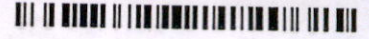


ADMISSION SHEET

Registration Details :



Admission No : IP5-00173837 Admit Date : 14-May-2026 Admit Time : 03:29 PM UHID : KUH-00151388

Patient Details :

Patient Name	: Mrs LANKA LAVANYA	Age	: 30 Y 6 M 7 D
Guardian	: Mr ROHIT BHEEMUNI	DOB	: 07-11-1995
Gender	: Female	Religion	:
Occupation	:	Martial Status	: Married
Address (H)	: FLAT NO 503, JYOTSNA NIVAS APARTMENT, NRI COLONY, BEHIND NARAYANADRI GATED APARTMENTS, PRAGATHI NAGAR, NIZAMPER, MEDCHAL-MALKAJGIRI Bachupally Hyderabad Telangana INDIA 500090	Phone No	: 8886070716
		E-mail	: no@gmail.com

Admission Details :

Bed Type : SHARED WARD Bed No : SW 415 Ward Name : 4F-BIRTHING CENTRE
 Room No : SW 415 Admission Type : First Visit

Contact Details :

Name : Mr ROHIT BHEEMUNI Relationship : Husband
 Contact Address : FLAT NO 503, JYOTSNA NIVAS APARTMENT, NRI COLONY, BEHIND NARAYANADRI GATED APARTMENTS, PRAGATHI NAGAR, NIZAMPER, MEDCHAL-MALKAJGIRI Bachupally Hyderabad Telangana INDIA 500090 Phone No : / 8886070716

ROHIT B
 Signature

Doctor Details :

Doctor Name : Dr. HIMABINDU VEERLA Specialisation : OBSTETRICS AND GYNECOLOGY
 Referral Doctor : Self Phone No :
 Co-Consultant :

Payment Details :

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

①



ACTIVITY RECORD FOR BILLING

Name : _____
 UHID No. : _____

KUH-00151388 IP5-00173837
 Mrs LANKA LAVANYA
 07-11-1995 30 Y 6 M 7 D (F)
 Dr. HIMABINDU VEERLA



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

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Anand (P.S. Needles)	14/5/26		[Signature]
2				
3				
4				
5				
6				
7				
8				
9				
10				



IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

Came with leaking per vagina: 8 AM 14/5/26.

Obstetric Formula: Primigravida

Obstetric History:

LMP: 16/9/20

EDD: 23/6/26

Corrected EDD: 23/06/2026

GA: 34+2 wks.

Menstrual History: Regular: Yes No

Obstetric Examination

Fundal Height: 84

Ut. Activity: Relaxed Mild Mod Severe

Liquor: Adequate Oligo Poly

PP: Cephalic Breech Others _____

Head Fifths Palpable: _____

FHS: Normal Tachy Brady Absent

Present Pregnancy Record:

Booked at - 21 wks of GA.
 previous ANC @ Revive Hospital, Hyd.
RISK FACTORS:

+ Cervical Insuff.
 : 20+1 wks of GA.
 at Revive Hospital, Hyd.

Per Speculum Examination

Draining: Present Absent Bleeding

Colour of Liquor: Clear Meconium Blood Stained

Cervical stitches insitu.

Vaginal Examination

Cervix: Long Partially effaced Effaced

Os: Closed _____ Dilated Admitting tip of 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: 151 cm

Weight: _____ kg

Allergies: NKA

Breast: Normal Abnormal

General Examination:

consciousness: clear Pallor: Absent

Reflexes: Absent Edema: Absent

Temp: Afebrile PR: 76 BPM

BP: 118/76 mmHg DTR: present

CVS: S1S2 (+) RS: BAE (+)

Liver/Spleen: Palpable not Urine Output: Adequate

DIAGNOSIS

Primigravida / 34+2 weeks. / came with leaking per / cervical stitches insitu with PPRM.

KUH-00151388
 Mrs LANKA LAVANYA IP5-00173837
 07-11-1993 30 Y 6 M 7 D (F)
 Dr. HIMABINDU VEERLA

Family History:

Father - DM
 Mother - HTN, DM, Hypothyroid

Surgical History:

cerclage @ 20 wks

Medical History:

+ used T. Udiliv + Biot advised by Dr. HB to stop, & to take only if itching.
 small RT kidney.

Medication History:

see Medical record for
 Boostin ✓
 flu ✓

Plan of Care:

- 1) Admission
- 2) IV cannulation
- 3) NST - Reactive
- 4) Monitor vitals
- 5) NNC.

→ Send EBP, CRP, Urine culture, CBC, HVS, G trace.

→ Ifecond coverage.
 CRBS → 103 mg/dl.

Investigations:

BCT → O + ve.

Virals → Neg

CBP - Hb - 10.7 / WBC - 14,400 / PLT - 2.33

11/3/26 Cr (1.3) HSM - 2.9 6/2/26 - Cr (4.07)

24/4/26 - BA - 3.50

6/2/26 - urine cu - NO growth
 10/4/26

- 29th wk, 1260 gm, 15C, cephalic
 Al on (a.c), AFI - 16.8 cm,
 placenta - posterior high
 EFW - 1,260 g (15%).
 UA Dopplers - (N)

TIFFA - (N)
 NT - 1.2 mm (CX length - 46.0 mm)

11/3/26
 TBS - 76 / 1st PL - 133 / 2nd PL - 129 /
 BT - 1:30 / CT - 7:00

Doctor Name: Dr. Divya

Signature: [Signature]

Date & Time: 14/5/26; 5:30 pm

Consultant Name: Dr. Himma Bishu

Signature: [Signature]

Date & Time: 15/5/26, 9 am

KUH-00151388 IP5-00173837
 Mrs LANKA LAVANYA
 07-11-1995 30 Y 6 M 7 D (F)
 Dr. HIMABINDU VEERLA



RESULT SHEET

Date	14/5/26	15/5/26			
Time		9:16 AM			
Hb	11.5				
PCV	35.1				
RBC	4.01				
WBC	15.42				
N/L					
Platelets	304				
CRP	22				
ESR					
PCT					
RBS					
Na		133			
K		4.3			
Cl		104			
Ca/Mg					
Phosphate					
Urea		39			
Creatinine	1.1	1.2			
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					

KUH-00151388 IP5-00173837
 Mrs LANKA LAVANYA
 07-11-1995 30 Y 6 M 7 D (F)
 Dr. HIMABINDU VEERLA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/10/2016		
17/10/2016 8:00pm	Pt comfortable ole	<u>Adv</u> - drugs as prescribed - vitals stability
<u>labs</u>	all fair	- Regular diet
CBP - 11.5 / 10.2 / 13.0 / 13.0	vitals stable	- plenty of oral fluids
CRP - 22	MA - vit relaxed FHRT ⊕	- w/f S/S chorio amnionitis
trace CVG, Urine /s, HVS.	UG clear leak ⊕	- Gentle pad for obstination
		- plan for cord clamping removal
		- Inform all

[Signature]
Dr. [Name]

~~14/10/2016~~
8:00pm

Prickum - Antenatal counselling:

At 3 weeks pPROM, short cervix, AFP - 16.8
 counselled for possible risk of shortness of breath due to
 RDS/PPH requiring oxygen support/dPP, umbilical care,
 low sugars (hypoglycaemia), jaundice, risk of early
 infection (sepsis) - may require NICU stay of 2-3 days.

Dr. VILSON

KUH-00151388 IP5-00173837
 Mrs LANKA LAVANYA 30 Y 6 M 8 D (F)
 07-11-1993
 Dr. HIMABINDU VEERLA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/5/2026		
9:15 AM	<p>Term / 3rd 2 wks / ceclage in situ / P/Plon Plan - ceclage removal at home. (Plon / kidney) Clo-Nil C.c - farr. P - 20 mi</p>	<p>- Jay Bicheral 12 mg at 11:00 on 13/5/26</p>
	<p>Bp - 115 / 70 mm Hg Pl - uterus relaxed fms B.</p>	<p>- water for uterine contractions</p>
	<p>Cep - 22 WBC - 15,600.</p>	<p>- Vitals - Temp / Pulse / Bp Monitoring</p>
	<p>- HUS } awaiting - urine culture }</p>	<p>- continue to Antibiotics - water for Chondromyxoma /</p>
		<p>- seen ceclage in situ.</p>
15/5/2026		
12 AM	<p>Pt comfortable no pain. fms + good</p>	<p>CM MAM</p>
	<p>Dr Ceclage 1.1 urine Proben 1.1</p>	<p>CM MAM</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/11/2016 2 AM	Pt is sleeping.	
15/11/16 5 AM	Pt is comfortable. No pain Cecy four. P/A - cut relaxed Fus @ Clear leak @	Adm - NST - Post - Breakfast - Growth scan today - 2nd dose of steroids at 6 PM.
	Plan - Cecyge Removal	- w/d signs & symptoms of chorioamnionitis - G IV Antibiotics
15/11/2016 2 AM	No-tidal Pelvic Pain Cecy four - P/A - cut relaxed Fus @ Clear leak. Sp - 79/41 Bp - 101/60 SpO2 - 100 NAC ✓	Adm - NST - post breakfast - Growth scan today. - w/d signs & symptoms of chorioamnionitis

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 Mrs LANKA LAVANYA
 07-11-1993 30 Y 6 M 8 D (F)
 Dr. HIMABINDU VEERLA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/10/16 9 AM	Primi / 34 th wks / Cervix 9 cm / PPRON	
	No clo pain.	R
	Clo: leaving ph	1) Monitor vitals - q6c
	GC: fair	2) w/f sqs of Itherio-dm
	Afebrile	3) NST once daily
	B.P - 110/70	PT Breakfast.
	P.R - 75	4) plac - Stich Remov
	P/A: Ut 34 wks	today
	relax	5) Iufe sus.
	FHR ⊕	6) Growth scan (now)
	CV - 1.1	
	CUE - protein +	DR. D. D. D.
	Hemolysed Blood	
	Leucocytes - Trace.	
	PC - 6-8	
	EC - 5-6	
	RBC - 4-5	
	CRP - 22.1	
	Hb - 11.5	
	WBC - 15.42	
	PLT - 3.04 L	

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 Mrs LANKA LAVANYA (F)
 07-11-1995 30 Y 6 M 8 D
 Dr. HIMABINDU VEERLA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/5/2026	S/O. Dr. HIMABINDU.	Adv
10.15 AM	Pt comfortable NO H/O pain Abd Blak +	Cervix 2cm + Doppler.
	PA - 4 - 3 weeks relaxed Cephalic FHS +	
	Couple Counseled about present - condition.	
	Explained about - pre-maturity & associated complications, possibility of infection, early delivery & NICU admission.	
	(Dr. Himabindu)	
10/5/26 4 PM	Primis / 34 ⁺ wks / Cervix 2cm + Blak + (1.2cm)	R
	G.C: pain ckle	1) monitor vitals - q 4h
	B.P: 110/70 P-R: 72	2) w/ f S/S of chorioamnionitis
Na/Ket + 133/4.3/104 Cmt: 1.2 Wca: 39	P/A: 0/0 - 34 wks relaxed FHS:	3) NST once daily. 4) Shift to Birster for C/S - stick renal

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 Mrs LANKA LAVANYA
 07-11-1993 30 Y 6 M 8 D (F)
 Dr. HIMABINDU VEERLA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>4pm</u>	<p>↓ Aseptic Coautition pt placed in lithotomy position Cervical stick removed - NO Bleeding noted Post procedure Gc: pair etc B.P: 110/70 P.R: 72 P/A: Ut-34cm reband</p>	<p>R 1) 2)</p>
<u>10:30hr</u>	<p>USG → SLIUG, cephalic, placenta → post/lower, AFI: 1.2cm, EFW: 1318gm (2nd b), AC: 270 (3rd b) CrL → 110mm, Doppler</p>	
<u>10:30hr</u> <u>4pm</u>	<p>Primi / 34th w / Cervical stick removed FGR (2nd b) 01190 (1.2cm)</p>	
<u>NNE</u> <u>stands</u>	<p>Gc: pair etc B.P: 110/70 P.R: 72 P/A: Ut-34cm reband Pre-NAB</p>	<p>R 1) Monitor vitals + by 2) w/ f 548 of Chesidant 3) NST secondary 4) (2) diet 5) Drug as checked 6) DPK & STO 7) Tube son</p>
		<p>Dr. Sranthw</p>

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 07-11-1995 30 Y 6 M 8 D (F)
 Dr. HIMABINDU VEERLA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/12/20 6pm	primi / 34 ³ wks	FHR / PROM / COLIC
	GC: fair	Asu → regular diet
	BP: 120/74	Monitor BP / PRR / FHR
	PR: 89/min	→ Cyt h bly
	SpO ₂ : 100%	→ inform sos if
	Temp: 97.6°F	PR > 100 or Temp > 99°F
	P/A: ut relaxed.	
	ds: pad dry.	→ follow drug chart
	!	→ strict fetal kick count
		→ inform sos
		Aboneth Dr G S... 15/12/20

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Mrs LANKA LAVANYA

07-11-1995 30 Y 6 M 8 D (F)

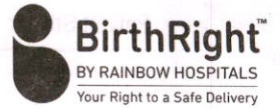
Dr. HIMABINDU VEERLA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/5/26 6 AM	primi 34 th weeks	Fet / Placental oligo
	Ac failure	Co stitch removed yesterday. Adv
	BP:	regular diet
	RR:	follow drug chart
	Temp:	Monitor BP/RR/Temp
	SpO ₂ :	PRN only
	P/A: uter 32-34 wks.	rest three daily
	relaxed	w/ signs of chorioamnionitis
	fit & good	pad for observation
		inform sos.
		A. Sonika Dr. Sonika

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 Mrs LANKA LAVANYA
 07-11-1993 30 Y 6 M 8 D (F)
 Dr. HIMABINDU VEERLA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>16/08/20</u>	Case seen by Dr. Himabindu	
<u>10 AM</u>	P/GM / 34 weeks / FGR & PPRM & oligohydramnios	
	C/S: / air PT-C/E/C R.P: 110/70 P.R: 72	<ol style="list-style-type: none"> 1) NBM from 10 AM 2) Monitor vitals - 4hr 3) I/O fluids - RL - 100ml/hr
NST reactive	P/A: Ut - 34-36 hrs reband, fHR ⊕ Rfx ⊕	<ol style="list-style-type: none"> 4) Prepare parts 5) NST twice Daily 6) PAC
		<ol style="list-style-type: none"> 7) Wt + DF ke > 10 8) Wt S/S of chorioamnion 9) IUFM ses.
	<u>Noted by Dr. Himabindu</u>	<p style="text-align: center;">Hindu. (Dr. HIMA BINDU)</p>

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 Dr. HIMABINDU VEERLA



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	T. LIVOCLEN	1tab	PO	OD	13/5/26	<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
2	T. SHELICAL-XT	1tab	PO	OD	14/5/26	<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
3	INT. PROLUTON DEPOT	500mg	INA	weekly	8/5/26	<input type="checkbox"/> C <input type="checkbox"/> DC
4	T. SUSTEN	500mg	PO	OD	13/5/26	<input type="checkbox"/> C <input type="checkbox"/> DC
5	T. UDILIV	300mg	PO	BD	12/4/26	<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Dmye

Date & Time: 14/5/26

Nurse Name & Signature: Suf

Date & Time: 14/5/26 @ 3:29pm

KUH-00151388 IP5-00173837
 Mrs LANKA LAVANYA
 07-11-1993 30 Y 6 M 7 D (F)
 Dr. HIMABINDU VEERLA



DRUG CHART

Date of Admission: 14/5/26 Drug Allergies: NEDA 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

REGULAR PRESCRIPTIONS

Weight - Ward. 024



DRUG : JMS CEFOTAXIM					Date Time																	
Dose	Route	Frequency	Start Date																			
1g	IV	BD	14/5/26		4 AM	14/5																
Name & Signature of the Doctor Starting the Drugs: Smitli Dr Smitli																						
Additional Instructions:																						
Daily Doctor's Endorsement by a Sign																						
DRUG : 2i SUSTIN					Date Time																	
Dose	Route	Frequency	Start Date																			
100mg	IM	OD	15/5/26			15/5																
Name & Signature of the Doctor Starting the Drugs: (Dr. V. Hema Bindu)																						
Additional Instructions:																						
Daily Doctor's Endorsement by a Sign																						
DRUG : I.V. NETROXYL					Date Time																	
Dose	Route	Frequency	Start Date																			
500mg	IV	TID	15/5/26		5 AM	15/5	16/5															
Name & Signature of the Doctor Starting the Drugs: (Dr. V. Hema Bindu)																						
Additional Instructions:																						
Daily Doctor's Endorsement by a Sign																						
DRUG : 2ij PANTOPRAZOLE					Date Time																	
Dose	Route	Frequency	Start Date																			
40mg	IV	O.D	16/5			15/5	16/5															
Name & Signature of the Doctor Starting the Drugs: Dr. Sravankumar																						
Additional Instructions:																						
Daily Doctor's Endorsement by a Sign																						



VARIABLE DOSE		Date		Nurse Sig.		Nurse Sig.		Nurse Sig.	
		Time							
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		Nurse Sig.		Nurse Sig.		Nurse Sig.	
		Time							
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
14/12/26	4pm	INI BETAMETHASONE	12mg	IM	Suthi	Sona Anjali
15/12/26	6pm	BETAMETHASONE	12mg	IM	P	Sunanda Swarupa

Signature
VERIFIED BY - Name

KUH-00151388 IP5-00173837
 Mrs LANKA LAVANYA
 07-11-1995 30 Y 6 M 7 D (F)
 Dr. HIMABINDU VEERLA



FLUID CHART



Sheet No. : 11

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	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	H ₂ O								✓	0		Ajaly
	05:00 pm	H ₂ O									0		Ajaly
	06:00 pm	H ₂ O								✓	0		Ajaly
	07:00 pm										0		Ajaly
Total Intake : Taken						Total Output : passed							
	08:00 pm	H ₂ O								✓	0		Shobha
	09:00 pm	H ₂ O									0		
	10:00 pm	H ₂ O								✓	0		Shobha
	11:00 pm	H ₂ O									0		
	12:00 am	H ₂ O									0		Shobha
	01:00 am	H ₂ O								✓	0		
Total Intake :						Total Output :							
	02:00 am									✓	0		Shobha
	03:00 am	H ₂ O									0		
	04:00 am										0		
	05:00 am	H ₂ O								✓	0		Shobha
	06:00 am										0		
	07:00 am	H ₂ O								✓	0		Shobha
Total Intake : Taken						Total Output : passed							
Total 24 hrs. Intake			Total 24 hrs. Output										

KUH-00151388 IP5-00173837
 Mrs LANKA LAVANYA
 07-11-1995 30 Y 6 M 8 D (F)
 Dr. HIMABINDU VEERLA



FLUID CHART

Sheet No. : 2

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

Date	Time	Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
	08:00 am	R/L		Water						0	} Anna	
	09:00 am	R/L	H ₂ O	Water					✓	0		
	10:00 am	R/L		Water		✓				0		
	11:00 am		H ₂ O						✓	0		
	12:00 pm									0		
	01:00 pm									0		
Total Intake : <u>taken</u>					Total Output : <u>passed</u>							
	02:00 pm		Water			1				0	} Anna	
	03:00 pm		100ml						✓	0		
	04:00 pm									0		
	05:00 pm		Water			NP			✓	0		
	06:00 pm									0		
	07:00 pm		Water							0		
Total Intake : <u>taken</u>					Total Output : <u>passed</u>							
	08:00 pm		H ₂ O			1				0	} Anna	
	09:00 pm									0		
	10:00 pm		H ₂ O			NP			✓	0		
	11:00 pm					P				0		
	12:00 am		H ₂ O							0		
	01:00 am									0		
Total Intake : <u>taken</u>					Total Output : <u>passed</u>							
	02:00 am		H ₂ O			1			✓	0	} Anna	
	03:00 am									0		
	04:00 am		H ₂ O			NP				0		
	05:00 am	metabone	100ml	100ml					✓	0		
	06:00 am		H ₂ O							0		
	07:00 am									0		
Total Intake : <u>taken</u>					Total Output : <u>passed</u>							

Total 24 hrs. Intake taken

Total 24 hrs. Output passed

KUH-00151388 IP5-00173837
 Mrs LANKA LAVANYA
 07-11-1993 30 Y 6 M 8 D (F)
 Dr. HIMABINDU VEERLA



FLUID CHART



Sheet No. : (3)

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am	Idly								✓	0	Becky	
	09:00 am										0	Becky	
	10:00 am	Cocunut rice					✓			✓	0	Becky	
	11:00 am	PK		150 ml							0	Becky	
	12:00 pm	PK		150 ml							0	Becky	
	01:00 pm	PK		150 ml							0	Becky	
Total Intake : <i>totaly</i>						Total Output : <i>posital</i>							
	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