

BAH-00640370
Mrs RUBEENA SAMREEN (F)
02-10-2000 25 Y 9 M 1 D
Dr. DR.M PRATHYUSHA REDDY

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

SURGERY DETAILS

Date : 3/7/26
Patient Name: Mrs. Rubeeena Samreen Date of Birth: 2/10/2000 Age: 25y
Gender: female Ward: BC UHID No: BAH-00640370
Date of Surgery: 3/7/26 ☐ OT -1 ☒ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2
Name of the Surgery: Normal vaginal delivery

Time in : 2:30 pm

Time Out : 3:30 pm

	NAME	AMOUNT
1. Surgeon	Dr. Prathyusha Reddy	
2. Anaesthetist	Dr. Sunidheora	
3. Assistant Surgeon	Dr. Shruthi	
4. OT Technician		
5. Circulating Nurse	Sis. Veena	
6. Assistant Nurse	Sis. Swarna	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9686226

Order by: Swarna

ADMISSION SHEET



Registration Details :

Admission No : IP5-00175909

Admit Date : 03-Jul-2026

Admit Time : 08:41 AM UHID : BAH-00640370

Patient Details :

Patient Name : Mrs RUBEENA SAMREEN

Age : 25 Y 9 M 1 D

Guardian : Mr SYED MATEEN UDDIN

DOB : 02-10-2000

Gender : Female

Religion :

Occupation :

Martial Status : Married

Address (H) : H NO 17-2-134/1, CHAUNINADEALI BAIG,
YAKUTPURA Yakutpura Hyderabad Telangana
INDIA 500023

Phone No : 7097417097/

E-mail : SYEDMATEEN05@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 SYED MATEEN UDDIN

Relationship : Husband

Contact Address : H NO 17-2-134/1, CHAUNINADEALI BAIG,
YAKUTPURA Yakutpura Hyderabad Telangana
INDIA 500023

Phone No : 8309038370 / 7097417097

[Handwritten Signature]

Signature

Doctor Details :

Doctor Name : Dr. DR.M PRATHYUSHA REDDY

Specialisation : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : SELFPAY

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ Consultant: _____ Dept : _____

BAH-00640370 IP5-00175909
Mrs RUBEENA SAMREEN
02-10-2000 25 Y 9 M 1 D (F)
Dr. DR.M PRATHYUSHA REDDY

Date of Admi: _____ Date of Discharge : _____ Time: _____



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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
3/7/26	7.Pm	BBT	Room (302)	Swathi

Cross Consultation Visit

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

[illegible]

Date _____

Investigations

Order No.

Signature

3/9/26

NST — ①

Swande

3/2/26

NIST - (2)

2650 33100

Бухарин

37/26

NST — (3)

Sachin

377/26

CBP.

2606650

Rebu

305

~~cross checking done~~

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
3/12/26	IV placement	01	9685591	Suanda
3/12/26	PAC	of		Kemper

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints Spotting.
Came with ~~loosing~~ per vagina.
since morning
Obstetric Formula: primigravida.

Obstetric History:

I-PP - spon. concept. A -
Booked at 5+2 wks.
Present Pregnancy Record:

LMP: 9/10/2025 **EDD:** 16/7/2026
Corrected EDD: 15/7/2026 **GA:** 38+2 wks.
Menstrual History: Regular: ☒ Yes ☐ No

Obstetric Examination

Fundal Height: ~ Term
Ut. Activity: ☒ Relaxed ☒ Mild ☐ Mod ☐ Severe
Liquor: ☒ Adequate ☐ Oligo ☐ Poly
PP: ☒ Cephalic ☐ Breech **Others** _____
Head Fifts Palpable: 4/5
FHS: ☒ Normal ☐ Tachy ☐ Brady ☐ Absent

RISK FACTORS:

Per Speculum Examination

Draining: ☐ Present ☐ Absent ☐ Bleeding
Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination

Cervix: 1/2 inch ☒ Long ☐ Partially effaced ☐ Effaced
Os: Closed 1-2 cm Dilated
Membranes: ☐ Present ☒ Absent **ARM done.**
Liquor: ☒ Clear ☐ Meconium ☐ Blood Stained
Presenting Part: ☒ Vertex ☐ Breech ☐ Others
Sutton: ☒ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2
Pelvis: ☒ Adequate ☐ Doubtful

Height: 1.59 cm

Weight: 62.3 kg

Allergies: NKDA

Breast: ☐ Normal ☐ Abnormal

General Examination:

Consciousness: c/c/c

Icterus: absent

Temp: c/c/c

BP: 123/73 (91) mmHg

CVS: S1+S2

Liver/Spleen: not palpable

Pallor: absent

Edema:

PR: 77 Bpm

DTR: (+)

RS: B+E (+)

Urine Output: adequate

DIAGNOSIS

primigravida / 38+2 wks / for in early labour
Get thrombocytopenia



Family History: father - HTN	Surgical History: Nil
Medical History: Nil	Medication History: Ac, ca
Plan of Care: 1. Admission 2. iv cannulation 3. Drugs as charted 4. NST - reattach 5. Test T. Miso 25 mg po stat 6. Drugs as charted 7. Monitor vital 8. Written & Informed consent 9. Inform sur. 10. NST 3rd day 11) Recount at 10:30 pm. 12) send a trace CBP. 13) PAC 14) part preparation 15) Epidural sur.	Investigations: BAT - Positive viral - NR 10/6/2020 13.8 / 1.2 L / 8800 19/5/2020 (Gs) 316wks, cephalic, 1745 gram (24y.), Ac - 18 y. PLT - p/H, coagulation (N) TIFSA - (N) NT - 1.4mm FIS - Low risk.

Doctor Name: Dr. Divya

Signature:

Date & Time: 3/7/20; 9:10 AM

Consultant Name: Dr. Prathyusha

Signature: _____

Date & Time: _____

BAH-00640370 IP5-00175909

Mrs RUBEENA SAMREEN

02-10-2000

25 Y 9 M 1 D

(F)

Dr. DR.M PRATHYUSHA REDDY



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7/2026 11Am	P/A: mild Action (+) Pv: en 80%. Effaced os 3cm, 80ff PPVn -2 not well applied clear hsk. NST: No acceleration Good variability	✓ Enema: ✓ Plan oxy Dr. Y. Sneha
3/7/26 12:00pm	Primi / 38th wks	Get thrombolytics
3/7/26 Hb-15.2 WBC-1043 PLT-1.08L+	O/F Get am Bp-120/70 PR-84bpm SpO2-98%+RA 1st-acting	Adv 1) w/F POL 2) Monitor vital 3) NST 3rd hrs 4) Inform sus 5) Epidural sus.
3/7/26 NST on going		Dr. Dhyer.

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7/26 3:30pm	PND-O / G. thrombocytopenia. Immediate post delivery Pt is stable ✓ ABG c/o BP - 120/64 (83) PR - 84bpm spo ₂ - 99% on RA. P/A - Ut well retracted 4c - BUNL.	<u>Advice:</u> ① Soft diet ② Hydrate & ambulate ③ Drugs as charted ④ Vitals & bleeding ptb 15mm per hr for 2hr ⑤ w/o hypotension, tachycardia, bleeding ptb ⑥ Tufem so
3/7/26 6:40pm	PND-O / G. TCF G C: per B.P - 126/86 (90) P.R - 92 Spa: 100% on RA P/A: Ut (2) well Solr BS (4) Ph: 1000 NAB	<u>Re</u> 1) Soft diet & plenty of oral fluid 2) Drug as charted 3) w/o ptb bleeding 4) Ambulation 5) Monitor vitals - 4hr 6) Encourage breast feeds 7) Tufem so
	B-coel Vented VIE ✓ Shift to Room	<u>Dr. Sravathi</u> noted for

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/1/16 9 AM	POD-1 / P/L / G-TCP	
	G.C. pair vitals: stable P/A: U+R well S/Lt BSA P/v: NAB	1) R diet 2) Drug as charted 3) W/L flv Bleeding 4) Analgesia 5) Teflex ses
V/E S/H / due	plan disage	- Dr. Stavand

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

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RESULT SHEET

Date	3/7/26.					
Time						
Hb	15.2					
PCV	45.1					
RBC	4.89.					
WBC	10.43.					
N/L						
Platelets	1.08.					
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						

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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:

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
1	T-IRON	1tab	PO	OD	3/7/26	☐ C ☒ DC
2	T-CALCIUM	1tab	PO	OD	3/7/26	☐ C ☒ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature

Dr. D. D. D.

Date & Time :

3/7/26; 9:10 AM

Nurse Name & Signature:

S. S. S.

Date & Time :

3/7/26. 10 AM.



DRUG CHART

Date of Admission: 21/7/20 Drug Allergies: NKA ☒ 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. 62.3 kg, Ward. DB5



VERIFIED

VERIFIED

VERIFIED

VERIFIED

DRUG : <u>T. PARACETAMOL</u>				Date Time	<u>3/7</u>	<u>4/7</u>
Dose	Route	Frequency	Start Date			
<u>lg</u>	<u>PO</u>	<u>QID</u>	<u>3/7/20</u>	<u>12pm</u>	<u>12pm</u>	<u>12pm</u>
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Sathish Sathish</u>				<u>6pm</u>	<u>6pm</u>	<u>6pm</u>
Additional Instructions:				<u>12pm</u>	<u>12pm</u>	<u>12pm</u>
Daily Doctor's Endorsement by a Sign				<u>6pm</u>	<u>6pm</u>	<u>6pm</u>
DRUG : <u>T. DICLOFENAL</u>				Date Time	<u>3/7</u>	<u>4/7</u>
Dose	Route	Frequency	Start Date			
<u>50mg</u>	<u>PO</u>	<u>TID</u>	<u>3/7/20</u>	<u>7am</u>	<u>7am</u>	<u>7am</u>
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Sathish Sathish</u>				<u>3pm</u>	<u>3pm</u>	<u>3pm</u>
Additional Instructions:				<u>11pm</u>	<u>11pm</u>	<u>11pm</u>
Daily Doctor's Endorsement by a Sign				<u>3pm</u>	<u>3pm</u>	<u>3pm</u>
DRUG : <u>T. PANTOPRAZOLE</u>				Date Time	<u>3/7</u>	<u>4/7</u>
Dose	Route	Frequency	Start Date			
<u>40mg</u>	<u>PO</u>	<u>QD</u>	<u>3/7/20</u>	<u>6am</u>	<u>6am</u>	<u>6am</u>
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Sathish Sathish</u>				<u>6pm</u>	<u>6pm</u>	<u>6pm</u>
Additional Instructions:				<u>6pm</u>	<u>6pm</u>	<u>6pm</u>
Daily Doctor's Endorsement by a Sign				<u>6pm</u>	<u>6pm</u>	<u>6pm</u>
DRUG : <u>SIP DIPHENHIDRAMINE</u>				Date Time	<u>3/7</u>	<u>4/7</u>
Dose	Route	Frequency	Start Date			
<u>15ml</u>	<u>PO</u>	<u>OD</u>	<u>3/7/20</u>	<u>10pm</u>	<u>10pm</u>	<u>10pm</u>
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Sathish Sathish</u>				<u>10pm</u>	<u>10pm</u>	<u>10pm</u>
Additional Instructions:				<u>10pm</u>	<u>10pm</u>	<u>10pm</u>
Daily Doctor's Endorsement by a Sign				<u>10pm</u>	<u>10pm</u>	<u>10pm</u>

BAH-00640370

IP5-00175909

Mrs RUBEENA SAMREEN

02-10-2000 25 Y 9 M 1 D

Dr. DR. M PRATHYUSHA REDDY

(F)

Weight. 62.3 Ward. QK5



DRUG :

Route

Start Date

Name & Signature of the Doctor

Additional Instructions:

Date
Time

Nurse Sig.

Nurse Sig.

Nurse Sig.

Nurse Sig.

Dose

Dose

Dose

Dose

Dr. Sign.

Dr. Sign.

Dr. Sign.

Dr. Sign.

Dose

Dose

Dose

Dose

Dr. Sign.

Dr. Sign.

Dr. Sign.

Dr. Sign.

Dose

Dose

Dose

Dose

Dr. Sign.

Dr. Sign.

Dr. Sign.

Dr. Sign.

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 :

Route

Start Date

Name & Signature of the Doctor

Additional Instructions:

Dose

Dose

Dose

Dose

Dr. Sign.

Dr. Sign.

Dr. Sign.

Dr. Sign.

Dose

Dose

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Dose

Dr. Sign.

Dr. Sign.

Dr. Sign.

Dr. Sign.

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Dr. Sign.

Dr. Sign.

Dr. Sign.

Dr. Sign.

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
3/7/26	8:45 AM	T. Misoprostol	25mg	PO	Dr. Y	Dr. Y
3/7/26	11 AM	2mg cetotaxime	18m	IV	Dr. Y	Dr. Y
3/7/26	10:30 AM	Enema	100ml	PR	Dr. Y	Dr. Y
3/7/26	3:10 PM	INT OXYTOCIN	100	IM	Dr. Y	Dr. Y
3/7/26	3:15 PM	JUSTIN SORBITOL	100mg	PR	Dr. Y	Dr. Y
3/7/26	3:09 PM	T. MISOPROSTOL	400mg	PR	Dr. Y	Dr. Y

Signature

Verified BY : Name

Weight. 62.3 Ward. 085

Page: 4/4

BAH-00640370

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02-10-2000

02-10-2000 25 Y 9 M 1 D
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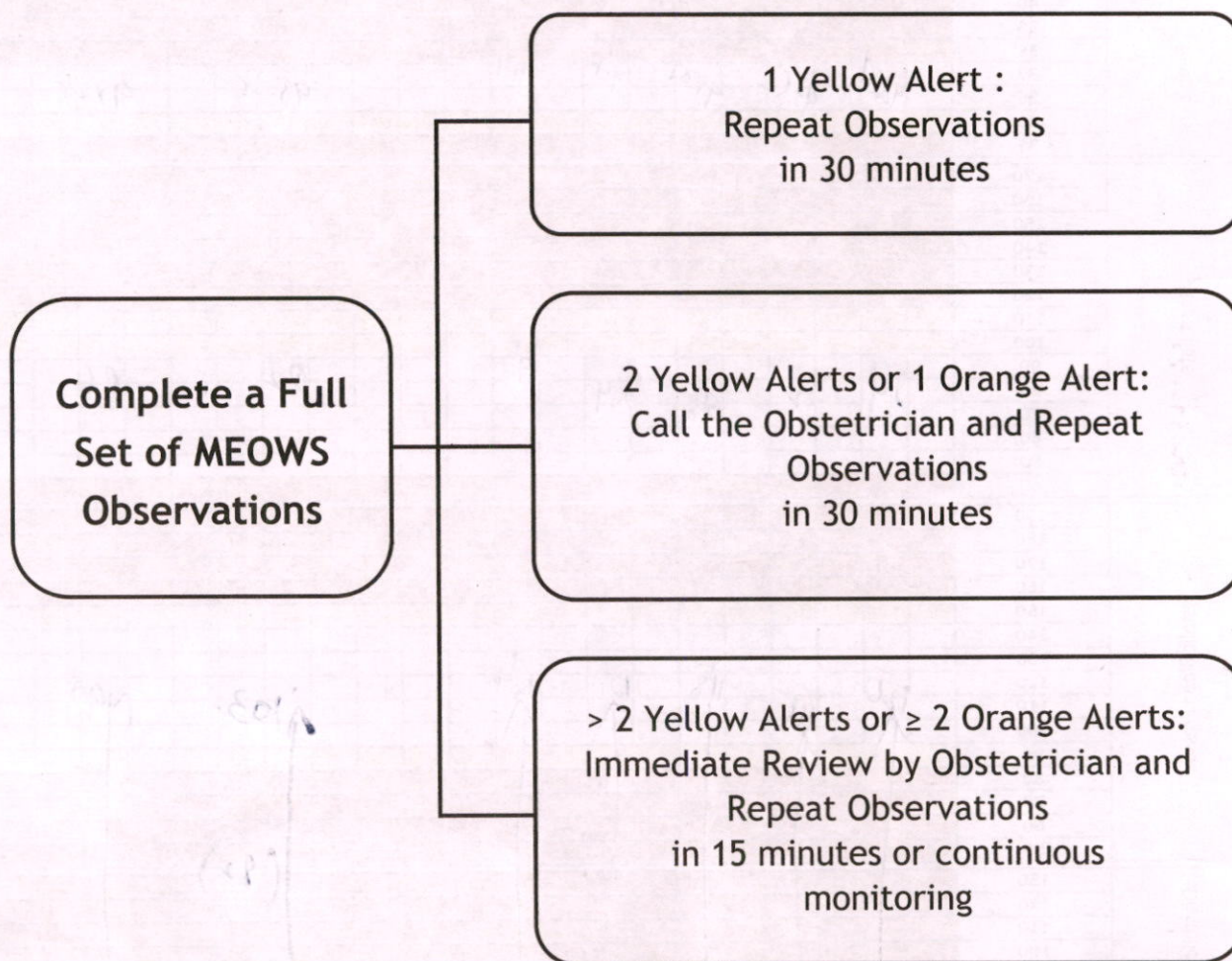
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CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT

TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

[illegible]

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

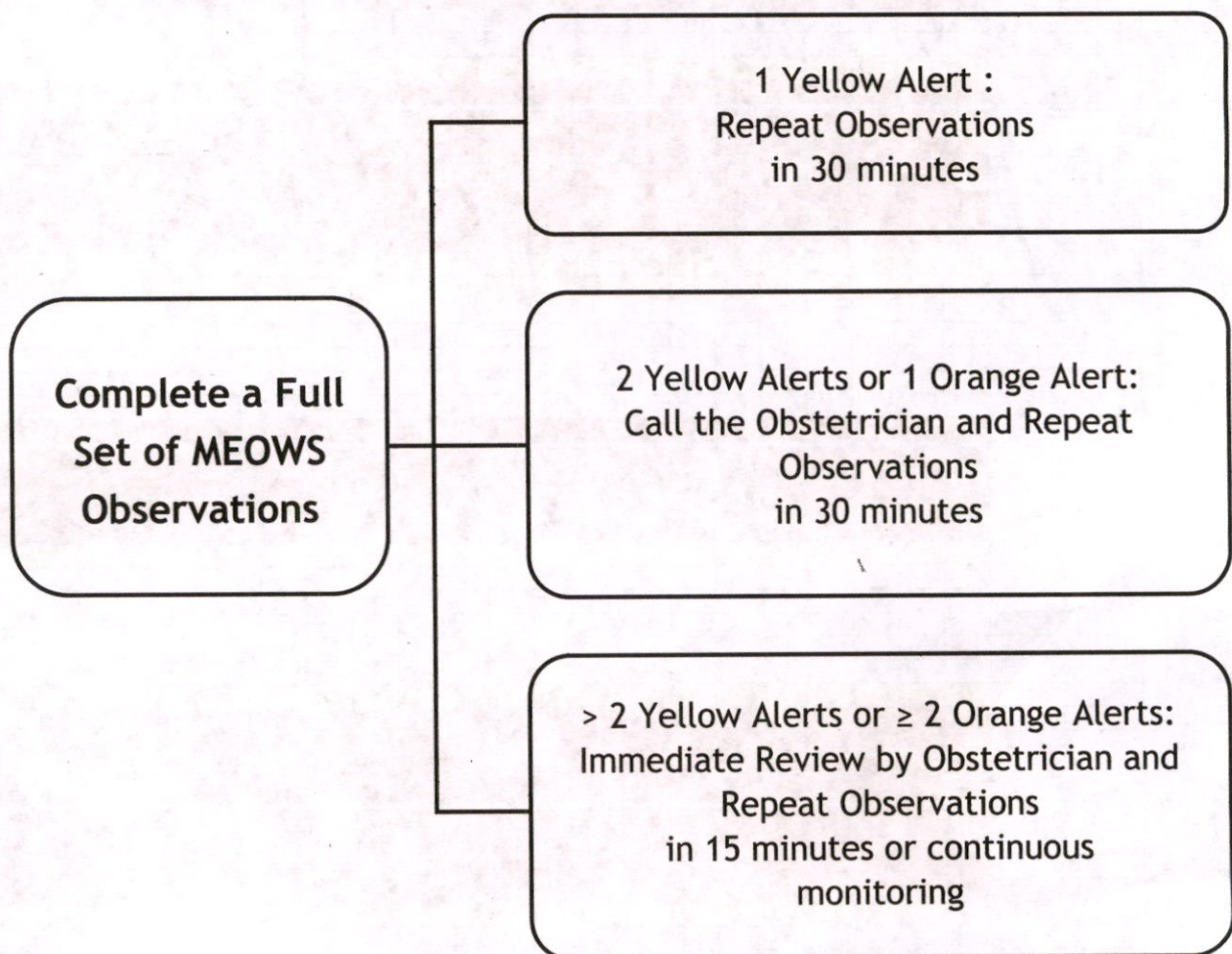
4/7/26.



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

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

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

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 02-10-2000 25 Y 9 M 1 D (F)
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3/7/25

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FLUID CHART

Sheet No. : ①

- 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	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am										0	Cathy
	09:00 am	RL	thru	can						✓	0	Cathy
	10:00 am	RL	thru	can							0	Cathy
	11:00 am	RL		can							0	Cathy
	12:00 pm	RL	thru	can							0	Cathy
	01:00 pm	RL		can							0	Cathy
Total Intake :			Taken			Total Output :			U - M -			
	02:00 pm	RL	Idly.	100ml							0	Cathy
	03:00 pm	RL	water								0	Cathy
	04:00 pm		Idly							✓	0	Cathy
	05:00 pm		H2O								0	Cathy
	06:00 pm										0	Cathy
	07:00 pm										0	
Total Intake :			Taken			Total Output :			U - M -			
	08:00 pm										0	Pooja
	09:00 pm		thru								0	Pooja
	10:00 pm										0	Pooja
	11:00 pm									✓	0	Pooja
	12:00 am		thru								0	Pooja
	01:00 am										0	Pooja
Total Intake :						Total Output :			U - M -			
	02:00 am										0	Pooja
	03:00 am		thru								0	Pooja
	04:00 am										0	Pooja
	05:00 am										0	Pooja
	06:00 am		thru							✓	0	Pooja
	07:00 am										0	Pooja
Total Intake :						Total Output :			U - M -			
Total 24 hrs. Intake						Total 24 hrs. Output			U - M -			

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FLUID CHART

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Sheet No. :

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

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

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 8/2/20

Assessment: patient complains on pain in Abdomen

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	→ Assess the pt condition	8:10 am	→ Assess the pt condition	→ patient is stable
9am	→ Monitor vitals	9:10 am	→ vitals checked and Rnded	
11am	→ R/o chest	11:10 am	→ R/o chest maintained	
12pm	→ Administer medication	12:05 pm	→ Administered IV medications	
1:00 pm	→ IV fluids	1:10 pm	→ Ringer lactate 1000ml/hr	
2pm	→ Safety	2:15 pm	→ Ensured Safety	

Re-Assessment: vitals checked and Rnded.

Special Notes: NA

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date & Time: 8/2/20 9pm

BAH-00640370
Mrs RUBEENA SAMREEN
02-10-2000 25 Y 9 M 1 D (F)
Dr. DR.M PRATHYUSHA REDDY

IP5-00175909

NURSING CARE RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 3/7/26

Assessment: Complaints of bleeding.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	* Assess the patient condition.	2:10 pm	* Assessment done.	patient - is comfortable and stable.
2pm	* Advised soft diet	3:10 pm	* Soft diet taken.	
4pm	* w/ Bleeding.	4:10 pm	* Bleeding minimal.	
5pm	* Room Shifting. Advised.	5:10 pm	* Shifted to room.	
6pm	* Nipple care Advised.	6:10 pm	* Nipple care Advised.	

Re-Assessment: Reassessment done.

Special Notes: w/ Bleeding.

Nurse Signature: Sachin

Nurse Name: Sachin

Date & Time: 3/7/26 5pm

BAH-00640370 IP5-00175909
 Mrs RUBEENA SAMREEN
 02-10-2000 25 Y 9 M 1 D (F)
 Dr. DR.M PRATHYUSHA REDDY



NURSING CARE RECORD

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 3/7/26

Assessment: Mild pain at Surgical site

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the patient condition	8:10pm	Assessed the patient condition	Now the pt is stable
10pm	plan for monitor vitals	10:30pm	monitored vitals	
11am	plan for maintain Ilo chart	12:30pm	maintained Ilo chart & recorded.	
12am	plan for Administer medication as per drug chart	2:30am	Administered medication as per drug chart	
1am	plan for provide comfortable position	4:30am	provided comfortable position	
8am	Ensure safety	7:10am	Ensured safety	

Re-Assessment: Re-assessment done

Special Notes: NA

Nurse Signature: Pooja

Nurse Name: Pooja (018504)

Date & Time: 4/7/26 @ 8Am

NURSING CARE RECORD



Date:

Assessment:

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

Time	Plan of Care	Time	Implementation	Evaluation
10:00 AM	1. Monitor vital signs (BP, HR, RR, SpO2) every 4 hours. 2. Administer pain medication (Morphine 2mg IV) as needed for pain. 3. Encourage deep breathing and coughing every 2 hours to prevent atelectasis. 4. Provide emotional support and reassurance.	10:00 AM	1. Monitored vital signs: BP 120/80, HR 90, RR 18, SpO2 98%. 2. Administered Morphine 2mg IV for pain. 3. Encouraged deep breathing and coughing. 4. Provided emotional support.	1. Patient is comfortable and pain is managed. 2. Vital signs are stable. 3. Patient is able to breathe deeply and cough. 4. Patient is reassured and calm.

Re-Assessment:

Special Notes:

Nurse Signature: _____ Nurse Name: _____ Date & Time: _____

Patient Sticker

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

Patient Sticker

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Prathyusha Department: OBS Date of Admission: 2/7/26

SITUATION	Diagnosis: <u>prim 38+2 wks (Twins)</u> <u>labour thrombocytopenia.</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:				
	Area	Shift Time					
BACKGROUND	Medical Condition (Any special condition to be noted):	<u>OBS</u> <u>2am-4pm</u> <u>NA</u>	<u>OBS</u> <u>4pm-8pm</u> <u>NA</u>	<u>3rd floor</u> <u>8pm-2am</u> <u>NA</u>			
ASSESSMENT	Allergy:	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Tubes/Drains/Catheter:	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp:	<u>98.5</u>	<u>98.1</u>	<u>98.2</u>		
		Res:	<u>14/10</u>	<u>14/10</u>	<u>20/17</u>		
		SpO ₂ :	<u>100%</u>	<u>99%</u>	<u>98%</u>		
		Pulse:	<u>84/10</u>	<u>84/10</u>	<u>82/10</u>		
		BP:	<u>110/70</u>	<u>120/66</u>	<u>103/63</u>		
		Fall Risk Score:	<u>20</u>	<u>20</u>	<u>20</u>		
	Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>			
	Recommendations	Safety Needs:	<u>Side rail</u>	<u>Yes</u>	<u>Yes</u>		
Physiotherapy		☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
Others Specify:		<u>NA</u>	<u>NA</u>	<u>NA</u>			
Special Diet:		☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>	<u>NA</u>			
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>			
Handed Over By Name :		<u>Karthi</u>	<u>Sandhya</u>	<u>Pooja</u>			
Signature :		<u>Karthi</u>	<u>Sandhya</u>	<u>Pooja</u>			
Date:		<u>3/7/26</u>	<u>3/7/26</u>	<u>4/7/26</u>			
Time:		<u>2pm</u>	<u>8pm</u>	<u>8am</u>			
Taken Over By Name :		<u>Quany</u>	<u>Pooja</u>	<u>Lalitha</u>			
Signature :		<u>Quany</u>	<u>Pooja</u>	<u>Lalitha</u>			
Date:		<u>3/7/26</u>	<u>3/7/26</u>	<u>4/7/26</u>			
Time:		<u>2pm</u>	<u>8pm</u>	<u>8am</u>			

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area							
	Shift Time							
	Medical Condition (Any special condition to be noted):							
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp:						
		Res:						
		SpO ₂ :						
		Pulse:						
		BP:						
		Fall Risk Score:						
	Pain Score:							
	Recommendations	Safety Needs:						
Physiotherapy		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
Others Specify:								
Special Diet:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
Other Special Orders / Medications:								
Post Operative Procedure Special Orders:								
Handed Over By Name :								
Signature :								
Date:								
Time:								
Taken Over By Name :								
Signature :								
Date:								
Time:								

Morse Fall Risk Assessment Form

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

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

Morse Fall Risk Assessment Form

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

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

BRADEN 'Q' SCALE

					Date :	2/2/20	3/4/20	9/3/20
					Time :	8:00 AM	2 PM	6 PM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:tremitry position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and insic'e room at least once every 2 hours during walking hours.	4	4	4	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28	28	28
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	\$	8/4	Poor

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

BRADEN 'Q' SCALE

Patient ID

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

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
3/6/26	10pm	9/10	nee pin	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Baepu
3/6/26	1pm	1/10	level Abdomen	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Breathing cured	Baepu
3/7/26	3pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Sandhya
3/7/26	5pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	sandhya
3/7/26	11pm	1/10	Surgey site	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☒ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	T. Diclo given	Pooja
3/7/26	12am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Pooja
4/7/26	1am	1/10	Surgey site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	T. Calpol given	Pooja
4/7/26	2am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Pooja
4/7/26	6am	1/10	Surgey site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Trig. pcn given	Pooja
4/7/26	7am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Pooja

Re-assessment Frequency:

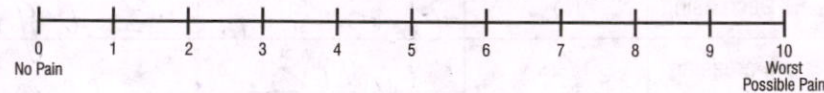
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

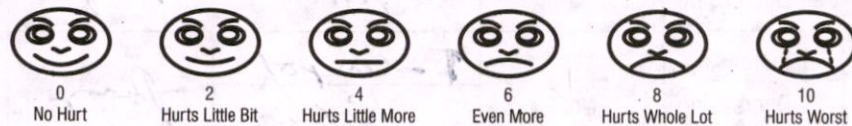
Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



PAIN ASSESSMENT FORM

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

Re-assessment Frequency:

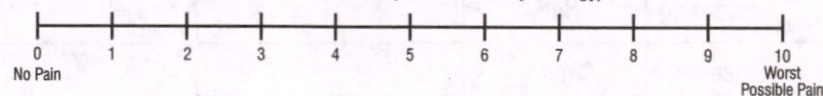
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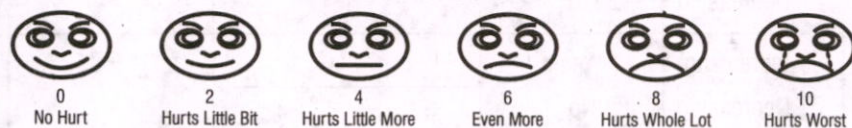
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Wong - Baker (Pediatrics) Above 7 Years





CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

Signature : [Signature] Name : [Signature]

Signature of Ward In Charge :

Signature : [Signature] Name : [Signature]

BAH-00640370

IP5-00175909

Mrs RUBEENA SAMREEN

02-10-2000

25 Y 9 M 1 D

(F)

Dr. DR.M PRATHYUSHA REDDY



MULTI-DISCIPLINARY PLAN OF CARE FORM

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Diagnosis:

Prim: 38+2 wks / Early labour

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
3/7/26 9:00am	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☒ Per-Op ☐ Post Op	Prim gravid / 38+2 Early labour	Safe Delivery	Vaginal Delivery	<i>[Signature]</i>	☒ Nursing ☐ Others:
3/8/26 @ npt	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	→ Comfort position	→ proceed comfortable position	→ Safe delivery	<i>[Signature]</i>	☒ Medical ☐ Others:
4/7/26 8am	☐ Medical ☐ Nursing ☒ Others: <i>high fever</i>	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	prob	Soft birth	Soft high protein diet	<i>[Signature]</i>	☐ 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:

BAH-00640370

IP5-00175309

MRS RUBEENA SAMREEN

02-10-2000

25 Y 9 M 1 D

(F)

Dr. DR. M PRATHYUSHA REDDY



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Part - I.

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
05/12/2024	12pm	1	5 12 (Case plan, patient not finished case)	PT	1	0	1	1	nil	Q
26/12/24	12pm	2	Refraction (cataract)	pt	1	0	1	1	-	B
4/1/26	8am	9	lactation diet	pt	1	0	1	1	-	Sam

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	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice					
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)					
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing						
Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed									
Mechanism/s to overcome barrier/s:									
1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify						
2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference							
Understanding:									
1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review							

OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 2/10/20 Time of Arrival: 8:35 AM Time Seen by Nurse: 8:40 AM

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

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

☒ Severe Pain / Moderate Pain

☐ Preterm rupture of Membranes / Leaking Water PV

☐ Bleeding PV: Slight / Heavy

☐ Preterm Labor/ Labor

☐ Decreased Fetal Movement

☐ Spontaneous Rupture of Membrane / Leaking Water PV

☐ No Fetal Movement

☐ Other Reason:

3) Vital Signs: Temperature: 98.6°F Pulse: 89 RR: 20 SpO₂: 100 BP: 119/42 Weight: -

4) Gestational Criteria:

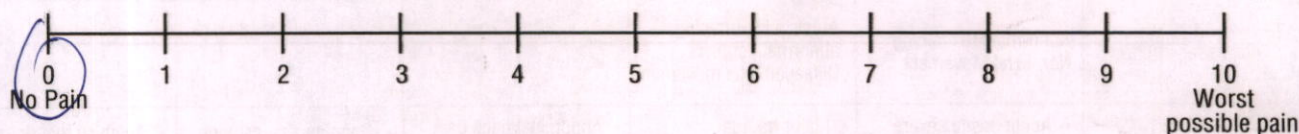
Gravida:	G <u>1</u>	P <u>1</u>	L <u>1</u>	A <u>1</u>
----------	------------	------------	------------	------------

LMP: 9/10/19 EDD: 15/10/20 Gestational Age: 38+2 wks

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: low back
- Duration: 1 day Days / Weeks/ Months (Strike out which is not applicable)
- Character: low back
- Frequency: 1 per day
- Interventions: 1

6) Past History:

- a) Surgeries: nil
- b) Medical: nil

7) Allergy: ☐ Yes ☒ No, If Yes :8) Current Medications: ☐ Prenatal Vitamin ☒ None ☐ Others:

9) Prenatal Medical History:

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

Triage Category: (Please tick on the category)

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

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

OTAS	Level 1 (Resuscitative)	Level 2 (Emergent)	Level 3 (Urgent)	Level 4 (Less Urgent)	Level 5 (Non Urgent)
Level 1 (Resuscitative)	Immediate	≤ 15 minutes	≤ 30 minutes	≤ 60 minutes	≤ 120 minutes (2 Hours)
Re-Assessment	Continuous Nursing Care	Every 15 Minutes	Every 15 Minutes	Every 30 Minutes	Every 60 Minutes
Labour / Fluid	Imminent Birth	Suspected Pre-term Labour / 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: 9 AM

Nurse Name: Kruper Nurse Signature: Kruper

Date: 3/2/26 Time: 8:30 AM



OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 21.08.20

Baseline Information:

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

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

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

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

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

If yes, identify

Chief Complaints: Conc. her spotting per
Vaginal Green Mucous

Doctor Notified on Admission: ☒ Yes ☐ No

Name of the Doctor: Dr. Sneha

Time Notified: 8:30 AM

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>nil</u>	<u>nil</u>	<u>nil</u>

Gynecology Assessment: ☐ Not Applicable

Menstrual History:

Onset of Menarche:

Menstrual Cycle: ☐ Regular ☐ Irregular

Last Menstrual Period: 9/10/25

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 1 L A

Previous LSCS: no

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

Family History: ☐ No Abnormalities Detected

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

☐ Liver disease ☐ Other

Vital Signs / Measurements: Temp: 97.8 HR: 94 RR: 19 bpm
BP: 110/60 Weight: 62.3 Height: BMI:
Kgs

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



PHYSICAL ASSESSMENT

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

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

Risk of Pressure Sore: ☐ Yes ☒ No Score 25 (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

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: Rubeena

Orientation not given Reason:

Nurse Signature: Rubeena

Nurse Name: Rubeena

Date & Time: 20th Oct 2020

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00640370 IP5-00175909 Mrs RUBEENA SAMREEN 02-10-2000 28 Y 9 M 1 D (F) Dr. DR.M PRATHYUSHA REDDY 		Date & Time of Admission 3/7/26. 8:44 AM	Date & Time of Transfer Order 3/7/26 06:50 PM
		Transfer Ordered by Dr. Prathyusha Reddy	Reason for Transfer observation
From Unit OBS	To Unit Room (302)	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 40	Number of Imaging Films NST - (3)	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.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring Dr. Sandhya		Name of Person Ordered Transfer Dr. Prathyusha Reddy	
Patient & Clinical Records Received by : Lovely			
Date & Time of Patient Received : 3/7/26 @ 8 PM			

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

BAH-00640370 IP5-00175909
Mrs RUBEENA SAMREEN
02-10-2000 25 Y 9 M 1 D (F)
Dr. DR. M PRATHYUSHA REDDY



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INDUCTION OF LABOR CONSENT

Name: Mrs. Rubena Samreen Age: 25 Gender: Male ☐ Female ☒
UHID.No : 640370 Date: 3/7/26

You are scheduled for an induction of labor on 3/7/26 (date) at 32+2 (weeks of gestation).

The reason for your induction is term

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

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

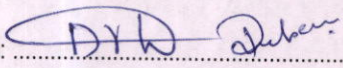
Elective induction of labor (scheduled induction without a medical indication) may not be done until you are at least 39 weeks. This is important so that your newborn does not have complications due to possible prematurity.

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

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

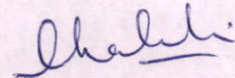
I understand the risks and benefits of this procedure and wish to proceed.

Patient

Signature: 

Name: Mrs. Rubena

Date & Time: 3/7/26 9:00 am

Patient Attendant: 

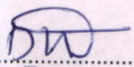
Signature: _____

Name: Shakeela Parveen

Relationship with Patient: Mother

Date & Time: 3/7/26; 9:00 am

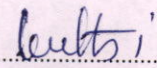
Doctor:

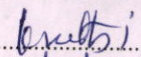
Signature: 

Name: Dr. M. Rubena

Date & Time: 3/7/26; 9:00 am

Witness

Signature: 

Name: 

Date & Time: 3/7/26 @ 12 PM

INFORMED CONSENT FOR VAGINAL BIRTH

BAH-00640370 IP5-00175909
Mrs RUBEENA SAMREEN
02-10-2000 25 Y 9 M 1 D (F)
Dr. DR.M PRATHYUSHA REDDY

Patient Name : Mrs. Rubeena Samreen UHID No : 640370

Gender: ☐ Male ☒ Female Date : 31/7/2016 Time : 9:10 am

I hereby authorized the performance of the following procedure:

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

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

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

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

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

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

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

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

Consentee :

Signature : [Signature]

Name : Mrs. Rubeena

Date & Time : 31/7/2016, 9:00 am

Witness :

Signature : [Signature]

Name : [Signature]

Date & Time : 31/7/2016 @ 9:00 am

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

Patient Attendant :

Signature : [Signature]

Name : Shakeela Parveen

Relationship with Patient : Mother

Date & Time : 31/7/2016, 9:00 am

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Divya

Date & Time : 31/7/2016, 9:00 am

సహజ ప్రసవం కొరకు సమ్మతి పత్రము

రోగి పేరు : వయస్సు లింగం పు స్త్రీ

యు.పాచ్.బి.డి. విభాగము

తేదీ

ఈ ప్రక్రియ యొక్క వివరములను నేను ఆమోదించాను:

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

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

సహజ ప్రసవం బిజయవంతం కాకపోతే, తగిన అనస్థీసియా ఇచ్చి పొత్తికడుపు కోతతో సిజేరియన్ ద్వారా డెలివరీ చేయవలసిన అవసరం కలగవచ్చు

సహజంగా లేదా పరికరం సహాయంతో అంటే ఫోర్స్ప్స్ లేదా వాక్యూమ్ సహాయంతో జడ్డను ప్రసవించే ప్రయత్నంలో, ప్రమాదాలు ఉండవచ్చు: అంటువ్యాధులు, అలెర్జీ, మచ్చలు, రక్త నష్టం, రక్త మార్పిడి అవసరం పడటం, నొక్కి మరియు అశాకర్మం, మూత్ర నాళానికి గాయం, శిశువుకు గాయం అయ్యే అవకాశం (ప్రెనరేషన్, హిమటోమా, పుర్రె గాయం ఆయె అవకాశం, నరాలకు గాయం మరియు మెడడు గాయం) మరియు భవిష్యత్తులో కటి ప్రదేశంలోని ఎముకల వలయం పనిచేయకపోవడం

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

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

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

ఈ ప్రక్రియను నిర్వహించే డాక్టరు పేరు:

సహాయకుడు(అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

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NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 4/7/26

Time: 8am

Origin: Indian

Height: 159cm

Weight: 62.3kg

BMI: 25kg/m²

Food Allergies: NO

Diagnosis: pns-o / post normal delivery

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

Diet Advised:

Soft high protein diet

with plenty of oral liquids

→ Avoid spicy, chilled & outside foods

Patient's / Attendant's

Signature: [Signature]

Name: Rubena

Date & Time: 4/7/26

8am

Dietician's

Signature: [Signature]

Name: Sarma

Date & Time: 4/7/26

8am

DIETARY NOTES[illegible]

BAH-00640370 IP5-00175909
Mrs RUBEENA SAMREEN 26 Y 9 M 1 D (F)
02-10-2000
Dr. DR.M PRATHYUSHA REDDY

BREAST FEEDING HANDOVER AND ASSESSMENT FORM

1. Breastfeeding initiated?

- ☒ a. Yes ☐ b. No

2. If No, Reason

3. Nipple condition:

- ☒ a. Nipple well formed
☐ b. Flat nipple
☐ c. Inverted nipple
☐ d. Short nipple

4. Milk flow:

- ☒ a. Good
☐ b. Drops of colostrums
☐ c. Dry

5. Steps for Positioning and attachment:

- ☒ a. Baby goes to the breast
☐ b. Mother always sits with a back support
☐ c. Ear-shoulder-hip should be in a straight line
☐ d. The baby takes a latch on the areola and not on the nipple



Feeding Positions:
Cross Cradle



Feeding Positions:
Football / Clutch

6. Was the position explained:

- ☒ a. Yes
☐ b. No

7. For Caesarian mothers:

- ☐ a. Mother is required sit and feed from the 4th feed
☒ b. Please explain football hold

8. NICU admission:

- ☐ a. Mother needs to stimulate her breast for 2 min every 2 hours

9. Additional notes:

Continuity of Care:

Date: 3/2/26

Handover given by Sandhya

Handover taken by

Signature

Signature

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

Date & Time: