Mrs. Ankitha

Patient Sticker

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I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : ..... Time of Admission : .....

Allergies: ..... ☐ Not know any drug allergies

PRESENTING COMPLAINTS :

PoAD with irregular cycles ? hypothyroidism

USG abdomen & pelvis (1/6/26) — uterus — subseptum of 1.5cm with ET - 6mm, B/L ovaries — (N).

MENSTRUAL HISTORY	
Year of Marriage :	4 yrs, NCM
Previous Periods :	irregular
LMP :	8/6/26
Contraception :	Nil

OBSTETRIC HISTORY	
Parity :	G_1 - TOP @ 16 wks / PPROM / anhydramnios / SERPC / 2023
Mode of Delivery :	
Last Child Birth :	G_2 - TOP / 13+4 wks / PPROM / anhydramnios / ?? cervical incompetence / 2024

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
pelvic kidney	Nil

Patient Sticker

FAMILY HISTORY:

father – HTN
mother – DM

MEDICATION HISTORY:

On Thyronorm 12.5 mcg.

INITIAL ASSESSMENT :

Date 16/6/26
Ht. _____ Wt. 66.1 kg
BMI _____
B.P _____
Pallor _____
CVR S1S2 (+)
Respiratory System BLAE (+)
Thyroid _____

Breasts (W)

Abdominal Examination
Soft, non tender

Local/Speculum Examination
Not done

Bimanual Pelvic Examination
not done

PROVISIONAL DIAGNOSIS : POA2 with hypothyroidism with uterine subseptum for hysteroscopic septal resection

INVESTIGATIONS ORDERED

BGT – 'B' POSITIVE
HIV
HBsAg } NR
HCV

CBP (1/6/26) – 13.4 | 8240 | 3.63L

1/6/26
AMH – 1.3
prolactin – 7.23
TSH – 5.57

PLAN OF MANAGEMENT

NBM
follow diet chart
monitor vitals
PAC
part preparation
Inform BOS

Name of the Doctor : Dr. Lakshmi Kiran
Signature of Doctor _____
Date & Time : 16/6/26

MAH-00389959 IP2-00056570
Mrs ANKITHA BAWGI (F)
07-03-1995 31 Y 3 M 9 D
Dr. LAKSHMI KIRAN S

Patien

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/6/26 10:50AM	0-POD	
		Adv
	PR	NBM for 4 hrs
	BP	Vitals Monitoring
	P/A = soft	w/f pain abdomen & bleeding pv
		i/form
	P/V- No active bleeding	
	Notes by	Dr 16/6/26

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

MAH-00389959 IP2-00056570
Mrs ANKITHA BAWGI
07-03-1995 31 Y 3 M 9 D (F)
Dr. LAKSHMI KIRAN S

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☐ 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. THYRONORM	12.5MCG	PO	OD		☑ C ☐ DC
2						☐ 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. Ranjani, Rf

Date & Time : 16/6/26 @ 9 AM

Nurse Name & Signature: Preethu B

Date & Time : 26/06/26 @ 9 AM

Docu. No. : RCH / FRM / GENERAL / 090

MAH-00389959 IP2-00056570
Mrs ANKITHA BAWGI
07-03-1995 31 Y 3 M 9 D (F)
Dr. LAKSHMI KIRAN S

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DRUG CHART

Date of Admission: ..... Drug Allergies: ..... ☐ 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 .....

MAH-00389959 IP2-00056570
Mrs ANKITHA BAWGI
07-03-1995 31 Y 3 M 9 D (F)
Dr. LAKSHMI KIRAN S

REGULAR PRESCRIPTIONS

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

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

DRUG : Tab PARACETAMOL				Date / Time
Dose	Route	Frequency	Start Date	
1gm	ORAL	QID	16/6/20	
Name & Signature of the Doctor Starting the Drugs: Klhe				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG : Tab DICLOFENAC				Date / Time
Dose	Route	Frequency	Start Date	
50mg	ORAL	TID	16/6	
Name & Signature of the Doctor Starting the Drugs: Klhe				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG : Tab TRAMADOL				Date / Time
Dose	Route	Frequency	Start Date	
100mg	ORAL	TID	16/6	
Name & Signature of the Doctor Starting the Drugs: Klhe				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

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16/06/26

ACTIVITY RECORD FOR BILLING

MAH-00389959 IP2-00056570
Mrs ANKITHA BAWGI
07-03-1995 31 Y 3 M 9 D (F)
Dr. LAKSHMI KIRAN S

Name: ---------- ----------

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

Date of Admission : ---------- Time : ---------- Date of Discharge : ---------- Time: ----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
16/06/20	HPE (Small)	26008367	[signature]
16/06/20	PAP SMEAR		
		Corr checked by [illegible] 16/6/20 [illegible]	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
16/06/26	CAP Equipment	9:50 Am	10:38 Am	946429	[illegible]
16/06/26	VERSO PAIN01	10 Am	10:25 Am		
16/06/26	Cardiac Monitor	10:58 Am	2 PM	946478	[illegible]
			Cross checked by [illegible] 16/6/26 2:19 Pm		

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
16/06/26	IV Placement PAC (OP)	1	946477 BCS2-0021 2972	[signature]
16/6/26	Hysteroscopic Septal Resection done by	1	946430	[signature]
16/06/26	Dr Lakshmi Kiran		946431	
		Cross checked by		[signature]
			16/6/26	[signature]

ANY OTHER INFORMATION

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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Ref. No. : F / HW / DC / RP / INPR / 05.a

Patient Name :	I.P. No.	Sheet No.	Wards	Weight (kg)

REGULAR PRESCRIPTIONS

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

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

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

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

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Ref. No. : F / HW / DC / RP / INPR / 05.a

Patient Name :	I.P. No.	Sheet No.	Wards	Weight (kg)

REGULAR PRESCRIPTIONS

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

Date ➤ / Time ▼

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

Date ➤ / Time ▼

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

Date ➤ / Time ▼

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

Date ➤ / Time ▼

Patient Sticker

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

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

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

Signature .....

VERIFIED By Name .....

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
16/6	8.36 Am	INJ. TAXIM	1 GM	IV		
16/6	8.31 Am	INJ. PANTOP	40MG	IV		
16/6	10.00 AM	INJ PARACETAMOL	1 gm	IV		
16/6	10.40 Am	SUPP TRAMADOL	100MG	P/R		
16/6	10.40 Am	SUPP DICLOFENAC	100MG	P/R		

Patient Sticker

I.V. FLUIDS CHART

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

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
16/6		1 (D) RL	IV	100 ML/HR			26/6/26		
16/6	10.05 AM	RINGER LACTATE	IV	200 ml/h			16/8/26		

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

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OPERATION THEATER NOTES

Patient's Name : Mrs Ankita Age : 31 Gender : F

UHID.: ..... I.P.No.: ..... Weight : .....

Surgeon : Dr Lakshmi Kiran	Asst. Surgeon : Dr Nishita
Anesthetist : Dr Swati Dr. Usha.	OT Nurse : Babu Brothers, Sister Anitha Sister

Surgical Procedure : Hysteroscopic Septal Resection

Indications for Surgery : Uterus → Supsetum

Date : 16/6/26	Start Time : 9:45 AM	End Time : 10:45 AM

PRE-OPERATIVE PREPARATION : NBM
Pre op medication
Prepare parts

OPERATION NOTES :

Pt in lithotomy position, Parts painted and draped.

Vaginal wall retracted with Sim's speculum. Pap smear taken on Anterior lip of cervix held with vulsellum

Hysteroscope introduced.

Uterine septum of 1X1.5 cm arising from fundus seen. Septal resection done by Hysteroscopic scissors & forceps.
B/L ostia seen
Gentle curettage done and endometrial tissue sent for HPE
Hemostasis checked.
Post procedure scan showed free fluid in cavity

POST-OPERATIVE ORDERS :

NBM for 4 hrs

Vitals Monitoring

~~T Azee 500mg once daily~~

T. Taxim 200mg BD x 5 dy

T Pantop 40mg OD x 5 day

T. Calpol 500mg BD x 2 day

w/f bleeding p/v

Collect to OPE report

....

Consultant Surgeon's Name Consultant Surgeon's Signature

Date : .... Time : ....

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Lakshmi Kiran
Asst. Surgeon : .....
Anaesthetist : Dr. Swathi
Scrub Nurse : Balu

Patient Name : Mrs. Anitha Bangi Age : 30 Gender : F
UHID No. : ..... Surgery Name : Hysteroscopy
Date : 16/6/22 In-time : ..... Out-time : .....

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Before Induction of Anaesthesia ➤➤

SIGN IN Time:.....

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

Site Marked ☐Yes ☐No ☐NA

Anaesthesia Safety Check Completed ☐Yes ☐No

Pulse Oximeter on Patient & Functioning ☐Yes ☐No

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

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

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

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

Signature :.....

Name :.....

Before Skin Incision ➤➤

TIME OUT Time:.....

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

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

Anticipated Critical Events

Surgeon Reviews:
- What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? Uterine perforation ☐Yes ☐No ☐NA

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

Nursing Team Reviews:
- Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☑Yes ☐No ☐NA
- **Is Essential Imaging Displayed?** ☑Yes ☐No ☐NA

Signature :.....

Name : Anitha

Before Patient Leaves Operating Room

SIGN OUT Time:.....

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

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

Signature :.....

Name : Dr Sonal

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : Mx. Ankitha Gender: ☐ Male ☐ Female Age : 31Y

UHID No : Date : 16/6/26

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

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

HYSTEROSCOPIC SEPTAL RESECTION

upon Mx. Ankitha
(Name of the Patient)

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

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

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

BLEEDING, UTERINE PERFORATION, INFECTION, FLUID OVERLOAD, INTRA UTERINE ADHESIONS

My signature on this form indicates that

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

Name of the Doctor who is performing the Surgery / Procedure: Dr. Lakshmi Kiran

Consentee :

Signature :

Name :

Date & Time :

Patient Attendant :

Signature : B. Ambica

Name :

Relationship with Patient:

Date & Time :

Witness :

Signature :

Name :

Date & Time :

Doctor (who is taking the consent) :

Signature :

Name : Dr. Rajani

Date & Time : 16/6/26

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : ANKITHA Age : 31yrs Gender : Male ☐ Female ☑

UHID NO: ..... Surgeon Name: Dr. Lakshmi Kiran

Anaesthesiologist : Dr. Susethi

Operative procedure planned : hysteroscopy + Septal resection

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

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

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

☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure

☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma / Renal Tubular Aacidosis

☐ Incapacitating Cronic Obstructive Pulmonary Disease

☐ Others : Bleeding

Comments : .....

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

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient ANKITHA the above mentioned (operation) / Diagnostic / Therapeutic procedures hysteroscopy + Septal resection

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

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

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

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

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

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

- Pregnant : ☐ Yes ☑ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

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

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

Patient / Patient Attendant :

Signature : .....

Name : Ankitha Bawgi

Relationship with Patient: Self

Date & Time : 1/6/2026, 4:00pm.

Witness :

Signature : .....

Name : Yaswanth K Chakka

Date & Time : 1/6/26 4:00 PM

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. S. Mohan

Date & Time : 1/6/2026, 4:00pm

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: ANKITHA BAWGI Age: 31 Year Sex: Female UHID.No :

Date: 1/6/2026 Time: 4:00pm Proposed Operation: hysteroscopy + septal resection

Diagnosis: recurrent early pregnancy loss

B.P / CRT: 123/76 mmHg H.R: 97bpm Weight: 68 Kg ASA Physical Status: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

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

Allergies: MORPHINE (+)

Medical History: CVS :

RESP : Diabetes : H/O Dust allergy on Rx

CNS : Nothing significant

Renal : NO H/o fever/cold/cough.

Hepatic / GE : Physical Activity: > 4METS.

Others :

Past Anaesthetic History: H/O D&C ↓ sedation

Physical Exam:

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

Lungs : B/L AE (+) clear

Heart: S1S2

CNS:

Pregnant: ☐ Yes ☐ No ☑ NA | Venous Access Site : | Spine Exam for regional :

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

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

CURRENT MEDICATIONS	DOSAGE
T. MONTELUKAST	OD - daily.
T. DESLOR	OD HS - Daily

Pre-Operative Instructions:

1. DVT Prophylaxis :
2. ✓ NIL ORAL → Water / ORS 2 Hours; → Others 6 Hours
3. ✓ Informed Consent: ☐ Standard ☐ High Risk
4. Post Operative Pain Management: ☐ Discussed with Patient
5. Other Instructions:
   (1) DO CBP, HIV, HBsAg, HCV, Blood group.
   (2) Review c̄ reports
   (3) Consent pending

Signature: [signature] Name: Dr. S. Mohan

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

Patient Sticker

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No

Fasting Status: >6 hr

Physical Status: ☑ Patient Identified ☑ Consent Present ☑ Chart Reviewed

H.R: 86/min | B.P / CRT: 124/76 | SpO_2: 99 RA | R.R: 16/min | Last Feed: 1st 8 hrs

Pre-OP Diagnosis: Uterine septum | Operation: Hysteroscopy septal resection | Date: 10/8/26

Surgeon: Dr Lakshmi Kiran | Anaesthesiologist: Dr Swati / Dr Ulka | Technician: Shiva

TIME	9.45	10.15	10.45
N_2O /AIR /O_2 LPM			
HALO /SEVO	4%	3%	3%
Drugs:			
Midazolam 2mg			
Fentanyl 100µg			
Propofol 150mg + 50mg			
FIO_2 / SaO_2	100	100	100
$ETCO_2$	36	35	33
ECG 3 lead	SR	SR	SR
Temperature			
Urine Output			
Fluids	RL		RL
Blood			

Antibiotic

Suppository: Diclofenac 100mg, Paracetamol 1000mg

Blood Loss

NOTES

B.P
V Systolic
Λ Diastolic
X Mean
• Heart Rate

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

240 220 200 180 160 140 120 100 80 60 40 20 10 0

LAB Values: ABG, GRBS, Others

☑ Equipment Checked and Functional
☑ BP
☐ Cuff Site: RUL
☐ Art Site:
☑ EKG Lead
☐ Temp Site
☐ FIO_2 Monitor
☐ Agent Monitor
☑ Pulse Oximeter
☐ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position: Lithotomy
☐ Pressure Points Checked

Eye Care:
☐ Oint
☑ Tape
☐ Padding
☐ Awake

Temp:
☐ HME ☐ Fluid Warmer
☐ Cling Film ☐ OH Warmer
☐ Hugger's ☐ Cotton Wool
☑ Other

Times:
Anaes Start: 9.45AM
OP Start:
OP End:
Leave OR: 10.45AM

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP:
☐ ART:
☐ IV: LUL
☐ IV:
☐ IV:

Induction
☑ IV ☑ Inhal
☑ Pre O_2 ☐ RSI
☐ Others

☐ Mask ☑ SGA
☐ Airway ☐ Oral ☐ Nasal
ETT# ..... at ..... cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug:

☐ Awake ☐ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# ..... Attempts:
Difficulty Why?

☐ **Bilat = BS**
☐ Semi-Closed Circle
☑ Closed Circle
☐ Other

Regional:
Extremity Specify:
☐ Spinal ☐ Epidural ☐ Caudal
Others:
Position:
Site:
Needle Size: Depth:
Parasthesia ☐ Yes ☐ No
Catheter at skin ..... cm
Drug Name & Conc:
Bolus:
Infusion:
Block Level:
Comments:

Transportation to
☐ PACU ☐ ICU ☑ Other
Relaxant Reversed ☐ Yes ☐ No ☐ NA

Name of the Doctor: KUSHA
Signature of the Doctor:

Patient Sticker

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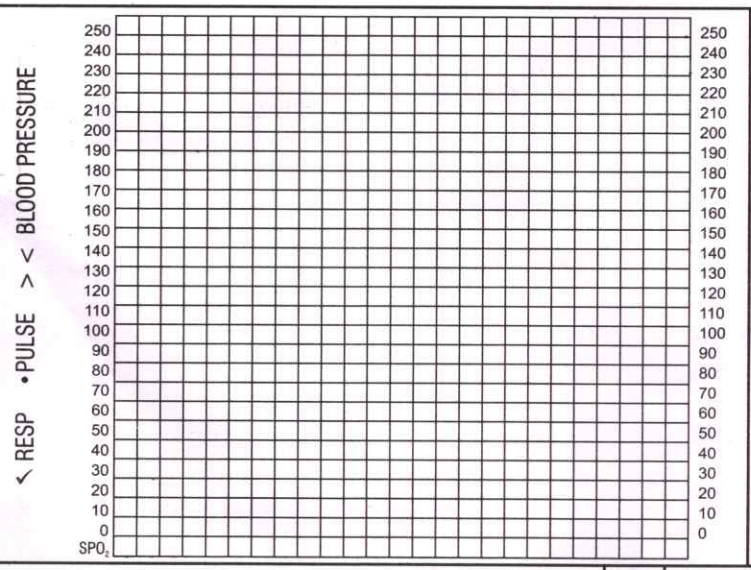
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : ..... Time Received : ..... Time Discharged : .....



IV Cannula Site : .....

- ☐ O_2 Mask
- ☐ Nasal Prongs
- ☐ Tracheostomy
- ☐ T-Piece
- ☐ Oral Airway
- ☐ Nasal Airway

Vomiting : ☐ Yes ☐ No Drug: .....

NG Tube : ☐ Yes ☐ No

Drain: ☐ Yes ☐ No

Urinary Catheter: ☐ Yes ☐ No

Chest Tube: ☐ Yes ☐ No

Nil Oral ☐ Yes ☐ No

IV Fluids: .....

Oral Feeds: .....

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature

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

Reassessment Frequency:

1. Every eight hours for all hospitalized patients.
2. For post surgical patient, patient with chronic pain, patient with severe pain
   a. Every 2 hours for first 24 hours
   b. After 24 hours every 4 hours
   c. Prior to pain reliving intervention
   d. With in 30-60 minutes after pain relief intervention

Anaesthesiologist Name : .....

Anaesthesiologist Signature: .....

Date & Time: .....

PACU Nurse Name : .....

PACU Nurse Signature: .....

Date & Time: .....

Transferred to Unit by (PACU): .....

Date & Time: .....

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: ..... Time: ..... Procedure done by .....

CSE /Spinal /Epidural Position : ..... Space :..... Technique (LOR/LOS) .....

Depth: ..... Catheter at Skin: ..... Attempts : .....

Parasthesia : Yes/No if yes details : .....

Solution Composition : .....

Any other issues :

a) .....

b) .....

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level Left Right	Maternal BP	Maternal Pulse	FHR	Comments

Delivery Details : Time : ..... APGAR: ..... SVD / Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected : .....

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....