VIH-00205867 IP-00060599
Mrs DIVYA GUJJA
24-06-1998 28 Y 0 M 13 D (F)
Dr. BHAVANA K

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SURGERY DETAILS

Date : 7/07/26

Patient Name: Mrs. Divya Gujja Date of Birth: 24/06/1998 Age: 28 yrs

Gender: female Ward : OT UHID No.: 205867

Date of Surgery: 07/07/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Cervical Cerclage L/SA

Time in : 9:40 am Time Out : 10:20 am

		NAME	AMOUNT
1.	Surgeon	: Dr. Bhavana. K.	OT charges
2.	Anaesthetist	: Dr. Ayesha.	
3.	Assistant Surgeon	: Dr. Nausheen	
4.	OT Technician	: Br. Rakesh	
5.	Circulating Nurse	: Sr. Ruby. P	
6.	Assistant Nurse	: Sr. Jyothi	

Special Equipment: ☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others .....

Dr Nausheen.
Signature of the Surgeon

Signature of Circulating Nurse

Order No: 3098383 | 3098384 Order by: Ruby P

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ACTI **_ING**

Name ----------

UHID No : ---------- IP No : ---------- Consultant : ---------- Dept : ----------

Date of Admission : 7/7/26 Time : 7AM Date of Discharge : ---------- Time: ----------

Room / Bed No : 219 Ward : CIW Suggested Billable bed type : ----------

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
7/7/26	9:25 AM	MICU	OT	
7/7/26	10:25 AM	OT	MICU	CY

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
7/7/26	Infusion pump	8:10am	2pm	3098333	S
7/7/26	Cardiac monitor	10:30am	2pm.	3098333	
	cross checked by	Sukesini	7/7/26	11:30am	

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
7/7/26	IV placement	(1)	3098335	SS
7/7/26	PAC	(1)	3098384	
	JOSS checked by Suvarna 7/7/26 11:30AM			

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

DEFICIENCY CHECK LIST OF MEDICAL CASE SHEET

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Dr. BHAVANA K

Patient Name :

Ward:

IP.No: 60599

DOA: 7/7/26

Sl.No	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission Sheet	2			
2	Discharge Summary	1			
3	Nursing Initial assessment form	1			
4	Patient Trasfer Forms	2			
5	In-patient Medical Record	1			
6	Doctors Progress Sheets	1			
7	Nurses Progress notes	2			
8	Consultation Sheets	—			
9	General Consent for Treatment	1			
10	Conset for Surgery	1			
11	Consent for Blood Transfusion	—			
12	Consent forChemotherapy	—			
13	Consent for High Risk	—			
14	Consent for Restraint	—			
15	DAMA Consent	—			
16	Consent for Special Procedure	—			
17	Consent for Radiological Investigations	—			
18	Consent for HIV Test	—			
19	Anaesthesia consent form	1			
20	Anaesthesia notes(Pre Anaesthesia & Post)	1			
21	Pre Operative checklist	1			
22	Surgical safety Checklist	1			
23	Operation Theatre notes	1			
24	Nurses Clinical Presentation	1			
25	TPR & BP chart	2			
26	Intake and Output chart (fluid Chart)	1			
27	Drug Chart (Regular prescription)	1			
28	~~Daily Investigation sheet~~ SS	1			
29	Investigation Values (Result Sheet)	1			
30	Nebulization Chart To Page	1			
31	~~Diabetic chart~~ Braden's Scale	1			
32	Nutritional Review chart ~~Thrombophelia~~	1			
33	MLC form (in case of MLC)	—			
34	Patient Educatlon Form	—			
35.	pain Assessment	1			
36.	morse fall	1			
37.	Billing sheet	5			
	Total No. of Pages	34			

Signature and Date: 7/7/26 11:30 pm

ERROR LOG

LOCATION: - NICU / PICU / HDU / OT / GENERAL WARD

ICD CODE :-

OBSERVATION: -

DATE :

MRD EXECUTIVE

Rainbow Children's Hospital - Secunderabad
H.No.3-7-222/223,Sy.No.51 to 54,Opp.Karkhana P S,Karkhana Main Road,Kakaguda, Karkhana ,Hyderabad ,Telangana, INDIA ,500009.
TEL NO :040-42462200, Ext 2000,2001,2002
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP-00060599 **Admit Date** : 07-Jul-2026 **Admit Time** : 07:00 AM **UHID** : VIH-00205867

Patient Details :

Patient Name	: Mrs DIVYA GUJJA	**Age**	: 28 Y 0 M 13 D
Guardian	: Mr ALSA AJAY	**DOB**	: 24-06-1998
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 4-70/4/1,NOTH AVENUE,SARASWATHI NAGAR,KARIMNAGAR Karimnagar Hyderabad Telangana INDIA 505001	**Phone No**	: 7893294947/ 9533119079
		E-mail	: NA@GMAIL.COM

Admission Details :

Bed Type : MICU **Bed No** : LW 219 **Ward Name** : N 2F-LABOUR WARD

Room No : LW 219 **Admission Type** : First Visit

Contact Details :

Name	: Mr ALSA AJAY	**Relationship**	: W/O
Contact Address	: 4-70/4/1,NOTH AVENUE,SARASWATHI NAGAR,KARIMNAGAR Karimnagar Hyderabad Telangana INDIA 505001	**Phone No**	: 7893294947

Signature

Doctor Details :

Doctor Name	: Dr. BHAVANA K	**Specialisation**	: OBSTETRICS AND GYNECOLOGY
Referral Doctor	: Self	**Phone No**	:
Co-Consultant	:		

Payment Details :

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

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IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

LMP: 11/3/26 EDD:

Corrected EDD: 20/12/26 GA: 16+2 weeks

Obstetric Formula: Primigravida.
ML-1:5yr, NCM

Menstrual History: Regular: ☑ Yes ☐ No

Obstetric Hostory:
G1- PP, Spontaneous Conception

Obstetric Examination

Fundal Height: ~16 wks

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

Present Pregnancy Record: Booked to RCH since 13+3 weeks. Previous ANCs at Kavinagar. Tri-uneventful.

Liquor: ☑ Adequate ☐ Oligo ☐ Poly

PP: ☑ Cephalic ☐ Breech Others _____

Head Fifths Palpable: _____

FHS: ☑ Normal ☐ Tachy ☐ Brady ☐ Absent
(+) 138 bpm.

RISK FACTORS:

- High BMI
- Short Cervix (25mm).

Per Speculum Examination Not done.

Draining: ☐ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☑ Meconium ☐ Blood Stained

Vaginal Examination Not done.

Cervix: ☐ Long ☐ Partially effaced ☐ Effaced

Os: Closed _____ Dilated _____

Membranes: ☐ Present ☐ Absent

Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Presenting Part: ☐ Vertex ☐ Breech ☐ Others

Sutton: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Pelvis: ☐ Adequate ☐ Doubtful

Height: 154 cm
Weight: 78.15 kg
Allergies: NIL
Breast: ☑ Normal ☐ Abnormal
General Examination:
Consciousness: C/C/C Pallor: (-)
Icterus: (-) Edema: (-)
Temp: Afebrile. PR:
BP: DTR: (+)
CVS: S1S2 (+) RS BAE (+)
Liver/Spleen: (N) Urine Output: Adequate.

DIAGNOSIS

Primigravida with 16+2 weeks with High BMI with Short Cervix for Cervical Cerclage.

VIH-00205867 IP-00060599
Mrs DIVYA GUJJA
24-06-1998 28 Y 0 M 13 D (F)
Dr. BHAVANA K

Family History:	Surgical History:
Father - DM Mother - HTN.	NAD.
Medical History:	**Medication History:**
Nil	~~Allergic~~ Nil
Plan of Care: Cs to Dr. Bhavana Mam - Admission - NPBM - Consent - PAC. - Pack preparation - FHR monitoring - Monitor vitals - Follow dug chart - Tablets. Noted by pooja 7/7/26 @ 9 AM	**Investigations:** Blood Group - 'O' POSITIVE 7/7/2026 HIV, HBsAg, HCV, VDRL } NR CBP - 12.5 / 7750 / 2.142 Creat - 0.6. Cervical length assesment scan 6/7/2026. SLIUF 16+1 wks. PL - Anterior. AF - 4cm. CL - 25mm Funnelling absent. • NT scan 16/6/2026 SLIUF 12+6 wks. NT - 1.5mm FTS - low risk

Doctor Name: Dr. Greeshma
Signature:
Date & Time: 7/7/2026. 8:30 Am.

Consultant Name: Dr. Bhavana k.
Signature:
Date & Time: 7/7/2026

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OBSTETRICS / GYNECOLOGY
NURSING INITIAL ASSESSMENT FORM

Date of Admission: 7/7/26

Baseline Information:

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

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: Admitted for cervical cerclage

Doctor Notified on Admission: ☑ Yes ☐ No

Name of the Doctor: D.R. Sreeshma

Time Notified:

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Nil	Nil	NO

Gynecology Assessment: ☑ Not Applicable

Menstrual History:

Onset of Menarche:

Menstrual Cycle: ☐ Regular ☐ Irregular

Last Menstrual Period: 11/3/26

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 2Uni L — A —

Previous LSCS: NO

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

Family History: ☐ No Abnormalities Detected

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

☐ Liver disease ☐ Other father - DM, mother - HTN

Vital Signs / Measurements: Temp: 98.4F HR: 89 b/mts RR: 19 b/mts

BP: 114/70 mm/Hg Weight: 78.15 kg Height: 154 cm BMI: 32.95 kg/m2

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

Oscar

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PHYSICAL ASSESSMENT

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

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

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

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

☐ Mobility problem ☐ Walking Problem ☑ No Abnormality Detected

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☑ No Abnormality Detected

☐ Overweight ☐ Poor Appetite > 3 Days ☐ Needs Therapeutic Diet.

☐ Under Weight ☐ Diabetes Mellitus ☐ Hyperemesis Gravidarum

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

☑ Calm & Cooperative ☐ Restless ☐ Depressed ☐ Agitated ☐ Confused

☐ Others —

Inform consultant for positive criteria

SOCIAL SCREENING:

1. **Marital Status:** ☐ Single ☑ Married ☐ Divorced ☐ Widow
2. **Special Habits:** **Smoker:** ☐ Yes ☑ No **Alcohol Abuse:** ☐ Yes ☑ No **Drug Abuse:** ☐ Yes ☑ No

Social History: Lives With Family

Orientation has been given regarding the following aspects:

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

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

Above information given to Mrs. Divya Gujja

Name of Person Orientation was given to: Mrs. Divya Gujja

Orientation not given Reason: —

Nurse Signature:

Nurse Name: Manga Devi

Date & Time: 7/7/26 @

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PATIENT TRANSFER FORM

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
VIH-00205867 IP-00060599 Mrs DIVYA GUJJA 24-06-1998 28 Y 0 M 13 D (F) Dr. BHAVANA K	7/7/26 @ 7AM	7/7/26 @ 9:25AM
	Transfer Ordered by DR. Naveen	Reason for Transfer cervical cerclage
From Unit MICU	To Unit OT	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 35	Number of Imaging Films Nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

DR.

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
SIS. Pooja	DR. Naveen

Patient & Clinical Records Received by : Ruby-F

Date & Time of Patient Received : 7/7/26 @ 9:25AM

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

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

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
VIH-00205867 IP-00060599 Mrs DIVYA GUJJA 24-06-1998 28 Y 0 M 13 D (F) Dr. BHAVANA K	7/07/26 @ 7am	7/07/26 @ 10:25am
	Transfer Ordered by Dr. Ayesha	Reason for Transfer postoperative care.
From Unit OT	To Unit MICU.	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 40	Number of Imaging Films nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sr. Ruby. P	Dr. Ayesha

Patient & Clinical Records Received by : K. Sukanya

Date & Time of Patient Received : 7/7/26 10:25Am

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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Mrs DIVYA GUJJA
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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... NIL ..... ☑ 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: ..... MICU ..... Shifted to: ..... OT .....

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	T-DOXINATE	10mg	PO	ONCE DAILY	6/7/26	☐ C ☑ DC
2	T-(ZOFER) ONDANSETRON	4mg	PO	ONCE DAILY	6/7/26	☐ C ☑ DC
3	T- CALCIUM	1TAB	PO	ONCE DAILY	6/7/26	☐ C ☑ DC
4	T- IRON.	1TAB	PO	ONCE DAILY	6/7/26	☐ 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. Sreelekha. .....

Date & Time : ..... 7/7/26, 6:50 Am. .....

Nurse Name & Signature: ..... Manga, (RN) .....

Date & Time : ..... 7/7/26 @ 6:50AM .....

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/7/26 10:15 AM	POD-0	
	O/E pt is c/c/c	Adv
	Gc fair	- NBM
	Afeb	- Rest
	BP - 117/72 mmHg	- Monitor Vitals
	PR - 85 bpm.	- Follow drug chart
3 gauze in situ in vagina	S/E NAD	- FHR monitoring
	P/A ~~soft~~	- Inform SOS.
	FHR (+) good	
Noted by Subashini 10:15 AM		Dr Nausheen
7/7/26 11:50 AM.	POD-0	Adv:
	O/E - pt is c/c/c	- NBM till 12:15 pm
	Gc - Fair	- Rest
	Afebrile.	- monitor Vitals
	BP - 121/76 mmHg.	- FHR monitoring
pt can be discharged	PR - 88 bpm.	- Follow drug chart
	S/E - NAD.	- Inform SOS.
	P/A - Soft.	
	FHR (+) good.	
	ut ~~-~~ just palpable.	Dr. Nikkita
	3 gauze in situ in Vagina to be removed before patient leaves	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: primi c 16+2 wks c high BMI c short cervix for cervical cerclage				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
	Surgery / Procedure:				Post OP Day:		
BACKGROUND	Date / Shift	7/7/26 Nigh	7/7/26 M	7/7/26 M	7/7/26 M		
	Medical Condition (Any special condition to be noted):	–	–	–	–		
	Diet:	NBM	NBM	NBM	NBM		
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	RA	RA	RA	RA		
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.4°F	98.4°F	98.6°F	98.6°F		
	Res:	19b/m	18bmt	19b/mt	19b/m		
	SpO_2:	99%	99%	99%	99%		
	Pulse:	76b/m	76 bmt	82bpm	82b/m		
	BP:	114/70	100/70	110/70mmHg	110/70mm		
	LOC:	Conscious	Conscious	Conscious	Conscious		
	Fall Risk Score:	0	0	0	0		
	Pain Score:	0 score	0 score	0	0		
	Skin Integrity	Intact	Intact	Intact	Intact		
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	Nil	Nil	–	–		
	Others Specify:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	Nil	Nil	–	NBM		
	Critical Lab Test / Values:	Nil	Nil	–			
	Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	Dependent	dependent	dependent	Dependent		
Post Operative Procedure Special Orders:		–	–	NBM -3 gauze pack	–		
Handed Over By Name :		manager	pooja	Sr. Ruby p	K. Sahi		
Signature / ID :		020157			020477		
Date:		7/7/26	7/7/26	7/7/26	7/7/26		
Time:		@8AM	@9:45am	@10:30pm	10pm		
Taken Over By Name :			Ruby.F	K. Sahi			
Signature / ID :				020477			
Date:			7/07/26	7/7/26			
Time:			@9:45pm	10:30pm			

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:					Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:	
	Surgery / Procedure:					Post OP Day:	
BACKGROUND	Date / Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	LOC:						
	Fall Risk Score:						
	Pain Score:						
	Skin Integrity						
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:						
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							

VIH-00205867 IP-00060599
Mrs DIVYA GUJJA
24-06-1998 28 Y 0 M 13 D (F)
Dr. BHAVANA K

NURSING CARE RECORD

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

Date: 7/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night	7AM	⇒ Ensure safety	7:10 AM	⇒ Provided side rails	⇒ Patient safety	⇒ Patient safe & comfortable	Mary 7/7/26 @8M

Docu. No: RCH /FRM / CLINICAL / 148

VIH-00205867 IP-00060599
Mrs DIVYA GUJJA
24-06-1998 28 Y 0 M 13 D (F)
Dr. BHAVANA K

NURSING CARE RECORD

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

Date: 7/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	9 AM	Ensure Safety	9 AM	provide side rails	To prevent falls	patient is safe	7/7/26 09 AM
	11 AM	maintain Fluid Balance	11 AM	RL 100ml/hr	Prevent dehydration	Patient well hydrated	
Afternoon							
Night							

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Secunderabad

H.No.3-7-222/223,Sy.No.51 to 54,Opp.Karkhana P S,Karkhana Main Road,Kakaguda, Karkhana ,Hyderabad ,Telangana, INDIA ,500009.
TEL NO :040-42462200, Ext 2000,2001,2002
WEB : https://rainbowhospitals.in

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Mrs DIVYA GUJJA**	**Age :**	**28 Y 0 M 13 D**
IP No:	**IP-00060599**	**Sex:**	**Female**
Consultant:	**Dr. BHAVANA K**	**Ward/Bed No:**	**N 2F-LABOUR WARD/LW 219**

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science and that no guarantee have been made to me as the results of my evaluation and I or treatment.

I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal items and valuables.

"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process as per evidence based guidelines".

Note:
1 We do not allow use of medication brought from outside by the patient.
2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.
(Receivers Signature:.....

3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.
4 Financial and billing counseling has been done to me.

Signature of Patient/Relative:

Name: Alsa Ajay
Relationship: Husband
Date: 07-07-2026 Time:
Witness Name:
Witness Signature:

Patient Address:
4-70/4/1,NOTH AVENUE,SARASWATHI NAGAR,KARIMNAGAR Karimnagar Hyderabad Telangana INDIA 505001

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : Mrs. DIVYA GUJJA Gender: ☐ Male ☑ Female Age : 28 years

UHID No : VIH-00205867 Date : 7/7/26

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

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

CERVICAL CERCLAGE

upon Mrs. DIVYA GUJJA
(Name of the Patient)

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

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

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

BLEEDING, INFECTION, CHANCES OF RUPTURE OF MEMBRANES, CHANCES OF SPONTANEOUS MISCARRIAGE, CHANCES OF PRETERM LABOR

My signature on this form indicates that

1. I have read and understood the information provided in this form
2. My doctor had adequately explained to me the operation or procedure along with the complications written above, along with the risks, benefits and other information.
3. I have had a chance to ask my surgeon questions.
4. I have received all the information I desire concerning the operation or procedure and
5. I authorize the consent to the performance of the operation or procedure.

Name of the Doctor who is performing the Surgery / Procedure: Dr. BHAVANA. K

Consentee :

Signature : Divya

Name : Divya Gujja

Date & Time : 7/7/26, 6:50 AM

Patient Attendant :

Signature : A. Ajay

Name : Alsa Ajay

Relationship with Patient: Husband

Date & Time : 7/7/26, 6:50 AM

Witness :

Signature :

Name :

Date & Time :

Doctor (who is taking the consent) :

Signature :

Name : Dr. Lohani

Date & Time : 7/7/26

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CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MAC

Patient Name : Mrs. Divya Gupta Age : 28yrs
Gender : M ☐ F ☑ - IP No : 00060599 Consultant : Dr. K. Bhavana
Ward / Bed No. : 300 Anaesthesiologist : Dr. Ayesha
Operative procedure planned : Cervical Cerclage

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief without numbness can be achieved by infusing weak solutions of local anesthetics arid narcotic drugs to particular parts of the body after surgery or injury, using catheters.

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

☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure

☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma / RTA

☐ Incapacitating COPD ☑ Others : Hypotension

Comments : .....

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

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient Mrs. Divya Gupta the above mentioned operation I Diagnostic I Therapeutic procedures Cervical Cerclage

I authorize and give consent for anaesthesia (☑ Regional / ☐ General Anesthesia / ☐ Monitored anesthesia care (MAC)) as considered appropriate by the anaesthetic team.

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

I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, asthmatic reactions, headaches.

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

That I authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter in need arises.

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

- Pregnant : ☑ Yes ☐ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

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

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

Patient / Patient Attendant :

Signature : .....

Name : Divya. Gujjo

Relationship with Patient: .....

Date & Time : 7/7/2026

Witness :

Signature : G. Sribami

Name : G. Sribami

Date & Time : 7/7/2026 9 AM

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. Sk. Ayesha

Date & Time : 07/07/26 9:00Am

SURGICAL SAFETY CHECKLIST

VIH-00205867 IP-00060599
Mrs DIVYA GUJJA
24-06-1998 28 Y 0 M 13 D (F)
Dr. BHAVANA K

Surgeon : Dr. Bhavana.c
Asst. Surgeon : Dr. Nausheen
Anaesthetist : Dr. Ayesha
Scrub Nurse : Sr. Jyothi

Date : 7/04/24 In-time : 9:40am Out-time : 10:20am
Age : ..... Gender : .....
Surgery Name : cerclage

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 9:35am

Patient Has Confirmed
- Identity ☑ Yes ☐ No
- Site ☑ Yes ☐ No
- Procedure ☑ Yes ☐ No
- Consent ☑ Yes ☐ No

Site Marked ☐ Yes ☐ No ☐ NA

Anaesthesia Safety Check Completed ☑ Yes ☐ No

Pulse Oximeter on Patient & Functioning ☑ Yes ☐ No

Does Patient have a:
- Known Allergy? ☐ Yes ☑ No

Difficult Airway / Aspiration Risk?
- Yes, & Equipment / Assistance Available ☑ Yes ☐ No

Risk of > 500ml Blood Loss (7ml/kg In Children)?
- Yes, and Adequate Intravenous Access and Fluids Planned ☐ Yes ☑ No ☐ NA
- Blood Units Reserved ☐ Yes ☑ No ☐ NA

Has Antibiotic Prophylaxis been given within the last 60 minutes? ☑ Yes ☐ No ☐ NA

Signature : Ayesha
Name : Dr. Sk. Ayesha

Before Skin Incision ➤➤

TIME OUT Time: 9:40AM

Confirm all team members have introduced themselves by Name and Role ☐ Yes ☐ No

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm
- Correct Patient (Check ID Band) ☑ Yes ☐ No
- Correct Site ☑ Yes ☐ No
- Correct Procedure ☑ Yes ☐ No

Anticipated Critical Events

Surgeon Reviews:
- What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? Bleeding, 30min, 100ml ☑ Yes ☐ No ☐ NA

Anaesthesia Team Reviews:
- Are There Any Patient-specific Concerns? ☑ Yes ☐ No ☐ NA

Nursing Team Reviews: Bleeding, hypotension

- Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☑ Yes ☐ No ☐ NA
- **Is Essential Imaging Displayed?** ☐ Yes ☑ No ☐ NA
- Power Supply, Earthing, Power Backup and functioning of equipment checked. ☑ Yes ☐ No

Signature : Rf
Name : Ruby. f

Before Patient Leaves Operating Room

SIGN OUT Time: 10:20am

Nurse Verbally Confirms with the Team:
- The Name of the Procedure Recorded ☑ Yes ☐ No
- That Instrument, Sponge and Needle Counts are Correct (or Not Applicable) ☑ Yes ☐ No ☐ NA
- The Specimen is Labelled (including patient name) ☐ Yes ☐ No ☑ NA
- Whether there are any Equipment Problems to be addressed ☐ Yes ☑ No ☐ NA

To Surgeon, Anaesthetist and Nurse:
- What are the key concerns for recovery and management of this patient? ☐ Yes ☑ No

Signature : [signature]
Name : Dr. Nausheen .

VIH-00205867 IP-00060599
Mrs DIVYA GUJJA
24-06-1998 28 Y 0 M 13 D (F)
Dr. BHAVANA K

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OPERATION NOTES

Surgeon : Dr BHAVANA.K.	Asst. Surgeon : DR. Nausheen.
Pre-Operative Diagnosis: Primigravida with 16+2 weeks with high BMI with Short Cervix.	
Surgical Procedure : Cervical Cerclage. V/SA	
Indications for Surgery : Short Cervix 25mm.	
Date : 7/07/26.	Start Time : 9:40AM / End Time : 10:20AM
Post Operative Diagnosis:	
Peri-Operative Complications:	
Amount of Blood Loss:	Blood Transfused (in ML)
Name and Number of Surgical Specimen sent for examination:	
Operation Notes:	

- Under strict aseptic conditions, under spinal Anesthesia, patient placed in lithotomy position, parts painted & and draped.

(P.T.O.)

- Anterior and posterior vaginal walls retracted using sims speculum.
- Anterior lip of cervix held using Allis forceps.
- Cervical cerclage done using McDonalds cerclage and knot placed anteriorly.
- Hemostasis secured.
- Instruments and gauze count tallied.

Adv

- NBM
- Rest
- Monitor Vitals
- follow drug chart
- Inform SOS.

Dr Nasreen

Name of the Surgeon: DR. Bhavana. K

Signature of the Surgeon: .....

Date & Time: 7/7/26 ; 10:15 Am.

VIH-00205867 IP-00060599
Mrs DIVYA GUJJA
24-06-1998 28 Y 0 M 13 D (F)
Dr. BHAVANA K

(1)

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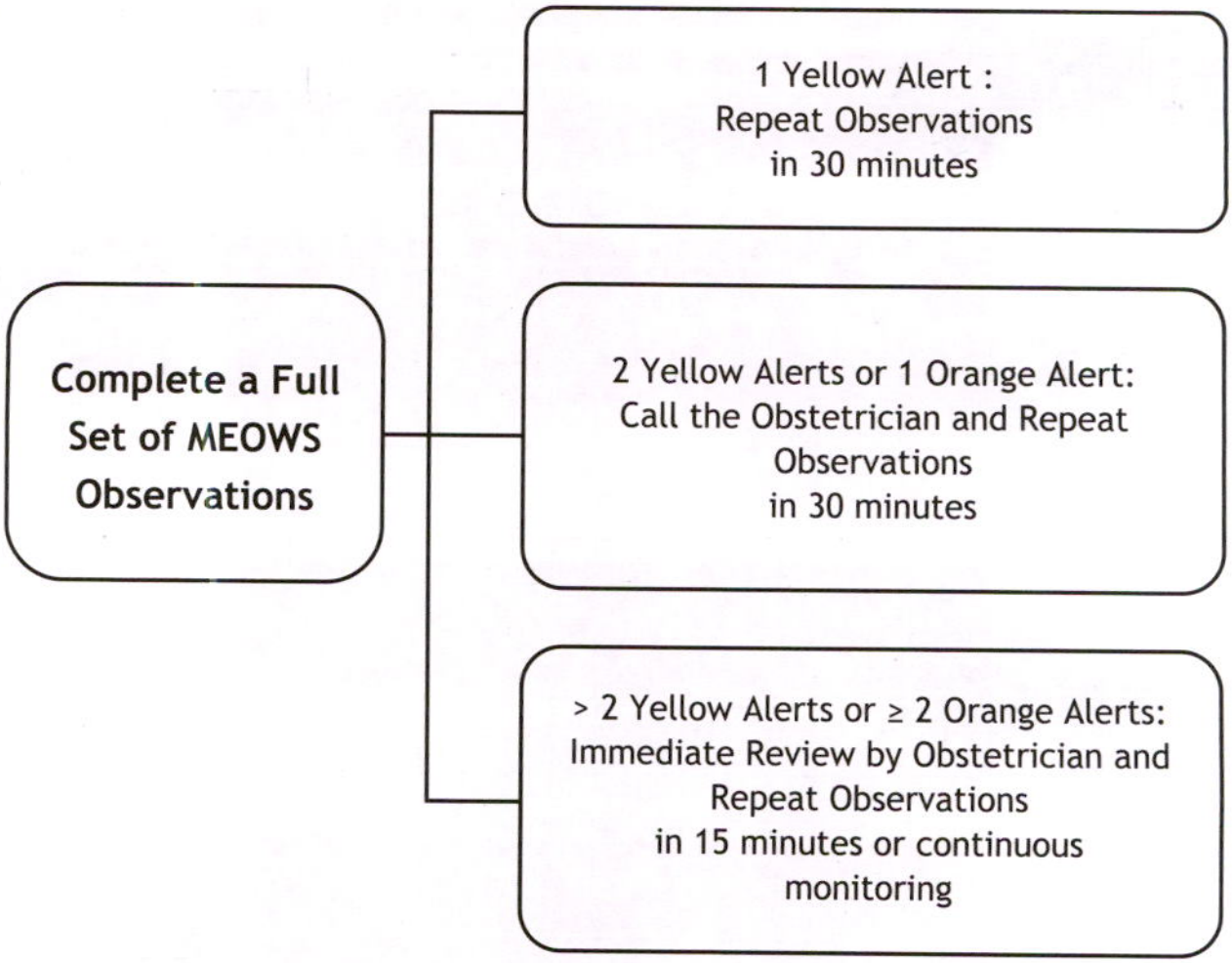
Early Warning Observation Score Chart - Obstetrics

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

7/7/26	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																								19
	11 - 20																								
	0 - 10																								99
Saturations	94 - 100 %																								
	< 94 %																								
Administered O_2 (L/min.)																									
Temp°c	40																								
	39																								
	38																								
	37																								36.6
	36																								
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80																								89
	70																								
	60																								
	50																								
	40																								
Systolic Blood Pressue ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								114
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70																								70
	60																								
	50																								
	40																								
NEURO RESPONSE [✓]	Alert																								✓
	Voice																								
	Pain																								
	Unresponsive																								
URINE mls / hour	> 30																								✓
	< 30																								
Proteinuria	Protein + +																								
	Protein > + +																								
Lochia	Normal																								NA
	Heavy / Foul																								
Liquor	Clear / Pink																								NA
	Green																								
TOTAL YELLOW SCORES																									3
TOTAL ORANGE SCORES																									2
Nurse Initial																									

Obstetrics and Gynaecology Early Warning Signs



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

VIH-00205867 IP-00060599
Mrs DIVYA GUJJA
24-06-1998 28 Y 0 M 13 D (F)
Dr. BHAVANA K

(2)

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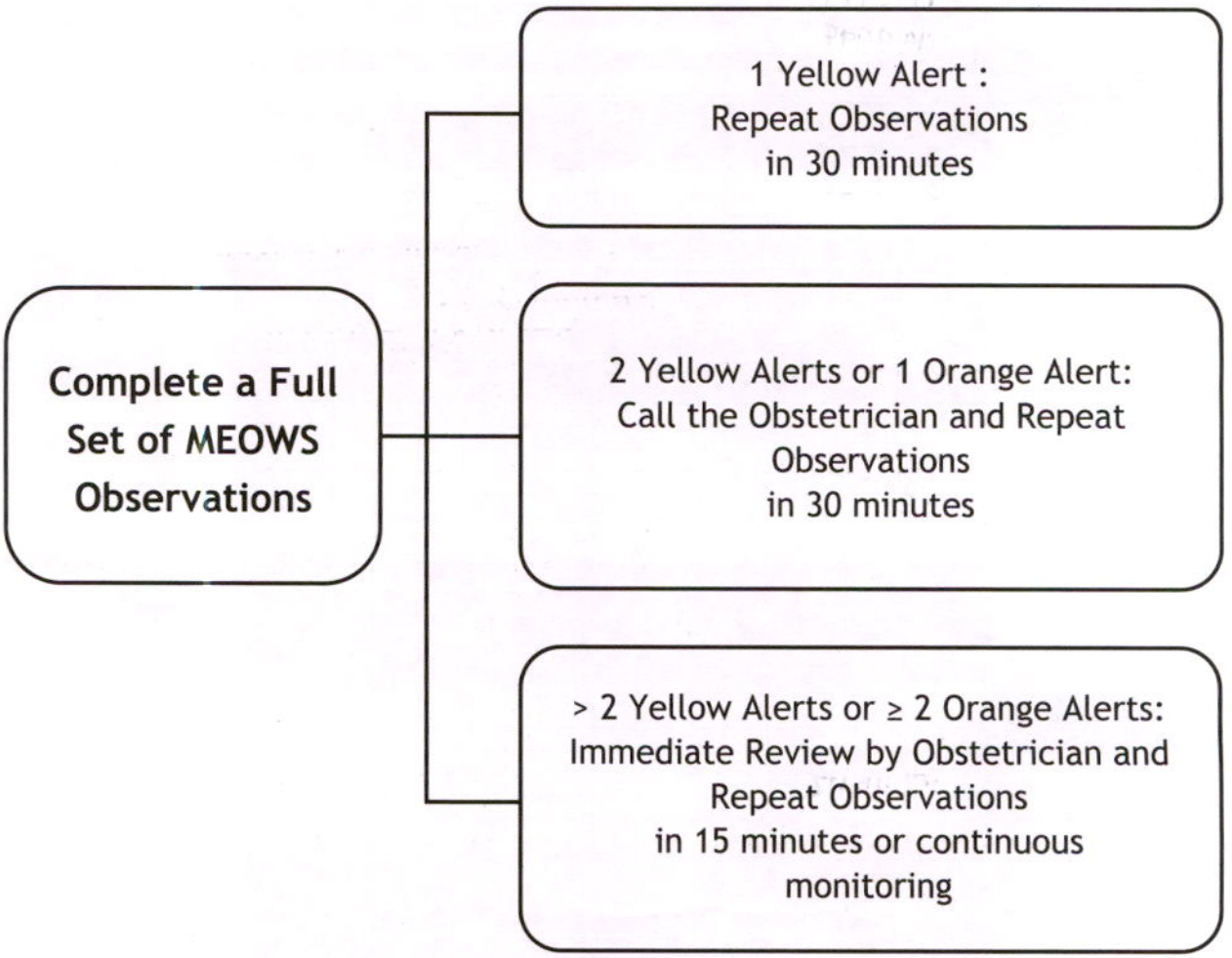
Early Warning Observation Score Chart - Obstetrics

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

7/7/26	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		19	19	19																				
	0 - 10																								
Saturations	94 - 100 %		a	a	99																				
	< 94 %																								
Administered O_2 (L/min.)																									
Temp°c	40																								
	39																								
	38																								
	37		37	37																					
	36																								
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80		85	82	80																				
	70																								
	60																								
	50																								
	40																								
Systolic Blood Pressue ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110		101	110	112																				
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70		70	75	70																				
	60																								
	50																								
	40																								
NEURO RESPONSE [✓]	Alert		✓	✓	✓																				
	Voice																								
	Pain																								
	Unresponsive																								
URINE mls / hour	> 30		✓	✓	✓																				
	< 30																								
Proteinuria	Protein + +		—																						
	Protein > + +																								
Lochia	Normal		✓	✓	✓																				
	Heavy / Foul																								
Liquor	Clear / Pink		✓	✓	✓																				
	Green																								
TOTAL YELLOW SCORES			0	0	0																				
TOTAL ORANGE SCORES			0	0	0																				
Nurse Initial																									

Obstetrics and Gynaecology Early Warning Signs



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

VIH-00205867 IP-00060599
Mrs DIVYA GUJJA
24-06-1998 28 Y 0 M 13 D (F)
Dr. BHAVANA K

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FLUID CHART

Sheet No. : 1

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

Date	Time	Intake: Nature of Fluid	Intake: Route: Mouth	Intake: Route: I.V	Intake: Route: N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
	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											
7/7/26	05:00 am											
	06:00 am	NBM										
	07:00 am	NBM+RLFA								✓	0	~~HH~~
Total Intake :		500ml				**Total Output :**				Passed		

Total 24 hrs. Intake	500ml	Total 24 hrs. Output	Passed

Docu. No. : RCH /FRM / CLINICAL / 092

VIH-00205867 IP-00060599
Mrs DIVYA GUJJA
24-06-1998 28 Y 0 M 13 D (F)
Dr. BHAVANA K

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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.

		Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	IV	N.G							
7/7/26	08:00 am	NBM+RL 100ml									0	
	09:00 am	NBM + RL 100ml									0	
	10:00 am		NBM RL 1000ml/hr.								0	
	11:00 am	NBM+RL 100ml										
	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	

VIH-00205867 IP-00060599
Mrs DIVYA GUJJA
24-06-1998 28 Y 0 M 13 D (F)
Dr. BHAVANA K

(1)

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

DRUG CHART

Date of Admission: 7/9/26 Drug Allergies: NIL ☑ 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 .....

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I.V. FLUIDS CHART

Weight. 78.15kg Ward. CW

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
7/6	8:10 am	RINGER LACTATE	IV	FF			7/7		
7/6	9 AM	RINGER LACTATE	IV	100ml/hr			7/7		
7/7	9:50Am	RINGER LACTATE	IV	1000 ml/hr					

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

VIH-00205867 IP-00060599
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24-06-1998 28 Y 0 M 13 D (F)
Dr. BHAVANA K

Weight. 78.15kg Ward. 2W

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
7/6/26	9:5 PM	INJ. CEFOTAXIME (AFTER TEST DOSE)	1GM	IV		
7/6/26	8:10 AM	INJ. PANTOPRAZOLE	40 MG	IV		
7/6/26	8:10 AM	INJ. METOCLOPRAMIDE	10MG	IV		
7/6	9 AM	INJ. HYDROXYPROGESTERONE ACETATE	500 MG	IM		HOLD
7/7	9:10 AM	INJ. HYDROXYPROGESTERONE CAPROATE	500 MG	IM		
7/7/26	10:15 AM	TRAMADOL Suppository	100 mg	PR		

VERIFIED BY : Name Signature

VIH-00205867 IP-00060599
Mrs DIVYA GUJJA
24-06-1998 28 Y 0 M 13 D (F)
Dr. BHAVANA K

REGULAR PRESCRIPTIONS

Weight: 78.5kg Ward. LIW

DRUG : T. PARACETAMOL

Dose	Route	Frequency	Start Date
1gm	PO	TID	7/7/26

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

Additional Instructions:

STOP

Dr. Ayesha 7/7/26

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG : T. TRAMADOL

Dose	Route	Frequency	Start Date
100mg	PO	BD	7/7/26

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

Additional Instructions:

STOP

Dr. Ayesha 7/7/26

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG : T. PARACETAMOL

Dose	Route	Frequency	Start Date
1gm	PO	8th July	7/7/26

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG : T. TRAMADOL

Dose	Route	Frequency	Start Date
100mg	PO	12th July	7/7/26

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

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Mrs DIVYA GUJJA
24-06-1998 28 Y 0 M 13 D (F)
Dr. BHAVANA K

(1)

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date: 7/7/26

To Be Filled In By Assigned Nurse:

Department: L&W

Duration of Procedure : 1hr 40min

Name of Surgeon: DR. Bhavana. k

Date of Admission : 7/7/26

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:- Tazam 1gm	
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	
3.	Patient's body temperature immediately post operation (Recovery Room) 36.4 °C ☐ Oral Or ☑ Axilla (Goal: 36-37°C)	
4.	Name of doctor or staff administering the antibiotic: Dr: Nausheen Date & Time of antibiotic administration: 7/7/26 9 AM Date & Time procedure started: 7/7/26 10:40AM	

- 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

ESTIMATION SLIP

Rainbow® Children's Hospital — It takes a lot to treat the little.
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Date : 6/7/26 UHID/IP No.: VIH-OD205867 Sl. No.: 29136

Name of Patient : Mrs. Divya Gupta Age : 28y Gender : F

Father's / Husband's Name : Mr Ajay.A Corporate/Occupation : pvt

Address : Kavimagu . Phone : 9533119679. Email :

Procedure/Plan: Cuclage DOS :

MODE OF PAYMENT : ☑ SELF ☐ TPA : CASH ☐ GIPSA : ☐ OTHER

TARIFF INFORMATION : DR. Bhavana. K.

	ROOM CATEGORY	GW	SW	TSW	PR	DLX	NICU	PICU	MICU	DAY CARE
(Per Day)	Room Rent & Nursing Charges							8hrs		/
	Doctor's Fee									
	L. Tax									4800.

PARTICULARS	AMOUNT (₹)
Surgeon's / Anesthetist's Fee / O.T Charges	36000
O.T Consumables	3000 Subject to approval by TPA/Insurance Company
Instrument Charges	Not Covered by TPA/Insurance Company
Pharmacy, Consumables & Investigations	5K DAE As per actual – Not Included In Estimation

Equipment Charges				
	Monitor :	Oxygen:	Infusion Pump/Syringe Pump:	
	Ventilator	*Conventional:*	*HFO-SLE 5000:*	*HFO-Sensormedix:*
	Phototherapy	*Single Surface:*	*Double Surface:*	*Triple Surface:*

Blood / Blood Products / Implants / IP or OP Procedures / Cross Consultations, etc.	As per actual – Not Included In Estimation
Package	
Others	MRA-2K, MRD-2500, Consultant-2200, PR-2K.
Initial Minimum Deposit	40K.

REMARKS :

1. The estimated amount may change according to duration of stay, medical condition, investigations, pharmacy and any other procedure.
2. **The estimated surgical charges may vary subject to Surgeon's decisions / Complications / Patient's requirements / Modes of Procedure (like Laparoscopic, Thorocoscopic, etc) / Unilateral to Bilateral Procedure.**
3. In case the patient is shifted from lower category to higher category, all charges for the consultant visit, investigations, operations and/or procedures from the date of admission will be according to the higher category.
4. Room eligibility is purely subject to TPA approval and the Package/Room tariff starts from the time of admission.
5. Proportionate difference of bill amount is applicable in case the patient opts for a category higher than the TPA approved, which has to be paid by the patient and may not be reimbursed by the TPA / Insurance Company at later stage.
6. **For Non – Medicals, Disposables, Consumables, Infusion Pump, Taxes, Implants, HIV/HbsAg, Medical Records, Insurance Processing Fee, Double Occupancy and Registration Charges, etc, credit cannot be extended. These items are not payable to us as per Insurance Company norms.**
7. During Non-working hours of O.T (8:00PM to 6:00AM), Sundays & Public Holidays, 30% extra charges are applicable on surgical cost, and this is not covered by TPA / Insurance Company. In case the length of stay is beyond the package permitted, additional payment is applicable, for which kindly contact the Financial Counseling desk between 9 am to 6 pm.
8. Difference, if any between the final bill amount and amount permitted / approved by the TPA or total bill amount in case of denial from TPA has to be paid by the patient. In case of denial, cash tariff would be applicable.
9. Two attendants are permitted with patients in SDLX, DLX and PVT Rooms and only one is permitted in the rest of the categories of rooms. And no attendant is permitted in ICUs.
10. Tariffs are subject to revision.
11. Kindly check your billing status on day to day basis at IP Billing Department .

DECLARATION

I Also Ajay have attended the Financial Counseling desk and understood the expected costs and other conditions applicable. In case the TPA/Insurance Company rejects the claim for whatsoever reasons at any point of time after discharge, I promise to settle the claim with the hospital.

Also Ajay
Signature of the Client

Husband
Signatory Relationship

Signature of the Financial Counselor