



I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 20/06/2024 Time of Admission :

Allergies: Not know any drug allergies

PRESENTING COMPLAINTS :

G₂P₁L₀ @ 9wk⁺ with prev. LSCS @ k/c/o Bipolar disorder @ k/c/o Asthma @ k/c/o Hypothyroidism

cl/o vomitings - Multiple episodes. - 2 day.

alw sore throat

cl/o ^{dry} cough - 2 day.

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : <u>18/11/2022</u> NCM. Previous Periods : <u>Irregular</u> LMP : <u>17/4/26</u> <u>12-3 month</u> Contraception : <u>EDD: 24/1/26.</u>	Parity : <u>G₂P₁L₀</u> <u>preterm</u> Mode of Delivery : <u>1 prev LSCS - 2025</u> Last Child Birth : <u>@ 32wks / Male / 1.7kg died at D₇ of life i/c/o sev. sepsis @ shock.</u> <u>11 - PP, O/S conceptus</u>

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
<u>Hypothyroidism (Thyronam 75mg)</u> <u>k/c/o Asthma since childhood</u> <u>(uses tab Deciphyllin sos)</u> <u>k/c/o Bipolar disorder on</u> <u>T. Aripri, prazole 20mg on.</u>	-



FAMILY HISTORY:

MEDICATION HISTORY:

- 7. Folvite 5mg ON
- 7. Duphaston 10mg BD
- 7. Zonazole BD
- Syp Duphalac 15ml at Bedtime
- 7. Aripiprazole 20mg ON
- 7. Thyronorm 75mcg ON

INITIAL ASSESSMENT :

Date <u>20/6/2026</u> Ht. _____ Wt. _____ BMI _____ B.P. <u>121/75mmHg</u> Pallor <u>PR: 87bpm</u> CVR _____ Respiratory System _____ Thyroid _____	Breasts <p style="text-align: center;">Not done</p>	Local/Speculum Examination <p style="text-align: center;">Not done</p>
	Abdominal Examination <p style="text-align: center;">Soft</p>	Bimanual Pelvic Examination <p style="text-align: center;">Not done</p>

PROVISIONAL DIAGNOSIS : G2P1, L0, 9⁺ weeks ± 1 prev LSCS = K/Co. Bipolar disorder
 also Hypothyroid, Asthma
 ? Acute Otitis

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT
<ul style="list-style-type: none"> - Vitals AB+ve - IVF - Drugs as charted - CRBS - 61mg/dl - Serum Electrolytes to send 	<ul style="list-style-type: none"> - Vitals Monitor - IVF - Drugs as charted Infam ses.

Name of the Doctor : _____

Signature of Doctor _____


Date & Time : _____



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/6/2026 6:30pm	cls by Dr. Naveena	
	OLE GC-fair	Adv
	A/obn/c. SpO ₂ - 99% on RA	- Soft diet
	PR: 77bpm	- Inform AXON
	BP: 107/67 mm Hg	Se-electrolytes
	CUS/RS: NAD	reports
	PA: soft, NIT	- Ty: Ondansetron
	UE: NAD	4mg iv stat
	Se-electrolytes	- Monitor Vitals
	↳ (N)	- Inform SOS
	patient can be discharged	Dr. Naveena

ACTIVITY RECORD FOR BILLING

Name: HNH-00014816 IP26-00006617
Mrs AVARAM ASFIYA FARZEEN
 UHID No. : 18-04-1999 27 Y 2 M 4 D (F) Consultant: _____ Dept : _____
Dr. SWAPNA SAMUDRALA
 Date of Adm  Date of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

Cross Consultation Visit

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

Patient Sacker

Mrs. Asf Raza



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						<input type="checkbox"/> C <input type="checkbox"/> DC
2						<input type="checkbox"/> C <input 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. Anam Naveed

Date & Time : 20/6/26 @ 2pm

Nurse Name & Signature : Anushka D

Date & Time : 20/6/26 @ 2pm

HNH-00014816 IP26-00006617
 Mrs AVARAM ASFIYA FARZEEN
 18-04-1999 27 Y 2 M 4 D (F)
 Dr. SWAPNA SAMUDRALA



DRUG CHART

Date of Admission: 20/6/2026 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

HNH-00014816 IP26-00008817
 Mrs AVARAM ASFIYA FARZEEN
 18-04-1988 27 Y 2 M 4 D (F)
 Dr. SWAPNA SAMUDRALA



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

BirthRight[™]
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

RESULT SHEET

Date	20/6/26				
Time					
Hb					
PCV					
RBC					
WBC					
N/L					
Platelets					
CRP					
ESR					
PCT					
RBS					
Na	22 136				
K	22 4.3				
Cl	22 10.4				
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					



OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 20/8/20 Time of Arrival: 2pm Time Seen by Nurse: 2:5pm

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: Pulse: RR: SpO₂: BP: Weight:

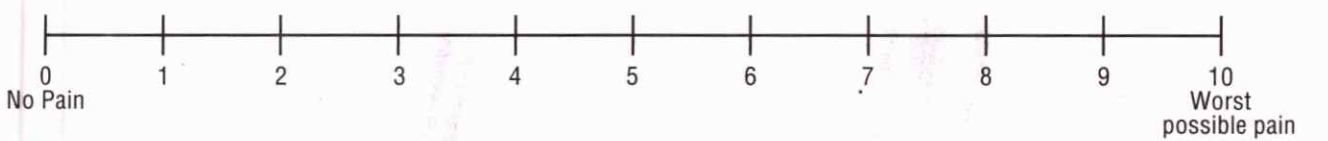
4) Gestational Criteria:

Gravida:	G	P	L	A
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LMP: EDD: Gestational Age:

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

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 / PPRM < 37 Weeks	Signs of Active Labour > 37 weeks	Signs of Early Labour/ SRM > 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

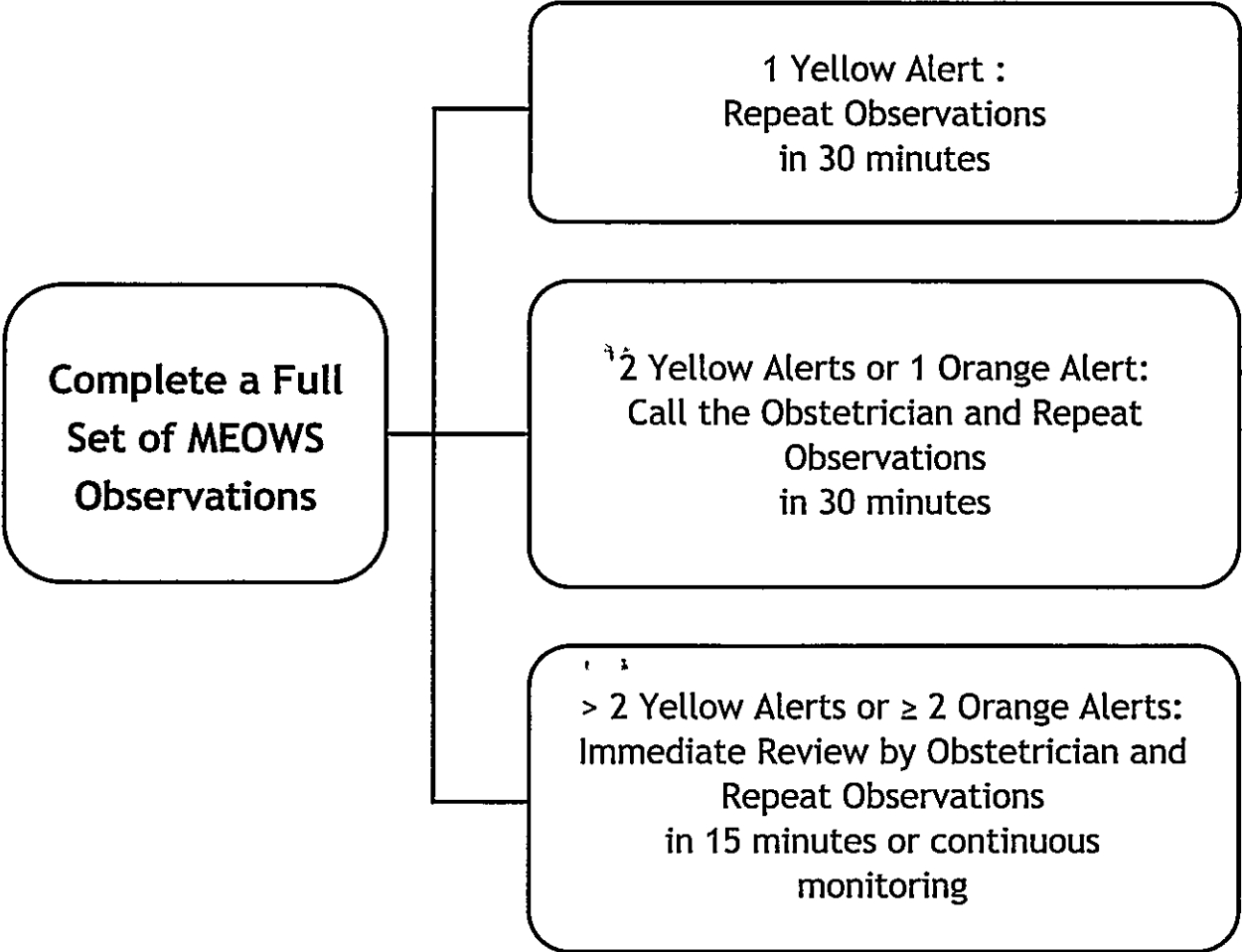
Time seen by Doctor:

Nurse Name : *S. Narasimhan*

Nurse Signature: *(Signature)*

Date: *20/6/20* Time: *2:30pm*

**Obstetrics and Gynaecology
Early Warning Signs**



* The Modified Early Warning Score (MEOWS)



FLUID CHART

Sheet No. : 11

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

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	RL 1720		150ml							✓		
	04:00 pm	RL 5ml		150ml							✓		
	05:00 pm	RL		150ml									
	06:00 pm	RL 100ml		150ml									
	07:00 pm	RL		150ml									
Total Intake : 750ml						Total Output : passed							
	08:00 pm	RL -		150ml									
	09:00 pm	RL -		150ml									
	10:00 pm	RL -		150ml									
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

Patient Sticker



FLUID CHART

Sheet No. :

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

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

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

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

HNH-00014818
 Mrs AVARAM ASFIYA FARZEEN IP28-00006617
 18-04-1999 27 Y 2 M 4 D (F)
 Dr. SWAPNA SAMUDRALA

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
20/6/20	2pm	0/8	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	(Signature)
				<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		
				<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		
				<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		
				<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		
				<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		
				<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		
				<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		
				<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		

Re-assessment Frequency:

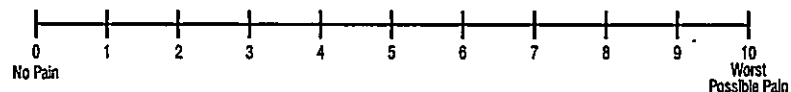
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn 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



HNH-00014816 IP26-00006617
 Mrs AVARAM ASFIYA FARZEEN
 18-04-1999 27 Y 2 M 4 D (F)
 Dr. SWAPNA SAMUDRALA



BRADEN 'Q' SCALE



Date : 20/6
 Time : 12

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

AS

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

Docu. No. : RCH /FRM / CLINICAL / 119

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

HNH-00014816 IP28-00006617
 Mrs AVARAM ASFIYA FARZEEN
 18-04-1999 27 Y 2 M 4 D (F)
 Dr. SWAPNA SAMUDRALA



Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	Fall Risk Grading			
		Score	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				
	No	0				
Ambulatory Aid	Furniture	30		Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	Crutches, Cane(S), Walker	15				
	None /Bed Rest /Nurse Assist	0				
IV / Heparin Lock or Saline	Yes	20	High Risk	≥ 51	Implement High Risk Fall Prevention Intervention	
	No	0				
GAIT / Transferring	Impaired	20				
	Weak (uses touch for balance)	10				
	Normal /On Bed Rest /Immobile	0				
Mental Status	Forgets limitations	15				
	Oriented to own ability	0				
Total Morse Fall Scale Score:		20				
Signature						

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

HNH-00014816 IP28-00006617
 Mrs AVARAM ASFIYA FARZEEN
 18-04-1999 27 Y 2 M 4 D (F)
 Dr. SWAPNA SAMUDRALA



CHECKLIST FOR THROMBOPHLEBITIS

20/10/26

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

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 : NP Name : Mounika

Signature : Name :

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 :

HNH-00014618 IP26-00006617
 Mrs AVARAM ASFIYA FARZEN
 18-04-1999 27 Y 2 M 4 D

Dr. SWAPNA SAMUDRALA (F)



NURSING CARE RECORD

Date:

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							
Afternoon	2pm 7pm	<ul style="list-style-type: none"> ⇒ plan for vitals ⇒ plan for mediat ⇒ plan for sending electrolytes ⇒ plan for I/O chart 	2pm 8pm	<ul style="list-style-type: none"> ⇒ Assess ed the patient condition ⇒ maintain vital & record. ⇒ maintain I/O chart 	patient is stable	<ul style="list-style-type: none"> vital is normal 	<ul style="list-style-type: none"> Cluck CA
Night				D/C			

Patient Sticker

NURSING CARE RECORD



Date:

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:	Hyper emipic for OBS.		Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known				
				If Yes Specify:				
BACKGROUND	Area	20/6/26						
	Shift Time	12						
	Medical Condition (Any special condition to be noted):	-						
ASSESSMENT	Allergy:	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Tubes/Drains/Catheter:	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:	97.8					
		Res:	16					
		SpO ₂ :	99					
		Pulse:	87					
		BP:	111/70					
Fall Risk Score:	-							
Pain Score:	-							
Recommendations	Safety Needs:	Yes						
	Physiotherapy	<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	
	Others Specify:	-						
	Special Diet:	<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	
	Other Special Orders / Medications:	NB						
	Post Operative Procedure Special Orders:							
	Handed Over By Name :	Nani						
	Signature :							
	Date:	20/6/26						
	Time:	8pm						
	Taken Over By Name :							
	Signature :							
	Date:							
	Time:							

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:						
BACKGROUND	Area .							
	Shift Time	/	/	/	/	/	/	
	Medical Condition (Any special condition to be noted):							
ASSESSMENT	Allergy:	<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	
	Tubes/Drains/Catheter:	<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	
	Vital Signs:	Temp:						
		Res:						
		SpO ₂ :						
		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:								

Rainbow Childrens Hospital-Himayatnagar**Rainbow
Children's
Hospital**

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.

TEL NO :040-48873000

WEB : <https://rainbowhospitals.in>**ADMISSION SHEET****Registration Details :**

Admission No : IP26-00006617

Admit Date : 20-Jun-2026

Admit Time : 02:34 PM UHID : HNH-00014816

Patient Details :

Patient Name : Mrs AVARAM ASFIYA FARZEEN

Age : 27 Y 2 M 4 D

Guardian : Mr MOHAMMAD SHAKEEL

DOB : 16-04-1999

Gender : Female

Religion :

Occupation :

Marital Status :

Address (H) : HNO:5-81/82,MAQSOOD AHMED NAGAR
MARKET ROAD Mancherial Mancherial
Telangana INDIA 504208

Phone No : 8688169033/

E-mail : FARZEENASFIYA@GMAIL.COM

Admission Details :

Bed Type : TWIN SHARING

Bed No : LDR-415

Ward Name : 4F -OT

Room No : LDR-415

Admission Type : First Visit

Contact Details :

Name : Mr MOHAMMAD SHAKEEL

Relationship : W/O

Contact Address : HNO:5-81/82,MAQSOOD AHMED NAGAR
MARKET ROAD Mancherial Mancherial
Telangana INDIA 504208

Phone No : 8688169033


Signature**Doctor Details :**

Doctor Name : Dr. SWAPNA SAMUDRALA

Specialisation : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self.

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY