

BAH-00551472 IP26-00006526
Mrs KHATIJA FATIMA
21-03-2000 26 Y 2 M 17 D (F)
Dr. SWAPNA SAMUDRALA



SURGERY DETAILS

Date : 7/6/26
Patient Name: Mrs. Khatiya Fatima Date of Birth: 21/3/2000 Age: 26Y/F
Gender: F Ward : OT UHID No.: BAH-00551472
Date of Surgery: 7/6/26 OT-1 OT-2 OT-3 OT-4 OBG OT-1 OBG OT-2
Name of the Surgery : EM-LSCS J. S.A

Time in : 6:20pm Time Out : 7:20pm

	NAME	AMOUNT
1. Surgeon	Dr. Swapna Samudrala	
2. Anaesthetist	Dr. Sai Raj	
3. Assistant Surgeon	Dr. Veena	
4. OT Technician	Sasawathi	
5. Circulating Nurse	Sujatha	
6. Assistant Nurse	Sandhya	

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: 26-0000205079

Order by: Sangeetha

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Em. LSCC
CONSUMABLES OF OT

Circulating staff: *Sugatha* Technician: *Sarunwalb* Date: *7/6/26* Time:

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube			Major Pack <i>LSCC</i>		<i>01</i>	Inj Vit.K		<i>01</i>
LMA			Sutures <i>2346, 2364 & 1</i>		<i>1+1</i>	Cord Clamp		<i>01</i>
ECG leads: A/P/N		<i>03</i>	<i>4242, 1326</i>		<i>1+1</i>	Suction Catheter		
HME filter: A/P/N						Feeding Tube <i>5</i>		<i>01</i>
Syringes : 10 cc		<i>03</i>				Vaccum Suction Set		
05 cc		<i>03</i>	Gloves <i>S. G. 6, 6 1/2 → 3+2</i>			Surgical Gloves <i>S. G. 6 1/2</i>		<i>2</i>
02 cc		<i>03</i>	<i>Gloves 6, 6 1/2 → 2+1</i>			Gauze Pack <i>7.5cm</i>		<i>1</i>
01 cc		<i>01</i>				Syringe 1ml / 2ml		<i>01</i>
Cautery plate: A/P/N		<i>01</i>	Surgical blade <i>22</i>		<i>01</i>	Surgical Blade # 20		<i>01</i>
IV set			NG tube			Koochies (S)		
RL		<i>03</i>	Cautery pencil		<i>01</i>	<i>oxygen mark (p)</i>		<i>01</i>
NS : 10ml / 100ml / 500ml / 1000ml			Koochies <i>XXL</i>		<i>01</i>			
			Ointments <i>betadine</i>		<i>01</i>	<i>26-0000205-104/105</i>		
			Suction Catheter					
Fentanyl		<i>01</i>	Cap, Mask		<i>10+10</i>			
Morphine			Gauze Pack <i>7.5cm</i>		<i>2</i>			
Ketamine			Mop Pack		<i>2</i>			
Propofol			Steristrip					
Rocuronium <i>Metheorgine</i>		<i>04</i>	Underpad		<i>02</i>			
Glycopyrolate			Draw sheet					
Myopyrolate			Abgel		<i>01</i>			
Ondansetron			Foleys catheter					
Pencan 25g / Spinal Needle 22		<i>01</i>	Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)		<i>01</i>	Romodrain bag					
Antibiotics <i>Metrogel (Agugel)</i>		<i>01</i>	Bandage					
<i>Tranexa 1g+m</i>		<i>02</i>	Tegaderm					
Suppositories <i>Thericaïne</i>		<i>01</i>	Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg		<i>01</i>	Vaccum Suction set		<i>01+1</i>			
Justin : 12.5 mg / 25mg / 100mg		<i>01</i>	Plastic Bed Sheet <i>Aprons</i>		<i>4</i>			
Tab. Misoprost : 200mg		<i>04</i>	Betadine Solution		<i>2</i>			
<i>Enure 7.0</i>		<i>01</i>	Microshield		<i>2</i>			
<i>oxytocin</i>		<i>03</i>	Cotton Balls		<i>01</i>			
<i>gauze 7.5</i>		<i>01</i>	Latex Gloves		<i>20</i>			
			Ramdione Scrub					
			Saral					

Surgeon: Anaesthesiologist: Nurse: *Sarunwalb* OT Technician:
 Order No.: *26-00002058/057/205074* Ordered by:
 Doc. No.: RCH / FRM / GENERAL / 125

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ELECTRONIC MEDICINE PRESCRIPTION

MRN : BAH-00551472 Name : Mrs KHATIJA FATIMA
 Age / Sex : 26 Y 2 M 18 D / Female Doctor : SWAPNA SAMUDRALA
 Adm/Reg Date/Time : 07/06/2026 17:03 Payor : SELFPAY
 Order Date : 07/06/2026 18:08 Ordernumber : 26-0000205057
 Visit ID : IP26-00006526 Ward/Bed No : 4F -OT / LDR-416
 Patient Address : H NO 10-1-20/1, PENT HOUSE, BINTRIF APT,PENT HOUSE,BINTRIF APT,PENT HOUSE,BINTRIF APT,PENT HOUSE,BINTRIF APT,PENT HOUSE,BINTRIF APT, Humayun Nagar, Hyderabad, INDIA, 500028

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	SGLOVE # 6 (SURGICARE)	SURGICAL GLOVES 6.0	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
2	TRUGUT CHROMIC CATGUT SN4242	TRUGUT CHROMIC CATGUT SN4242	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
3	MISOPROST TAB 200MCG 4S		1 Tabs	External / Once Daily	1 Days		4 Tabs	Dispensed
4	VICRYL 1-0 VP 2346	VICRYL 1-0 VP 2346	1 Nos	/ Once Daily	2 Days		2 Nos	Dispensed
5	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
6	SUPRIDOL SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
7	ENCORE MICROPTIC GLOVES-6 PF		1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
8	PREGELLED SURGICAL PLATES(ADULT)	PREGELLED PLATED ADULT	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
9	JUSTIN SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
10	MONOCRYL 3-0 NW 1326	MONOCRYL 1326	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
11	RL 500 ML CLOSED SYSTEM	RINGER LACTATE 500ML CLOSED	1 Bottle	/ Once Daily	1 Days		1 Bottle	Dispensed
12	Encore Microptic gloves-6.5		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
13	EYATOCIN (OXYTOCIN) INJ 5 IU 1 ML		1 Nos	/ Once Daily	3 Days		3 Vial	Dispensed
14	DSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
15	ENCORE MICROPTIC GLOVES-7 PF		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
16	VICRYL 1-0 NW 2364	VICRYL 1-0 NW 2364	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
17	SURGICAL BLADE 22	SURGICAL BLADE 22	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
18	BUPICAIN HEAVY 80MG INJ 4ML	BUPIVACAINE 80MG INJ	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed

SWAPNA SAMUDRALA

Reg No : 69924

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Note

* This prescription is valid only for specified duration.

* Do not refill medicines.



ELECTRONIC MEDICINE PRESCRIPTION

MRN : BAH-00551472 Name : Mrs KHATIJA FATIMA
Age / Sex : 26 Y 2 M 18 D / Female Doctor : SWAPNA SAMUDRALA
Adm/Reg Date/Time : 07/06/2026 17:03 Payor : SELFPAY
Order Date : 07/06/2026 20:31 Ordernumber : 26-0000205075
Visit ID : IP26-00006526 Ward/Bed No : 4F -OT / LDR-416
Patient Address : H NO 10-1-20/1, PENT HOUSE, BINTRIF APT,PENT HOUSE,BINTRIF APT,PENT HOUSE,BINTRIF APT,PENT
HOUSE,BINTRIF APT,PENT HOUSE,BINTRIF APT, Humayun Nagar, Hyderabad, INDIA, 500028

	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	BIOXAMIC 500 MG INJ		1 Nos	/ Once Daily	2 Days		2 Ampule	Dispensed
2	PENCAN 25G*3 1 2	PENCAN 25G*3 1 2	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
3	ABGEL SURGI PAD (BIG) (GELSPON)	ABGEL	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
4	VACCUME SUCTION SET	VACCUME SUCTION SET	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
5	ADULT DIAPERS-XXL		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
6	METHERGIN INJ 1 ML		1 Vial	/ Once Daily	1 Days		1 Vial	Dispensed
7	BACTOPREP SOLUTIONS 100 ML	CHLORHEXIDINE GLUCONATE2% &ALCOHOL80% 500	1 mL	/ Once Daily	2 Days		2 Nos	Dispensed
8	WOKADINE 10% OINT 15GM	POVIDONE IODINE 10% 15GM	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
9	COTTON BALLS 2 GM 5 NOS	COTTON BALLS 2G- 5 NOS	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
10	THEMICAINE 2% 30ML INJ		1 Nos	Injection / Once Daily	1 Days		1 Nos	Dispensed
11	DISPOSABLE APRONS STERILE XL	DISPOSABLE APRON STERILE XL	1 Nos	/ Once Daily	4 Days		4 Nos	Dispensed
12	MOPS 30X30 8PLY 5S X-RAY	MOPS 30X308 PLYDATT	1 Nos	/ Once Daily	2 Days		2 Nos	Dispensed
13	CAUTERY PENCIL (ADVANCE)	CAUTERY PENCIL (ADVANCE)	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed

SWAPNA SAMUDRALA

Reg No : 69924

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Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar ,Hyderabad ,
Telangana, INDIA ,500029.
040-48873000, info@rainbowhospitals.in



ELECTRONIC MEDICINE PRESCRIPTION

MRN : BAH-00551472 Name : Mrs KHATIJA FATIMA
Age / Sex : 26 Y 2 M 18 D / Female Doctor : SWAPNA SAMUDRALA
Adm/Reg Date/Time : 07/06/2026 17:03 Payor : SELFPAY
Order Date : 07/06/2026 20:31 Ordernumber : 26-0000205074
Visit ID : IP26-00006526 Ward/Bed No : 4F -OT / LDR-416
Patient Address : H NO 10-1-20/1, PENT HOUSE, BINTRIF APT,PENT HOUSE,BINTRIF APT,PENT HOUSE,BINTRIF APT,PENT HOUSE,BINTRIF APT,PENT HOUSE,BINTRIF APT, Humayun Nagar, Hyderabad, INDIA, 500028

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	FACE MASK 3 LAYER - ELASTIC	FACE MASK 3 LAYER	1 Nos	/ Once Daily	10 Days		10 Nos	Dispensed
2	SURGEON CAP(FEMALE) (PROTECTCARE)		1 Nos	/ Once Daily	1 Days		10 Nos	Dispensed
3	UNDERPADS 60X90 BUTTERFLY		1 Nos	External / 10 AM	1 Days		2 Nos	Dispensed
4	ACUGYL 500MG INJ		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
5	NITRILE EXAMINATION GLOVES P F- MEDIUM	NITRILE GLOVES M	1 Nos	/ Once Daily	20 Days		20 Nos	Dispensed
6	POVINANZ SOLUTION 10% 100 ML		1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed

SWAPNA SAMUDRALA

Reg No : 69924

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Telangana, INDIA ,500029.
040-48873000, info@rainbowhospitals.in



ELECTRONIC MEDICINE PRESCRIPTION

MRN : HNH-00015857 Name : Baby Of KHATIJA FATIMA
 Age / Sex : 0 Y 0 M 0 D 7 H / Female Doctor : S TEJASWI REDDY
 Adm/Reg Date/Time : 07/06/2026 20:54 Payor : SELFPAY
 Order Date : 07/06/2026 23:51 Ordernumber : 26-0000205104
 Visit ID : IP26-00006530 Ward/Bed No : 4F -NICU 1 / NICU1-401
 Patient Address : H NO 10-1-20/1, PENT HOUSE, BINTRIF APT,PENT HOUSE,BINTRIF APT,PENT HOUSE,BINTRIF APT,PENT HOUSE,BINTRIF APT,PENT HOUSE,BINTRIF APT, Humayun Nagar, Hyderabad, INDIA, 500028

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	Oxygen Mask With Tubing - PeadROMSONS-FC		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
2	CORD CLAMP-ALPHAMEDICARE		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
3	EASYCLOT-K1 1MG INJ 0.5 ML		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
4	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
5	INFANT FEEDING TUBE-5	INFANT FEEDING TUBE 5	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
6	SURGICAL BLADE 20	SURGICAL BLADE 20	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed

S TEJASWI REDDY

Reg No : APMC/FMR/94068

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Note

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Dr. Seepne

ESTIMATION SLIP

Date : 14/5/2026 UHID / IP No. : BAH-00551472 SI No. 1513

Name of Patient : Khatija Fatima Age: 26Y Gender: F

Father's / Husband's Name : Fahad Bin Yeshrah Corporate / Occupation : _____

Address : Hymayun Nagar Phone : 9959919786 Email : _____

Procedure / Plan : NP/LSCS EDD/Dos: 13/06/2026

MODE OF PAYMENT : SELF TPA : _____ GIPSA : _____ OTHER _____

TARIFF INFORMATION :

Particulars	Package Amounts (Rs.)	
	Normal Delivery	LSCS
Room Category		
Multi Shared Ward		
Shared Ward		
Twin Shared Ward		
Private Room		
Super Deluxe Room		
Suite Room	<u>2.40</u>	<u>2.40</u>
Package includes (Package starts from the time of admission)	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee and Labour Ward Charges	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee Anesthetist's Fees and OT Charges
	Length of Stay for :	Length of Stay for :
	Pharmacy up to	Pharmacy up to
	Investigations up to	Investigations up to
Others		

Neonatologist Charges : Covered Not Covered Epidural / Entonox : Covered Not Covered

Initial Minimum Deposit : _____

REMARKS :

- Room eligibility is purely subject to TPA approval and the Package / Room Tariff starts from the time of admission. The estimated amount may Change according to duration of stay, medical condition, investigations, pharmacy and any other procedure.
- Proportionate difference of bill amount is applicable in case the patient opts for a category higher than the TPA approved, which has to be paid by the patient and may not be reimbursed by the TPA at later stage.
- Total baby charges are extra which include admission, pharmacy, vaccinations, investigations, disposables, consumables, equipments, speciality consultations, etc.
- In Case the patient gets discharged earlier than the packages permitted days, no refund of any type is applicable and if the length of stay is beyond the package permitted, additional payment is applicable for which kindly contact the Financial Counselling desk between 9am to 6pm
- For Non-medicals, Disposables, Consumables, Taxes, Kiwi Cup charges, Implants, Tubectomy charges, HIV/HbsAg, Anti-D, Medical Records, Double Occupancy and Registration Charges, etc. credit cannot be exchanged. These items are not payable to us as per Insurance company norms.
- Difference if any between the final bill amount and amount permitted/approved by TPA or total bill amount in case of denial from TPA has to be paid by the patient. In case of denial, cash tariff would be applicable.
- Two attendants are permitted with patients in SDLX, DLX and PVT rooms and only one attendant is permitted in the rest of the categories of rooms and no attendant is permitted in ICU's
- Tariffs are subject to revision
- Kindly check your billing status on day to day basis at IP Billing Department.
- Additional Charges on package are applicable for Non-working hours and Non-working days (sundays and public holidays)

DECLARATION

I _____ have attended the Financial counseling desk and understood the expected costs and other conditions applicable. In case the TPA / Insurance Company rejects the claim for whatsoever reasons at any point of time I promise to settle the hospital bill with the hospital without any ambiguity.

Signature of the Client

Signature Relationship

Signature of the financial Counselor



13/01/2022

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Khalifa Fatima

Faktor Bin Asyraf

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Name	Mrs KHATIJA FATIMA	UHID	BAH-00551472
Father/Guardian	KHATIJA FATIMA (HNH-00015857)	Age/Gender	26 Y 2 M 18 D/ Female
Address	H NO 10-1-20/1, PENT HOUSE, BINTRIF APT, PENT HOUSE, BINTRIF APT, PENT HOUSE, BINTRIF APT, PENT HOUSE, BINTRIF APT, PENT HOUSE, BINTRIF APT, Humayun Nagar, Hyderabad, INDIA, 500028		
IP No	IP26-00006526	Admission Date	07-06-2026
Ref Doctor	Self.		
Discharge Date	10.06.2026		

DISCHARGE SUMMARY

Consultant:
Dr. SWAPNA SAMUDRALA
MBBS, MS (OBG)
69924

Diagnosis: G4P3L3 WITH 36+1 WEEKS PERIOD OF GESTATION WITH PREVIOUS 3 LOWER SEGMENT CAESERIAN SECTIONS WITH PRETERM PREMATURE RUPTURE OF MEMBRANES.

EMERGENCY LOWER SEGMENT CAESERIAN SECTION DONE ON 07.06.2026.

Name	Mrs KHATIJA FATIMA	UHID	BAH-00551472
IP No	IP26-00006526	Admission Date	07-06-2026

History:

LMP:13.10.2025

Obstetric formula: G4P3L3

EDD: 25.07.2026

Gestation at admission: 36⁺¹ weeks

Obstetric History:

G1 - 2019-PT-LSCS with 32 weeks with APH with baby girl 1.8kg with A & H.

G2 - 2020-FT-LSCS with baby girl with 2.8kg with A & H.

G3 - 2024-FTLSCS with baby girl with 3kg with A & H.

G4 -Present pregnancy, Spontaneous conception.

Medical History: Nil

Surgical History: LSCS-2019,2020,2024

Allergies: Nil

Family History: Nil

Antenatal Details:

Mrs KHATIJA FATIMA was booked to Rainbow hospital at 7⁺³ weeks of gestation. She had regular antenatal checkups and investigations as advised. NT scan was normal. FTS low risk. MTAS was normal. Fetal surveillance done by serial growth scans. Scan done on (04.06.2026) at 35⁺⁵ weeks showed single live intrauterine fetus with cephalic presentation, AFI:7.9cm EFW: 2.3kg(17%), AC(4%) placenta: anterior high ,Doppler normal.She was admitted at 36⁺¹ weeks Preterm Premature rupture of membranes.

Investigations: Enclosed

Blood group: "O" Positive

Name	Mrs KHATIJA FATIMA	UHID	BAH-00551472
IP No	IP26-00006526	Admission Date	07-06-2026

Management:

Course in hospital and Delivery Details:

At admission on clinical examination the vitals were stable, uterus was mildly acting, cervix was long and os closed. Fetal well being was confirmed by an admission CTG which was found to be reactive. She was decided for emergency C-section in view of previous LSCS in Early labour, prepared with indwelling Foley's catheter and IV canula under aseptic conditions. Written informed consent for surgery taken. Preanesthetic check up done. Couple / Attenders counselled regarding concurrent Tubectomy in v/o 3 prev LSCS status, but they deferred sterilisation. Anesthetic premedication (IV Pantop and Perinorm) given. Antibiotic prophylaxis with Inj. Taxim 1 gm IV given. Patient shifted to theatre.

Surgery Notes:

Under spinal anesthesia she was painted and draped as per hospital protocol. Previous lscs scar excised. Abdomen opened in layers. The parietal and visceral peritoneum carefully opened after identifying the urachus. Bladder was reflected. A lower segment curvilinear incision given on the uterus. Baby delivered. Cord clamped and cut and cord blood collected for blood grouping and Rh typing. Baby handed over to pediatrician. Placenta delivered with controlled cord traction. Uterus closed in layers. Hemostasis secured. Instruments and swab count checked. Rectus sheath closed. Skin closed with subcuticular sutures. Wound dressing done. Vagina cleaned with Betadine solution after expelling clots. Misoprostol 400 mcg given per rectum as prophylaxis against Postpartum hemorrhage. Patient was shifted out of theatre

Name	Mrs KHATIJA FATIMA	UHID	BAH-00551472
IP No	IP26-00006526	Admission Date	07-06-2026

to post operative recovery room.

***Liquor absent.**

*** Lower Uterine Segment thinned out.**

***Omental adhesions present.**

***Single loop of cord around neck.**

Delivery Details :

Date : 07.06.2026

Time of Delivery: 06:34pm

Type of Delivery: Emergency lower segment caesarean section

Indication : 3 Previous lscs with pprom

Anaesthesia : Spinal

Baby Details:

Date : 07.06.2026

Time : 06:34pm

Sex : Female

Weight : 2.5kg

Apgar : 8,9

Gestational Age: 36⁺¹ weeks

NICU Admission: Yes

Post-Operative Notes:

She was closely monitored. Her vital signs remained stable. Uterus was well retracted with no Postpartum hemorrhage. Breast feeding initiated. She was

Name	Mrs KHATIJA FATIMA	UHID	BAH-00551472
IP No	IP26-00006526	Admission Date	07-06-2026

shifted to room. Her postoperative period following that was uneventful. On second postoperative day dressing was changed. On inspection wound was healthy. Her general condition was satisfactory and she was found to be fit for discharge. Wound care and medications were explained to patient supplemented by written information. She was given the postpartum book for further reference.

Advice:

1. Tab. Taxim O 200mg twice daily till 13.06.2026 (9am-9pm) after food.
2. Tab. Calpol 500mg (Paracetamol 500mg) (2tabs) thrice daily till 11.06.2026 (8am-2pm-10pm) after food.
3. Tab. Voveran 50 mg (Diclofenac 50mg) thrice daily till 11.06.2026 (9am-3pm-11pm) after food.
4. Tab. Pantop 40mg twice daily till 13.06.2026 (7am-7pm) before food.
5. Tab. Livogen (Elemental Iron - 50mg, folic acid 1.5mg) once daily (7am) for three months before breakfast.
6. Tab. Shelcal (Elemental Calcium 500 mg, Vitamin D3 250 IU) once daily (2pm) till breast feeding for after food.
7. Nebasulf Powder for local application.

Home Blood pressure monitoring to be done **twice daily** for **two weeks**. Report to emergency if **BP >140/90mmHg**, presence of headache, vomitings, blurred vision, reduced urine output, epigastric pain, seizures.

* Suggest **PAP smear** and **HPV Vaccine** after **6 weeks**; Please discuss with your treating doctor regarding **HPV vaccination**.

Name	Mrs KHATIJA FATIMA	UHID	BAH-00551472
IP No	IP26-00006526	Admission Date	07-06-2026

Review with **Dr. SWAPNA SAMUDRALA** after **2 week** on **24.06.2026** at Rainbow Children's Hospital with prior appointment (**Review consultation will be charged**).

For Women Who Have Had a Caesarean Section
Care of the wound:

- 1.You can bath and shower.
- 2.The wound can get wet during a bath or shower. Dry it thoroughly and gently by dabbing with a gauze piece. Do not rub the wound.
- 3.This gauze piece needs to be discarded after one use.
- 4.Prior to touching the wound clean hands thoroughly with Microshield solution and allow them to air dry or use disposable paper napkins.
- 5.Apply Nebasulf or Neomycin dusting powder on the wound after it is dry.
- 6.Do not touch the wound with unwashed hands.

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, when and how to obtain emergency care etc also have been explained by doctor in a language that I can understand and I acknowledge.

Patient/ Attender

In case of emergency like bleeding, fever, headache [please refer to postpartum book for further details - Chapter II page 6] kindly contact 9154865045 at Rainbow Children's Hospital just dial one toll free number - 18002122.

Name	Mrs KHATIJA FATIMA	UHID	BAH-00551472
IP No	IP26-00006526	Admission Date	07-06-2026

You can also take appointments at any time by going online to our website www.rainbowhospitals.in


Registrar/Resident/C.M.O

Consultant:

Dr. SWAPNA SAMUDRALA
MBBS, MS (OBG)
69924

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006526 **Admit Date** : 07-Jun-2026 **Admit Time** : 05:03 PM **UHID** : BAH-00551472

Patient Details :

Patient Name : Mrs KHATIJA FATIMA **Age** : 26 Y 2 M 17 D
Guardian : Mr MR FAHAD BIN YESHRAH **DOB** : 21-03-2000
Gender : Female **Religion** : Muslim
Occupation : **Martial Status** : Married
Address (H) : H NO 10-1-20/1, PENT HOUSE, BINTRIF APT,
PENT HOUSE,BINTRIF APT,PENT HOUSE,
BINTRIF APT,PENT HOUSE,BINTRIF APT,PENT
HOUSE,BINTRIF APT Humayun Nagar **Phone No** : 9959919786/
Hyderabad INDIA 500028 **E-mail** : NOMAIL@GMAIL.COM

Admission Details :

Bed Type : TWIN SHARING **Bed No** : LDR-416 **Ward Name** : 4F -OT
Room No : LDR-416 **Admission Type** : First Visit

Contact Details :

Name : Mr MR FAHAD BIN YESHRAH **Relationship** : W/O
Contact Address : H NO 10-1-20/1, PENT HOUSE, BINTRIF
APT,PENT HOUSE,BINTRIF APT,PENT
HOUSE,BINTRIF APT,PENT HOUSE,BINTRIF
APT,PENT HOUSE,BINTRIF APT Humayun
Nagar Hyderabad INDIA 500028 **Phone No** : 9959919786

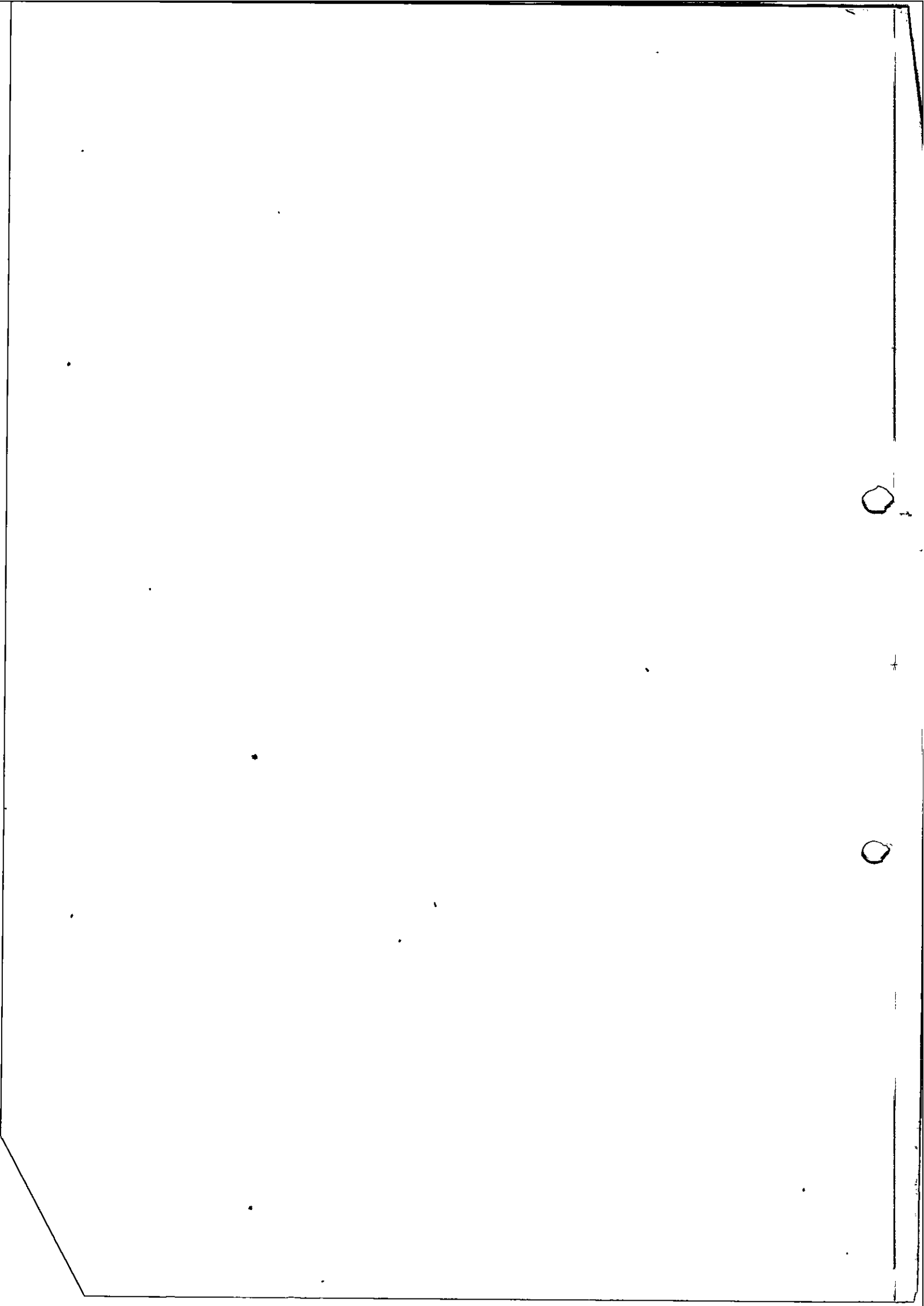

Signature

Doctor Details :

Doctor Name : Dr. SWAPNA SAMUDRALA **Specialisation** : OBSTETRICS AND GYNECOLOGY
Referral Doctor : Self. **Phone No** :
Cc-Consultant :

Payment Details :

Deposit Amount : 240000.00
Payment Mode : Cash **Payor Name** : SELFPAY



ACTIVITY RECORD FOR BILLING

Name : _____ BAH-00551472 IP26-001 _____
 Mrs KHATIJA FATIMA
 21-03-2000 26 Y 2 M 17 D
 UHID No. : _____ IP Dr. SWAPNA SAMUDRALA _____ Int: _____ Dept : _____
 Date of Admission: _____ Discharge : _____ Time: _____
 Room / Bed No : _____ Ward : _____ Suggested Billable bed type : _____



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
7/6/26	6:10pm	Pre-post	OT	Ruitha/Suj
7/6/26	8pm	OT	Pre-post	Sandy/Ruitha
8/6/26	10:30pm	LDR	FLOOR(SH)	AKRISHA

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. S. Tejaswi Reddy		5239	Bala
2				Cross checked by Bala
3				
4				
5				
6				
7				
8				
9				
10				

EET FOR OBSTETRICS

Presenting Complaints

clo leaking PLV. 1:2pm

Obstetric Formula: $G_4P_3L_3$

Obstetric History:

1st preg (2019) - PT-LSCS / 32wks / APH / ♀
 (NICU x 25d) 1.8kg / A&H
 2nd preg (2020) - FT-LSCS @ / ♀ / 2.8kg / A&H
 3rd preg (2024) - FT-LSCS / ♀ / 3kg / A&H.
 4th preg: - Sp. conceptn. Booked @ 13 wks
 NT - (10), Pts (10) low risk, TIFFA - (10)

Present Pregnancy Record:

LMP: 13/10/25 EDD:

Corrected EDD: 25/7/26, GA: 36⁺ wks.

Menstrual History: Regular: Yes No

Obstetric Examination

Fundal Height: Ut ~ Term

Ut. Activity: Relaxed Mild Mod Severe

Liquor: Adequate Oligo Poly

PP: Cephalic Breech Others _____

Head Fifths Palpable: 5/5

FHS: Normal Tachy Brady Absent

RISK FACTORS:

- Prev 3 LSCS.

Per Speculum Examination

Draining: Present Absent Bleeding

Colour of Liquor: Clear Meconium Blood Stained

Vaginal Examination

Cervix: Long Partially effaced Effaced

Os: Closed Dilated _____

Membranes: Present Absent - N/A

Liquor: Clear Meconium Blood Stained

Presenting Part: Vertex Breech Others

Sutton: -3 -2 -1 0 +1 +2

Pelvis: Adequate Doubtful

Height: 161 cm

Weight: 65 kg

Allergies: Nil

Breast: Normal Abnormal

General Examination:

Consciousness: (+)

Pallor: (-)

Icterus: (-)

Edema: (-)

Temp: Afebrile

PR: 78 bpm

BP: 100/70 mmHg

DTR: (+)

CVS: S1, S2 (+)

RS: B/L N/R/S

Liver/Spleen: N

Urine Output: N

DIAGNOSIS

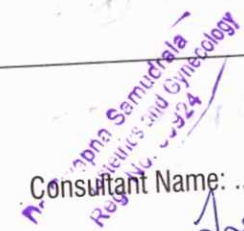
$G_4P_3L_3$ / 3 prev LSCS @ 36⁺ wks \rightarrow PPRDM



<p>Family History: Nil</p>	<p>Surgical History: LSCS - 2019, 2020, 2024.</p>
<p>Medical History: Nil</p>	<p>Medication History: On T. Fe / T. Ca</p>
<p>Plan of Care:</p> <p><u>Emergency LSCS</u></p> <ul style="list-style-type: none"> - Informed consent - Preop parts - CB Admission CTG - Pre-op medications as charted - Inform OT, Anesthetist, Pediatrician. - Shift to OT on call - CBP - Reserve 10 PRBC. 	<p>Investigations:</p> <p>Blood Group - "O positive"</p> <p>Hb - 10.9 g/dl Plt - 2.1 Lakh WBC - 8.6 k</p> <p>AMV HbSfg MCV RDW</p> <p>USG. (4/6/26) ~ 35⁺ wks</p> <p>SLR, Cephalic, Pl - Ant. high h AFI - 7.9 cm EFW - 2.3 kg (12⁺)</p>

Doctor Name: Dr. G. Veenu
 Signature: [Signature]
 Date & Time: 7/6/26

Consultant Name: Dr. Swapna
 Signature: [Signature]
 Date & Time: 7/6/26





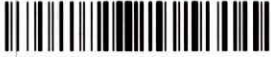
PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/6/26 8:10 AM	POD-0 (Pulu / Em. hse)	- <u>Adv</u>
	NO Comp	- NBM - Ill Junction Orders
Baby well	O/E - GC fair adherent	- IVF / analgesia Thrombocytopenia - Adv
U/O → 300 ml	O ₂ Sat - 99% RA	- Drugs as charted
clear	PR - 70 bpm	- TPR / RR charting 1/2 hourly
	B.P - 120/60 mmHg	- No chart
	P/A - Ut well retracted	- Wf excessive PU
	L/E - MARS	- Bleeding
		- Japan Rx.
		<p>Dr. Swapna Samudrala Consultant Obstetrics and Gynecology Reg. No: 69924</p>
		<p>(M. Swagun's)</p>
7/6/26 @ 10:30 PM	-cls/B Dr. Veena	
Baby in NICU	POD-0 / P ₄ L ₄	
↓ CPAP mode	Pt is stable, Noct	
	o/e GC fair, Afebrile	- Adv
	BP - 100 / 72 mmHg	- NBM
	PR - 78 bpm	- Oral sips @ 12am f/b liquid diet
	SpO ₂ - 100% on RA	- Drugs as charted
	P/A - Ut well retracted	- Tlo charting
	BS - sluggish	- vital monitoring
	L/E - RWNL	- off excessive bloody PU
	U/O - 60ml/hr, clear	- Remove Foley's cath @ 10am - Inform SAs - Shift to room



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/6/26 #PM	e/c/s Dr. Veena	
	POD-1 P ₁ , L ₄	
Baby in view	Pt is stable, No c/o ple ac-fair - Afebrile vitals - stable	- Adv. - Soft diet
- RDS - On CPAP mode	PIA - Ut well retracted BS (+) L/E - BUNL	- Remove Foley's catheter. - Vital monitoring - P/O clarity - Ambulation
	B/c Breasts - Soft, MS (+) O/O - 100ml/hr, high coloured Ec clear tube.	- Adequate hydration - Perform S/O
		2/17/26 [Signature]



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/6/2026 11:00am	cls/by	Dr. Naveena
U-V F-X S-X	<p>OLE GC-Fair Afebrile Vitals- stable. PA- ut retracted well Soft, NT. Dressing: dry & clean HE: PV bleeding w/NC.</p>	<p>Adv Soft diet Adequate hydration Ambulation drugs as charted w/ PV bleeding Ty: Penicillin iv</p>
	<p>Baby: NICU</p>	<p>start Monitor Vitals In farm SCS.</p>
		<p>Dr. Naveena.</p>
8/6/26 1:30pm	<p>POS - 2 NO comp OLE - Guffari Afebrile O₂ Sat - 99% on RA Vitals - @</p>	<p>Adv - Soft Diet - Oral hydration - Drugs as charted - Monitor vitals - Ambulation</p>
Baby - NICU Urinal Stool + Glucose +	<p>PA - ut well retracted Soft HE - MARS -</p>	<p>- Japa Ses</p>

Dr. Swapna Samudrala
 Consultant Obstetrics and Gynecology
 Reg. No: 69924

(Signature)



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/6/2000	cb/b or mumble	
6:30pm	Poo 1	
		Adv.
	GC - For Afebrile	- Soft Diet
	BD 1/0/70	- Adeq Hydration
Baby - New (low birth)	PR SG	- Drops as charted
	PHA ut well retained / BSO	- Wf retub & BSV
	LIS Bleedy wate	- Ambulation (3 rd hourly)
W ✓	t/o	- Inform us
F ✓ (min)		
S ✓ (min)		w/B piperates <u>My Amant</u>
8/6/2000	S - Poo	
10:30pm		
	No complaints	
	V: ✓	
	F: ✓	
	P: not freely	Kumar DANAYA




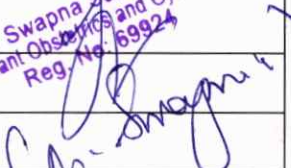
PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/6/2026 8:35am	cls by Dr. Naveena OLE GC-fair Afebrile Vitals - stable PA: ut. retracted. Soft, NT	Ado - Regular diet - Adequate hydration - Ambulation - drugs as charted
U-V F-V	Dressing: dry & clean. S-V U/E: PV bleeding wNL	- w/f PV bleeding - Monitor Vitals - Inform SOS
	Baby: NICU	
9/6/26		Dr. Naveena
9/6/2026 12:40pm	cls by Dr. Swapna pna OLE GC-fair Afebrile Vitals - stable PA: ut. retracted well Soft, NT	Ado - Regular diet - Adequate hydration - Ambulation - drugs as charted
	Dressing: dry & clean U/E: PV bleeding wNL	- w/f PV bleeding - Monitor Vitals - Inform SOS
	Baby: NICU	
		NB - M... @ IPM

Dr. Swapna Samudrala
 Consultant Obstetrics and Gynecology
 Reg. No. 63924



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/6/26	<u>CS/B Dr. Dmg</u>	
<u>7:15 AM</u>	POD-3 P/L c/o Breast Pain AC fair, Afebrile vitals - Normal P/A ut retracted well L/E NAB	<u>Adv</u> - Regular diet - Adequate hydrate - Ambulate.
Baby @ NICU		- Drugs as charted - Monitor vitals
U ✓ F ✓ S ✓		w/o P/V bleed. Enjoin so Hot compresses over Breast. <u>Steeisteip dressing today</u> N/B priyanka
<u>10/6/26</u>	<u>POD - III</u>	
<u>11:30 AM</u>	NO comp O/E - AC fair vitals - @	<u>Adv</u> - Regular Diet - Oral hydrate - Drugs as charted
Baby - NICU	P/A - ut milk retracted wound - (H)	- monitor vitals - Ambulate - Enjoin so
Can be discharged	Dressing wound can ✓	 Dr. Swapna Samudrala Consultant Obstetrics and Gynecology Reg. No. 69924

BAH-00551472 IP26-004
 Mrs KHATIJA FATIMA
 21-03-2000 28 Y 2 M 17 D
 Dr. SWAPNA SAMUDRALA



RESULT SHEET

Date	TP	7/6/26				
Time		5:16 PM				
Hb		10.9				
PCV		31.3				
RBC		4.00				
WBC		8.69				
N/L						
Platelets		215				
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
blood grouping	10	positive				
HEV	} NR	10 PRBC reserved in surya blood bank				
VDPL						
HIV						

Culture and Sensitivities :

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Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.) :

BAH-00551472
 Mrs KHATIJA FATIMA IP26-00006526
 21-03-2000 28 Y 2 M 17 D (F)
 Dr. SWAPNA SAMUDRALA



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	TAB. IRON	Tab	PO	OD	8/6/26	<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
2	TAB. CALCIUM	Tab	PO	OD	6/6/26	<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : *Dr. G. Veena*

Date & Time : *7/6/26 @ 5pm*

Nurse Name & Signature: *Sujatha Jy*

Date & Time : *7/6/26 @ 5pm*

BAH-00551472 IP26-00006526
Mrs KHATIJA FATIMA
21-03-2000 26 Y 2 M 18 D (F)
Dr. SWAPNA SAMUDRALA



311



NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 8/6/26 Time: 11:10Am

Origin: Indian Height: 161cms Weight: 65kg BMI: ~ 26 kg/m²
 ~ 28 kg/m²
 ~ 30 kg/m²

Food Allergies: NO

Diagnosis: LSCS

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

2.6 kg

Diet Advised:

Liquid Diet – ORS/ Coconut Water/ Butter Milk/ Barley Water/ Soups

Normal Diet – Rice, Rotis, Dal and Soft Cooked Vegetables and Curd

Soft Diet – Soft Rice, Dal and Vegetable Curries Soft Cooked, Curd

Diabetic Diet – Brown Rice/ Oats/ Dahlia/ Rotis, Dal and Vegetables and Curd (Avoid Roots/ Tubers)

Patient's / Attendant's

Signature: [Signature]

Name: Fatima

Date & Time: 8/6/26 ; 11:10Am

Dietician's

Signature: [Signature]

Name: Sathwika

Date & Time: 8/6/26 ; 11:10Am

BAH-00551472 IP26-00006526
Mrs KHATIJA FATIMA
21-03-2000 26 Y 2 M 18 D (F)
Dr. SWAPNA SAMUDRALA



31)



CROSS CONSULTATION FORM

Doctor Name : Dr. Swapna Date : 8/6/26 Time : 12pm

Diagnosis : LSCS

Hospital : RCH - HMNR

Type of Referral :

- Emergency
- Urgent
- Non Urgent

Referred for : Opinion Co-Management Transfer of care

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature: _____

Findings and Recommendations :

Lactation care plan

- well formed Breast & Nipples
- Baby NICU
- Advice expressed Breast milk every 2-2 1/2 hours
on each side 20 mins.
- colostrum seen.

Consultant :

Name : Sathwik Signature : Sis Date & Time : 8/6/26; 12pm

BAH-00551472 IP26-00006526
 Mrs KHATIJA FATIMA
 21-03-2000 26 Y 2 M 17 D (F)
 Dr. SWAPNA SAMUDRALA



DRUG CHART

Date of Admission: 7/6/26 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



REGULAR PRESCRIPTIONS

Weight. 60kgs Ward.

Verified by Dr. Dhakshayani
 Verified by Dr. Dhakshayani
 Verified by Dr. Dhakshayani
 Verified by Dr. Dhakshayani

DRUG : INS - CEROTAXIME Date/Time 7/6/26 9/6

Dose	Route	Frequency	Start Date
<u>1g</u>	<u>iv</u>	<u>BD</u>	<u>7/6/26</u>

Name & Signature of the Doctor Starting the Drugs: [Signature]

Additional Instructions: ATTN X 24hrs → Oral

Daily Doctor's Endorsement by a Sign: [Signature]

Handwritten notes: STOP [Signature] Dr. Naveen

DRUG : TAB PARACETAMOL Date/Time 8/6 9/6 10/6

Dose	Route	Frequency	Start Date
<u>1gm</u>	<u>PO</u>	<u>QID</u>	<u>7/6/26</u>

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign: [Signature]

DRUG : TAB TRAMADOL Date/Time 8/6 9/6 10/6

Dose	Route	Frequency	Start Date
<u>100mg</u>	<u>PO</u>	<u>TID</u>	<u>7/6/26</u>

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign: [Signature]

DRUG : TAB DICLOFENAC Date/Time 8/6 9/6 10/6

Dose	Route	Frequency	Start Date
<u>50mg</u>	<u>PO</u>	<u>TID</u>	<u>7/6/26</u>

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

Additional Instructions:

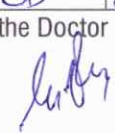
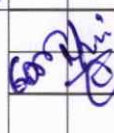
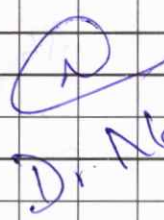
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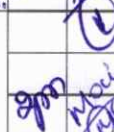
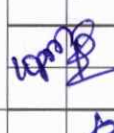


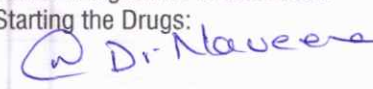

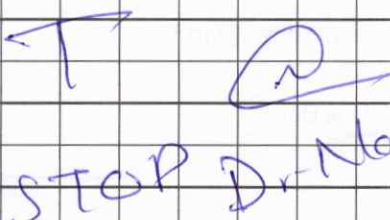
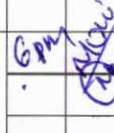
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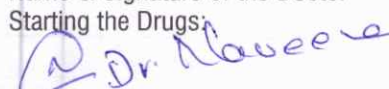
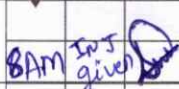
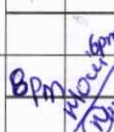
REGULAR PRESCRIPTIONS

Weight 6kgs Ward

DRUG : T. PANSIAPRAZOLE				Date/Time	8/6																
Dose	Route	Frequency	Start Dt.																		
Long	PO	OD	8/6/20																		
Name & Signature of the Doctor Starting the Drugs:				  																	
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					

DRUG : SWI-METRONIDAZOLE				Date/Time	8/6	9/6															
Dose	Route	Frequency	Start Dt.																		
500mg	IV	TID	8/6/20																		
Name & Signature of the Doctor Starting the Drugs:				  																	
Additional Instructions:				x 24hrs → stop 																	
Daily Doctor's Endorsement by a Sign																					

DRUG : INI-PANTOPRAZOLE				Date/Time	8/6	9/6															
Dose	Route	Frequency	Start Dt.																		
40mg	IV	BD	8/6																		
Name & Signature of the Doctor Starting the Drugs:				  																	
Additional Instructions:				TILL IV ANTIBIOTICS 																	
Daily Doctor's Endorsement by a Sign																					

DRUG : T. CEFIXIME				Date/Time	9/6	10/6															
Dose	Route	Frequency	Start Dt.																		
200mg	PO	BD	9/6																		
Name & Signature of the Doctor Starting the Drugs:				 																	
Additional Instructions:				AFTER FOOD 																	
Daily Doctor's Endorsement by a Sign																					

Verified by Dr. Dhakshayani
 Verified by Dr. Dhakshayani
 Verified by Dr. Dhakshayani

BAH-00551472 IP26-00006526
 Mrs KHATIJA FATIMA
 21-03-2000 28 Y 2 M 17 D (F)
 Dr. SWAPNA SAMUDRALA



REGULAR PRESCRIPTIONS

Weight 6kgs Ward

Sheet No:

DRUG : T. PANTOPRAZOLE				Date Time	9/6	10/6														
Dose	Route	Frequency	Start Dt.																	
40mg	PO	BD	9/6	6AM given																
Name & Signature of the Doctor Starting the Drugs:				Dr. Naveena																
Additional Instructions:				BEFORE FOOD																
Daily Doctor's Endorsement by a Sign				[Signature]																
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																				

Verified by Dr. Dhakshayani

Signature

Verified by Name

BAH-00551472 IP26-00006526
 Mrs KHATIJA FATIMA
 21-03-2000 28 Y 2 M 17 D (F)
 Dr. SWAPNA SAMUDRALA

Weight. 60kgs Ward.



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

VARIABLE DOSE

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
7/6/26	5: pm	INT-PANTOPRAZOLE	40mg	IV	[Signature]	Sriatha Anusha
7/6/26	5: pm	INT-METOCLOPRAMIDE	10mg	IV	[Signature]	Sriatha Anusha
7/6/26	6:34 pm	INT Oxytocin	9u	IV	[Signature]	[Signature]
7/6/26	6:45 pm	INT TRANEXAMIC ACID	1gm	slow IV	[Signature]	[Signature]
7/6/26	7:15 pm	Sup. TRAMADOL	100mg	PR	[Signature]	[Signature]
7/6/26	7:15 pm	Sup. DICLOFENAC	100mg	PR	[Signature]	[Signature]
7/6/26	7:05 pm	INT ONDANSETRON	4.0mg	IV	[Signature]	[Signature]
7/6/26	7:05 pm	INT METHYLERGIN	0.2mg	slow IV	[Signature]	[Signature]
7/6/26	7:20 pm	INT METROGYL	0.5gm	IV	[Signature]	[Signature]

VERIFIED BY: Name Signature

Verified by: [Signature]

I.V. FLUIDS CHART

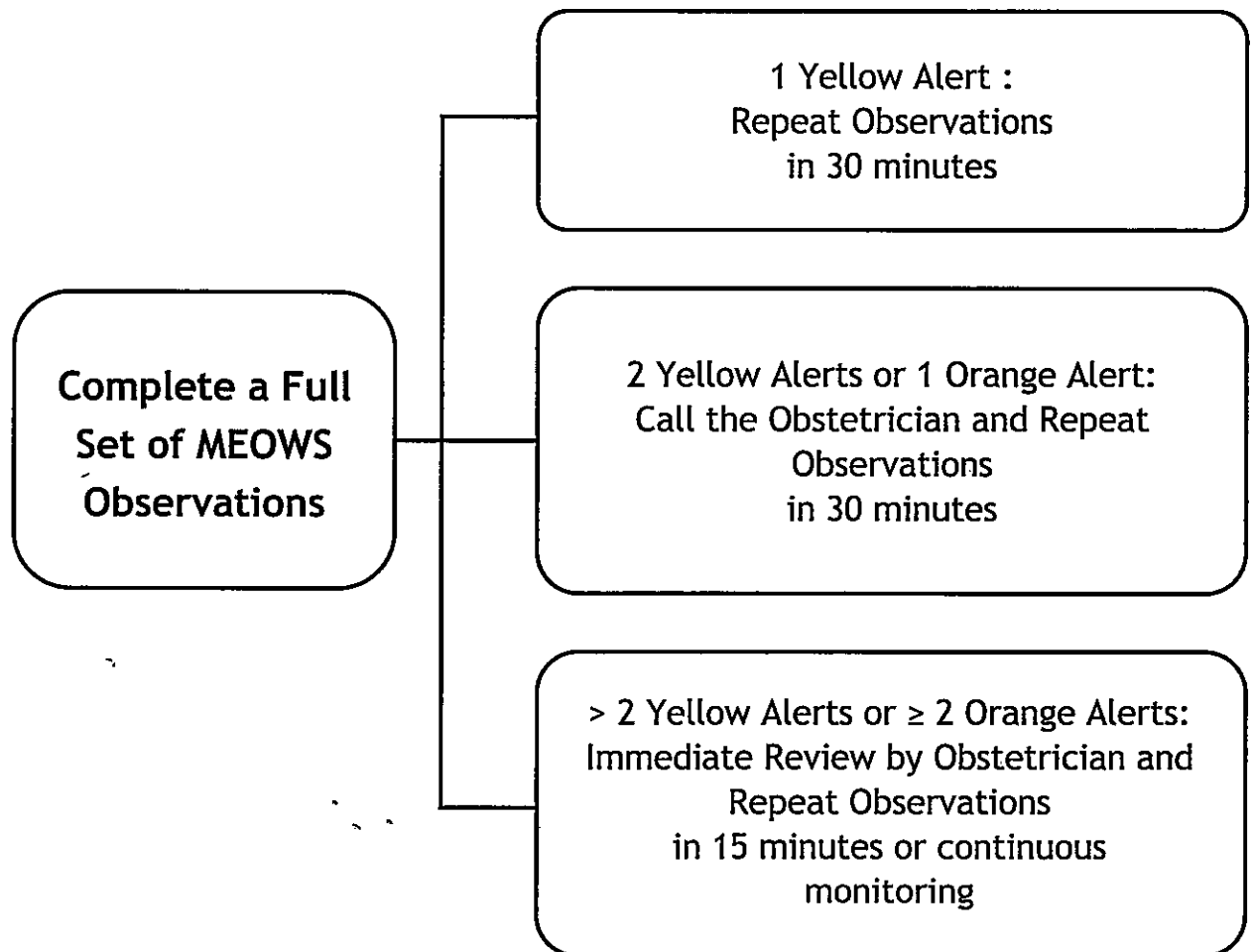
Weight: 60kgs Ward:



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
7/6/26	5PM	RINGER LACTATE	IV	100ml/hr	<u>Dr. Swapna</u>	<u>Li</u> <u>(M)</u>	7/6	<u>Dr. Swapna</u>	<u>(M)</u>
7/6/26	6:30 pm	Ringer Lactate	IV	FF	<u>Dr. Swapna</u>	Li (M)	7/6/26	<u>Dr. Swapna</u>	(M)
7/6/26	7:05 pm	Ringer Lactate	IV	FF	<u>Dr. Swapna</u>	Li (M)	7/6	<u>(M)</u>	(M)
8/6/26	1PM	RINGER LACTATE	IV	100ml/hr	<u>(M)</u>	<u>Li</u> <u>(M)</u>	8/6	<u>(M)</u>	<u>Li</u> <u>(M)</u>
8/6/26	6AM	RINGER LACTATE	IV	100ml/hr	<u>(M)</u>	<u>(M)</u> <u>Li</u>	8/6	<u>(M)</u>	<u>Li</u> <u>(M)</u>
8/6/26	11AM	RINGER LACTATE	IV	100ml/hr	<u>(M)</u>	<u>(M)</u> <u>Li</u>	8/6	<u>(M)</u>	<u>Li</u> <u>(M)</u>
8/6/26	6PM	RINGER LACTATE		100ml/hr	<u>(M)</u>	<u>Li</u> <u>Li</u>	8/6	<u>(M)</u>	<u>Li</u> <u>(M)</u>
8/6/26	6PM	STOP			<u>Dr. Naveena</u>		8/6/26		

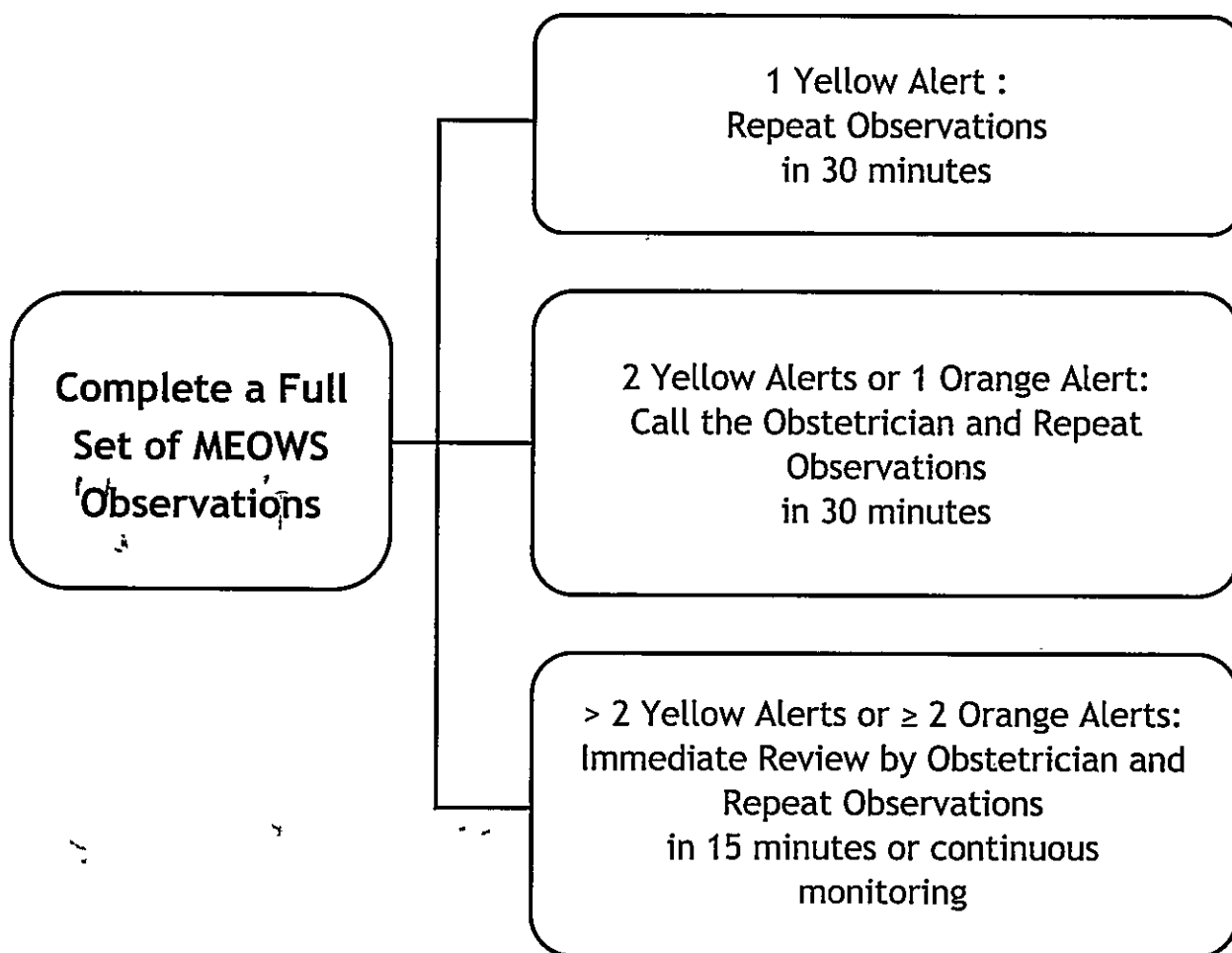
VERIFIED BY: Name Signature

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

BAH-00551472
 Mrs KHATILJA FATIMA IP26-00006526
 21-03-2000 26 Y 2 M 18 D (F)
 Dr. SWAPNA SAMUDRALA

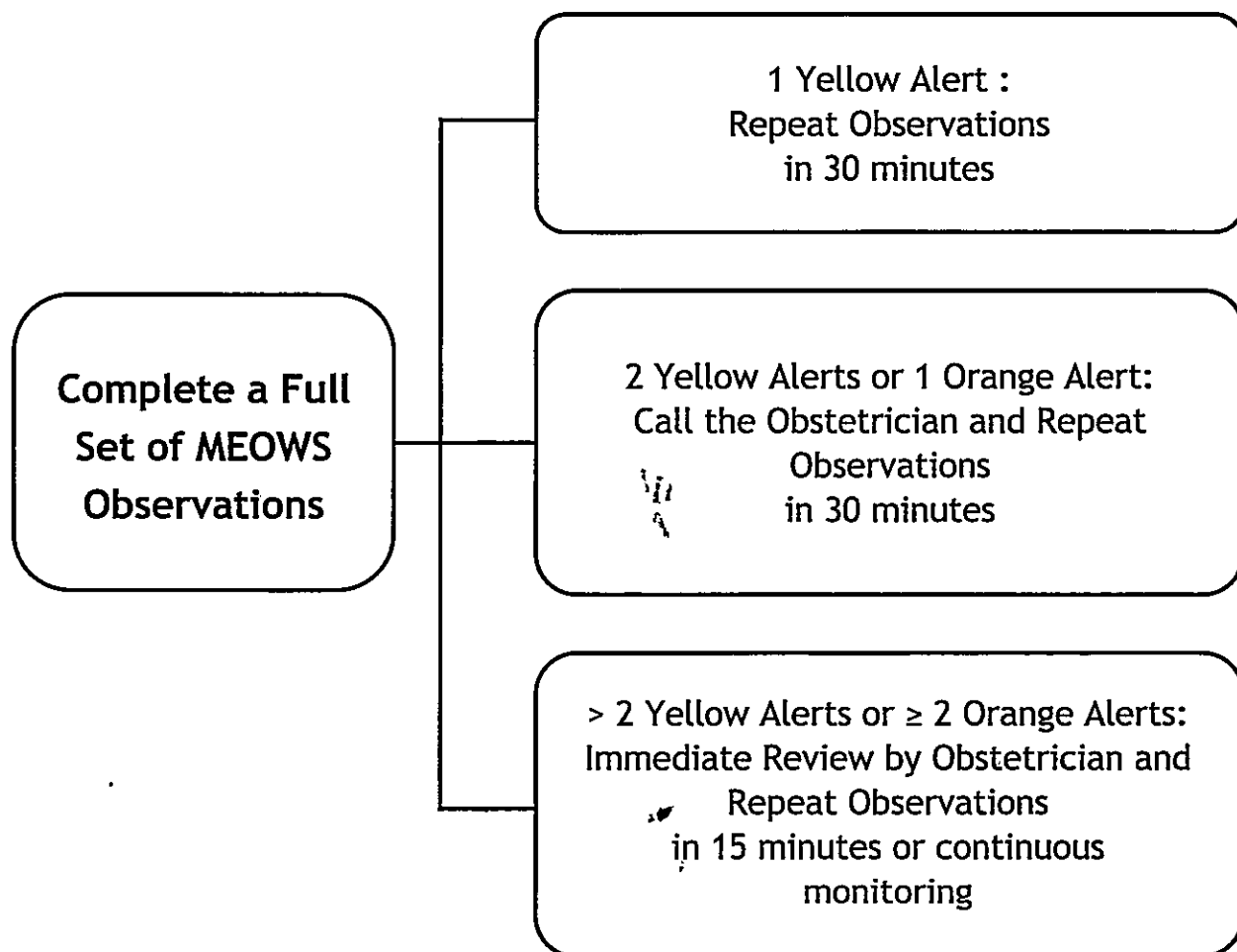


Early Warning Observation Score Chart - Obstetrics

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

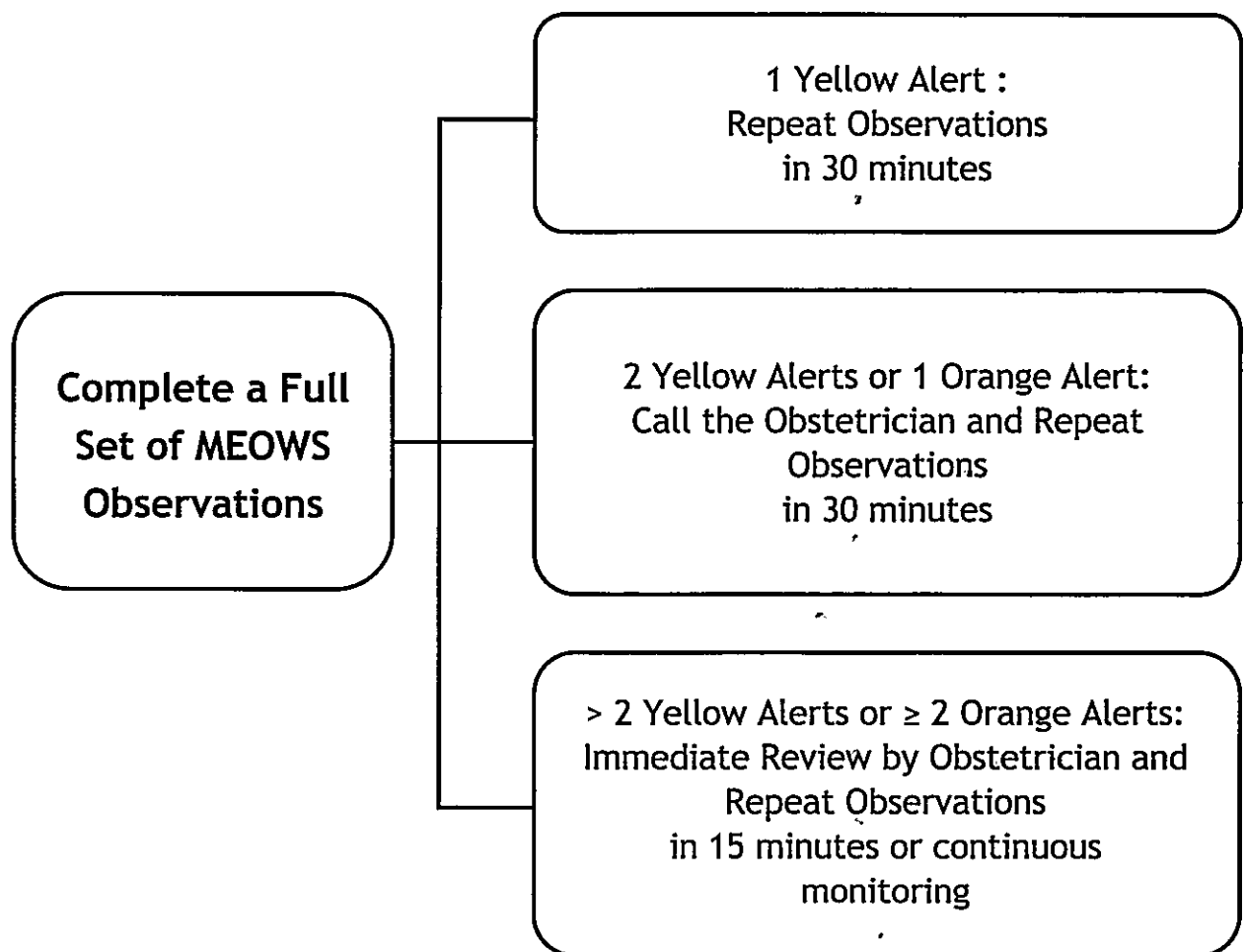
Date		Time																								
		8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20			20			20				20				20					20				20		
	0 - 10																									
Saturations	94 - 100 %			99%			100%				100%				100%					100%				100%		
	< 94 %																									
Administered O ₂ (L/min.)																										
Temp °C	40																									
	39																									
	38																									
	37																									
	36			98.8			97.4				98.1				98.8					98.8				98.8		
	35																									
< 35																										
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80			80			72				75				86					82				78		
	70																									
	60																									
	50																									
40																										
↑ Systolic Blood Pressure	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
60																										
50																										
↓ Diastolic Blood Pressure	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
	40																									
	NEURO RESPONSE [✓]	Alert			-			✓																		
		Voice																								
		Pain																								
Unresponsive																										
URINE mls / hour	> 30			-			✓																			
	< 30																									
Proteinuria	Protein ++																									
	Protein > ++																									
Lochia	Normal						✓																			
	Heavy / Foul																									
Liquor	Clear / Pink						✓																			
	Green																									
TOTAL YELLOW SCORES				0			0			0				0					0					0		
TOTAL ORANGE SCORES																										
Nurse Initial				SA			SA			SA				SA					SA					SA		

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

BAH-00551472 IP26-006
 Mrs KHATIJA FATIMA
 21-03-2000 28 Y 2 M 17 D
 Dr. SWAPNA SAMUDRALA



FLUID CHART

Sheet No. :

- 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												
	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	RL	100ml										
	06:00 pm	RL	100ml										
	07:00 pm	RL	100ml										
Total Intake : <i>taken</i>						Total Output : <i>passed</i>							
	08:00 pm	RL	100ml							400ml			
	09:00 pm	RL	100ml										
	10:00 pm	RL	100ml							100ml			
	11:00 pm	RL	100ml										
	12:00 am		100ml										
	01:00 am		100ml										
Total Intake :						Total Output :							
	02:00 am		100ml							200ml			
	03:00 am		100ml										
	04:00 am	RL	100ml										
	05:00 am		100ml										
	06:00 am		100ml										
	07:00 am		100ml							500ml			
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output *1200ml = 0*
N = 0

BAH-00551472 IP26-00C
 Mrs KHATIJA FATIMA
 21-03-2000 26 Y 2 M 17 D
 Dr. SWAPNA SAMUDRALA



FLUID CHART

Sheet No. :

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

Date	Time	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
8/6/26	08:00 am	RL		100ml								
	09:00 am	RL	2ly	100ml					✓			
	10:00 am	RL	+H2O	100ml								
	11:00 am	RL		100ml								
	12:00 pm	RL		100ml								
	01:00 pm	RL		100ml								
Total Intake : taken					Total Output : passed							
8/6/26	02:00 pm	RL		100ml								
	03:00 pm	RL	urine	100ml					✓			
	04:00 pm	RL		100ml								
	05:00 pm	RL	+H2O	100ml								
	06:00 pm	RL		100ml								
	07:00 pm	RL		100ml								
Total Intake : taken					Total Output : passed							
8/6/26	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake : taken					Total Output : passed							
9/6/26	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake : taken					Total Output : passed							
Total 24 hrs. Intake					Total 24 hrs. Output							

BAH-00551472 IP26-00006526
 Mrs KHATIJA FATIMA
 21-03-2000 26 Y 2 M 19 D (F)
 Dr. SWAPNA SAMUDRALA



FLUID CHART

Sheet No. :

- 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
				Route			NG	Diarrhoea	Vomit	Drainage	Urine		
9/6/26				Mouth	I.V	N.G							
		08:00 am	1	idly							✓		
		09:00 am		Ho									
		10:00 am	0					NO		✓			
		11:00 am	1								✓		
		12:00 pm											
		01:00 pm	1										
Total Intake : taken						Total Output : passed							
9/6/26		02:00 pm	1										
		03:00 pm											
		04:00 pm	1	rice							✓		
		05:00 pm	0	+H2O									
		06:00 pm	1					NO			✓		
		07:00 pm											
Total Intake :						Total Output :							
9/8/26		08:00 pm	1										
		09:00 pm											
		10:00 pm	0	Rice							✓		
		11:00 pm	1	H2O				NA					
		12:00 am											
		01:00 am	1								✓		
Total Intake :						Total Output :							
10/8/20		02:00 am	1										
		03:00 am											
		04:00 am	0	Belly									
		05:00 am	1	+ H2O				NA					
		06:00 am											
		07:00 am	1								✓		
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

BAH-00551472 IP26-00006526
 Mrs KHATIJA FATIMA
 21-03-2000 28 Y 2 M 18 D (F)
 Dr. SWAPNA SAMUDRALA



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
10/6/20	08:00 am	1									0	
	09:00 am	1	Oral								0	
	10:00 am	0									0	
	11:00 am	1									0	
	12:00 pm	1									0	
	01:00 pm	1									0	
Total Intake :						Total Output : 0- 21-						
	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

FLUID CHART

Sheet No. :

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

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

Total 24 hrs. Intake	
-----------------------------	--

Total 24 hrs. Output	
-----------------------------	--

Patient Sticker



FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site Thrombophlebitis 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	
-----------------------------	--

BAH-00551472 IP26-00006526
 Mrs KHATIJA FATIMA
 21-03-2000 26 Y 2 M 17 D (F)
 Dr. SWAPNA SAMUDRALA



NURSING CARE RECORD



Date: 7/6/26

- 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	Nurse Name & Signature
Morning							<i>[Signature]</i>
Afternoon	2pm 7pm 8pm	→ ASSESS the pt condition → plan for vitals → plan for I/O chart → plan for IV placement	2pm 7pm 8pm	→ ASSESSED the pt condition → vital are checked & recorded → IV placement done	I/O chart maintained	patient is stable	<i>[Signature]</i>
Night	8pm 11pm 8AM	→ ASSESS the pt condition → monitor the vitals & I/O → Administration of medication → maintain I/O chart & I/O	8pm 11pm 8AM	→ ASSESSED the pt condition → monitored the vitals & I/O → Administered medication as per doctor's → maintained I/O chart	pt is stable	maintain I/O chart & I/O	<i>[Signature]</i>

BAH-00551472 IP26-00006526
 Mrs KHATJJA FATIMA 28 Y 2 M 18 D (F)
 21-03-2000
 Dr. SWAPNA SAMUDRALA



NURSING CARE RECORD

Date: 8/6/26

- 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	Nurse Name & Signature
Morning	8pm to 2pm	→ assess the pt condition → monitor vitals → maintain I/O chart → Administer medications	8am to 2pm	→ Assessed the pt condition → Medication given → Pt recap →	Now pt is stable	Re-check vitals	<u>meas</u> Ca
Afternoon	Day						
Night	8pm 8am	Assess the pt. condition - Monitor vitals & records - Maintain I/O chart - Give medication as prescribed by doctor	8pm 8am	Assessed the pt. condition - Monitored vitals & records - Maintained I/O chart - Given medication as prescribed by doctor.	patient is stable now	Re-checked vitals	<u>§</u>

BAH-00551472 IP26-00006526
 Mrs KHATIJA FATIMA 26 Y 2 M 19 D (F)
 21-03-2000
 Dr. SWAPNA SAMUDRALA



NURSING CARE RECORD

Date: 9/6/20

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	Nurse Name & Signature
Morning	8AM	→ Assess the pt condition	8AM	→ Assessed the pt condition	I/O chart maintained	patient is stable	Sri
	To	→ plan for vitals	To	→ vitals are checked & recorded			
	2PM	→ plan for I/O chart	2PM	→ I/O chart maintained			
Afternoon	2PM	→ Assess the pt condition	2PM	→ Assessed the pt condition	Now pt is stable	Re-check vitals	mai
	To	→ monitor vitals	To	→ Monitored vitals			
	8PM	→ maintain I/O chart	8PM	→ Administered medications as for doctor's order			
Night	8PM	Assess the pt. condition	8PM	Assessed the pt. condition	Patient is stable now	Re-checked vitals	S
	8AM	Monitor vitals & record Maintain I/O chart. Give medication as prescribed by doctor.	8AM	Monitored vitals & record Maintained I/O chart Given medication as prescribed by doctor.			

BAH-00551472 IP26-00006526
 Mrs KHATIJA FATIMA 26 Y 2 M 18 D (F)
 21-03-2000
 Dr. SWAPNA SAMUDRALA



NURSING CARE RECORD

Date: 10/6/26

- 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	Nurse Name & Signature
Morning	8AM 10 2PM	→ To assess the pt. condition → To checked the vitals & recorded → To administer the medication as per drug chart → I/O chart maintain	8AM 10 2PM	→ To checked the vitals & recorded → To assessed the pt. condition → To administered the medication as per drug chart → I/O chart maintained	→ Patient is stable	→ Re-checked the vitals → I/O → Dressing to be done today	<i>Supriya</i>
Afternoon							
Night							



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission: 7/6/26

SITUATION	Diagnosis: <p style="font-size: 1.2em; margin-left: 20px;">EM - LSCS</p>	Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:					
BACKGROUND	Area Shift Time	7/6 2PM	7/6/26 N1	8/6/26 N6	9/6 8AM	9/6/26 E2	9/6/26 N1
	Medical Condition (Any special condition to be noted):	NA	NA	NA	NA	NA	NA
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Tubes/Drains/Catheter:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp: 98F	92.1F	97.8F	97F	97.4	97.8F
		Res: 20	20bmt	20blu	20f.	20f.	20blu
		SpO ₂ : 99.1	98.1	99.1	99.1	99.1	100%
		Pulse: 85	82bmt	88blu	85blm	85blm	86blu
		BP: 117/69	119/70	110/70	115/75	110/70	121/72
	Fall Risk Score:	-		-		-	
	Pain Score:	-		0/10		-	
RECOMMENDATIONS	Safety Needs:	NA		NA		NA	
	Physiotherapy	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Others Specify:	NA		NA		-	
	Special Diet:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Other Special Orders / Medications:	NA		NA		NA	
	Post Operative Procedure Special Orders:	NA		depedit		depedit	
	Handed Over By Name :	Sujatha Akhils		Mouli Sujatha		Mouli priyanka	
	Signature :	<i>[Signature]</i>		<i>[Signature]</i>		<i>[Signature]</i>	
	Date:	7/6/26		8/6/26		9/6/26	
	Time:	8PM		8AM		8AM	
	Taken Over By Name :	Akhils		Sujatha mouli		priyanka Supriya	
	Signature :	<i>[Signature]</i>		<i>[Signature]</i>		<i>[Signature]</i>	
	Date:	7/6/26		9/6/26		9/6/26	
	Time:	8PM		8AM		8AM	

BAH-00551472 IP26-00006526

Mrs KHATIJA FATIMA

21-03-2000 26 Y 2 M 18 D (F)

Dr. SWAPNA SAMUDRALA



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis: EM-LSCS	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:					
BACKGROUND	Area	/					
	Shift Time	10/6/26 MG					
	Medical Condition (Any special condition to be noted):	-					
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Vital Signs:	Temp: 98.1^oF					
		Res: 20b/m					
		SpO ₂ : 99.1%					
		Pulse:					
		BP:					
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Others Specify:						
	Special Diet:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Other Special Orders / Medications:						
	Post Operative Procedure Special Orders:						
	Handed Over By Name :						
	Signature :						
	Date:						
	Time:						
	Taken Over By Name :						
	Signature :						
	Date:						
	Time:						



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	7/6 DAY-1			2/6 DAY-2			2/6 DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0		NA	0	0	NA	NA	NA	NA	NA	
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	1	NA	-	-	NA	NA	NA	NA	NA	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2		NA	-	-	NA	NA	NA	NA	NA	
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		NA	-	-	NA	NA	NA	NA	NA	
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		NA	-	-	NA	NA	NA	NA	NA	
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		NA	-	-	NA	NA	NA	NA	NA	
Signature of the Nurse					Li	Li	Li	Li	Li	Li	Li	Li	

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 : Li Name : Sujatha

Signature of Ward In Charge :

Signature : Pri Name : Karthikeyan

Patient Sticker



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										
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													

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 of Ward In Charge :

Signature : Name :

Signature : Name :

BAH-00551472 IP26-00006526
 Mrs KHATIJA FATIMA
 21-03-2000 26 Y 2 M 17 D (F)
 Dr. SWAPNA SAMUDRALA



BRADEN 'Q' SCALE



Date : 7/6/21 8/6/21 8/6/21 8/6/21
 Time : 2PM 11 10 11

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.	4	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 inside room at least once every 2 hours during walking hours.	4	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	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	4
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."	4	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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	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	4

TOTAL SCORE 21 28 28 28
Evaluator's Name [Signatures]

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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

BAH-00551472 IP26-00006526
 Mrs KHATIJA FATIMA
 21-03-2000 26 Y 2 M 18 D (F)
 Dr. SWAPNA SAMUDRALA



BRADEN 'Q' SCALE



Date : 10/6
 Time : 10AM

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.	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 inside room at least once every 2 hours during walking hours.	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			
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			
FRICITION-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			
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			
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			
TOTAL SCORE					28			
Evaluator's Name					[Signature]			

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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

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 Mrs KHATIJA FATIMA
 21-03-2000 26 Y 2 M 17 D (F)
 Dr. SWAPNA SAMUDRALA



Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	2/6	2/6/26	8/6/24	Fall Risk Grading		
		Score	2 PM	8 PM	PM	Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25				Low Risk	0 - 24	Standard Fall Precaution
	No	0						
Secondary Diagnosis (more than one diagnosis)	Yes	15				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0	0	0	0			
Ambulatory Aid	Furniture	30				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0					
IV / Heparin Lock or Saline	Yes	20	20	20	20	Moderate Risk	25 - 50	Implement Moderate 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:			20	20	20			
Signature			<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>			

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

9
10
11

10 10 10 10
10 10 10 10

10 10 10 10
10 10 10 10
10 10 10 10

BAH-00551472 IP26-00006526
 Mrs KHATIJA FATIMA 28 Y 2 M 17 D (F)
 21-03-2000
 Dr. SWAPNA SAMUDRALA

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
7/6	5pm	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	Li'
7/6	8pm	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	Li'
8/6/26	12 AM	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	Li'
8/6/26	10 AM	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	Li'
9/6/26	8 AM	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	Li'
9/6/26	1 PM	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	Li'
9/6/26	2 pm	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	Li'
9/6/26	10 pm	0/10	NA	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	Li'
10/6/26	10 AM	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	Li'
				<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input checked="" type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		

Re-assessment Frequency:

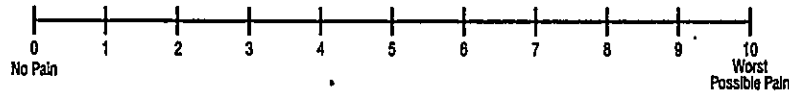
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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, rigid, 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



BAH-00551472 IP26-00006526
 Mrs KHATIJA FATIMA
 21-03-2000 28 Y 2 M 17 D (F)
 Dr. SWAPNA SAMUDRALA



URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 7/6/26 Date of Removal: 8/6/26

Parameters	Date	Shift Time						
Need for the Catheter			<u>7/6</u> 2PM	<u>8/6</u> 800				
Hand Hygiene			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Usage of Sterile Equipment			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the Collection bag below the level of bladder			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Check the Tube for Obstruction (Free of Kinking)			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is Catheter dated as policy			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Collecting bag is been emptied regularly?			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Maintenance of closed system for the catheter			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dressing clean and dry?			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the line removed as Policy?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Performance of Perineal Care			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Onset of New Fever			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asses for the leakage at the site of insertion			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of the Nurse			<u>Srinatha</u>	<u>apal</u>				
Signature of the Nurse			<u>[Signature]</u>	<u>[Signature]</u>				

10
10

(8/11/13.9)
C. H. King

1111

12/11

1/11



OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 7/6/26 Time of Arrival: Time Seen by Nurse:

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: 97.4 Pulse: 87 RR: 20 SpO₂: 99+ BP: 112/79 Weight:

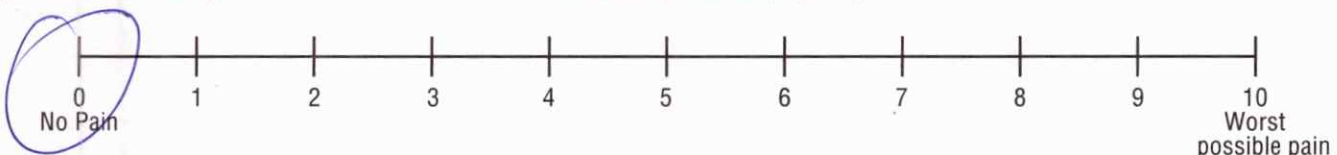
4) Gestational Criteria:

Gravida:	G <u>4</u>	P <u>3</u>	L <u>3</u>	A
----------	------------	------------	------------	---

LMP: 13/10/25 EDD: 25/7/26 Gestational Age: 36+1 weeks

Uterine Contraction	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA	Onset	Time	Frequency:
Membrane Rupture	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA	Onset	Time	Fluid Color:
Vaginal bleeding	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA	Onset	Time	Amount:
Pre Eclampsia Symptoms	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA	If Yes specify: Headache / Visual Symptoms / Pain Abdomen / Vomiting		
Good fetal Movement	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	If No specify:		

5) Pain Screening: Numerical Pain Scale (NPS)



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

6) Past History:

- a) Surgeries:
- b) Medical:



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	<ul style="list-style-type: none"> • Acute onsite severe abdominal pain • Altered level of consciousness • Cord prolapse • Severe respiratory distress • Suspected sepsis 	<ul style="list-style-type: none"> • Major trauma • Shortness of breath • Unplanned and unattended birth 	<ul style="list-style-type: none"> • Abdominal/back pain greater than expected in pregnancy • Flank pain / hematuria • Nausea/vomiting and /or diarrhea with suspected dehydration 	<ul style="list-style-type: none"> • 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) 	<ul style="list-style-type: none"> • 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:

Nurse Name : Swathi Nurse Signature: [Signature]

Date: 7/6/20 Time: 5 PM

BAH-00551472
 Mrs KHATIJA FATIMA
 21-03-2000 26 Y 2 M 17 D
 Dr. SWAPNA SAMUDRALA

IP26-00X



LABOUR AND DELIVERY NURSING ASSESSMENT

Date of Admission: 4/6/26

Baseline Information:

Admission From: ER OPD Admission Desk Others: specify

Primary Language: Telugu English Hindi Others

Do you require an interpreter? Yes No

Source of Information: Patient Family Others

Personal belonging if any: Jewelry Nose Ring Bangles Anklets Finger Ring Bracelets
 handed over to

Allergies: Yes No Medications Blood Transfusion Food Other:
 If yes, identify

Chief Complaints: Doctor Notified on Admission: Yes No
 Name of the Doctor: Dr. V. L. N.
 Time Notified:

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

Past Medical History	Past Surgical History	Previous Hospital Admission
-	<p>paever 3 LSCS</p>	-

Blood Group: Positive LMP: 13/10/25 EDD: 25/2/26 Gestational age during admission: 36+ weeks

Contractions: Vaginal Discharge:

Obstetric History: G 4 P 3 L 3 A Previous LSCS

Height: Weight: BMI:

Temp: 98.6 HR: 87 RR: 20 BP: 119/85 SpO₂ 99.1

High Risk Factors: (Please select by ticking (✓) the box as applicable)

<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Rh Incompatibility	<input type="checkbox"/> Fertility Treatment
<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Previous LSCS	<input type="checkbox"/> Preterm Labour
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Gestational Hypertension	<input type="checkbox"/> Others: (Specify)
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Bad Obstetric History	
<input type="checkbox"/> Anemia	<input type="checkbox"/> Obesity (BMI)	
	<input type="checkbox"/> Twins / Multiple Pregnancy	



normalities Detected

- Heart Disease Hypertension Diabetes Stroke Seizures Kidney disease
 Liver disease Other

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

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

Risk of Pressure Sore: Yes No Score (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:

- Overweight Poor Appetite > 3 Days Needs Therapeutic Diet.
 Under Weight Diabetes Mellitus No Abnormality Detected

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

- Calm & Cooperative Restless Depressed Agitated Confused
 Others

Inform consultant for positive criteria

SOCIAL SCREENING:

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

Social History: Lives With

Orientation has been given regarding the following aspects:

- Call Bell in Reach : Yes No Waste Disposal Explained: Yes No
Infusion Pump : Yes No Hand hygiene Explained: Yes No Others

Above information given to *patient*
Name of Person Orientation was given to: *Mrs. Khatiya Fatima*
Orientation not given Reason:

Nurse Signature: *[Signature]*
Nurse Name: *Sujatha*
Date & Time: *7/6/26 @ 5 PM*

BAH-00551472 IP26-00006526
 Mrs KHATIJA FATIMA
 21-03-2000 26 Y 2 M 17 D (F)
 Dr. SWAPNA SAMUDRALA



EAN SECTION OPERATIVE NOTES

Surgeon's Name: <u>Dr. Swapna Samudrala</u>	Date of Delivery: <u>07/06/2026</u>
Assistant Surgeon: <u>Dr. Vidya</u>	Time of Delivery: <u>6:34 PM</u>
Anaesthetist's Name: <u>DR. SAIRAJ</u>	Gender of Baby: <u>FEMALE</u>
Type of Anaesthesia: <u>SPINAL ANESTHESIA</u>	Weight of Baby: <u>2.5 kg</u>
Neonatologist: <u>DR. ANIKET / DR. TANVI</u>	AGPAR Score: <u>8, 9</u>
Scrub Nurse: <u>SN SANDHYA</u>	NICU Admission: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Pre-Operative Diagnosis: G₁P₃ L₃ / 3LSCS @ 36⁺ Wks ± PPRM

Elective Emergency Indication: Previous LSCS ± PPRM

Urgency

Immediate Threat to life of woman or fetus
 Maternal or fetal compromise not immediately life threatening
 No maternal or fetal compromise but needs early delivery
 Delivery timed to suit woman and staff

Decision time: 10mins Knife to rectus: 3mins

CTG Description: Reactive

If there was a delay give the reasons:

Surgical Procedure: Emergency LSCS

Post Operative Diagnosis: POD - 0

Peri-Operative Complications: None

Amount of Blood Loss: 300ml Blood Transfused (in ML): None

Name and Number of Surgical Specimen sent for examination:

Examination Findings when Appropriate:

Presentation: Cephalic Breech Other Cervical Dilatation: cm
 5th Palpable: 5/5 Fetal Position:
 Station: -3 -2 -1 0 +1 +2 Moulding: None + ++ +++
 Caput: + ++ +++ *None* Meconium: None + ++ +++
 Bladder Catheterized: Yes No Urine: Clear Blood Stained

Skin Incision: Pfannenstiel Transverse Midline Other
 Uterine Incision: Lower Segment Classical Inverted T J Incision
 Previous Scar: Intact Thinned out Ruptured No Scar ** Absent liquor*
 Incision Through Placenta: Yes No ** Omental adhesions (+)* ** LUS thinned out*
 Delivery of head: Manual Forceps ** 1 cord around neck*
 Liquor: Clear Meconium: I II III Blood Offensive Not Offensive
 Delivery of Placenta: Manual CCT Complete Incomplete Piecemeal
 Cord Appearance: *Intact & normal* Cord around the neck: Yes No
 Appearance of placenta: *Normal & intact* Cavity explored: Yes No
 Uterus, tubes and ovaries: Normal Not Normal Sterilization: Yes No

Uterine Closure: One Layer Two Layers *Nicryl No-1* Suture
 Peritoneal Closure: Pelvic Abdominal None *Catgut* Suture
 Sheath Closure: *Nicryl 2-0* Suture
 Fat Closure: Yes No *Catgut* Suture
 Skin Closure: Subcuticular Mattress *Monocryl 3-0* Suture
 Vaginal Evacuated: Yes No
 Drain: Yes No Remove in days Await instructions
 Catheter: Yes No Remove in days Await instructions
 Swap & Instruments count correct?: Yes No Post-op Antibiotics: Yes No
 Intra-Operative Antibiotics Cover: Yes No Thromboprophylaxis: Yes No

Post-Operative Notes:
 - NBM for 4-6 hours
 - IV's, Analgesics & Thromboprophylaxis as per AXON
 - No chills
 - Vital monitoring
 - w/ excessive bleeding PV
 - Foley's removal clm @ 6am
 - IV ABx for 24 hours (Zij. trim & metrogyl)

Doctor Name: *Dr. Swapna Samudra* Doctor Signature: *[Signature]*
 Date & Time: *5/6/26*

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Swapna S
 Asst. Surgeon : Dr. Veena
 Anaesthetist : Dr. Sai Raj
 Scrub Nurse : Sandya

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 Mrs KHATIJA FATIMA
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 Dr. SWAPNA SAMUDRALA



Age : Gender :
 Surgery Name : Am. L&L
 Date : 7/6/26 In-time : Out-time :



Before Induction of Anaesthesia >>

SIGN IN	Time: <u>6:15 pm</u>
Patient Has Confirmed	
Identity	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Site	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Procedure	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Consent	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Site Marked	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA
Anaesthesia Safety Check Completed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Pulse Oximeter on Patient & Functioning	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Does Patient have a:	
Known Allergy?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Difficult Airway / Aspiration Risk?	
Yes, & Equipment / Assistance Available	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Risk of > 500ml Blood Loss (7ml/kg In Children)?	
Yes, and Adequate Intravenous Access and Fluids Planned	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Blood Units Reserved	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Has Antibiotic Prophylaxis been given within the last 60 minutes?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Signature : <u>Dr. Sai Raj</u>	
Name : <u>Dr. SAIRAJ V</u>	

Before Skin Incision >>

TIME OUT	Time:
Confirm all team members have introduced themselves by Name and Role <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm	
Correct Patient (Check ID Band)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Correct Site	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Correct Procedure	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Anticipated Critical Events	
Surgeon Reviews:	
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Anaesthesia Team Reviews:	
Are There Any Patient-specific Concerns?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Nursing Team Reviews:	
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Is Essential Imaging Displayed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Power Supply, Earthing, Power Backup and functioning of equipment checked.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Signature : <u>Swapna</u>	
Name : <u>Swapna</u>	

Before Patient Leaves Operating Room

SIGN OUT	Time:
Nurse Verbally Confirms with the Team:	
The Name of the Procedure Recorded	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
The Specimen is Labelled (including patient name)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA
Whether there are any Equipment Problems to be addressed	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
To Surgeon, Anaesthetist and Nurse:	
What are the key concerns for recovery and management of this patient?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Signature : <u>[Signature]</u>	
Name :	

PATIENT TRANSFER FORM

BAH-00551472 IP26-00006526
Mrs KHATIJA FATIMA
21-03-2000 26 Y 2 M 17 D (F)
Dr. SWAPNA SAMUDRALA



Date & Time of Admission <i>7/6/26 @ 5:03pm</i>		Date & Time of Transfer Order <i>7/6/26 @ 8pm</i>
Treating Consultant Name	Transfer Ordered by <i>Dr. Sai raj</i>	Reason for Transfer <i>Observation</i>
From Unit <i>OT</i>	To Unit <i>Pre - post</i>	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File <i>—</i>	Number of Imaging Films <i>—</i>	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what ?
Medications / Consumables / Surgicals / Hand over		
Sl.No.	Item Name	Quantity
1.	<i>RL</i>	<i>(1)</i>
2.		
3.		
4.		
5.		
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>		
Name & Signature of Person who is Transferring <i>Santhya Hobes @ 8pm</i>		Name of Person Ordered Transfer <i>Dr. Sai raj</i>
Patient & Clinical Records Received by : <i>Santhya</i>		
Date & Time of Patient Received : <i>7/6/26 @ 8pm</i>		

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

Handwritten scribbles and marks at the top left of the page.

Handwritten mark resembling a stylized 'J' or 'G' at the top right.

Small handwritten mark in the middle left section.

Small handwritten mark in the middle right section.

Small handwritten mark in the lower middle left section.

Handwritten scribbles in the lower middle section.

Handwritten scribbles in the lower section.

Handwritten scribbles in the lower section.

Handwritten scribbles at the bottom left.

Handwritten scribbles at the bottom right.

Small handwritten mark at the bottom left corner.

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE



Patient Name : MRS. KHATJA FATIMA Gender: Male Female Age : 25yrs.
 UHID No : BAH-00551672 Date : 7/6/26

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)

EMERGENCY LOWER SEGMENT CAESAREAN SECTION
 upon
MRS. KHATJA FATIMA (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.

Excessive bleeding, postpartum hemorrhage, need for transfusion of blood or blood products, inadvertent injury to bowel, bladder or uterus, wound infection.

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. Susapna Samudrala

Consentee :
 Signature : [Signature]
 Name : Mrs. khatja fatima
 Date & Time : 7/6/26 @ 5:30pm

Patient Attendant :
 Signature : [Signature]
 Name : Fahad Bin Yessir
 Relationship with Patient: husband
 Date & Time : 7/6/26 @ 5:30pm

Witness :
 Signature : [Signature]
 Name : Sujatha
 Date & Time : 7/6/26 @ 5pm

Doctor (who is taking the consent) :
 Signature : [Signature]
 Name : Dr. G. Veera
 Date & Time : 7/6/26 @ 5pm

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE



Patient Name : Mrs. KHATISA FATIMA Age : 26yr Gender : Male Female
 UHID NO: SMU-55142 Surgeon Name: Dr. SWAGNA
 Anaesthesiologist : Dr. SAMIR
 Operative procedure planned : Em. LSCS

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 and 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 Acidosis
- Incapacitating Chronic Obstructive Pulmonary Disease
- Others :

Comments :

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

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient Mrs. KHATISA FATIMA the above mentioned operation / Diagnostic / Therapeutic procedures Em. LSCS

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 : [Signature]

Name : Mrs. KHADIJA FATIMA

Relationship with Patient: SELF

Date & Time : 7/6/26 @ 5:00pm

Witness :

Signature : [Signature]

Name : Fahad.

Date & Time : 7/6/26 @ 5:00pm

Doctor (who is taking the consent) :


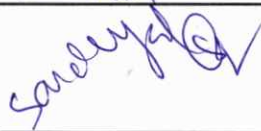
Signature : [Signature]

Name : Dr. SARIK

Date & Time : 07/06/2026 5:00pm

PATIENT TRANSFER FORM




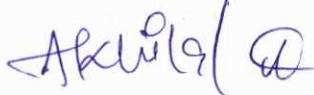

Patient Name & UHID No. BAH-00551472 IP26-001 Mrs KHATIJA FATIMA 21-03-2000 28 Y 2 M 17 D Dr. SWAPNA SAMUDRALA 		Date & Time of Admission 7/6/26 @ 5:30pm	Date & Time of Transfer Order 7/6/26 @ 6:10pm
		Transfer Ordered by DR. Veena	Reason for Transfer EM - LSCS
From Unit Pre - post	To Unit OT	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 28	Number of Imaging Films -1-	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	RL - 500ml	①	
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Dr. S. Sathya		Name of Person Ordered Transfer DR. Veena	
Patient & Clinical Records Received by : 			
Date & Time of Patient Received : 7/6/26			

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

- Unavailable Bed
 Nurse not Available
 Available Bed not ready

PATIENT TRANSFER FORM



Patient Name & UHID No. BAH-00551472 IP26-00006526 Mrs KHATIJA FATIMA 21-03-2000 26 Y 2 M 17 D (F) Dr. SWAPNA SAMUDRALA 		Date & Time of Admission 7/6/26 @ 5:03 PM	Date & Time of Transfer Order 7/6/26 @ 10:30 PM
		Transfer Ordered by Dr. Veena	Reason for Transfer observation
From Unit LDR	To Unit Floor	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 30	Number of Imaging Films NST - 1	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	R L sound	2	
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring 		Name of Person Ordered Transfer Dr. Veena	
Patient & Clinical Records Received by : 			
Date & Time of Patient Received : 7/6/26 @ 10:30 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-00551472 IP26-00006526
Mrs KHATIJA FATIMA
21-03-2000 28 Y 2 M 17 D (F)
Dr. SWAPNA SAMUDRALA



Department of Anaesthesiology PRE-ANAESTHETIC EVALUATION

Name: Mrs. KHATIJA FATIMA Age: 26 yrs Sex: female UHID.No: BAH-551472
Date: 07/06/2026 Time: 5:00pm Proposed Operation: Em-LSCS
Diagnosis: Gy P3 L3 E 3 prev LSCS E 36 wks E PPRom
B.P./CRT: 110/70 H.R: 92/min Weight: 60 kgs ASA Physical Status: 1 2 3 4 5

Laboratory Data:

Hgb: 10.9	Glucose:	Protein:	HIV:	X-Ray:
PCV:	Urea:	Alb:	HBS Ag: /AN	ECG:
WBC:	Creat:	Total Bill:	HCV:	2D Echo:
Plate: 2.11 lku	Na:	Dir. Bill:	Blood group: O+ve	Stress/Angio:
PT:	K:	LDH:	T3:	Other:
PTT:	Ca++:	Alk phos:	T4:	
INR:	Mg++:	Amylase:	TSH:	placenta: Ant. high.
	Cl-:	SGOT/SGPT:		

Allergies: NKA

Medical History: CVS: -
RESP: | Diabetes: -
CNS: |
Renal: |
Hepatic / GE: | Physical Activity: |
Others: |

Past Anaesthetic History: 3 prev ↓ 2019, 2020, 2024. all under SAB w/E.
Physical Exam: Mod. Built & nourished.

Airway: MP 1 2 3 4 Mouth Opening: Mentohyoid Distance: Neck: Teeth: NLT
Lungs: S/L AET, clear
Heart: S/S 2+

CNS: NAD
Pregnant: Yes No NA Venous Access Site: Peripheral Spine Exam for regional: (A)

Anaesthetic Plan: MAC REGIONAL GA-ETT LMA

Peri-Operative Plan Explained to the Patient: Yes No

CURRENT MEDICATIONS	DOSAGE
NKA	

- Pre-Operative Instructions: Last food @ 1:30 pm
- DVT Prophylaxis: Water / ORS 2 Hours
 - NIL ORAL: Others 6 Hours
 - Informed Consent: Standard High Risk
 - Post Operative Pain Management: Discussed with Patient
 - Other Instructions:

Signature: Dr. SATEESH Name: Dr. SATEESH

BAH-00551472 IP26-00006526
 Mrs KHATJA FATIMA
 21-03-2000 28 Y 2 M 17 D (F)
 Dr. SWAPNA SAMUDRALA



ANAESTHESIA CHART



Pre Induction Assessment:

Change in Patient Condition: Yes No Fasting Status: 1:30 pm

Physical Status: Patient Identified Consent Present Chart Reviewed

H.R: 91/min B.P/CRT: 110/70 SpO₂: 99% RA R.R: Last Feed: 1:30 pm

Pre-OP Diagnosis: 94P2L3C3PrvRSpS C3C¹² Operation: Em LSCS Date: 07/06/2026

Surgeon: Dr. SWAPNA Anaesthesiologist: Dr. SAIRAS Technician: SARATHI

TIME	N ₂ O / AIR / O ₂ , LPM	HALO / SO / SEVO	Drugs:
6:20	6	6	6
6:25	6	6	6
6:30	6	6	6
6:35	6	6	6
6:40	6	6	6
6:45	6	6	6
6:50	6	6	6
6:55	6	6	6
7:00	6	6	6
7:05	6	6	6
7:10	6	6	6
7:15	6	6	6
7:20	6	6	6
7:25	6	6	6
7:30	6	6	6
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23:35	6	6	6
23:40	6	6	6
23:45	6	6	6
23:50	6	6	6
23:55	6	6	6
00:00	6	6	6

Antibiotic
 TAPIM 1gm IV
 Suppository
 SUP-DICLOFENAC 100
 SUP-TRAMADOL 100mg
 Blood Loss

NOTES

LAB Values

ABG

GRBS

Others

- Equipment Checked and Functional
- BP
- Cuff Site: PLAM
- Art Site:
- EKG Lead
- Temp Site
- FIO₂ Monitor
- Agent Monitor
- Pulse Oximeter
- Capnograph
- Ventilator
- Non-Res Stimulator
- SPO₂
- Points Checked

Temp:

- HME
- Fluid Warmer
- Cling Film
- OH Warmer
- Hugger's
- Cotton Wool
- Other

Times:

Anaes Start: 6:20 pm

OP Start:

OP End:

Leze RT: 7:20 pm

Aspirator:

- GA
- Monitored Anesthesia
- Regional

Line (Size & No):

- CVP
- ART
- Z/N
- IN

Induction

- IV
- Inhal
- Pre O₂
- 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: LSAS

- Spinal
- Epidural
- Caudal

Others:

Position: SITTING

Site: L3-4

Needle Size: 25G Depth: 4.1/2 cm

Parasthesia Yes No

Catheter at skin cm

Drug Name & Conc: 2.0ml 0.5% Heavy

Bolus: 6 Bupivacaine

Infusion: 25 mg Fentanyl

Block Level: T6

Comments:

Transportation to

- PACU
- ICU
- Other
- Relaxant Reversed
- Yes
- No
- N/A

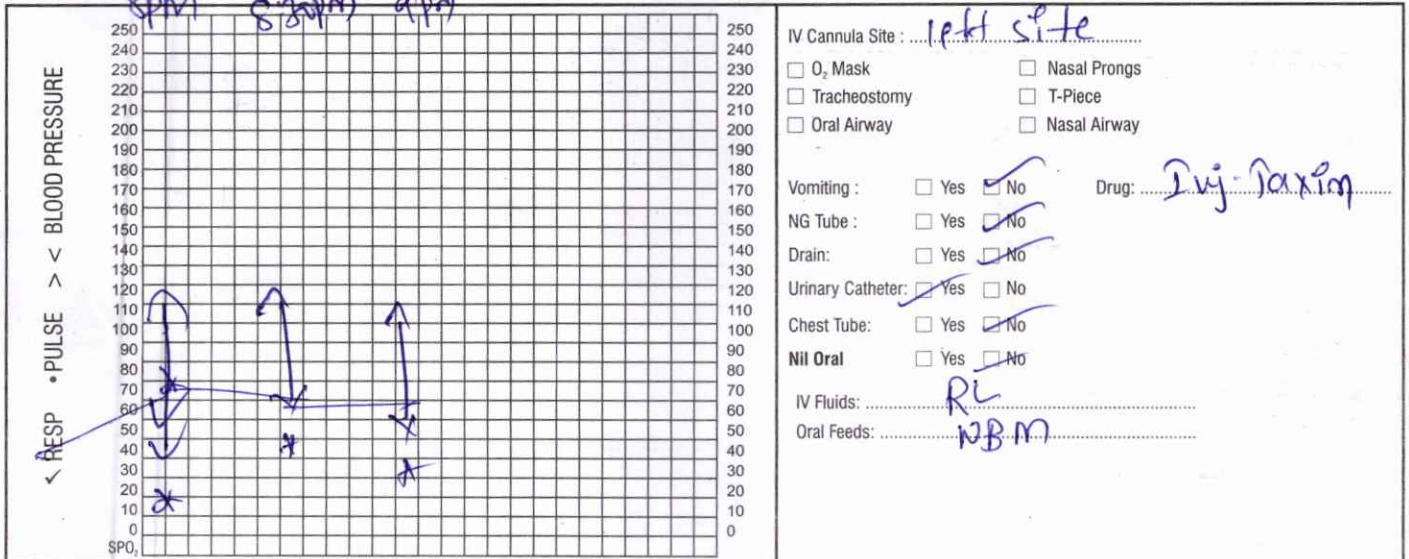
Name of the Doctor: Dr. SAIRAS

Signature of the Doctor:



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: Sriatha Time Received: 8 PM Time Discharged: 10:30 PM



POST ANAESTHESIA SCORE (Modified Aldrete Score)	IN	MINUTES			OUT	SCORING INTERPRETATION
		30	60	90		
Able to move 4 extremities voluntary or on command = 2 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 0	ACTIVITY	1	2	2	2	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 = 2 Dyspnea or limited breathing = 1 Apneic = 0	RESPIRATION	2	2	2	2	
BP ± 20 of Pre Anaesthetic level = 2 BP ± 20-50 of Pre Anaesthetic level = 1 BP ± 50 of Pre Anaesthetic level = 0	CIRCULATION	2	2	2	2	
Fully awake = 2 Arousable on calling = 1 Not responding = 0	CONSCIOUSNESS	2	2	2	2	
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0	COLOR	2	2	2	2	
TOTAL		9	10	10	10	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
7/6	8pm	0/10	NA	Li
7/6/26	9pm	0/10	NA	AK
7/6/26	10pm	0/10	NA	AK
7/6/26	10:30pm	0/10	NA	AK

Pain Tool Used: N PASS FLACC Wong Baker NPS

Anaesthesiologist Name: Dr. Sarasiv
 Anaesthesiologist Signature: [Signature]
 Date & Time: 07/06/2026
 PACU Nurse Name: AK
 PACU Nurse Signature: [Signature]
 Date & Time: 7/6/26

Reassessment Frequency:

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

Transferred to Unit by (PACU): 3/1
 Date & Time: 7/6/26

Patient Sticker



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		Maternal		FHR	Comments
			Left	Right	BP	Pulse		

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 :

26-0000205049

NARCOTIC PRESCRIPTION FORM (PATIENT COPY)

Patient Name: Mrs. Khalija Fatima	Age: 26y	Gender: Female	
UHID No: BAH-00531472	IP No: IP26-00006526	Date: 7/6/26	
Diagnosis: LSCS	ward-01	Time: 5:20pm	
PRESCRIPTION DETAILS (Tick only one of the following)			
S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/ML	100mcg	1amp
2.	Morphine Sulphate Inj. 15mg/ML	/	/
3.	Remifentanil Hydrochloride Inj. 2MG	/	/
4.	Remifentanil Hydrochloride inj. 1MG	/	/
Doctor Name: Dr. Anamir		Doctor Registration No: 67929	
Signature: [Signature]			

NARCOTIC DISPENSING FORM APPENDIX 4 – FORM NO. 3E

(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: IP26-00006526 Date: 7/6/26

Aadhaar No. of the Patient (Optional):

1.	Name : Mrs. Khalija Fatima	Remarks		
2.	Complete postal address (with contact number, if any)	H.NO 10-1-20/1 pratihar bazar APT humayunagar. Hyderabad 50008		
3.	Brief description of the illness	CN LSCS		
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	NO		
5.	Details of essential Narcotic drug dispensed	Fentanyl		
Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
7/6/26	Fentanyl	1amp	[Signature]	

Dispensed by (Name & ID No.): Same (015112) Signature: Same

Received by (Name & ID No.): Saraswati (021006) Signature: [Signature]

Time:



NARCOTIC PRESCRIPTION FORM (PATIENT COPY)

1	Drug Name	Codeine
2	Strength	30mg
3	Quantity	100 tablets
4	Indication	Pain
5	Physician's Name	Dr. [Name]
6	Signature	[Signature]
7	Date	10/10/20

NARCOTIC DISPENSING FORM

APPENDIX A - FORM NO. 32

(Details of the Patient to whom Essential Narcotic Usage Dispensed)

1	Registration No.	
2	Name of Patient	[Name]
3	Address	[Address]
4	Age	[Age]
5	Sex	[Sex]
6	Occupation	[Occupation]
7	Diagnosis	[Diagnosis]
8	Physician's Name	[Physician Name]
9	Signature	[Signature]
10	Date	[Date]