signs:** Temperature: 98.1F Pulse: 85/m RR: 20 SpO_2: 100% BP: 110/75 Weight: .....

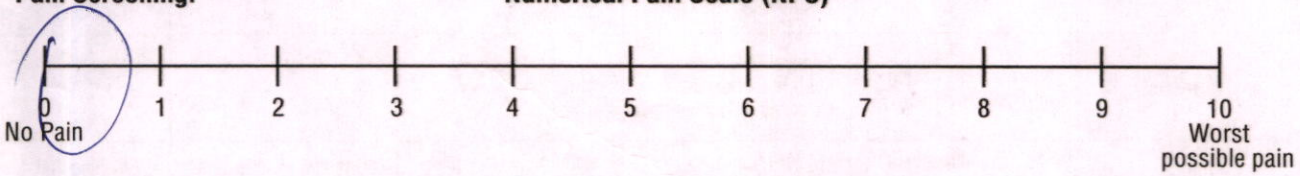
4) **Gestational Criteria:**

Gravida:	G	P	L	A

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

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

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



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

.....

6) **Past History:**

a) Surgeries: .....

b) Medical: .....

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

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

9) **Prenatal Medical History:**

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

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

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

Time seen by Doctor: 2:40pm

Nurse Name : Shobha Nurse Signature: .....

Date: 4/7/26 Time: 2:30pm

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OBSTETRICS / GYNECOLOGY
NURSING INITIAL ASSESSMENT FORM

Date of Admission: 4/5/26

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: .....

SERPC

.....

Doctor Notified on Admission: ☑ Yes ☐ No

Name of the Doctor: Dr. Shruthi

Time Notified: 2pm

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

Past Medical History	Past Surgical History	Previous Hospital Admission

Gynecology Assessment: ☐ Not Applicable

Menstrual History: .....

Regular

Onset of Menarche: .....

Menstrual Cycle: ☐ Regular ☐ Irregular

Last Menstrual Period: .....

Gynecology Surgical History:

Caesarean Section: ☐ No ☐ Yes

Cervical Cerclage: ☐ No ☐ Yes

Ectopic Pregnancy: ☐ No ☐ Yes

Myomectomy: ☐ No ☐ Yes

Others: _____

Gynecological History:

Contraceptives: ☐ No ☐ Yes

Vaginal Discharge: ☐ No ☐ Yes

Post-Coital Bleeding: ☐ No ☐ Yes

Infertility: ☐ No ☐ Yes

If Yes Type: ☐ Primary ☐ Secondary

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

Previous LSCS: .....

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

Family History: ☐ No Abnormalities Detected

☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Stroke ☐ Seizures ☐ Kidney disease

☐ Liver disease ☐ Other .....

Vital Signs / Measurements: Temp: 98.1F HR: 80/m RR: 20/m

BP: 117/75 Weight: ..... Height: ..... BMI: .....

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

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PHYSICAL ASSESSMENT

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

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

Risk of Pressure Sore: ☐ Yes ☐ No Score ..23.. (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 ..Family & 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: ..Mrs. Reshma..

Orientation not given Reason: ..NIL..

Nurse Signature: ..

Nurse Name: ..Kanna..

Date & Time: ..4/3/26 2:30pm..

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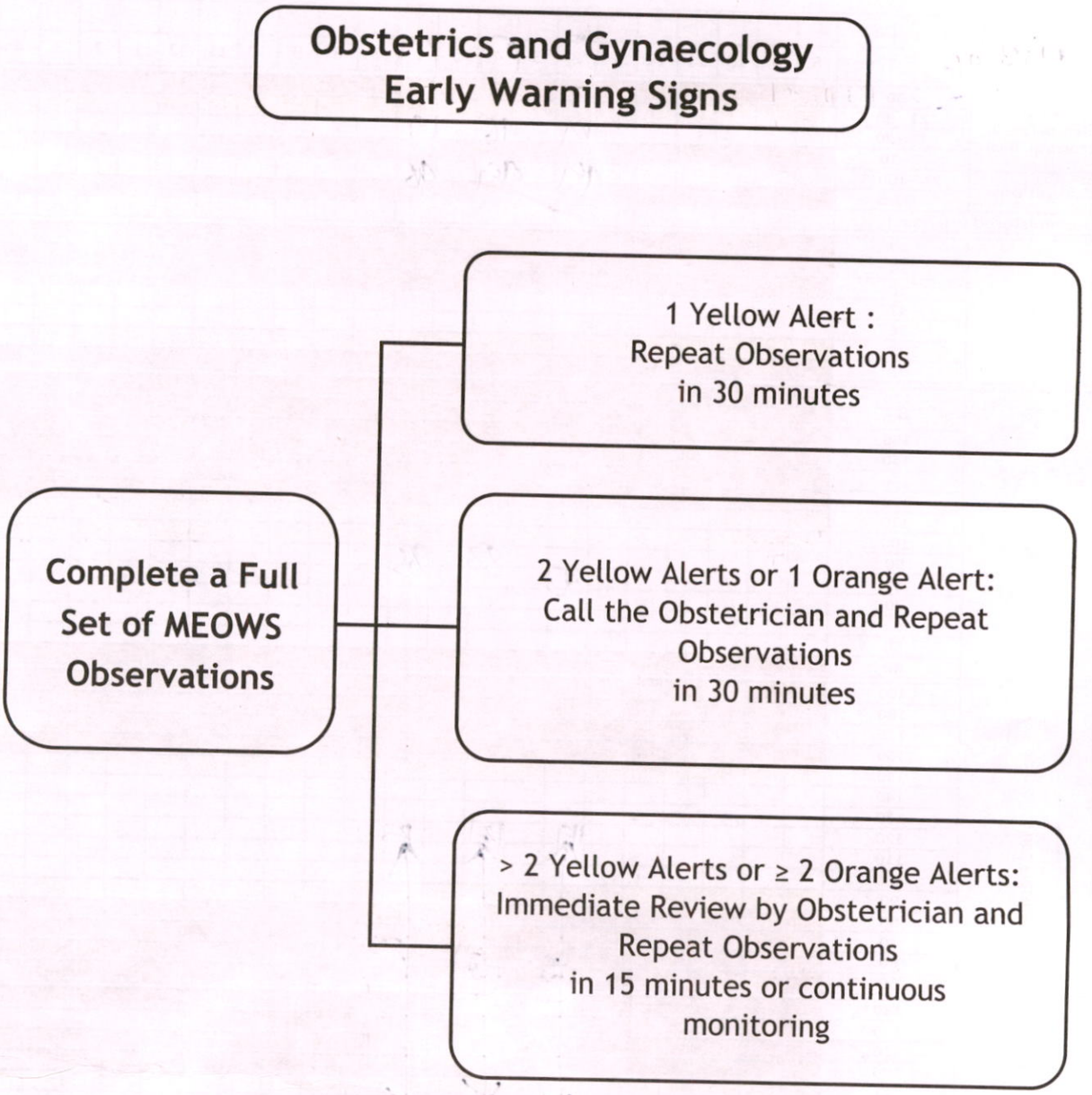
arning Observation Score Chart - Obstetrics

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

4/3/26

		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								19		18		19													
	11 - 20																									
	0 - 10																									
Saturations	94 - 100 %								94		95		98													
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37																									
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90								80		83		85													
	80																									
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressure ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120								115		121		123													
	110																									
	100																									
	90																									
	80																									
	70																									
	60								(80)		(80)		(79)													
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80								75		80		81													
	70																									
	60																									
	50																									
	40																									
NEURO RESPONSE [✓]	Alert								A		A		A													
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30								✓		✓		✓													
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal								✓		—		—													
	Heavy / Foul																									
Liquor	Clear / Pink																									
	Green																									
TOTAL YELLOW SCORES									0		0		0													
TOTAL ORANGE SCORES									2		2		2													
Nurse Initial									SP		SP		SP													



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

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FLUID CHART

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Sheet No. : 1

4/3/26

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						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am					NIL						
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm										0	
	03:00 pm		NIL							✓	0	
	04:00 pm		B				NIL				0	
	05:00 pm		NIL								0	Kavya
	06:00 pm										0	
	07:00 pm						1				0	
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

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FLUID CHART

Sheet No. : .....

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

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

Total 24 hrs. Intake		**Total 24 hrs. Output**	