ARTI REDDY — 9154949273.

Pooja Sanghi — 9951162691
9618181998.

NO - 2days

NSG - 3 day

Triple — 80,000/-

90,000/-

- CBP, NST

CBP, NST

- Pharmacy/ 12,000/-
- Any other Investigation. extra.
- Any other Cross Consultant Amt. extra

Baby Bill. — 15,000/-

Neonatologist = 2 visit

Blood Grouping. —

Vaccination. BCG, Hep B, Polio

SBL. Test - 1

Triple Sharing D-CAT

Dr. Ronya

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ESTIMATION SLIP

Date : 29/5/26 **UHID / IP No. :** HNH-0001469 **Sl No.** 1547

Name of Patient : MRS. Pooja Singhi **Age:** _____ **Gender:** F

Father's / Husband's Name : _____ **Corporate / Occupation :** _____

Address : _____ **Phone :** 9951162691 **Email :** 9618181948

Procedure / Plan : _____ **EDD/Dos:** _____

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

TARIFF INFORMATION :

Particulars	Package Amounts (Rs.)	
Room Category	Normal Delivery	LSCS
Multi Shared Ward		
Shared Ward Triple Sharing	80,000/-	90,000/-
Twin Shared Ward		
Private Room		
Super Deluxe Room		
Suite Room		
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 : 2 Days	Length of Stay for : 3 Days
	Pharmacy up to 12,000/-	Pharmacy up to 12,000/-
	Investigations up to 2500/-	Investigations up to 3000/-
Others	Well baby Cot	ISL

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

Initial Minimum Deposit : _____

REMARKS : Vaccination, Neonatal, SBR, B/G

1. 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.
2. 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.
3. **Total baby charges are extra which include admission, pharmacy, vaccinations, investigations, disposables, consumables, equipments, speciality consultations, etc.**
4. 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
5. **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.**
6. 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.
7. 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
8. Tariffs are subject to revision
9. Kindly check your billing status on day to day basis at IP Billing Department.
10. 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 | Signatory Relationship | Signature of the financial Counselor

HNH-00011469 IP26-00006514
Mrs POOJA SANGHI
02-06-2000 26 Y 0 M 4 D (F)
Dr. KADIYALA RAMYA THEJA

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SURGERY DETAILS

Date : 6/6/26

Patient Name: Mrs Pooja Sanghi Date of Birth: 2/6/2000 Age: 26y

Gender: Female Ward : LOR UHID No.: HNH – 00011469

Date of Surgery: 6/6/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : NVD E Epidural

Time in : 8:30AM Time Out : 9:30AM

		NAME	AMOUNT
1.	Surgeon	: DR Ramya Theja	
2.	Anaesthetist	: DR Samir	
3.	Assistant Surgeon	: DR Veena	
4.	OT Technician	:	
5.	Circulating Nurse	: Sis Kakture	
6.	Assistant Nurse	: Alate	

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

DR Ramya
Signature of the Surgeon

Alei
Signature of Circulating Nurse

Order No: 26-0000204673 Order by: Alei

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 : IP26-00006490 **Admit Date** : 03-Jun-2026 **Admit Time** : 10:52 PM **UHID** : HNH-00014101

Patient Details :

Patient Name	: Mrs S NIKITHA	**Age**	: 30 Y 9 M 28 D
Guardian	: Mr VENKAT MANOJ KUMAR	**DOB**	: 06-08-1995
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 1-9-252/9/66 ews 1 qtr-66 east mch colony Ram Nagar Hyderabad Telangana INDIA 500020	**Phone No**	: 8919928151/ 8328215763
		E-mail	: nikithasoma6895@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 VENKAT MANOJ KUMAR **Relationship** : W/O

Contact Address : 1-9-252/9/66 ews 1 qtr-66 east mch colony Ram Nagar Hyderabad Telangana INDIA 500020 **Phone No** : 8919928151

V. Venkat Manoj

Signature

Doctor Details :

Doctor Name : Dr. SWAPNA SAMUDRALA **Specialisation** : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self. **Phone No** :

Co-Consultant :

Payment Details :

Payment Mode : DC/CC Card **Deposit Amount** : 10000.00

Payor Name : RELIANCE GENERAL INSURANCE COMPANY LTD

F.C.: 303-M

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Name	Mrs S NIKITHA	**UHID**	HNH-00014101
Father/Guardian	Mr VENKAT MANOJ KUMAR	**Age/Gender**	30 Y 9 M 29 D/ Female
Address	1-9-252/9/66 ews 1 qtr-66 east mch colony, Ram Nagar, Hyderabad, Telangana, INDIA, 500020		
IP No	IP26-00006490	**Admission Date**	03-06-2026
Ref Doctor	Self.		
Discharge Date	06.06.2026		

DISCHARGE SUMMARY

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

Diagnosis: PRIMI AT 39^{+2} WEEKS FOR INDUCTION OF LABOUR WITH NON-PROGRESS OF LABOUR

EMERGENCY LOWER SEGMENT CAESAREAN SECTION DONE ON 04.06.2026

History:
LMP:02.09.2025
EDD:11.06.2026
Obstetric formula:Primigravida
Gestation at admission: 39^{+2} weeks

Name	Mrs S NIKITHA	**UHID**	HNH-00014101
IP No	IP26-00006490	**Admission Date**	03-06-2026

Obstetric History:
G1 - Present pregnancy, Spontaneous conception.

Medical History: Nil
Family History: Father-HTN,Mother-DM
Surgical History: Nil
Allergies: Nil

Antenatal Details:
Mrs S NIKITHA was booked to Rainbow hospital at 26 weeks of gestation. She had regular antenatal checkups and investigations as advised elsewhere. NT scan normal. FTS low risk. MTAS normal. She had an uneventful antenatal period. Fetal monitoring done by serial growth scans.Scan done at 37^{+1} weeks showed single live intrauterine fetus with cephalic presentation with Placenta-anterior,high,EFW-2.99kg(44%),AC- 30%,AFI-9.3cm with normal dopplers.Scan done on 27.05.2026 showed single live fetus,cephalic presentation, AFI-13.5cms. She was admitted at 39^{+2} weeks for induction of labour.

Investigations: Enclosed
Blood group: "A positive"

Management:
Course in hospital and Delivery Details:
At admission on clinical examination the vitals were stable, uterus was relaxed, cervix was uneffaced,os closed. Fetal well being was confirmed by an

Name	Mrs S NIKITHA	**UHID**	HNH-00014101
IP No	IP26-00006490	**Admission Date**	03-06-2026

admission CTG which was found to be reactive. Informed consent obatined for induction of labour and vaginal birth. She received 3 doses of PGE1(Misoprostol) for induction of labour. Serial CTGs done and reactive. She was decided for Emergency LSCS in view of Non-progress of labour.She is prepared with indwelling Foley's catheter and IV canula under aseptic conditions. As per hospital protocol she was started on IV. Taxim. Written informed consent for surgery taken. Preanesthetic check up done. Anesthetic premedication (IV Pantop and Perinorm) given. Patient shifted to theatre.

Surgery Notes:

Under spinal anesthesia she was painted and draped as per hospital protocol. 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 600 mcg given per rectum as prophylaxis against Postpartum hemorrhage. Patient was shifted out of theatre to post operative recovery room.

***LUS vascular**

***Liqour scanty**

***One loop of cord around neck**

Delivery Details :

Name	Mrs S NIKITHA	**UHID**	HNH-00014101
IP No	IP26-00006490	**Admission Date**	03-06-2026

Date : 04.06.2026
Time of Delivery: 2:36PM
Type of Delivery: Emergency Lower segment caesarean section
Indication : NPOL
Anaesthesia : Spinal

Baby Details:
Date : 04.06.2026
Time : 2:36PM
Sex : Female
Weight : 3060 grams
Apgar : 8,9
Gestational Age: 39^{+2}weeks
NICU Admission: No

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 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:

Name	Mrs S NIKITHA	**UHID**	HNH-00014101
IP No	IP26-00006490	**Admission Date**	03-06-2026

1. Tab. Taxim O 200mg twice daily till 10.06.2026 (9am-9pm) after food.
2. Tab. Calpol 500mg (Paracetamol 500mg) (2tabs) thrice daily till 08.06.2026 (8am-2pm-10pm) after food.
3. Tab. Voveran 50 mg (Diclofenac 50mg) thrice daily till 08.06.2026 (9am-3pm-11pm) after food.
4. Tab. Pantop 40mg twice daily till 10.06.2026 (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 6weeks; Please discuss with your treating doctor regarding **HPV vaccination.**

Review with **Dr. SWAPNA SAMUDRALA,** after **2 weeks** on **20.06.2026** 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.

Name	Mrs S NIKITHA	**UHID**	HNH-00014101
IP No	IP26-00006490	**Admission Date**	03-06-2026

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 [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.

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

Rainbow Children's Medicare Ltd. Himayathnagar 500029 Hyderabad

Registrar/Resident/C.M.

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

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ACTIVITY RECORD FOR BILLING

Name: ---------- HNH-00014101 IP26-00006490 ----------
Mrs S NIKITHA
08-08-1995 30 Y 9 M 28 D (F)
UHID No : ---------- Dr. SWAPNA SAMUDRALA onsultant : ---------- Dept : ----------

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
4/6/26.	2:00 pm	Pre-post	OT	Puja
4/6/26	3:40pm	OT	prepost	Puja / Ajay
4/6/26	9pm	PreePost	Floor	Moonira

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	Dr. Sindhura	5/6/26	4546	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS

Date	Investigations	Order No.	Sign
2/6/26	NST — ①	66972 ✓	Ashed
3/6/26	CBP — ①	9285 ✓	Mouni
3/6/26	GRBS 95mg dL @ 11:30pm	9286 ✓	Mouni
4/6/26	NST — ②	6698 ✓	Ashed
4/6/26	NST — ③	6699 ✓	Ashed
4/6	NST — ④	6706 ✓	⑥
4/6/26	NST — ⑤	6719 ✓	R
			Cross checked done

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
4/6/26	cardiac Monitor	8:40 pm	8pm	204/99	Anusha
4/6/26	Infusion pump		8pm		

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
3/6/26	Ir placement	1	204017	Asher
4/6/26	Catheterisation	(1)	4156	
4/6/26	PAC	(1)	4157	
5/6/26	NHA	(1)	4544	

Cross checked

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00014101 IP26-00006490
Mrs S NIKITHA
06-08-1995 30 Y 9 M 28 D (F)
Dr. SWAPNA SAMUDRALA

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IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

Came for IOL
PPM

Obstetric Formula: G1

G1 - PP, S P Conception
Obstetric Hostory: Boom @ 26wks
H/o 1st Trimester Bleeding → Rx Progesterone
NT + Double marker - LR
TIFFA N

Present Pregnancy Record:

RISK FACTORS:

Height: 154 cm

Weight: 71.60 kg

Allergies: nil

Breast: ☑ Normal ☐ Abnormal

General Examination:

Consciousness:

Pallor: ⊖

Icterus: ⊖

Edema: ⊖

Temp: Afebrile

PR:

BP:

DTR: ⊕

CVS: NAD

RS: BAE ⊕

Liver/Spleen: NAD

Urine Output: Adeq

LMP: 2/9/2025

EDD:

Corrected EDD: 11/6/2026

GA: 39+1

Menstrual History: Regular: ☑ Yes ☐ No

Obstetric Examination

Fundal Height: ~ Term

Ut. Activity: ☑ Relaxed ☐ Mild ☐ Mod ☐ Severe

Liquor: ☑ Adequate ☐ Oligo ☐ Poly

PP: ☑ Cephalic ☐ Breech Others ______

Head Fifths Palpable: 4/5

FHS: ☑ Normal ☐ Tachy ☐ Brady ☐ Absent

Per Speculum Examination N/A deferred

Draining: ☐ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination

Cervix: ☑ Long ☐ Partially effaced ☐ Effaced

Os: (Closed) ______ Dilated ______

Membranes: ☐ Present ☐ Absent

Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Presenting Part: ☐ Vertex ☐ Breech ☐ Others

Sutton: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Pelvis: ☑ Adequate ☐ Doubtful

DIAGNOSIS

Primi / 39+1 wks
for IOL

HNH-00014101 IP26-00006490
Mrs S NIKITHA
08-08-1995 30 Y 9 M 29 D (F)
Dr. SWAPNA SAMUDRALA

Family History:	Surgical History:
Father HTN Mother DM	Nil
Medical History:	**Medication History:**
Nil	T Iron + Calcium
Plan of Care:	**Investigations:**
Admission NST Drugs as charted W/F vitals & FHS Parts prepare Informed consent Collect Blood report Inform Pediatrician / Anesthetist NST 8th hourly FHS 2nd hourly Induction @ 3Am Tab misoprostol 25mcg Inform SVS Check for Blood availability	BGT A Pos HIV, HBsAg, VDRL, HCV } NR CBP (3/6/2026) Hb- 11.4 WBC - 6.26 Plt - 189 USG (20/5/2026) SUIUF/ 37+1/ Vx Pl A/H AFI 9.3cm EFW 2997g (44%) AC-30% UAD(N)

Doctor Name: Dr Manisha
Signature:
Date & Time: 3/6/2026 @ 10.30pm

Dr. Swapna Samudrala
Consultant Obstetrics and Gynecology

Consultant Name: Dr Swapna Samudrala
Signature:
Date & Time: 3/6/2026

HNH-00014101 IP26-00006490
Mrs S NIKITHA
08-08-1995 30 Y 9 M 28 D (F)
Dr. SWAPNA SAMUDRALA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/6/2026	C/S/b Dr Mamsha	
3AM	Primi / 39+2 wks / for IOL	
	CC - For Afebrile	Adv
	BP 110/74	- Early Breakfast
	PR 93	- Oral Hydration
	P/A ut TS	- W/F vitals
	Cephalic	- FHS monitoring 2° hourly
PFM (+)	FHS (R)	- NST 3rd hourly
NST - Reactive	ut Relaxed	- Rest in left lateral Position
	(1st dose)	Inform SOS
	Tab Misoprostol 25mcg	
	PV @ OS closed	Dr Mamsha
	@ 3am	
	PV - OS Closed : Long	
4/6/2026	C/S/b Dr Mamsha	
7Am	Primi / 39+2 / Ong @ IOL	
	CC - For Afebrile	Adv
	vitals stable	- Oral Hydration
	P/A ut TS irritable	- W/F vitals
NST (R)	Cephalic	- FHS 2° hourly / NST 3° hourly
	FHS (R) (2nd dose)	- Rest in left lateral Position
	Tab Misoprostol 25mcg P/O	- Inform SOS
	@ 7Am	Dr Mamsha

HNH-00014101 IP26-00006490
Mrs S NIKITHA
06-08-1995 30 Y 9 M 29 D (F)
Dr. SWAPNA SAMUDRALA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/6/26 10:15AM	C/S/B Dr. Dvg	
	Primi c 39+2 wk ↓IOL.	
		Adv
	P° Pt°: GC fair	- NBM
	vitals - (N)	- NST 3rd hourly
	P/A ut ≅ TG	- FHR 2nd hourly
	cephalic	- Rest in left lateral position
	NST - Reactive; FHS (+)	
	2C/10/10.	3rd dose T. MISOPROSTOL 25mcg PO
	head 4/5 palpable.	
	C/S/B Dr. Swapna.	
4/6/26.	Primi c 39+2 wk ↓IOL.	
10:45AM	GC fair	Adv
	vitals - (N)	NBM
	P/A ut ≅ TG	- NST 3r hourly
	cephalic	- FHR 2nd hourly
	FHS (+)	- Rest in left lateral position.
	2C/10/10.	
	P/V - os 1F	- Reassess @ 1:30pm.
	uneffaced 3/4" long	
	Vx - high up.	
	Memb flat over PP	

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

HNH-00014101 IP26-00006490
Mrs S NIKITHA
08-08-1995 30 Y 9 M 28 D (F)
Dr. SWAPNA SAMUDRALA

(2)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Couple requesting for	LSCS.
4/6/26 2:00 pm	c/o pain (Abd)	
	O/E) G.C fair	
	Afebrile	Adv
	O₂ Sat - 99 % RA	- for Em. LSCS Mev
	Vitals - (N)	(Ind: NPOL)
	P/A - UT acting	- PAC
	2-3 / 15-20" / 10'	- Informed Consent
	Ceph, 4/5 palp.	- Drugs as charted
	FHR - 148 b/m - ROH	- Monitor Vitals
	V/E - Cx 1f, 8/4th" long	- FHR monitoring
	Soft, post	- Shift to OT on call
	Vx - 3, membr flat	
	Inva PP.	
	Couple counselled regarding NPOL.	(Dr. Swapna)

Dr. Swapna Samudrala
Consultant Obstetrics and Gynecology

HNH-00014101 IP26-00006490
Mrs S NIKITHA
06-08-1995 30 Y 9 M 30 D (F)
Dr. SWAPNA SAMUDRALA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/6/26 4:00pm	POD-0 (P,L, / Em LSCS)	
	GC Fair	Adv
	Afebrile	- NBM for 6hr
	BP: 119/75mmHg	- IVF
	PR: 86/m.	- Drugs as charted
Baby-mth	SpO₂: 99% on RA.	- Monitor vitals
U.O → 100ml	P/A Uterus Retracted well	- W/F P/V bleed
(clear)		- Inform SOS
	LE NAB.	- Remove foley's C/m @ 6am
	Dr. Swapna Samudrala, Consultant Obstetrics and Gynecology, Reg. No. 69923 (stamp)	[signature] (Dr. Swapna)
4/6/2026 7:30pm	c/s/by Dr. Naveena	
	O/E GC-fair	Adv
Kindly shift the patient to Room	Afebrile	- Sips of water f/b
	Vitals - stable	liquid diet
	PA: ut retracted	- drugs as charted
	Soft, NT well.	- Adequate hydration
	Dressing: dry & clean	- Soft diet from T/M @ 6am
	LE: PV bleeding WNL	- Urine I/O charting
	U/O: Sometimes little blood tinged	- foley's removal @ 6am T/M
	Baby: MS	- W/F PV bleeding
	Dr. Naveena [signature]	- Monitor Vitals
		- Inform SOS

HNH-00014101 IP26-00006490
Mrs S NIKITHA
08-08-1995 30 Y 9 M 29 D (F)
Dr. SWAPNA SAMUDRALA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/6/2026 7:00am	c/s l/by Dr. Naveena	
	c/c GC-fair	Adv
	Afebrile	- Soft diet
	Vitals- stable	- Adequate hydration
U- X	PA: ut. retracted well	- drugs as charted
F- ✓		- Ambulation
S- X	Soft, NT	- w/f PV bleeding
	Dressing: dry & clean	- Monitor Vitals
	I/E: PV bleeding WNL	- Inform SOS
	Baby: Mother side	
		Dr. Naveena.
		noted by Sr. sandhya 5/6/26 7:a.m.

Docu. No. : RCH /FRM / CLINICAL / 088

(P.T.O)

HNH-00014101 IP26-00006490
Mrs S NIKITHA
06-08-1995 30 Y 9 M 30 D (F)
Dr. SWAPNA SAMUDRALA

Rainbow® Children's Hospital
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Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/6/2026	C/S/B Dr Swapna Samudrala	
12 pm	POD-1	
		Adv:-
	GC - Fair Afebrile	- Soft Diet / Adeq hydration
BMS	Vitals Stable	- Drugs as charted
	P/A Ut well retracted	- W/F vitals & BPV
UV	BS⊕	- Ambulation
FV	L/E Bleeding WNL	- Inform SW
SX		
	Dr. Swapna Samudrala Consultant Obstetrics and Gynecology Reg. No: 69924	
Remove IV Cannula		N/B Supriya @12pm
5/6/26	C/S/B. Dr. Dna	
9 pm	POD-1 (EmLSCS)	
		Adv
	BMS GC Fair Afebrile	- Soft diet / Adequate hydration
	Vitals - Stable.	- Drugs as charted
UV	P/A ut Retracted well	- Ambulation
FV		- vital Monitoring
SX	L/E Bleeding WNL	- W/F PV bleed
	Pt refused Dulcolax suppository wants tablet	- Inform SOI
		Tab Dulcolax 1tab stat.

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/6/26	C/S/B Dr. Dna.	
	POD-2/ Em (SCS)	
7AM.	GC Fair Afebrile	Adv.
BMS	Vitals - stable.	- Soft diet
UV ✓	P/A uterus retracted well.	- Adequate hydration
FV ✓		- Drug as charted
Sa.	L/E - Bleeding WNL.	- Ambulation.
		- Vital Monitoring
		- w/f PV bleed.
		- Inform SOS
	[signature]	[signature]
6/6/26	POD - II	Adv
11:30 AM	No comp	- Regular Diet
	O/E - G.C fair	- Oral hydration
	afebrile	- Drugs as charted
Baby - well	Vitals - ⓝ	- Monitor vitals
	P/A - UV well retracted	- Ambulation
Sutures ✓	Soft	- Inform SOS.
	L/E - NAR	
S/S Zone		Dr. Swapna Samudrala, Consultant Obstetrics and Gynecology, Reg. No: 69924
Dressing	Can be discharged	(Dr. Swapna's) [signature]

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00014101 IP26-00006490
Mrs.S NIKITHA
06-08-1995 30 Y 9 M 28 D (F)
Dr. SWAPNA SAMUDRALA

303

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RESULT SHEET

Date	3/6/26					
Time						
Hb	11.4					
PCV	33.4					
RBC	3.69					
WBC	6.26					
N/L						
Platelets	1.89					
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 group = A +ve

HIV
HBsAg
VDRL
HCV
} -ve

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

Others (ECG, Contrast Studies etc.,) : .....

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Early Warning Observation Score Chart - Obstetrics

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

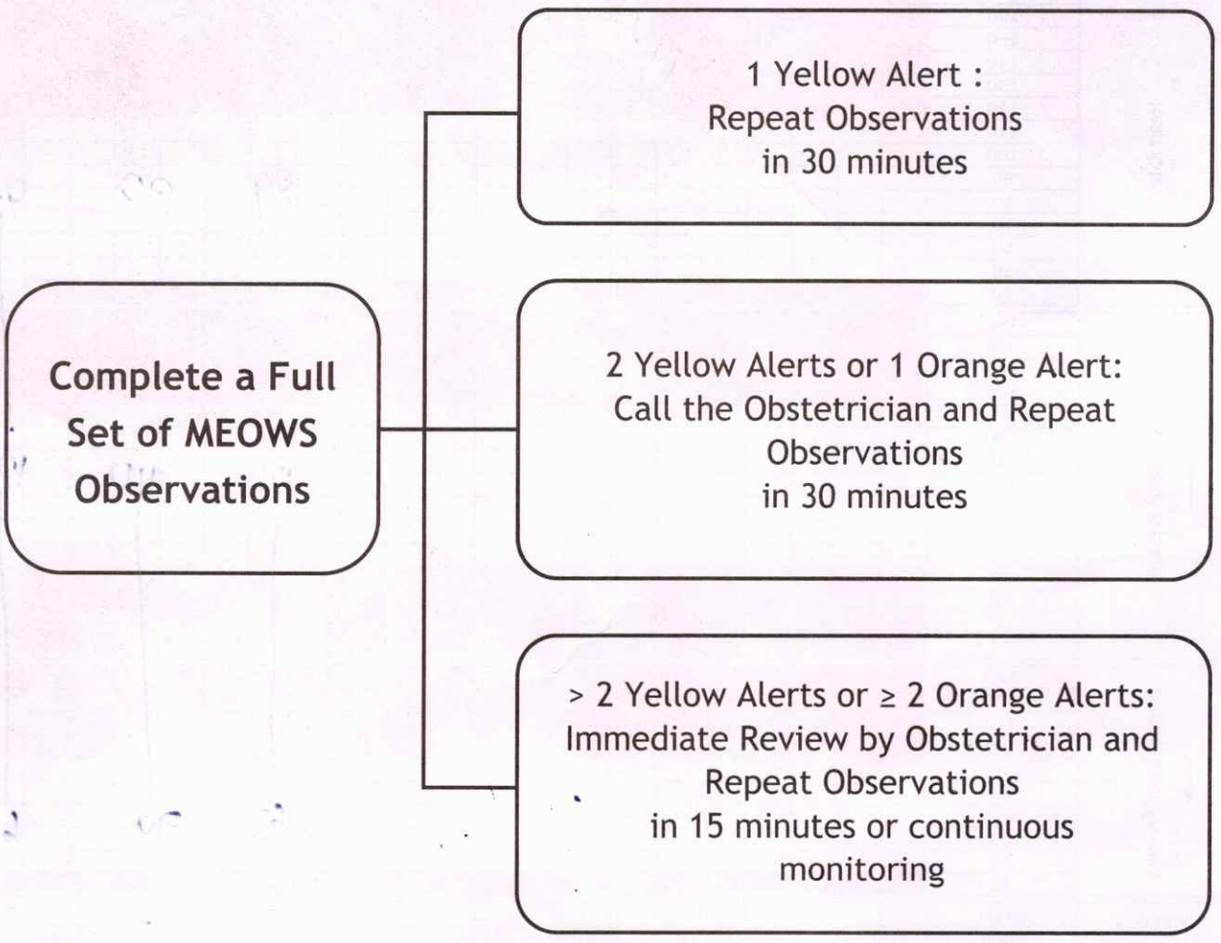
3/6/26	Date																								
	Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																								
	21 - 30																								
	11 - 20															20			20			20			20
	0 - 10																								
Saturations	94 - 100 %															99↑			99↑			99↑			99↑
	< 94 %																								
Administered O_2 (L/min.)																—									
Temp°c	40																								
	39																								
	38																								
	37															—			—			—			—
	36																								
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90															89			90			90			89
	80																								
	70																								
	60																								
	50																								
	40																								
Systolic Blood Pressue ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120															122			110			122			122
	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
	40																								
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
	40															62			70			62			62
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																									
TOTAL ORANGE SCORES																									
Nurse Initial																M			M			M			M

1 AM ⟹ 148 bmt.

4 AM ⟹ 150 bmt.

6 AM ⟹ 148 bmt

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score **(MEOWS)**

HNH-00014101 IP26-00006490
Mrs S NIKITHA
08-08-1995 30 Y 9 M 28 D (F)
Dr. SWAPNA SAMUDRALA

(2)

Rainbow® Children's Hospital
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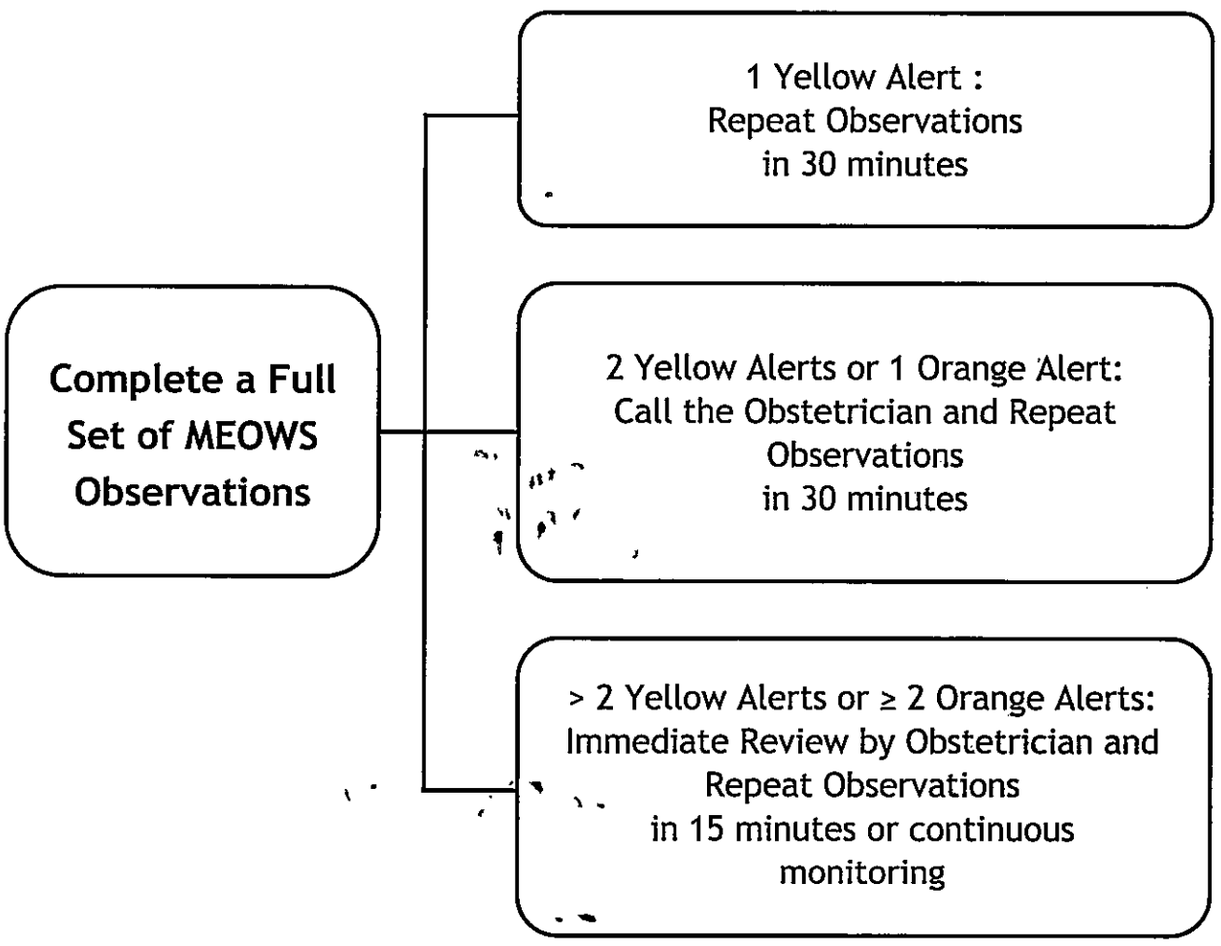
Early Warning Observation Score Chart - Obstetrics

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

4/6/26	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	20	20	20	20		20				20				20
	0 - 10																							
Saturations	94 - 100 %	99%		99%		99%		99%	99%	99%	99%	98%	98%	98%		99%				99%				99%
	< 94 %																							
Administered O_2 (L/min.)																								
Temp °c	40																							
	39																							
	38																							
	37																							
	36	36		36		36		36								37.2				37.3				37.3
	35																							
	< 35																							
Heart Rate	170																							
	160																							
	150																							
	140																							
	130																							
	120																							
	110																							
	100																							
	90																							
	80	89		84		86		87	79	81	88	85	81	87		85				83				85
	70																							
	60																							
	50																							
	40																							
Systolic Blood Pressue ↑	190																							
	180																							
	170																							
	160																							
	150																							
	140																							
	130																							
	120	116		118		116		118	113	109	117	119	115	115		110				114				119
	110																							
	100																							
	90																							
	80																							
	70																							
	60																							
	50																							
Diastolic Blood Pressure ↓	130																							
	120																							
	110																							
	100																							
	90																							
	80																							
	70	73		81		71		72	70	81	76	80	77	72		70				72				80
	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	0	0	0	0		0	1			0				0
TOTAL ORANGE SCORES		0		0		0		0	0	0	0	0	0	0		0	0			0				0
Nurse Initial																								

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score **(MEOWS)**

HNH-00014101 IP26-00006490
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Patien

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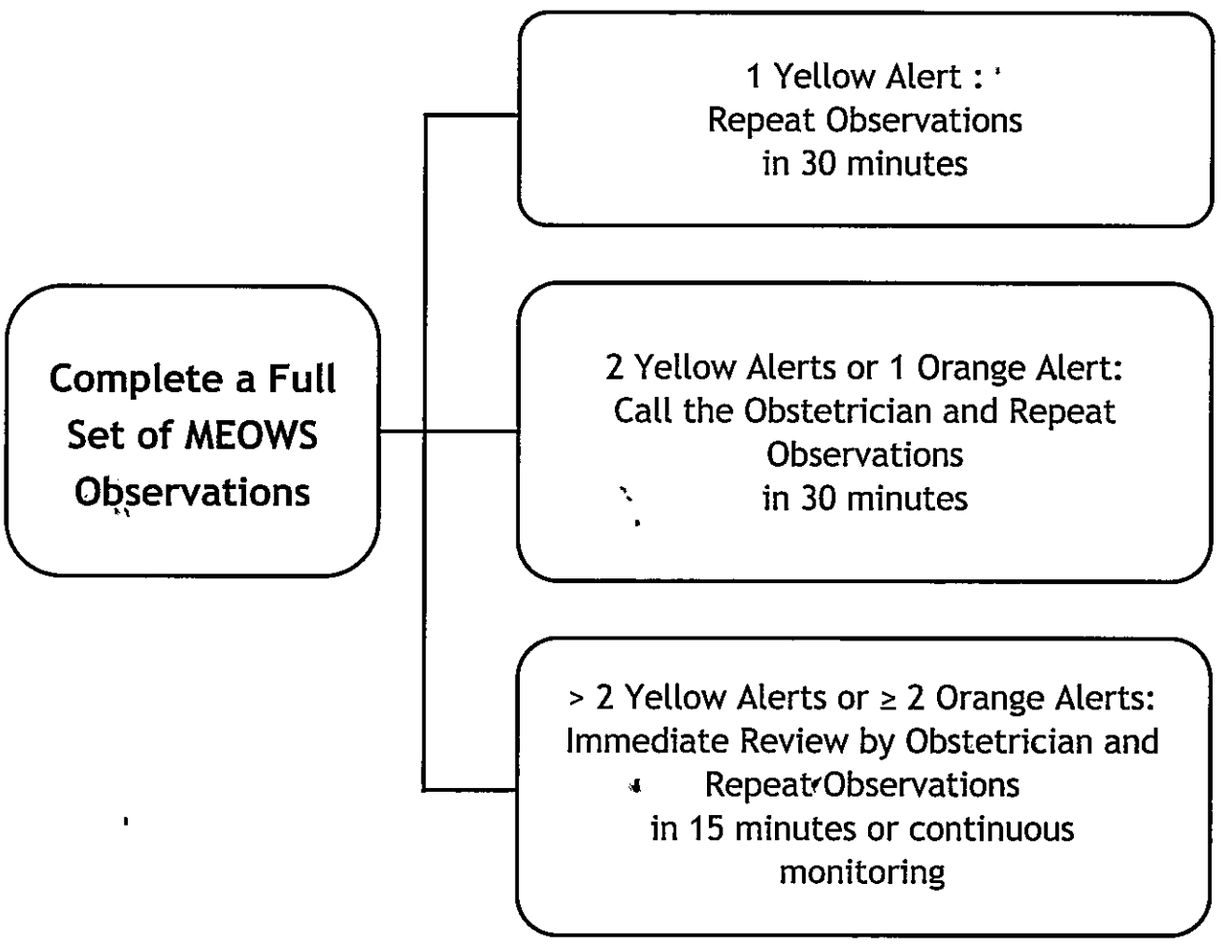
Early Warning Observation Score Chart - Obstetrics

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

5/6/20	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				22				20					20
	0 - 10																								
Saturations	94 - 100 %			99%				99%				99%				99%				100					100
	< 94 %																								
Administered O_2 (L/min.)																									
Temp°c	40																								
	39																								
	38																								
	37																								
	36			36				36.6				36.1				36.2				98.24					98
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80			98				80				95				78				72					76
	70																								
	60																								
	50																								
	40																								
Systolic Blood Pressue ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110			108				112				110				112				106					108
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70			70				72				74				80				62					82
	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				1					1
TOTAL ORANGE SCORES				0				0				0				0				0					0
Nurse Initial				[illegible]				[illegible]				[illegible]				[illegible]				[illegible]					[illegible]

Obstetrics and Gynaecology Early Warning Signs



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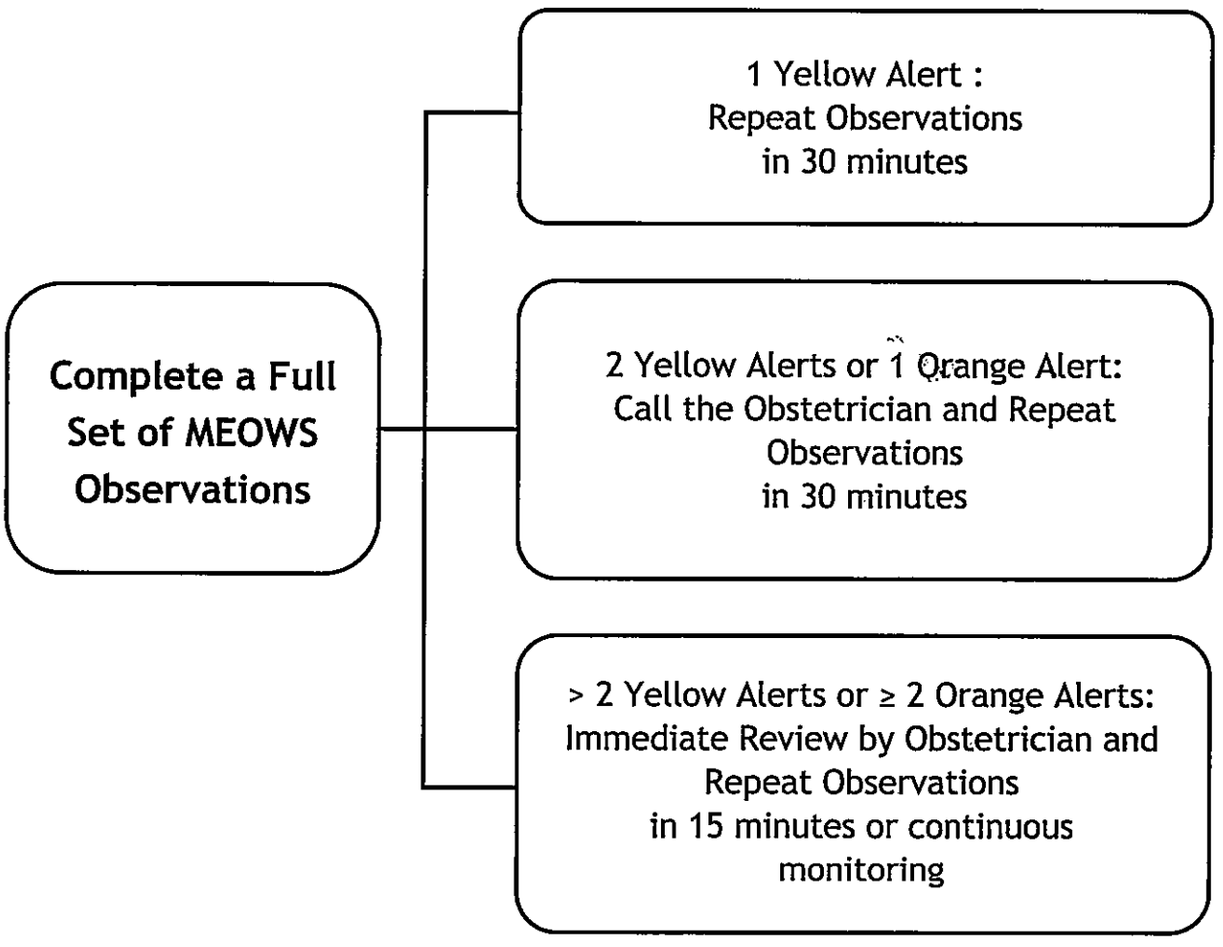
Early Warning Observation Score Chart - Obstetrics

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

6/6

		Date																							
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20																									
	0 - 10																									
Saturations	94 - 100 %																									
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37																									
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	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																										
TOTAL ORANGE SCORES																										
Nurse Initial																										

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score **(MEOWS)**

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FLUID CHART

Sheet No. : 1

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	Intake: Nature of Fluid	Intake: Route: Mouth	Intake: Route: I.V	Intake: Route: N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
	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											
3/8/26	10:00 pm	H20 ✓	-			-	-	-	-	✓		
	11:00 pm											
	12:00 am	H20 ✓										
	01:00 am									✓		
Total Intake :		Taken				**Total Output :**				Passed		
	02:00 am											
	03:00 am	H20 ✓										
	04:00 am	RL FF	-							✓		
	05:00 am											
	06:00 am	H20 + Idly								✓		
	07:00 am	-	-			-		-	-			
Total Intake :		Taken				**Total Output :**				Passed		

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : ......②......

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	Intake: Nature of Fluid	Route: Mouth	Route: I.V	Route: N.G	Output: NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
4/6/26	08:00 am	RL	N	100ml								
	09:00 am	RL		100ml							0	
	10:00 am	RL	B	100ml								
	11:00 am	RL		100ml			NA					
	12:00 pm	RL	M	100ml								
	01:00 pm	RL		100ml								
Total Intake :						Total Output : Passed						
4/6	02:00 pm	RL		100								
	03:00 pm	RL		100						100ml		Emp
	04:00 pm	RL		100							0	
	05:00 pm	RL		100			NA					Accu
	06:00 pm	RL		100ml						100ml		Emp
	07:00 pm	RL	sips	100ml								
Total Intake : Tolerated						Total Output : passed						
4/6	08:00 pm	RL		100ml								
	09:00 pm	RL	soup	100ml						300ml		Emp's 8:00pm
	10:00 pm	RL		100ml							0	
	11:00 pm	RL		100ml								
	12:00 am	RL		100ml		NA		NA				
	01:00 am	RL	soup	100ml						500		
Total Intake : Taken						Total Output : U-800ml M-0						
5/6/26	02:00 am	RL		100ml								
	03:00 am	RL	milk	100ml								
	04:00 am	RL		100ml							0	
	05:00 am	RL		100ml								
	06:00 am	RL		100ml		NA		NA		600ml		foley's Removed
	07:00 am	RL		100ml								
Total Intake : Taken						Total Output : U- M-0						

Total 24 hrs. Intake		Total 24 hrs. Output	

Docu. No. : RCH /FRM / CLINICAL / 092

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Mrs S NIKITHA
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FLUID CHART

Sheet No. : 2

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	Intake: Nature of Fluid	Intake: Route: Mouth	Intake: Route: I.V	Intake: Route: N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
5/6/26	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake : Taken						Total Output : U-2 m.						
5/6/26	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-00014101 IP26-00006490
Mrs S NIKITHA
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FLUID CHART

Sheet No. : 4

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	Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
6/8/26	08:00 am	0	RTW / S#20		NA			NA			0	[illegible]
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake : taken						Total Output : U — M —						
	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-00014101 IP26-00006490
Mrs S NIKITHA
06-08-1995 30 Y 9 M 28 D (F)
Dr. SWAPNA SAMUDRALA

NURSING CARE RECORD

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: 3/6/24

Goals

- ☐ Maintain Airway and Oxygenation
- ☐ Maintain Personal Hygiene
- ☐ Identify Potential Complications
- ☐ Relieve Pain & Discomfort
- ☐ Prevent Infection
- ☐ 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
- ☐ Any Others. Specify.....

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning				NA			
Afternoon							
Night	8pm 8am	plan for vitals plan for NST plan for Admission plan for Medication	8pm 8am	vitals Normal NST done Admission done. Medication given as per chart	Normal	stable	Anusha

Patient Sticker

NURSING CARE RECORD

Rainbow® Children's Hospital
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BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: 4/6/26

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	8Am – 9Am	→ Plan for vital → Plan for I/O chart. → Plan for medication.	8Am – 9Am	→ vital checked & recorded. → Maintain I/O chart. → All medication given	→ vital is normal	→ pt is stable	Ⓡ Madh[illegible]
Afternoon	2Pm – 8Pm	→ Assess the patient → monitor the vitals q 4hrly → Administration of medication → maintain I/O chart	2Pm – 8Pm	→ Assessed the patient → Administered meds → maintained I/O chart → monitored vitals	Pt is stable	monitor the vitals q hrly	Akhila [illegible]
Night	10Pm – 8Am	→ Assess the patient general condition → monitor vitals → Administer medications as per doctor's orders	10PM – 8Am	→ Assessed the patient general condition → Monitored vitals → Administered medications as per doctor's orders	Patient is stable	Rechecked vitals	[illegible]

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NURSING CARE RECORD

Date: 5/6/26

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 .... (drug)

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM – 2pm	- Assess the pt condition - Monitor vitals - Maintain I/O Chart - Medication giving as per drug chart	8AM – 2pm	- Assessed the pt condition - Monitored vitals - Maintain I/O Chart - Medication giving as per drug chart	pt is stable	Re checked vitals	[signature]
Afternoon	2PM – 8PM	→ Assess the general condition. → Monitor vitals. → Maintain I/O chart → Administer medication	2PM – 8pm	→ Assessed the general condition of pt → Monitored vitals. → Maintained I/O chart → Administered medication	Pt is stable	Re-assess vitals	[signature] Mounika
Night	8pm – 8am	Assess the patient condition Monitor V/s administer Med maintain I/O chart	8pm – 8am	Assessed the pt condition V/s Administered Med maintained I/O chart	Administered Med	Reassessed pt	[signature]

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30 Y 9 M 30 D
(F)

Patient Sticker

NURSING CARE RECORD

Rainbow® Children's Hospital
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Your Right to a Safe Delivery

Date: 6/6/26

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	8am 2pm	~~Assess the Pt condition~~ ~~monitor vitals~~ ~~maintain BI chart~~ ~~Pt on soft diet~~ ~~IV fluid stop~~ ~~administer medication as per drug chart~~	8am 2pm	~~Assess the Pt condition~~ ~~monitored vitals recorded~~ ~~maintained BI chart~~ ~~Pt on soft diet~~ ~~IV fluid stop~~ ~~medication as per drug chart~~	~~Pt is stable~~	~~rechecked vitals~~	D
Afternoon				DA D			
Night							

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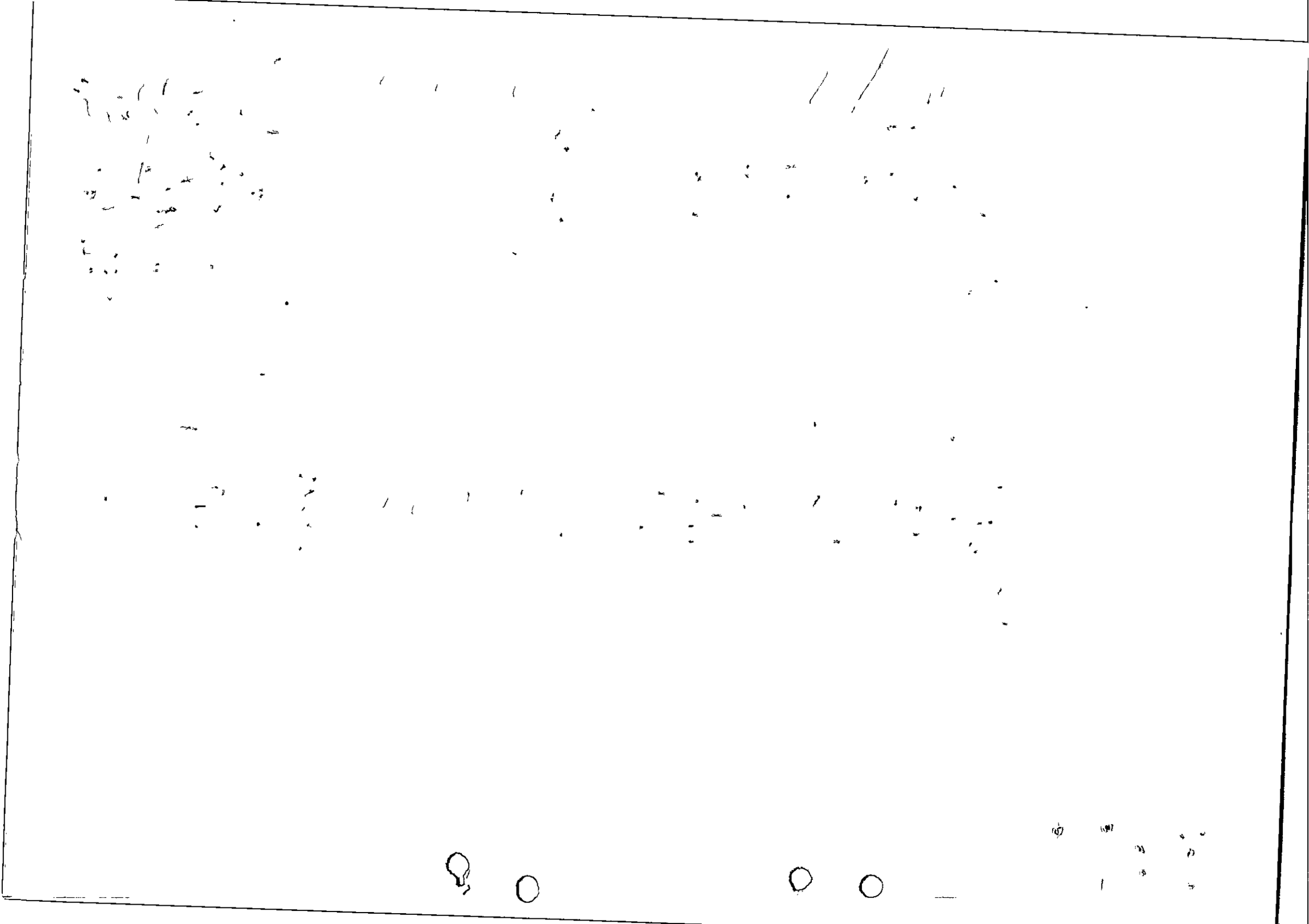
NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:			Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:			
	Surgery / Procedure: IOL			Post OP Day:			
BACKGROUND	Date / Shift	3/6/26 N	4/6 M6	4/6/26 E2	4/6/26 N8	5/6/26 M6	5/6/2. E2
	Medical Condition (Any special condition to be noted):	NA	NA	NA	NA	-	-
	Diet:	soft	liquid	liquid	liquid	liquid	Solid
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Ventilation (RA, NP, NIV, VENTI):	NA	—	—	—	—	—
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☑ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Vital Signs: Temp:	98.7	98.2°F	97°F	98.2°F	98.6°F	98.4°F
	Res:	20	90	20 b/mt	22 b/m	22 b/m	20 b/m
	SpO_2:	99%	99%	99%	99	99%	99%
	Pulse:	90	80	79 b/mt	82 b/m	78 b/m	76 b/m
	BP:	120/62	122/61	110/70	110/80	108/70	108/76
	LOC:	good			—	—	—
	Fall Risk Score:	0	—	—	—	—	—
	Pain Score:	0	—	—	—	0	0
	Skin Integrity	good	good	Good	Good	Good	Good
Recommendations	Safety Needs:	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No
	Physiotherapy:	—	—		—	—	—
	Others Specify:	☐ Yes ☑ No	☐ Yes ☑ No	☑ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Special Diet:	—	—	—	—	—	—
	Critical Lab Test / Values:	—	—	—	—	—	—
	Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	ADL (Dependent / Non Dependent):		—	—	—	—	—
	Post Operative Procedure Special Orders:	Anky	—	—	—	—	—
	Handed Over By Name :	0182158	Madhu	Anky	Sandhya	Supriya	Mounika
	Signature / ID :		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Date:	3/6	4/6	4/6/26	5/6/26	5/6/26	5/6/2.
	Time:	8am	8pm	2pm	8am	2pm	8pm
	Taken Over By Name :	Madhu	Anky	Sandhya	Supriya	Mounika	[illegible]
	Signature / ID :	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Date:	4/6	4/6/26	4/6/26	5/6/26	5/6/2	5/6
	Time:	8am	2pm	10:30pm	8am	8pm	8pm



HNH-00014101 IP26-00006490
Mrs S NIKITHA
06-08-1995 30 Y 9 M 30 D (F)
Dr. SWAPNA SAMUDRALA

Rainbow® Children's Hospital
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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: LSCS			Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:			
	Surgery / Procedure: LSCS			Post OP Day: POD-2			
BACKGROUND	Date / Shift	6/6/26 8:00	6/6/26 NS				
	Medical Condition (Any special condition to be noted):	LSCS	LSCS				
	Diet:	NPO	Continued				
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	—	—				
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.2°F	98.4°F				
	Res:	20/Min	20/Min				
	SpO_2:	100%	99%				
	Pulse:	72	80/Min				
	BP:	100/62	110/60				
	LOC:	—	—				
	Fall Risk Score:	—	—				
	Pain Score:	—	—				
	Skin Integrity	—	—				
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	—	—				
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	—	—				
	Critical Lab Test / Values:	—	—				
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	—	—				
Post Operative Procedure Special Orders:		—	—				
Handed Over By Name :		[signature]	Divya P				
Signature / ID :		[signature]					
Date:		6/6	6/6/26				
Time:		8:00	8				
Taken Over By Name :		Divya P					
Signature / ID :							
Date:		6/6/26					
Time:		8AM					

Patient Sticker

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:.....		
	Surgery / Procedure:				Post OP Day:		
BACKGROUND	Date / Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	LOC:						
	Fall Risk Score:						
	Pain Score:						
	Skin Integrity						
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:						
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							

HNH-00014101 IP26-00006490
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BRADEN 'Q' SCALE

					Date : 3/6/26	4/6	4/6	5/6/26
					Time : 8pm N	8am	2pm	Mb
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
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	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	24	28	28	28
					Evaluator's Name				

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	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for **"At Risk"** Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for **"Moderate Risk"** Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for **"High Risk"** Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

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BRADEN 'Q' SCALE

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Your Right to a Safe Delivery

					Date : 5/6/2...	6/6		
					Time :	8		
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		
"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		
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		
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		
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4		
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4		
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		
				TOTAL SCORE	28	28		
				Evaluator's Name				

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	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for **"At Risk"** Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for **"Moderate Risk"** Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for **"High Risk"** Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

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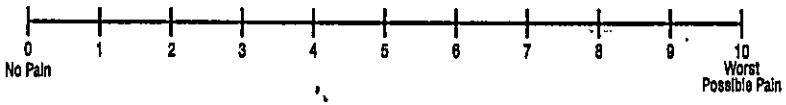
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
3/6/26	8PM	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	Anu
4/6/26	4AM	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	
4/6	8Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	
4/6	11Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	
4/6	2Pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	
4/6	7Pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	
4/6/26	10PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	
5/6/26	10Am	0/10	NA	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	NA	
5/6/26	6PM	0/0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	
6/6	6AM	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	—	

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

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, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

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, SaO_2	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

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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 3/6			DAY-2			5/6/24 DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0	0	0	0	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			-	✓	✓	✓	-	-	0	
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			-	✓	-	-	-	-	0	
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			-	✓	✓	✓	✓	-	0	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			-	✓	✓	✓	✓	-	0	
		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 : Anitha Name : Anitha

Signature of Ward In Charge :

Signature : Kasturi Name : Kasturi

Docu. No. : RCH /FRM / CLINICAL / 137

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	3/6/26	4/6	4/6/26
		Score	8am	8AM	2pm
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0	0	0	
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0	0	0	
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0			
IV / Heparin Lock or Saline	Yes	20	20	20	20
	No	0	0	0	
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0	0	0	
Mental Status	Forgets limitations	15			
	Oriented to own ability	0	0	0	
Total Morse Fall Scale Score:			20	20	20
		Signature			

Fall Risk Grading		
Risk Level	**Morse Fall Score (MFS)**	**Action**
Low Risk	0 - 24	Standard Fall Precaution
Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
High Risk	≥ 51	Implement High Risk Fall Prevention Intervention

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

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	5/6/26	6/6		Fall Risk Grading		
		Score						
History of Falling (immediately or w/in 3 months)	Yes	25				Risk Level	Morse Fall Score (MFS)	Action
	No	0						
Secondary Diagnosis (more than one diagnosis)	Yes	15						
	No	0				Low Risk	0 - 24	Standard Fall Precaution
Ambulatory Aid	Furniture	30						
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0	0				
IV / Heparin Lock or Saline	Yes	20	20	20		Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20						
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
Mental Status	Forgets limitations	15						
	Oriented to own ability	0						
Total Morse Fall Scale Score:			20	20				
		Signature						

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 4/6/26 Date of Removal: .....

Parameters	Date / Shift Time	4/6/26 E2	4/6/26 N8	5/6/26 M6				
Need for the Catheter		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hand Hygiene		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Usage of Sterile Equipment		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the Collection bag below the level of bladder		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Check the Tube for Obstruction (Free of Kinking)		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Catheter dated as policy		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Collecting bag is been emptied regularly?		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Maintenance of closed system for the catheter		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing clean and dry?		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the line removed as Policy?		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Performance of Perineal Care		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Onset of New Fever		☐ Yes ☑ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Asses for the leakage at the site of insertion		☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Nurse		Akash	Sandhya					
Signature of the Nurse								

5/6/26 6 AM Foley removed

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DRUG CHART

Date of Admission: 3/6/2026 Drug Allergies: Nil ☐ 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 / through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG :				Date ▸ / Time ▾
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

DRUG :				Date ▸ / Time ▾
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

DRUG :				Date ▸ / Time ▾
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

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

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REGULAR PRESCRIPTIONS

Weight. 71kg Ward. HDR

DRUG : INJ. CEFOTAXIME

Dose	Route	Frequency	Start Date
1g	IV	BD	4/6/26

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions: ATD. 0

Daily Doctor's Endorsement by a Sign

Date/Time: 4/6

T @ with Dr. Naveena

DRUG : Inj PANTOPRAZOLE

Dose	Route	Frequency	Start Date
40mg	IV	OD	4/6/26.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

STOP 4/6/26

DRUG : T. PANTAPRAZOLE

Dose	Route	Frequency	Start Date
40mg	P/O	OD	4/6/26

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time: 5/6, 6/6

6am

DRUG : INJ-CEFOTAXIME

Dose	Route	Frequency	Start Date
1Gm	IV	BD	5/6

Name & Signature of the Doctor Starting the Drugs: @ Dr. Naveena

Additional Instructions: x24h → f/b oral

Daily Doctor's Endorsement by a Sign

Date/Time: 5/6.

6am

6PM

Stop

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REGULAR PRESCRIPTIONS

Sheet No. ..... Weight 7.1kgs Ward .....

DRUG : INJ. CEFOTAXIME

Dose	Route	Frequency	Start Dt.
1g	IV	BD	4/6/26

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:
AFD

Daily Doctor's Endorsement by a Sign

Date / Time

Stop

DRUG : T. PARACETAMOL

Dose	Route	Frequency	Start Dt.
1GM	P/O	QID	4/6

Name & Signature of the Doctor Starting the Drugs:
Dr. M. Dhakshayani

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time 4/6 5/6

12am
6am
12PM
6pm

DRUG : T. TRAMADOL

Dose	Route	Frequency	Start Dt.
100MG	P/O	TID	4/6

Name & Signature of the Doctor Starting the Drugs:
Dr. M. Dhakshayani

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time 4/6 5/6 6/6 12.6

6am
2pm
10pm

DRUG : T. DICLOFENAC

Dose	Route	Frequency	Start Dt.
50MG	P/O	TID	4/6

Name & Signature of the Doctor Starting the Drugs:
Dr. M. Dhakshayani

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time 4/6 5/6 6/6 12.6

6am X
2pm X
10pm

Verified by Dr. Dhakshayani Signature

verified by Dr. Dhakshayani VERIFIED BY : Name

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REGULAR PRESCRIPTIONS

Sheet No: .... Weight .... Ward LDR

DRUG : T. CEFIXIME				Date/Time: 6/6
Dose	Route	Frequency	Start Dt.	
200mg	PO	BD	6/6/25	
Name & Signature of the Doctor Starting the Drugs: Dr. [signature]				
Additional Instructions:				10PM
Daily Doctor's Endorsement by a Sign				

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

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

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

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HNH-00014101
Mrs S NIKITHA
IP26-00006490

Weight: 71kgs Ward: LDR

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
4/6	3AM	TAB MISOPROSTOL	25mcg	PV		
4/6	7AM	T. MISOPROSTOL	25mcg	P/O		
4/6	8AM	Inj PANTOPRAZOLE	40mg	IV		
4/6.	8AM	Inj ONDANSETRON	4mg	IV		
4/6/26	10am	TAB. MISOPROSTOL	25mcg	P/O		
4/6/26	1:50pm	INJ. PANTAPRAZOLE	40mg	IV		
4/6/26	1:50pm	INJ. METOCLOPRAMIDE	10mg	IV		
4/6/26	2:36pm	INJ. OXYTOCIN	2 IU	IV		
4/6/26	2:50pm	TRANEXAMIC ACID	1gm	IV		

4/6/26 9AM. METOCLOPRAMIDE 10mg IV

08-08-1995 30 Y 9 M 28 D (F)
Dr. SWAPNA SAMUDRALA

I.V. FLUIDS CHART

Weight. 71kgs Ward. 2DR

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
4/6	3AM	RINGER LACTATE	IV	FF					
4/6	9AM	RINGER LACTATE	IV	100ml/hr			4/6		
4/6	2:40pm	RINGER LACTATE & 10U OXYTOCIN	IV	500			4/6		
4/6	3:20pm	RINGER LACTATE	IV	500			4/6		
4/6	8:30PM	RINGER LACTATE	IV	100ml/hr			4/6		
4/6		RINGER LACTATE	IV	100ml/hr			4/6		
5/6		RINGER LACTATE	IV	100ml/hr			5/6		
		STOP Dr. Nagarjuna							

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

HNH-00014101 IP26-00006490
Mrs S NIKITHA
06-08-1995 30 Y 9 M 30 D (F)
Dr. SWAPNA SAMUDRALA

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STAT / ONCE ONLY DRUGS

Name: ..... Weight: ..... kgs

Sheet No: .....

DATE	TIME	MEDICATION	DOSAGE & OTHER INSTRUCTIONS	ROUTE	SIGNATURE		
					Doctor	Nurse-1	Nurse-2
5/6/26	10pm.	Tab DULCOLAX.	2tab	PO			

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STAT / ONCE ONLY DRUGS

Weight: ..... kgs

Sheet No: .....

Name: .....

DATE	TIME	MEDICATION	DOSAGE & OTHER INSTRUCTIONS	ROUTE	SIGNATURE		
					Doctor	Nurse-1	Nurse-2
4/6	3:30pm	TRAMADOL suppository	100mg	PR		Puja	
4/6	1:30pm	DICLOFENAC suppository	100mg	PR		Puja	

Docu. No. : RCH /FRM / CLINICAL / 136

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Mrs S NIKITHA (F)
06-08-1995 30 Y 9 M 29 D
Dr. SWAPNA SAMUDRALA

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CAESAREAN SECTION OPERATIVE NOTES

Surgeon's Name: Dr. Swapna	Date of Delivery: 4/6/26.
Assistant Surgeon: Dr. Dua.	Time of Delivery: 2:36 pm
Anaesthetist's Name: Dr. Durga.	Gender of Baby: female.
Type of Anaesthesia: Spinal.	Weight of Baby: 3060 g.
Neonatologist:	AGPAR Score: 8, 9.
Scrub Nurse:	NICU Admission: ☐ Yes ☑ No

Pre-Operative Diagnosis: Primi ē 39+2 week. ē Non progress of labor.

☐ Elective ☑ Emergency Indication: Non progress of labor

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: .... Knief to rectus: ....

CTG Description: Reactive.

If there was a delay give the reasons: ....

Surgical Procedure:

Emergency LSCS.

Post Operative Diagnosis: POD-0 P1L1.

Peri-Operative Complications:

Amount of Blood Loss:	Blood Transfused (in ML):

Name and Number of Surgical Specimen sent for examination:

Docu. No. RCH / FRM / CLINICAL / 155 (P.T.O)

Examination Findings when Appropriate:

Presentation: ☑ Cephalic ☐ Breech ☐ Other ..... Cervical Dilatation: 1cm ..... cm

5th Palpable: 5/5 ..... Fetal Position: .....

Station: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2 Moulding: ☑ None ☐ + ☐ ++ ☐ +++

Caput: ☐ + ☐ ++ ☐ +++ Meconium: ☑ None ☐ + ☐ ++ ☐ +++

Bladder Catheterized : ☑ Yes ☐ No Urine: ☑ Clear ☐ Blood Stained

---

Skin Incision: ☑ Pfannensteil ☐ Transverse ☐ Midline ☐ Other .....

Uterine Incision: ☑ Lower Segment ☐ Classical ☐ Inverted T ☐ J Incision

Previous Scar: ☐ Intact ☐ Thinnedout ☐ Ruptured ☑ No Scar

Incision Through Placenta: ☐ Yes ☑ No

Delivery of head: ☐ Manual ☑ Forceps

Liquor: ☑ Clear ☐ Meconium: ☐ I ☐ II ☐ III ☐ Blood ☐ Offensive ☐ Not Offensive

Delivery of Placenta: ☐ Manual ☑ CCT ..... ☐ Complete ☐ Incomplete ☐ Piecemeal

Cord Appearance: Normal ..... Cord around the neck ☑ Yes ☐ No

Appearance of placenta: Normal ..... Cavity explored ☑ Yes ☐ No

Uterus, tubes and ovaries: ☑ Normal ☐ Not Normal Sterilization: ☐ Yes ☐ No

LUS - vascular.

Liquor - scanty

cord around neck.

Uterine Closure: ☐ One Layer ☑ Two Layers ..... Vicryl 1-0. ..... Suture

Peritoneal Closure: ☑ Pelvic ☐ Abdominal ☐ None ..... Vicryl 1-0. ..... Suture

Sheath Closure: ..... Vicryl 1-0. ..... Suture

Fat Closure: ☑ Yes ☐ No ..... Catgut ..... Suture

Skin Closure: ☑ Subcuticular ☐ Mattress ..... Monocryl. 1-0. ..... Suture

Vagineal Evacuated ☐ Yes ☐ No

Drain: ☐ Yes ☑ No ☐ Remove in ..... days ☐ Await instructions

Ctheter ☑ 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 6hrs
- IV Antibiotics.
- IV fluid.
- Analgesics & thromboprophylaxis as per Axon.
- Urine I/O charting.
- Monitor vitals, c/f bleeding P.V.

Inform Srs

Doctor Name: ..... Doctor Signature: .....

Date & Time: .....

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Swapna
Asst. Surgeon : Dr. DLA
Anaesthetist : Dr. Durga Bhavani
Scrub Nurse : Sr. Susheela

HNH-00014101 IP26-00006490
Mrs S NIKITHA
06-08-1995 30 Y 9 M 29 D (F)
Dr. SWAPNA SAMUDRALA

Age : 30 Y Gender : F
Surgery Name : FM: 2 SCS
Date : 04/06/26 In-time : Out-time :

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Before Induction of Anaesthesia ➤ ➤

SIGN IN Time: 2:10 PM

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

Site Marked ☐ Yes ☐ No ☑ NA

Anaesthesia Safety Check Completed ☑ Yes ☐ No

Pulse Oximeter on Patient & Functioning ☑ Yes ☐ No

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

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

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

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

Signature : Dr. [illegible]
Name : Dr. Durga Bhavani
4/6/26

Before Skin Incision ➤ ➤

TIME OUT Time: 2:15 pm

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

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

Anticipated Critical Events

Surgeon Reviews:
- What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? 1Hr's 500ml ☐ Yes ☑ No ☐ NA

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

Nursing Team Reviews:
- Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☑ Yes ☐ No ☐ NA
- **Is Essential Imaging Displayed?** ☐ Yes ☐ No ☑ NA
- Power Supply, Earthing, Power Backup and functioning of equipment checked. ☑ Yes ☐ No

Signature : [illegible]
Name : Sudipta

Before Patient Leaves Operating Room

SIGN OUT Time: 3:30 pm

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

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

Signature : [illegible]
Name :

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00014101 IP26-00006490 Mrs S NIKITHA 06-08-1995 30 Y 9 M 29 D (F) Dr. SWAPNA SAMUDRALA	03/6/26@10:52pm	04/06/26@3:40pm
	Transfer Ordered by Dr. Durga Bhavani	Reason for Transfer Observation
From Unit OT	To Unit Pre-Post	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 30	Number of Imaging Films 5	Personal belongings including clinical documents. If any handed over to attendant Yes ☑ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	RL	1
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☑ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sis. Puja	Dr. durgabhavani

Patient & Clinical Records Received by : Akbl @

Date & Time of Patient Received : 4/6/26

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

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00014101 IP26-00006490 Mrs S NIKITHA 06-08-1995 30 Y 9 M 28 D (F) Dr. SWAPNA SAMUDRALA	3/6/26 @ 10:52 pm	4/6/26 @ 2:00pm
	Transfer Ordered by	**Reason for Transfer**
	Dr Naveena	EM. LSCS
From Unit	**To Unit**	**Information to Attendant**
Pre - post	OT	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
85	(5)	Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.	R1500ml — (1)	
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
SS Alafat / Alei	Dr Naveena

Patient & Clinical Records Received by : Sr. Sandhya.

Date & Time of Patient Received : 4/6/26 @ 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

Docu. No. : RCH /FRM / CLINICAL / 102

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00014101 IP26-00006490 Mrs S NIKITHA 08-08-1995 30 Y 9 M 29 D (F) Dr. SWAPNA SAMUDRALA	03/06/26 @ 10:52 PM	04/06/2026 @ 9pm
	Transfer Ordered by Dr. Nareena.	Reason for Transfer observation
From Unit pre-post	To Unit 303	Information to Attendant Yes ☐ No ☐
Number of Sheets in Clinical File 32	Number of Imaging Films NST - 3	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	PE	500mg
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Anusha	Dr. Nareena

Patient & Clinical Records Received by : Sandhya 04/6/26 @ 9pm

Date & Time of Patient Received :

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

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06-08-1995 30 Y 9 M 28 D (F)
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OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 3/6/26 Time of Arrival: 11PM 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
- ☐ Bleeding PV: Slight / Heavy
- ☐ Decreased Fetal Movement
- ☐ No Fetal Movement
- ☐ Preterm rupture of Membranes / Leaking Water PV
- ☐ Preterm Labor/ Labor
- ☐ Spontaneous Rupture of Membrane / Leaking Water PV
- ☐ Other Reason: .....

3) **Vital Signs:** Temperature: 98.6F Pulse: 90 RR: 20 SpO_2: 99% BP: 121/62 Weight: .....

4) **Gestational Criteria:**

Gravida:	G	P	L	A

LMP: ..... EDD: ..... Gestational Age: .....

Uterine Contraction	☐ Yes	☐ No	☐ NA	Onset	Time	Frequency:
Membrane Rupture	☐ Yes	☐ No	☐ NA	Onset	Time	Fluid Color:
Vaginal bleeding	☐ Yes	☐ No	☐ NA	Onset	Time	Amount:
Pre Eclampsia Symptoms	☐ Yes	☐ No	☐ NA	If Yes specify: Headache / Visual Symptoms / Pain Abdomen / Vomiting		
Good fetal Movement	☐ Yes	☐ No	☐ NA	If No specify:		

5) **Pain Screening:** **Numerical Pain Scale (NPS)**

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

.....

6) **Past History:**

a) Surgeries: .....

b) Medical: Nil.

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Mrs S NIKITHA
06-08-1995 30 Y 9 M 29 D (F)
Dr. SWAPNA SAMUDRALA

7) **Allergy:** ☐ Yes ☑ No, If Yes : .....

8) **Current Medications:** ☐ Prenatal Vitamin ☐ None ☐ Others: .....

9) **Prenatal Medical History:**

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

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

OTAS	Level 1 (Resuscitative)	Level 2 (Emergent)	Level 3 (Urgent)	Level 4 (Less Urgent)	Level 5 (Non Urgent)
Level 1 (Resuscitative)	**Immediate**	**≤ 15 minutes**	**≤ 30 minutes**	**≤ 60 minutes**	**≤ 120 minutes (2 Hours)**
Re-Assessment	**Continuous Nursing Care**	**Every 15 Minutes**	**Every 15 Minutes**	**Every 30 Minutes**	**Every 60 Minutes**
Labour / Fluid	Imminent Birth	Suspected Pre-term Labour / PPROM < 37 Weeks	Signs of Active Labour > 37 weeks	Signs of Early Labour/ SROM > 37 weeks	Discomforts of Pregnancy
Bleeding	Active Vaginal bleeding with/ without abdominal pain	Bleeding associated with cramping (<spotting) <37 weeks	Bleeding associated with cramping (>spotting) >37 weeks	Spotting	
Hypertension	Seizure activity	Hypertension > 160/110 and / or headache, visual disturbance, RUQ pain	Mild hypertension >140/90 with/without associated signs and symptoms		
Fetal Assessment	Abnormal FHR tracing Non-Fetal Movement	Atypical FHR tracing, abnormal dopplers Diseased fetal movement			
Others	• Acute onsite severe abdominal pain • Altered level of consciousness • Cord prolapse • Severe respiratory distress • Suspected sepsis	• Major trauma • Shortness of breath • Unplanned and unattended birth	• Abdominal/back pain greater than expected in pregnancy • Flank pain / hematuria • Nausea /vomiting and /or diarrhea with suspected dehydration	• Ongoing assessment from out patient clinic (for hypertension, blood work) • Minor trauma (minor MVC/fall) • Nausea/Vomiting and /or diarrhea • Signs of infection (ie dysuria ,cough, fever, chills)	• Anything that does not seem to pose threat to mother or fetus • Cervical ripening • Out patient placenta previa protocols • Pre-booked visits (ie Rh and progesterone injections, NST • Assessment for version • Rashes

Time seen by Doctor: 11pm

Nurse Name : Anitha Nurse Signature: A

Date: 3/6 Time: 11pm

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LABOUR AND DELIVERY NURSING ASSESSMENT

Date of Admission: 3/6/26

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 attenders

Allergies: ☐ Yes ☑ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: .....

If yes , identify .....

Chief Complaints: ..... Doctor Notified on Admission: ☐ Yes ☐ No

..... Name of the Doctor: .....

..... Time Notified: .....

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Nil	Nil	Nil

Blood Group: ..... LMP: ..... EDD: ..... Gestational age during admission: .....

Contractions: ..... Vaginal Discharge: .....

Obstetric History: G ..... P ..... L ..... A ..... Previous LSCS .....

Height: ..... Weight: ..... BMI: .....

Temp: ..... HR: ..... RR: ..... BP: ..... SpO_2 .....

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

☐ Hypothyroidism	☐ Rh Incompatibility	☐ Fertility Treatment
☐ Hyperthyroidism	☐ Previous LSCS	☐ Preterm Labour
☐ Hypertension	☐ Gestational Hypertension	☐ Others: (Specify)
☐ Diabetes	☐ Bad Obstetric History	
☐ Anemia	☐ Obesity (BMI)	
	☐ Twins / Multiple Pregnancy	

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Mrs S NIKITHA
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Dr. SWAPNA SAMUDRALA

Family History: ☐ No Abnormalities 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 ..... family .....

Orientation has been given regarding the following aspects:

Call Bell in Reach : ☐ Yes ☐ No Waste Disposal Explained: ☐ Yes ☐ No

Infusion Pump : ☐ Yes ☐ No Hand hygiene Explained: ☐ Yes ☐ No ☐ Others

Above information given to ..... patient .....

Name of Person Orientation was given to: ..... patient .....

Orientation not given Reason: ..... patient .....

Nurse Signature: ..... Anushed .....

Nurse Name: ..... Anushed .....

Date & Time: ..... 03/6/2020 .....

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Mrs S NIKITHA
06-08-1995 30 Y 9 M 30 D (F)
Dr. SWAPNA SAMUDRALA

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NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 5/6/26 Time: 9:50 am

Origin: Indian Height: 154 Cms Weight: 71.6 kg 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

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: V. Venkatmaj

Name: Nikitha

Date & Time: 5/6/26; 9:50am

Dietician's

Signature: Sabiya

Name: Syeda Sabiya Zaheer

Date & Time: 5/6/26; 9:50 am

DIETARY NOTES

Date	Time	Notes	Sign

HNH-00014101
Mrs S NIKITHA
06-08-1995 30 Y 9 M 30 D (F)
Dr. SWAPNA SAMUDRALA
IP26-00006490

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CROSS CONSULTATION FORM

Doctor Name : Dr: Swapna Date : 5/6/26 Time : 12pm

Diagnosis : LSCS

Hospital : RCH HMNR

Referred for : ☐ Opinion ☐ Co-Management ☐ Transfer of care

Type of Referral :
☐ Emergency
☐ Urgent
☐ Non Urgent

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
- (R) Nipple was normal & (L) flat Nipple formed.
- Adv DBF every 2nd hrly on each side 15- 20 mints.
- Aim for deep latch as demostrated in cross cradle / cradle hold.
- make baby suck & stimulate while feeding.
- Nipple shield (SOS).
- colostrum seen.

Consultant :

Name : Sathwika. G Signature : Sig Date & Time : 5/6/26, 12pm

Doc. No. : RCH / FRM / CLINICAL / 049

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BREAST FEEDING HANDOVER AND ASSESSMENT FORM

1. Breastfeeding initiated?
   - ☐ a. Yes ☐ b. No

2. If No, Reason .....

3. Nipple condition:
   - ☐ a. Nipple well formed
   - ☐ b. Flat nipple
   - ☐ c. Inverted nipple
   - ☐ d. Short nipple

4. Milk flow:
   - ☐ a. Good
   - ☐ b. Drops of colostrums
   - ☐ c. Dry

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

Feeding Positions:
Cross Cradle

Feeding Positions:
Football / Clutch

6. Was the position explained:

- ☐ a. Yes
- ☑ b. No

7. For Caesarian mothers:

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

8. NICU admission:

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

9. Additional notes: ....

Continuity of Care:

Date: ....

-> Assess the pt condition
-> monitor the vitals & record
-> ~~Act~~ DAt 2nd hrly & bursting
-> maintain I/O chart & record

Handover given by: dKeshg

Handover taken by: [illegible]

Signature: [illegible]

Signature: [illegible]

Date & Time: 4/6/26

Date & Time: 9/6/26

HNH-00014101 IP26-00006490
Mrs S NIKITHA
08-08-1995 30 Y 9 M 29 D (F)
Dr. SWAPNA SAMUDRALA

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

BirthRight BY RAINBOW HOSPITALS Your Right to a Safe Delivery

Patient Name : Mrs S.Nikitha Age : 30yrs Gender : Male ☐ Female ☐

UHID NO: HNH00014101 Surgeon Name: Dr. Swapna Samudrala

Anaesthesiologist : Dr. Durga Bhavani

Operative procedure planned : Emergency Cesarean Delivery

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

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

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

☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure

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

☐ Incapacitating Cronic Obstructive Pulmonary Disease

☐ Others : Hemodynamic changes, Bleeding, PDPH, patchy block

Comments : Need for Blood transfusion

- 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 S.Nikitha the above mentioned operation / Diagnostic / Therapeutic procedures Emergency Cesarean Delivery

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 : Nikitha

Name : S. NIKITHA

Relationship with Patient: SELF

Date & Time : 4/6/26 1:56pm

Witness :

Signature : V. Venkatmanoj

Name : V. Venkat Manoj

Date & Time : 4/6/26 1:56pm

Doctor (who is taking the consent) :

Signature : Dr. [illegible]

Name : Dr. Dheeraj Bhavani

Date & Time : 4/6/26 1:56pm

HNH-00014101 IP26-00006490
Mrs S NIKITHA
08-08-1995 30 Y 9 M 29 D (F)
Dr. SWAPNA SAMUDRALA

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Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Mrs S. Nikitha Age: 30yr Sex: F UHID.No: HNH-00014101

Date: 4/6/26 Time: 1:55pm Proposed Operation: Em. LSCS

Diagnosis: Primi 39+1 weeks

B.P / CRT: ..... H.R: ..... Weight: 71kg ASA Physical Status: ☐ 1 ☑ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 11.4	Glucose:	Protein:	HIV: } -ve	X-Ray:
PCV:	Urea:	Alb:	HBS Ag: }	ECG:
WBC: 6.26	Creat:	Total Bill:	HCV: }	2D Echo:
Plate: 1.85 lakh	Na:	Dir. Bill:	Blood group: A +ve	Stress/Anglo:
PT:	K:	LDH:	T3	Other:
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH	
	Cl -:	SGOT/SGPT:		

Allergies: (-)

Medical History: CVS: (-) Placenta - Anterior high

RESP: (-) Diabetes: (-)

CNS: (-)

Renal: (-)

Hepatic / GE: (-) Physical Activity: METS>4.

Others: (-)

Past Anaesthetic History: (-)

Physical Exam:

Airway: MP 1 (2) 3 4 Mouth Opening: 3F (+) Mentohyoid Distance: N Neck: N Teeth: No loose teeth No dentures

Lungs: BAE (+), Clear

Heart: S1S2 (+)

CNS: Cl/c, Oriented

Pregnant: ☑ Yes ☐ No ☐ NA | Venous Access Site: (+) Spine Exam for regional Spine palpable

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

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

CURRENT MEDICATIONS	DOSAGE
Iron/Calcium	

Pre-Operative Instructions: NBM :: 5:45AM solids :: 12pm Clear liquids

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours; Others 6 Hours
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☐ Discussed with Patient
5. Other Instructions:

Signature: Dr. M Name: Dr. Durga Bhavani

HNH-00014101
Mrs S NIKITHA IP26-00006490
06-08-1995 30 Y 9 M 30 D (F)
Dr. SWAPNA SAMUDRALA

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No		Fasting Status: confirmed
Physical Status:	☑ Patient Identified	☑ Consent Present ☑ Chart Reviewed

H.R: 80 | B.P / CRT: 110/70 | SpO_2: 99% RA | R.R: 14/min | Last Feed: 6hr

Pre-OP Diagnosis: Primi | Operation: Emi.my | Date: 4/6/26

Surgeon: Dr. Swapna | Anaesthesiologist: Dr. Durga Bhavani | Technician: Pallavi

TIME 2:30pm 1:30pm

N_2O /AIR /O_2 LPM
HALO /SO /SEVO
Drugs: INJ. DAYTOLIN 8ml IV.

Antibiotic
Suppository: PR DICLOFENAC 100mg PARACETAMOL 150mg
Blood Loss
NOTES

FIO_2 / SaO_2: 99%/99%/99%/99%
$ETCO_2$
ECG: NR NR NR NR
Temperature
Urine Output
Fluids: RL RL RL
Blood

B.P
V Systolic
Λ Diastolic
X Mean
• Heart Rate
Tourniquet on Time
Tourniquet off Time
Throat Pack In
Throat Pack Out

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

LAB Values: ABG | GRBS | Others

☑ Equipment Checked and Functional
☑ BP
☑ Cuff Site: Rt
☐ Art Site:
☑ EKG Lead 3 lead
☐ Temp Site
☐ FIO_2 Monitor
☐ Agent Monitor
☑ Pulse Oximeter
☐ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position: supine
☑ Pressure Points Checked

Eye Care:
☐ Oint
☐ Tape
☐ Padding
☑ Awake

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

Times:
Anaes Start: 2:25pm
OP Start: 2:30pm
OP End:
Leave OR: 3:30pm

Anaesthesia:
☐ GA
☐ Monitored Anaesthesia Care
☑ Regional

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

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

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

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

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

Regional:
Extremity Specify: .....
☑ Spinal ☐ Epidural ☐ Caudal
Others: .....
Position: sitting
Site: L4-L5 interspace
Needle Size: 25G Depth: .....
Parasthesia ☐ Yes ☐ No
Catheter at skin ..... cm
Drug Name & Conc: 0.5%(+1)
Bolus: .....
Infusion: .....
Block Level: .....
Comments: .....

Transportation to
☑ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☑ NA
Name of the Doctor: Dr. Durga Bhavani
Signature of the Doctor: .....

HNH-00014101 IP26-00006490
Mrs S NIKITHA
06-08-1995 30 Y 9 M 30 D (F)
Dr. SWAPNA SAMUDRALA

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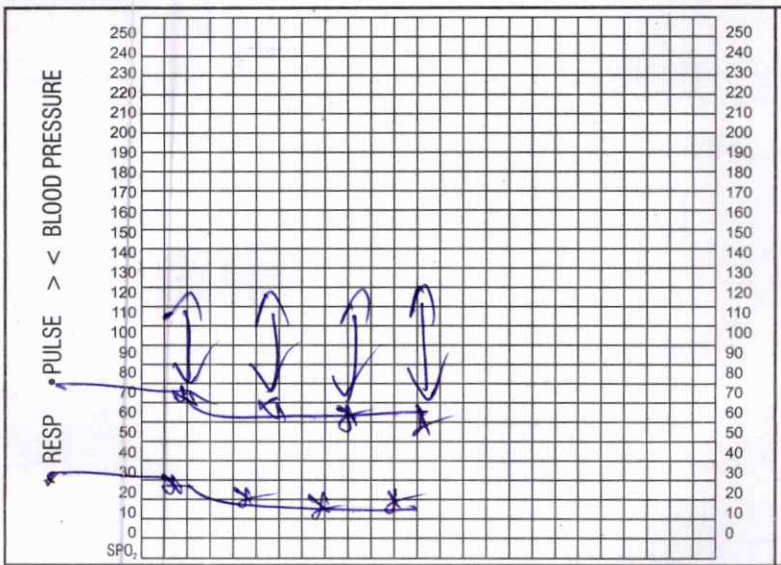
ANAESTHESIA CARE UNIT RECORD

Received in PACU by : G.S. Akhila Time Received : 2:50pm Time Discharged : 4pm



IV Cannula Site : left side

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

Vomiting : ☐ Yes ☑ No Drug: Inj Tarin
NG Tube : ☐ Yes ☑ No
Drain: ☐ Yes ☐ No
Urinary Catheter: ☑ Yes ☐ No
Chest Tube: ☐ Yes ☑ No
Nil Oral ☐ Yes ☐ No
IV Fluids: RL
Oral Feeds: NBM

POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	MINUTES 30	60	90	OUT	SCORING INTERPRETATION
Able to move 4 extremities voluntary or on command Able to move 2 extremities voluntary or on command Able to move 0 extremities voluntary or on command	= 2 = 1 = 0	ACTIVITY		1	2	2		A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be expiained in the space below by the Discharging Physician:
Able to deep breathe & cough freely Dyspnea or limited breathing Apneic	= 2 = 1 = 0	RESPIRATION		2	2	2		
BP ± 20 of Pre Anaesthetic leve BP ± 20-50 of Pre Anaesthetic leve BP ± 50 of Pre Anaesthetic leve	= 2 = 1 = 0	CIRCULATION		2	2	2		
Fully awake Arousable on calling Not responding	= 2 = 1 = 0	CONSCIOUSNESS		2	2	2		
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0	COLOR		2	2	2		
		TOTAL		9	10	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
4/6		0/10	NA	
4/6		0/10	NA	
4/6		0/10	NA	

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

Anaesthesiologist Name : Dr. SAIRAM
Anaesthesiologist Signature:
Date & Time: 04/06/2026.

PACU Nurse Name : Anshed
PACU Nurse Signature:
Date & Time: 4/6/26

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

Transferred to Unit by (PACU): 3rd floor 303
Date & Time: 4/6/26 9pm

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : .....

Any other issues :

a) .....

b) .....

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level		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 : .....

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : Mrs S Nikitha. Gender: ☐ Male ☑ Female Age : 30 yr.

UHID No : HNH-0001410 Date : 4/6/2026

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 CESAREAN SECTION.

upon

Mrs. Nikitha. (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, wound infection, injury to bladder, bowel, blood vessels, risk of Blood & blood transfusion.

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:

Consentee :

Signature : Nikitha

Name : S. NIKITHA

Date & Time : 4/6/2026 ; 1:55 pm

Witness :

Signature : Madhu

Name : Madhumitha

Date & Time : 4/6/26 @ 1:55 pm

Patient Attendant :

Signature : V. Venkatmanoj

Name : V. Venkat Manoj

Relationship with Patient: Husband

Date & Time : 4/6/26, 1:55 pm

Doctor (who is taking the consent) :

Signature :

Name : Dr. Dna.

Date & Time : 4/6/2026 2:

HNH-00014101 IP26-00006490
Mrs S NIKITHA
08-08-1995 30 Y 9 M 28 D (F)
Dr. SWAPNA SAMUDRALA

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INDUCTION OF LABOR CONSENT

Name: Mrs S Nikitha Age: 30y Gender: Male ☐ Female ☑

UHID.No : HNH-000141.01 Date: 3/6/2026

You are scheduled for an induction of labor on 3/6/2026 (date) at 37+11 wk (weeks of gestation).

The reason for your induction is Full term

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

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

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

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

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

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

Patient
Signature: Nikitha
Name: Mrs S Nikitha
Date & Time: 3/6/2026 @ 11pm

Patient Attendant:
Signature: V.Venkatramanaiah
Name: V.Venkatramanaiah
Relationship with Patient: Husband
Date & Time: 3/6/2026 @ 11pm

Doctor:
Signature:
Name: Dr Manisha
Date & Time: 3/6/2026 @ 11pm

Witness
Signature: Anusha
Name: Anusha
Date & Time: 3/6/2026 @ 11pm

INFORMED CONSENT FOR VAGINAL BIRTH

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Patient Name : Mrs S Nikitha UHID No : HNH-0001401

Gender: ☐ Male ☑ Female Date : 3/6/2026 Time : 11pm

I hereby authorized the performance of the following procedure:

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

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

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

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

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

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

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

Name of the Doctor performing the procedure: Dr Swapna Samudrala

Consentee :

Signature : Nikitha

Name : Mrs S Nikitha

Date & Time : 3/6/2026 @ 11pm

Patient Attendant :

Signature : V. Venkatmanoj

Name : V. Venkatmanoj

Relationship with Patient: Husband

Date & Time : 3/6/2026 @ 11pm

Witness :

Signature : Anushe D

Name : Anushe D

Date & Time : 3/6/2026 @ 11pm

Doctor (who is taking the consent) :

Signature :

Name : Dr Mamta

Date & Time : 3/6/2026 @ 11pm

26-0000204155

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NARCOTIC PRESCRIPTION FORM

(PATIENT COPY)

Patient Name: Mrs. S Nikitha		Age: 30 yrs	Gender: Female
UHID No: HNH-00014101	IP No: 26-00006490	Date: 4/6/26	Time: 2:05 PM
Diagnosis: E MLSCS			OT

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	100mcg	01
2.	Morphine Sulphate Inj. 15mg/Ml		
3.	Remifentanil Hydrochloride Inj. 2MG		
4.	Remifentanil Hydrochloride inj. 1MG		

Doctor Name: Dr. Aamir

Doctor Registration No: 67529

Signature: [signature]

NARCOTIC DISPENSING FORM

APPENDIX 4 – FORM NO. 3E

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

IP Registration No: 26-00006490 **Date:** 4/6/26

Aadhaar No. of the Patient (Optional): ....

		Remarks
1.	Name : Mrs S Nikitha	
2.	Complete postal address (with contact number, if any)	Ram nagar Hyderabad Telangana
3.	Brief description of the illness	E. MLSCS
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
4/6/26	Fentanyl	01	V. Venkatesh	

Dispensed by (Name & ID No.): Sania (018442) Signature: ....

Received by (Name & ID No.): U. Pallavi 017921 Signature: U. Pallavi

Time: 2:11

26-00002041S5

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NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name: Mrs. S Nikitha		Age: 30 Yrs	Gender: Female
UHID No: HNH-0001410I	IP No: 26-00006690	Date: 4/6/26	Time: 2.05PM
Diagnosis: C MISCS			OT

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	100mcg	01
2.	Morphine Sulphate Inj. 15mg/Ml		
3.	Remifentanil Hydrochloride Inj. 2MG		
4.	Remifentanil Hydrochloride inj. 1MG		

Doctor Name: Dr. SAMIR Doctor Registration No: 67729

Signature:

NARCOTIC DISPENSING FORM
APPENDIX 4 – FORM NO. 3E
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: 26-00006690 **Date:** 4/6/26

Aadhaar No. of the Patient (Optional): .....

1.	**Name :** Mrs. S Nikitha	**Remarks**
2.	Complete postal address (with contact number, if any)	Ram nagar Hyderabad Telangana
3.	Brief description of the illness	C MISCS
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
4/6/26	Fentanyl	01	V Vanitha	

Dispensed by (Name & ID No.): Sania (018442) Signature: .....

Received by (Name & ID No.): U Pallavi 017921 Signature: U Pallavi

Time: 2:11

NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name		Age	Gender
UHID No.	IP No.	Date	Time
Diagnosis			

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1	Pentazocine Inj. 30mg/ml		
2	Morphine Sulphate Inj. 15mg/ml		
3	Pentazocine Inj. 30mg/ml + Promethazine Hydrochloride Inj. 25mg/ml		
4	Buprenorphine Inj. 0.3mg/ml		

Doctor Name

Signature

Doctor Registration No.

NARCOTIC DISPENSING FORM
APPENDIX 3 – FORM NO. 3E
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

Date

IP Registration No.

Name of the Patient (Optional)

S.No	Name	Remarks
1	Complete postal address (with contact number, if any)	
2	Brief description of the illness	
3	Whether registered with any other registered medical practitioner / recognized medical institution (If yes, details of it is to be given)	
4	Details of essential Narcotic drug dispensed	

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb impression of the patient / Patient attender	Remarks, if any

Dispensed by (Name & ID No.)

Signature

Received by (Name & ID No.)

Signature

Time