

ARTI R RODY. — 9154949273.

Pooja Sanghi

9951162691
9618181998.

NO - idays

LSU - 3 day

Triple

80,000/-

90,000/-

- CBP, NST

CBP, NST

- Pharmacy/ 12,000/-

- Any other Investigation. extra.
Extra.

Ecotas BV
Capsules

- Any other cross Consultant
extra. Ann.

Baby Bill. - 15,000-

New natologist - 2 visit

Blood Grouping. -

Vaccination . Sca, Hep B, Polio

Sbl. Test - 1

[Signature]
Am.

Triples Shared
D-CAT

Dr. Romya



ESTIMATION SLIP

Date : 29/5/26 UHID / IP No. : HNH-00011469 SI No. **1547**
 Name of Patient : Mrs. Pooja Sanghi 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.)	
	Normal Delivery	LSCS
Room Category		
Multi Shared Ward		
Shared Ward <i>Triples Shared</i>	<u>80,000/-</u>	<u>90,000/-</u>
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 : <u>2 Days</u>	Length of Stay for : <u>3 Days</u>
	Pharmacy up to <u>12,000/-</u>	Pharmacy up to <u>12,000/-</u>
	Investigations up to <u>2500/-</u>	Investigations up to <u>3000/-</u>
Others	<u>well baby care 150</u>	

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

Initial Minimum Deposit : _____

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

DECLARATION

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

Signature of the Client _____ Signatory Relationship _____ Signature of the financial Counselor [Signature]

HNH-00011469

IP26-00006514

Mrs POOJA SANGHI

02-06-2000

26 Y 0 M 4 D

(F)

Dr. KADIYALA RAMYA THEJA



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.: H.N.H - 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 + Epidural

Time in : 8:30 AM

Time Out : 9:30 AM

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

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

Signature of the Surgeon: DR Ramya

Signature of Circulating Nurse: Alai

Order No: 26-000204673

Order by: Alai

F.C.
315

Name	Mrs POOJA SANGHI	UHID	HNH-00011469
Father/Guardian	Mr NAVEEN GANDU	Age/Gender	26 Y 0 M 4 D/ Female
Address	Himaytnagar, Himayatnagar, Hyderabad, Telangana, INDIA, 500029		
IP No	IP26-00006514	Admission Date	05-06-2026
Ref Doctor	Self.		
Discharge Date			

DISCHARGE SUMMARY

Consultant:

Dr. Kadiyala Ramya Theja
MBBS, DNB
TSMC/FMR/01458

Diagnosis: G2A1 WITH 39 WEEKS FOR INDUCTION OF LABOUR

SPONTANEOUS VAGINAL DELIVERY DONE ON 06.06.2026

History:

LMP: 05.09.2026
EDD: 12.06.2026

Obstetric formula: G2A1
Gestation at admission: 39 weeks

Obstetric History:

G1 - MTP at 6 weeks
G2 - Present pregnancy, Spontaneous conception.

Medical History : Nil

Surgical History: Nil

Allergies : Nil

Family History : Nil

Antenatal Details:

Mrs POOJA SANGHI was booked to Rainbow hospital at 6 weeks of gestation. She had regular antenatal checkups and investigations as advised. NT scan was normal with uterine artery showing PI 2.52 with unilateral notch. FTS was low risk. TIFFA was normal. Fetal growth monitoring was done by serial growth scan. Growth Scan done on 22.05.2026 showed SLIUP at 37 weeks with cephalic presentation with EFW: 2.5kg (14%) with AC 1% with AFI 16.2cm with

Name	Mrs POOJA SANGHI	UHID	HNH-00011469
IP No	IP26-00006514	Admission Date	05-06-2026

normal doppler. She was admitted at 39 weeks for IOL.

Investigations: Enclosed

Blood group: "A" positive

Management: Course in hospital and Delivery Details:

At admission on clinical examination the vitals were stable, uterus was relax, cervix was partially effaced and 2cm dilated, membranes present, vertex high up. Fetal well being was confirmed by an admission NST which was found to be reactive. Informed consent taken for Induction of labour. Consent for induction of labour and Vaginal Birth taken. Labour induction with 2 doses of PGE1. Patient opted for epidural analgesia at 4-5cm dilatation for pain relief. The same was sited by an anesthetist after informed consent. Artificial rupture of membranes done at 7-8 cms dilatation revealing clear liquor. As per hospital protocol. she was started on IV. Taxim in view of ruptured membranes. Partographic monitoring of labour was done. Further augmentation was done by oxytocin infusion. She progressed to full dilatation at 08:30am. Passive descent of fetal head was allowed post full dilatation. She was put into position for vaginal birth. Parts painted with betadine solution and draped to ensure full asepsis. She was encouraged to bear down. Baby was delivered by Spontaneous vaginal delivery, Cord clamped and cut and baby handed over to pediatrician. Cord blood collected for blood grouping and Rh typing. Placenta and membranes delivered completely with controlled cord traction. Prophylactic syntocinon given. Perineum inspected. ~2 cm left lateral vaginal tear noted, same sutured. Haemostasis secured. Instrument and swab count checked. 800 mcg of misoprostol given per rectally as prophylaxis against post partum hemorrhage. Vagina cleaned with betadine solution.

Delivery Details:

Date : 06.06.2026
Time of Delivery: 09:01am
Type of Labour : Induced
Type of Delivery: Spontaneous Vaginal Delivery

Baby Details:

Date : 06.06.2026
Time : 09:01am
Sex : Male
Weight : 2.92kg
Apgar : 8,9
Gestational Age: 39 weeks
NICU Admission: No

Name	Mrs POOJA SANGHI	UHID	HNH-00011469
IP No	IP26-00006514	Admission Date	05-06-2026

Post-Partum Notes: She was closely monitored for post partum haemorrhage. Breast feeding initiated. Vitals were stable; patient ambulated and was shifted to room. Patient was encouraged for spontaneous voiding. Dietary advice given. Her postpartum period following that was uneventful. Her general condition was satisfactory and she was found to be fit for discharge. Wound care and medications were explained to patient supplemented by written information. She was given the postpartum book for further reference.

Advice:

1. Tab. Taxim - O 200mg (Cefixime 200mg) twice daily till 12.06.2026 (9am-9pm) after food.
2. Tab. Calpol 500mg (Paracetamol 500mg) (2tabs) thrice daily till 10.06.2026 (8am-2pm-10pm) after food.
3. Tab. Pantodac (Pantoprazole - 40mg) 1 tablet twice daily till 12.06.2026 (7am-7pm) before food.
4. Tab. Voveran 50 mg (Diclofenac 50mg) thrice daily till 08.06.2026 (9am-3pm-11pm) after 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 after food.
7. Betadine ointment for local application.
8. Syp. Duphalac 15 ml (Lactulose 3.33gm/5ml) at bed time for one week.
9. Sitz bath x 1 week

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

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

Review with Dr. Kadiyala Ramya Theja after **2 weeks** on **22.06.2026** at Gynec OPD with prior appointment. (**Review consultation will be charged**)

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

Name	Mrs POOJA SANGHI	UHID	HNH-00011469
IP No	IP26-00006514	Admission Date	05-06-2026

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 or just dial one toll free number - 18002122.

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


Registrar/Resident/C.M.O

Consultant:

Dr. Kadiyala Ramya Theja
MBBS, DNB
TSMC/FMR/01458

**Rainbow Childrens Hospital-Himayatnagar**

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar ,Hyderabad ,Telangana, INDIA ,500029.
TEL NO :040-48873000
WEB : <https://rainbowhospitals.in>

ADMISSION SHEET**Registration Details :**

Admission No : IP26-00006514 Admit Date : 05-Jun-2026 Admit Time : 10:13 PM UHID : HNH-00011469

Patient Details :

Patient Name	: Mrs POOJA SANGHI	Age	: 26 Y 0 M 3 D
Guardian	: Mr NAVEEN GANDU	DOB	: 02-06-2000
Gender	: Female	Religion	:
Occupation	:	Martial Status	:
Address (H)	: Himaytnagar Himayatnagar Hyderabad Telangana INDIA 500029	Phone No	: 9951162691/ 9618181998
		E-mail	: naveenkumar9618@gmail.com

Admission Details :

Bed Type : TWIN SHARING Bed No : PPO-417 Ward Name : 4F -OT
Room No : PPO-417 Admission Type : First Visit

Contact Details :

Name	: Mr NAVEEN GANDU	Relationship	: Husband
Contact Address	: Himaytnagar Himayatnagar Hyderabad Telangana INDIA 500029	Phone No	: 9951162691


Signature


Doctor Details :

Doctor Name	: Dr. KADIYALA RAMYA THEJA	Specialisation	: OBSTETRICS AND GYNECOLOGY
Referral Doctor	: Self.	Phone No	:
Co-Consultant	:		

Payment Details :

Payment Mode	: DC/CC Card	Deposit Amount	: 20000.00
		Payor Name	: NIVA BUPA HEALTH INSURANCE COMPANY LIMITED

PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00011469 IP26-00006514 Mrs POOJA SANGHI 02-06-2000 26 Y 0 M 4 D (F) Dr. KADIYALA RAMYA THEJA 		Date & Time of Admission 5/6/26 @ 10:30 AM	Date & Time of Transfer Order 6/6/26 @ 11:15 AM
Transfer Ordered by DR Veena		Reason for Transfer OBS	
From Unit LOR	To Unit ROOM 315	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 35	Number of Imaging Films 3	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.	RBC		
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Sis Arathi		Name of Person Ordered Transfer DR Veena	
Patient & Clinical Records Received by : Divya 6/6/26 @ 11:30 AM			
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

HNH-00011489 IP26-00006514
 Mrs POOJA SANGHI
 02-06-2000 26 Y 0 M 3 D (F)
 Dr. KADIYALA RAMYA THEJA



NVD



ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP No : _____ Consultant: _____ Dept : _____

Date of Admission: _____ Time : _____ Date of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
6/6/22	11:18 AM	LDR	Room	[Signature]

Cross Consultation Visit

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



IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

No complaints
 Admitted for IOL

Obstetric Formula:

A2A1

Obstetric History:

1 - MTP @ 6 week

Present Pregnancy Record:

1 - PP, spont concept
 Booked @ 6 week
 NT scan (N)

RISK FACTORS: FTS - low sed.

TIFFA (N)

Nu

Height: cm

Weight: kg

Allergies: Nu

Breast: Normal Abnormal

General Examination:

Consciousness: Pallor: -

Icterus: Edema: -

Temp: AfcB PR: 84h

BP: 110/70 mmHg DTR:

VS: S1S2 (N) RS: BAE (+)

ver/Spleen: (N) Urine Output:

DIAGNOSIS

A2A1, @ 39 week = corrected Anemia
 for IOL.

LMP: 5/9/25 EDD:

Corrected EDD: 12/16/26 GA: 39wk.

Menstrual History: Regular: Yes No

Obstetric Examination

Fundal Height: ut > term

Ut. Activity: Relaxed Mild Mod Severe

Liquor: Adequate Oligo Poly

PP: Cephalic Breech Others _____

Head Fifths Palpable: 4/5 palpable

FHS: Normal Tachy Brady Absent

Per Speculum Examination Not done

Draining: Present Absent Bleeding

Colour of Liquor: Clear Meconium Blood Stained

Vaginal Examination

Cervix: Long Partially effaced Effaced

Os: Closed Dilated 2cm

Membranes: Present Absent

Liquor: Clear Meconium Blood Stained

Presenting Part: Vertex Breech Others

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

Pelvis: Adequate Doubtful



<p>Family History:</p> <p style="text-align: center;">Nil</p>	<p>Surgical History:</p> <p style="text-align: center;">Nil</p>
<p>Medical History:</p> <p style="text-align: center;">Nil</p>	<p>Medication History:</p> <p>1. Iron on</p> <p>1. Calcium on</p>
<p>Plan of Care:</p> <ul style="list-style-type: none"> - Admission CTG - Informed Consent - Send CBP - NST 3rd hourly - IOL = 7. Misoprostol 25mg PV - HR monitoring 2nd hourly - Rest in left lateral position 	<p>Investigations:</p> <p>Apositive:</p> <p>HIV } NR.</p> <p>HbsAg }</p> <p>VDRU }</p> <p>HCV }</p> <p>02/5/26</p> <p>SWT</p> <p>cephali</p> <p>PL - 4cm high 4cm away 20s</p> <p>AFI - 16.2cm.</p> <p>FDW: 2.5kg (147-)</p> <p>AC 14.</p> <p>Doppler (N)</p>

Doctor Name: Dr. Dna

Signature:

Date & Time: 5/6/26 11 pm.

Consultant Name: Dr. Ramya Theja

Signature:

Date & Time: 5/6/26 @ 11 pm

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/6/26	C/S/B Dr. Dwa	
11 pm	G2A1 39wk ↓ SOL.	
	AC Fair	<u>Adv</u>
	vitals - No emet	- RUP / Dfmc
	P/D ut & TG	- FHR Monitoring 2nd hrs
<u>NST-Reactive</u>	cephalic	- NST - 3rd hours
	FHS ⊕	- Vital Monitoring
	head up palpable.	
	Relaxed	
	P/v ca. 3/2 long post.	<u>1st dose</u>
	bs - 2F MF ⊕	T. Misoprostol 25mcg
	ppx pr	<u>kept PV.</u>
	-3 ↓ -2	
	C/S/B Dr. Dwa	
5/6/26	G2A1 39+1wk ↓ SOL	
2 AM	AC Fair - Afabuli	<u>Adv</u>
	vitals - No emet	- RUP / Dfmc
	P/D ut & TG	- FHR Monitoring 2nd hrs
<u>NST-Reactive</u>	cephalic	- NST 3rd hours
	FHS ⊕	- Vital Monitoring
	head 3/5 palpable.	
	1c / 5-10 sec / 10.	
		<u>2nd dose</u>
		T. Misoprostol 25mcg
		PO.



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/6/26 6AM	cls/B Dr. Dina G2A1 = 39 th wk \downarrow IOL	
	<p>P⁺ P⁺ Certain Afebrile Vitals (w) P/A w/ \pm CG cephalic fns (+) ec/20/10.</p>	<p><u>Adv</u> - RUP/DFMC - PRR Monitoring 2nd hrs - NST 3rd hourly - vital monitoring - Plenty of oral fluids - IV fluids</p>
	<p><u>Pr</u> ca 80% effluent as - uen. BOM fang PPRK. pl -</p>	
6/6/26 9am	cls/B Dr. Veena PND-0 G2A1 P, U, A	
Baby @ mms	<p>PT is stable, No clo o/e Gefair, Afebrile BP-120/77 w/ig PR- 92bpm SpO₂ - 100% on RA P/A - Ut well retracted L/e - BLUNE</p>	<p><u>Adv</u> - Regular diet - vital monitoring - No change - w/ excessive bleeding Ph - Remove Foley's catheter - Inform SOS</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/6/26 11am		c/s/B Dr. Veena
	PND-0 (P, L, A) Pt is stable, No clo	Adv
Baby @ms	ole GC fair, Afebrile BP - 103/73 mmHg PR - 85 bpm	Regular diet Encourage to void
Foley's removed @ 10:30am	SPO ₂ - 98% on RA PIA - Ut well retracted	Vital monitoring Debriding
	PIV - Episiotomy intact No active bleeding. BWNL.	off excessive bleeding PIV Drops as charted Perform SOS Shift to Room.
		Noted by Divya 6/6/26 @ 11am
6/6/26 7:30pm		c/s/B Dr. Manisha PND-0
BMS	GC - Fair Afebrile Vitals Stable PIA well retracted	Adv Regular Diet Adeq Hydrate
u	U/E NAD	Drops as charted Wt vials 7:30pm Infor SOS
		Noted by Divya 6/6/26 @ 7:30pm

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



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/6/2021	C/S in a	Mamulu
7:30 AM	PNDT	
		↓
	Ce Fan Apresnel	- Regula Diet
	Vitals Stable	- Oral Hydrated
	PIA ut well retracted	- Ambulation
	PV Bleedy w/NC	- Drags as chest
W	Episiotomy intact	- Intern s/s
SV	Vulva perineum mild	
	Oedematous → (Ice pack to apply)	M/B ppyanka
		M/ Amreulu

HNH-00011489

IP26-00006514

Mrs POOJA SANGHI

02-06-2000

28 Y 0 M 3 D

(F)

Dr. KADIYALA RAMYA THEJA

315

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

RESULT SHEET

Date	5/6/26				
Time					
Hb	11.5				
PCV	32.4				
RBC	4.38				
WBC	7.62				
N/L					
Platelets	1.79				
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	+ Positive					
	+Hw +HBSag VDRL } ⇒ GNR					

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.) :

8/6/26

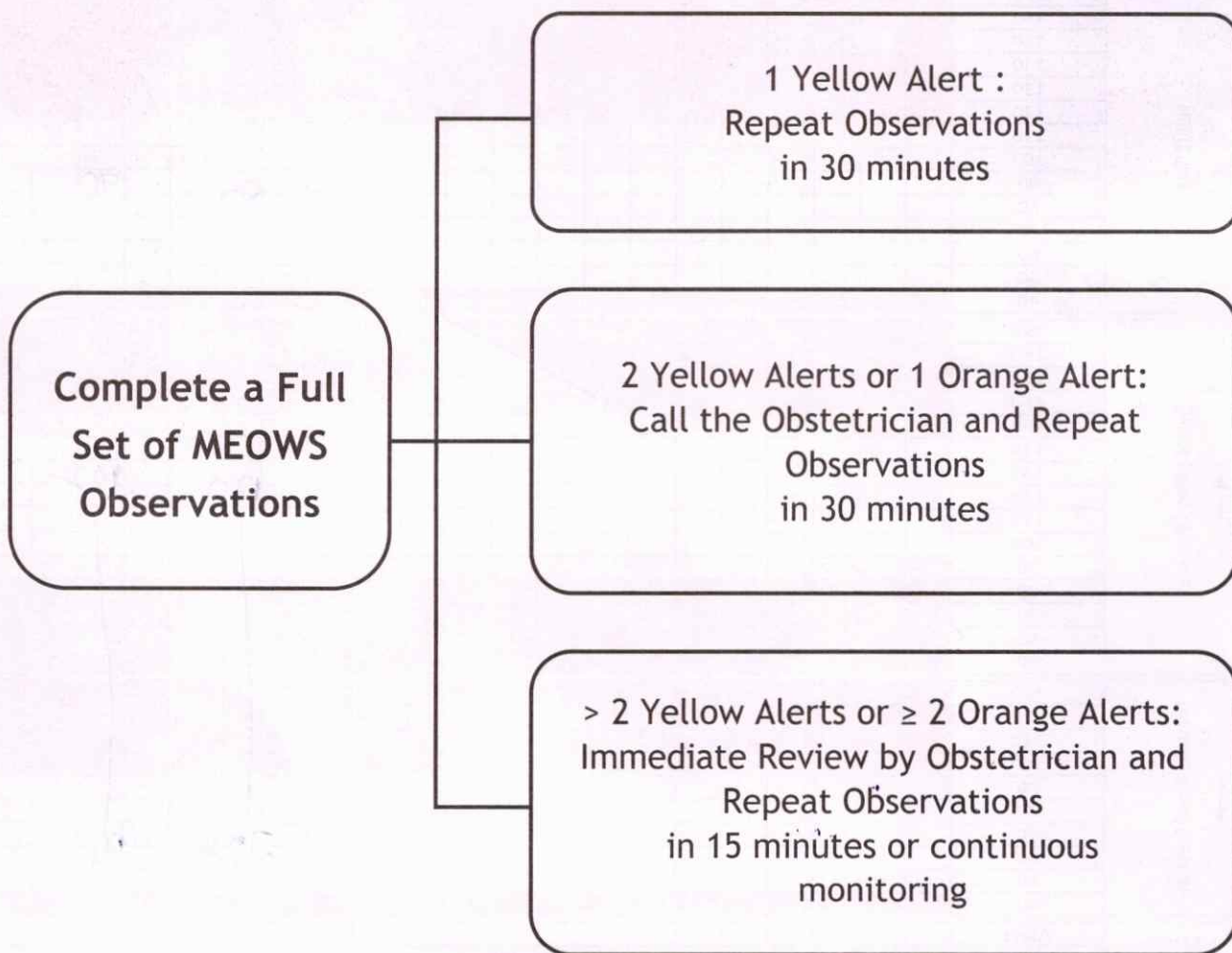
RHR ~~at~~ ~~fast~~

12 AM \Rightarrow 142 bmt

3 AM \Rightarrow 132 bmt

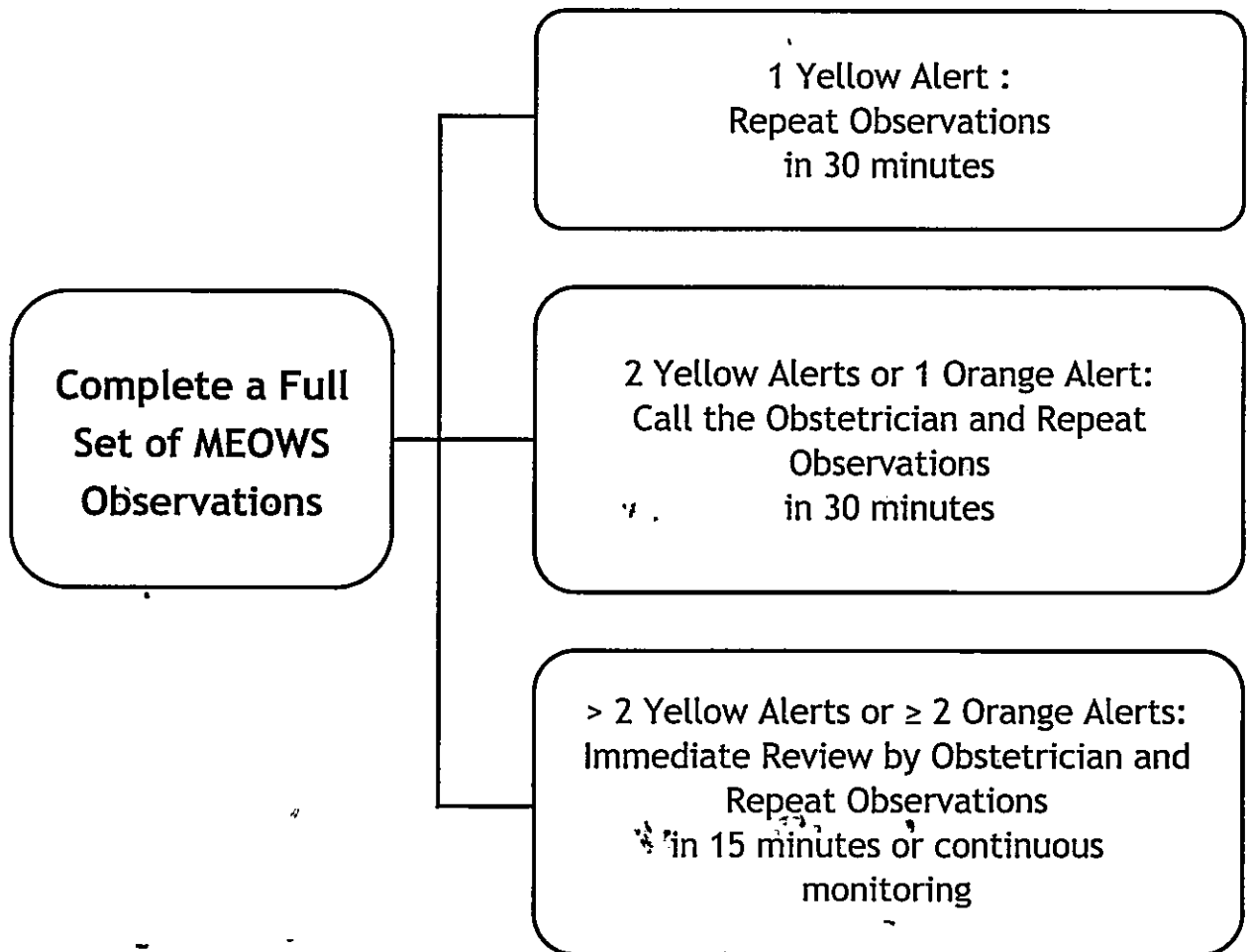
6 AM \Rightarrow 145 bmt.

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)



FLUID CHART

Sheet No. : 01

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

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

Patient Sticker

FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
6/6/20	08:00 am	RL	H ₂ O	150ml									
	09:00 am	RL	H ₂ O	150ml									
	10:00 am		Jelly						400ml				
	11:00 am		H ₂ O										
	12:00 pm		H ₂ O										
	01:00 pm												
Total Intake : Pakan						Total Output :							
6/6/20	02:00 pm												
	03:00 pm		Rice										
	04:00 pm		Jello										
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm		Rice										
	09:00 pm		H ₂ O										
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am		H ₂ O										
	04:00 am												
	05:00 am		H ₂ O										
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

HNH-00011489 IP26-00008514

Mrs POOJA SANGHI
02-06-2000 26 Y O M 3 D (F)
Dr. KADIYALA RAMYA THEJA



FLUID CHART

Sheet No. :

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

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

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

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

Patient Sticker



FLUID CHART

Sheet No. :

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

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

Total 24 hrs. Intake

Total 24 hrs. Output

HNH-00011489 IP26-00006514
 Mrs POOJA SANGHI
 02-08-2000 26 Y 0 M 3 D (F)
 Dr. KADIYALA RAMYA THEJA



NURSING CARE RECORD



Date:

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning				N/A			
Afternoon							
Night	8pm	<ul style="list-style-type: none"> = plan for vitals = plan for medication = plan for Admission = plan for NST 	8pm	<ul style="list-style-type: none"> = vitals Normal = medication given = Admission done = NST done 	Normal	Stable	Subes

Patient Sticker

NURSING CARE RECORD



Date: 6/6/28

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am ↓ 2pm	<ul style="list-style-type: none"> - Assess the patient's condition - plan for vital record - plan for Trochanter 	8am ↓ 2pm	<ul style="list-style-type: none"> - Assessed the patient condition - Maintain vitals - Maintain Trochanter 	- patient stable	- vitals were	<div style="text-align: right;"> </div>
Afternoon	Day						
Night	8pm to 8pm	<ul style="list-style-type: none"> → Assess the baby General Condition → Monitoring vitals checked and recorded 	8pm to 8pm	<ul style="list-style-type: none"> → Assess the baby condition. → Administration medication as per drug chart 	→ patient stable.	Vitals checked and recorded.	<div style="text-align: right;"> </div>

HNH-00011469 IP26-00006514
 Mrs POOJA SANGHI
 02-06-2009 28 Y 0 M 3 D (F)
 Dr. KADIYALA RAMYA THEJA



NURSING CARE RECORD

Date:

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

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

Patient Sticker

NURSING CARE RECORD



Date:

Goals

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

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

HNH-00011489
 Mrs POOJA SANGH 28 Y 0 M 3 D
 02-08-2000
 Dr. KADIYALA RAMYA THEJA
 IP28-0000 (F)



PAIN ASSESSMENT FORM

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

Re-assessment Frequency:

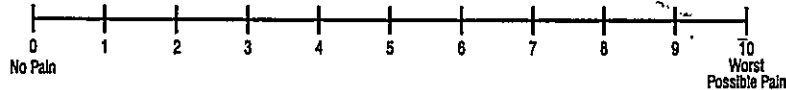
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 - a) At least every 2 hours for the first 24 hours
 - b) Then every 4 hours.
 - c) Prior to pain pain-relieving intervention.
 - d) Within 30 – 60 minutes after pain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

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years





PAIN ASSESSMENT FORM

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

Re-assessment Frequency:

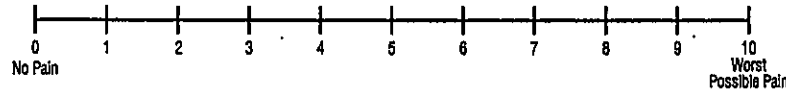
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PAIN ASSESSMENT TOOLS

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Wong - Baker (Pediatrics) Above 7 Years



HNH-00011469

IP26-00006514

Mrs POOJA SANGHI

02-08-2000

26 Y 0 M 3 D

(F)

Dr. KADIYALA RAMYA THEJA



BRADEN 'Q' SCALE



Date : 5/6/2016
Time : 11pm

Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.			
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	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	
FRICITION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	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	RD	AGP	

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

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	<ul style="list-style-type: none"> • Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	<ul style="list-style-type: none"> • Use the Same Protocol as for "At Risk" Patients • Position patient at 30 degree lateral incline using foam wedges 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> • Follow the same protocol as for "Moderate Risk" Patients • In addition to regular turning schedule • Make small shifts in their position frequently 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	<ul style="list-style-type: none"> • Use same protocol as for "High Risk" Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors. 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

HNH-00011489

Mrs POOJA BANGH

02-06-2000

Dr. KADIYALA RAMYA THEJA

IP26-00006514

(F)



BRADEN 'Q' SCALE



					Date :				
					Time :				
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.					
'Activity The degree of physical activity'	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.					
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.					
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.					
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."					
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings 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.					
Tissue Perfuson & 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.					
					TOTAL SCORE				
					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	<ul style="list-style-type: none"> • Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	<ul style="list-style-type: none"> • Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> • Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	<ul style="list-style-type: none"> • Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors. 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

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 Mrs POOJA SANGHI
 02-06-2000 26 Y 0 M 3 D (F)
 Dr. KADIYALA RAMYA THEJA



Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	Fall Risk Grading		
		Score	Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25	5/6/20 5:30 PM	N	Sum
	No	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	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	
	No	0			
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0			
Mental Status	Forgets limitations	15			
	Oriented to own ability	0			
Total Morse Fall Scale Score:					
		Signature			

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

HNH-00011469 IP26-00008514
 Mrs POOJA SANGHI 26 Y O M 3 D (F)
 02-06-2000
 Dr. KADIYALA RAMYA THEJA



Morse-Fall Risk Assessment Form

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

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2 6/6/26			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	NA	NA					
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			-	NA	NA					
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			-	NA	NA					
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			-	NA	NA					
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			-	NA	NA					
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			-	NA	NA					
Signature of the Nurse						<i>[Signature]</i>			<i>[Signature]</i>				

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 : *Anusha* Name : *Anusha*

Signature of Ward In Charge :

Signature : *Kasturi* Name : *Kasturi*

Patient Sticker



CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :
Signature : Name :

Signature of Ward In Charge :
Signature : Name :

HNH-00011489 IP26-00008514
 Mrs POOJA SANGH 26 Y 0 M 3 D (F)
 02-08-2000
 Dr. KADIYALA RAMYA THEJA



CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :

Patient Sticker



CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :

HNH-00011469

IP26-00006514

Mrs POOJA SANGHI

02-08-2000

28 Y 0 M 3 D

(F)

Dr. KADIYALA RAMYA THEJA



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	DOL				Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known	
	Surgery / Procedure:	DOL				If Yes Specify:	
BACKGROUND	Date	5/6/26	6/6/26	6/6	6/6/26		
	Shift	N	day	MS	N		
	Medical Condition (Any special condition to be noted):	NA	-	-	-		
	Diet:	soft	soft	-	-		
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	NA	-	-	-		
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	98.6	98.4	97.8	98.6	
		Res:	20	20	20	20	
		SpO ₂ :	99%	98	98	98%	
		Pulse:	90	94	97	105	
		BP:	110/70	103/73	105/70	101/65	
		LOC:	good	UDR	-	-	
		Fall Risk Score:	-	-	-	-	
Pain Score:	0	-	-	-			
Skin Integrity	good	good	good	-			
Recommendations	Safety Needs:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Physiotherapy:	-	-	-	-		
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Diet:	soft	soft	-	-		
	Critical Lab Test / Values:	-	-	-	-		
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
ADL (Dependent / Non Dependent):		NA	-	repeat			
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							

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 Dr. KADIYALA RAMYA THEJA



REGULAR PRESCRIPTIONS

Sheet No:

Weight Ward Loe

DRUG : S/P-DUPHALAC				Date Time	6/6
Dose	Route	Frequency	Start Dt.		
15ml	P/O	QOD	6/6/26		
Name & Signature of the Doctor Starting the Drugs:					
<i>[Signature]</i>					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

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

DRUG : OINT-POVIDONE IODINE				Date Time	6/6/26
Dose	Route	Frequency	Start Dt.		
1g	LA	BD	6/6/26		
Name & Signature of the Doctor Starting the Drugs:					
<i>[Signature]</i>					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

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

VERIFIED BY: Nantia Signature

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward 101

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

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

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

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

VIEWED BY: Name: Signature

Patient Sticker

Weight. Ward. *DR*

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
5/6/26	11pm	TAB MISOPROSTOL	25mcg	PV	<i>[Signature]</i>	<i>Aube</i> <i>Maeni</i>
6/6/26	3AM	TAB MISOPROSTOL	25mcg	P/O	<i>[Signature]</i>	<i>Aube</i> <i>Maeni</i>
6/6/26	8:30am	INJ COFOLAM	1gm	IV	<i>[Signature]</i>	<i>Abe</i> <i>[Signature]</i>
6/6/26	9:05am	INJ OXYTOCIN	100	IM	<i>[Signature]</i>	<i>Abe</i> <i>[Signature]</i>
6/6/26	9:07am	INJ METHYL ERGOMETRINE	0.2mg	Slow IV	<i>[Signature]</i>	<i>Abe</i> <i>[Signature]</i>
6/6/26	9:10am	INJ TRANEXAMIC ACID	1g	IV	<i>[Signature]</i>	<i>Abe</i> <i>[Signature]</i>
6/6/26	9:10am	INJ ONDANSETRON	4mg	IV	<i>[Signature]</i>	<i>Abe</i> <i>[Signature]</i>
6/6/26	9:20am	INJ DICLOFENAC SUPPOSITORY	1tab	P/R	<i>[Signature]</i>	<i>Abe</i> <i>[Signature]</i>
6/6/26	9:20am	TAB MISOPROSTOL	800mcg	P/R	<i>[Signature]</i>	<i>Abe</i> <i>[Signature]</i>

VERIFIED BY: Name Signature



I.V. FLUIDS CHART

Weight Ward. LD

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
6/6/20	6:30 AM	RINGER LAUREN	IV	1000 ml/hr	Ramesh	[Signature]	6/6	Ramesh	[Signature]
6/6/20	7 AM	RINGER LAUREN	IV	1000 ml/hr	Ramesh	[Signature]	6/6	Ramesh	[Signature]
6/6/20	8 AM	RINGER LAUREN + 100 OXYTOCIN	IV	100 ml/hr	Ramesh	[Signature]	6/6	[Signature]	[Signature]
			STOP						

Signature
 VERIFIED BY : Name

pooja sanghi

Patient Sticker

315

NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 6/6/26 Time: 12 pm

Origin: Indian Height: 157cm Weight: 53kg BMI: ~ 26 kg/m²
 ~ 28 kg/m²
 ~ 30 kg/m²
21 kg/m²

Food Allergies: NO

Diagnosis: NVD

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: G. Jareer

Name: pooja

Date & Time: 6/6/26; 12 pm

Dietician's

Signature: Sobiya

Name: Syeda Sobiya Zaher

Date & Time: 6/6/26; 12 pm

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 Mrs POOJA SANGHI
 02-08-2000 26 Y 0 M 3 D (F)
 Dr. KADIYALA RAMYA THEJA



IV MEDICATION RECONCILIATION FORM

Drug Allergies: Nil Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: Shifted to:

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Tab IRON	1Tab	PO	OD.		<input type="checkbox"/> C <input type="checkbox"/> DC
2	Tab CALCIUM	1Tab	PO	OD.		<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : *K. D. S.* *T.D.*

Date & Time : 5/6/2026 11 pm

Nurse Name & Signature: *Mounika* *M*

Date & Time : 5/6/26

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

PARTOGRAPH

Pooja Sanghi
HNH-00011489 IP26-00006514
Mrs POOJA SANGHI 28 Y O M 4 D (F)
02-08-2000
Dr. KADIYALA RAMYA THEJA

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

LABOUR

Labour: Spont IOL-PGE 1 E2 Others
Indications for IOL-Accel: None Oxytocin
Memb. Repture Type: SROM PROM ARM
Presentation: Vertex Breech Others

INTRA PARTUM COMPLICATION

Maternal: None Pyrexia HTN Others
Liquor: Adequate Oligo Poly Clear
 Blood Meconium Cord:
Shoulder Dystocia: Yes No

DELIVERY DETAILS

Anesthesia: None Epidural
Non-epi: Local Spinal General
Del. Type: SVD Asst. Breech Twins
AVD: Outlet Low Forceps Ventouse
 Trails of Forceps
Indications:
Application, Locking & Traction: *N/A*
Duration of Instrumentation:
No. of Pulls:
Catherised: Yes No
Type: Fileys Plain
Perineum: Intact Episiotomy Tear
Suture Material Used: *Rapidvicryl*

STAGE III

Placenta: Normal Abnormal RP Clots
 CCT Retained MRP
PPH: Atomic Traumatic None
Lacerations: *(E) lateral vaginal tear ~ 2cm note (Sutured?)*
Cervical: *Above*
Perineal: *Episiotomy*
Others:
Prophylaxis: *Synocinon* Prostodin
Blood Loss: *200ml*
Blood Transfusion: *None*
Other Details (if any):
Ractal Examination: *Intact & normal*

DURATION OF LABOUR

1st Stage: *5 1/2 hrs.*
2nd Stage: *30mins.*
3rd Stage: *10mins.*
Duration of Active Pushing: *20mins.*
No. of VE'S: *3*

BABY DETAILS

Gender: *MALE*
Weight: *2.920grams*
APGAR: *8, 9*
Date and Time of Delivery: *9:01AM on 6/5/26*
LW Doctor: *Dr. Ramya / Dr. Vena*
LW Sister: *D. S/AJ Kashri*

Time

8 AM @ 9 AM

Signature

[Handwritten Signature]

Fifths Palpable

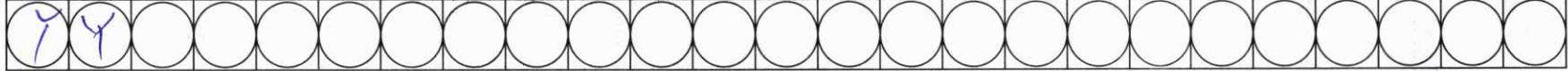
Moulding / Caput

⊖ ⊖

Amniotic Fluid

clear

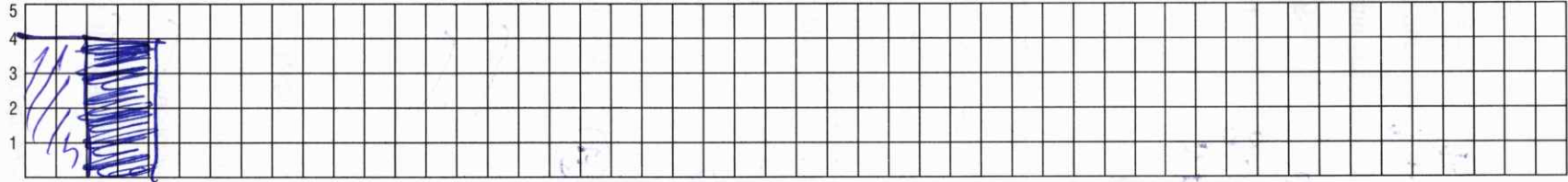
Position
Cephalic / Breeth



Oxytocin

No
⊖ ⊖ ⊖

Contractions
in 10 mins



Drugs and
IV Fluids

AC Oxytocin 100 units

Urinalysis

Test ⊖ ⊖
Amount ⊖ ⊖

PARTOGRAPH

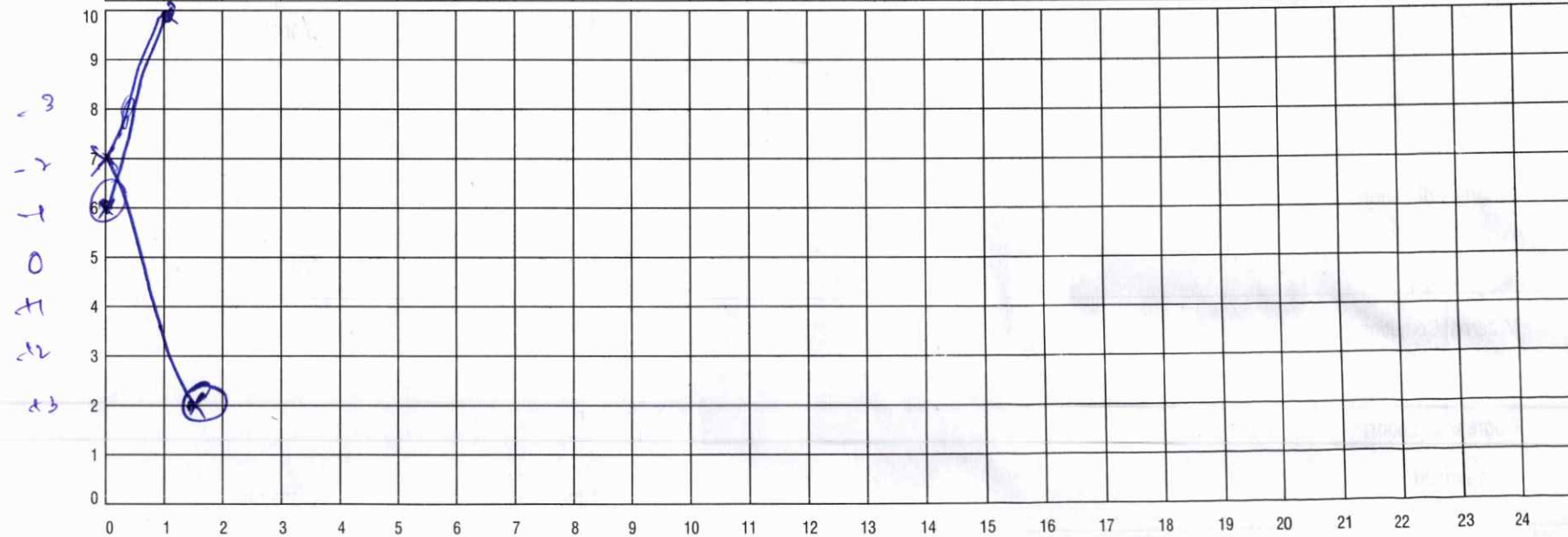
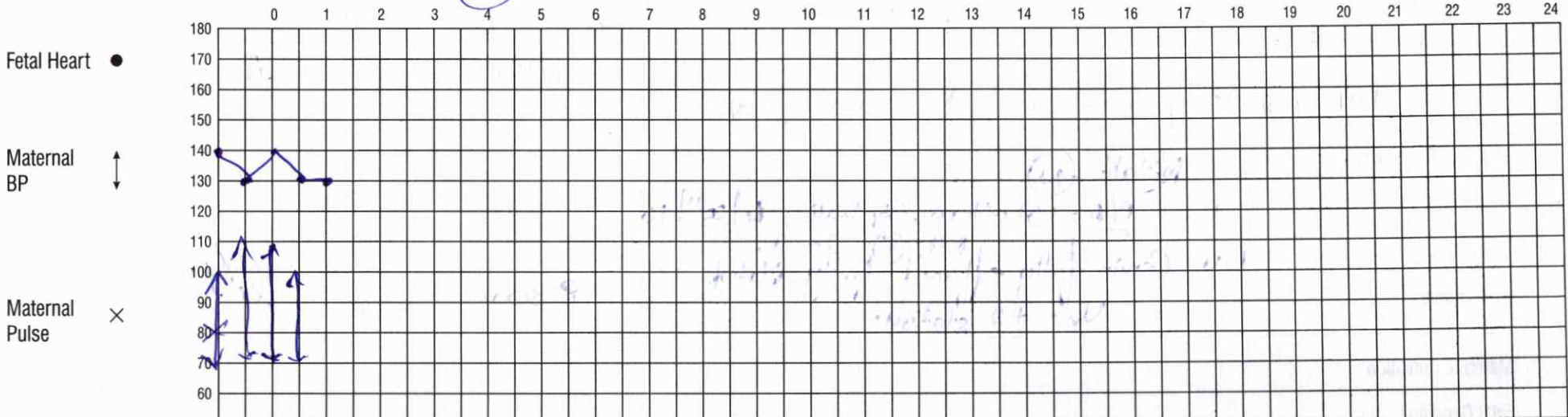
Name: Roopa Singh

Obstetrics Formula: GVA

Blood Group Type: A Rh +ve

Memb. Ruptured: SROM PROM ARM

Risk Factors: corrected anemia



Record of Labor:

Maternal Condition:

Good

Fetal Condition:

PA: term, active, cyclic

Progress of Labor:

Good

Management:

HR monitoring, hydration, w/f for, IV use.

PV: Cx effaced, 7-8cm

Vx -> 0, AM done clear leak (+)

8 AM

Time:

Signature:

[Signature]

Maternal Condition:

Vitals (+)

Fetal Condition:

P/A - uterine, cephalic, 4/35" / 10'

Progress of Labor:

P/V - Cervix fully effaced, fully dilated. FHS (+) - Good. Vx = +2 station.

Management:

Time: 8:30am

Signature:

[Signature]

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

Time:

Signature:

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

Time:

Signature:

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

Time:

Signature:



LABOUR AND DELIVERY NURSING ASSESSMENT

Date of Admission: 5/6/26

Baseline Information:

Admission From: ER OPD Admission Desk Others: specify

Primary Language: Telugu English Hindi Others

Do you require an interpreter? Yes No

Source of Information: Patient Family Others

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

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

Chief Complaints: Pol. Doctor Notified on Admission: Yes No
 Name of the Doctor: Dr. DUA
 Time Notified: 11:00 p.m

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

Past Medical History	Past Surgical History	Previous Hospital Admission
-	-	-

Blood Group: A, +ve LMP: 5/9/25 EDD: 2/6/26 Gestational age during admission: 39 weeks

Contractions: NA Vaginal Discharge: NA

Obstetric History: G 2 P 1 L 5 A 1 Previous LSCS NA

Height: Weight: BMI:

Temp: 97.8 HR: 84 RR: 20 BP: 110/70 SpO₂: 99

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

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

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: *Anusha*
Nurse Name: *Anusha*
Date & Time: *5/6/26*



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: 8/6/26

Assess the Patient conditions
 Explained position
 Milk flows good.
 2nd hourly feeding given

Handover given by: [Signature]

Handover taken by:

Signature: [Signature]

Signature:

Date & Time: 8/6/26 [Signature]

Date & Time:

CONSENT FOR SPECIAL PROCEDURES

Patient Name : Ms. Pooja Gender: Male Female

UHID No : HNH-11469 Department : labour Date : 6/6

I Ms. Pooja Sanghi S/D/TW/O Mr. Naveen Gandhi

Here by give consent for procedure of : Epidural labour Analgesia

For my patient, Named : - self -

The doctors have clearly explained to me that the procedure has following possible complications:

headache | hypotension | bradycardia | patchy epidural |
Need for re-site | epidural fracture

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :

entonox / iv analgesia

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure: Dr. Samir Nayak

Patient Attendant :

Signature : Pooja

Name : Ms. Pooja Sanghi

Relationship with Patient: - self

Date & Time : 6/6 at 6:00 am

Witness :

Signature : Naveen

Name : Mr. Naveen Gandhi

Date & Time : 6/6 at 6:00 am

Doctor (who is taking the consent) :

Signature : Samir

Name : Dr. Samir Nayak

Date & Time : 6/6 at 6:00 am

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



Name: Mrs. Pooja Sanghi Age: Sex: Female UHID.No: HNH-11469
 Date: 6/20/20 Time: 6/6 Proposed Operation: Guided Labour Analgesia
 Diagnosis: GA, 2 T4 in Labour
 B.P / CRT: 113/64 H.R: 80 Weight: 50 ASA Physical Status: 1 2 3 4 5

Laboratory Data:

Hgb: <u>11.5</u>	Glucose:	Protein:	HIV:	X-Ray:
PCV: <u>32.4</u>	Urea:	Alb:	HBS Ag:	ECG:
WBC: <u>7.6</u>	Creat:	Total Bil:	HCV:	2D Echo:
Plate: <u>1.79</u>	Na:	Dir. Bil:	Blood group:	Stress/Anglo:
PT:	K:	LDH:	T3	Other:
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH	
	Cl-:	SGOT/SGPT:		

Allergies: None

Medical History: CVS: /
 RESP: No significant medical history Diabetes: -
 CNS: Regula Anes - uneventful
 Renal:
 Hepatic / GE: / Physical Activity: good
 Others:

Past Anaesthetic History: nil

Physical Exam: coherent

Airway: MP 1 2 3 4 Mouth Opening: adq Mentohyoid Distance: 3cm Neck: 2 Teeth: intact

Lungs: / clear clinically

Heart:

CNS:

Pregnant: Yes No NA Venous Access Site: peripheral Spine Exam for regional: midline

Anaesthetic Plan: MAC REGIONAL GA-ETT LMA

Peri-Operative Plan Explained to the Patient: Yes No

CURRENT MEDICATIONS	DOSAGE
<u>Pelca/03</u>	

- Pre-Operative Instructions:**
- DVT Prophylaxis :
 - NIL ORAL $\left\{ \begin{array}{l} \rightarrow \text{Water / ORS 2 Hours} \\ \rightarrow \text{Others 6 Hours} \end{array} \right.$
 - Informed Consent: Standard High Risk.
 - Post Operative Pain Management: Discussed with Patient
 - Other Instructions:

Signature: [Signature] Name: Dr. Sami Charyak

Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: 6/6 Time: 6:20 AM Procedure done by Dr Sami Inayat

CSE / Spinal / Epidural DPE Position: Sitting Space: L3-4 Technique (LOR/LOS) (LOR)

Depth: 4cm Catheter at Skin: 9cm Attempts: 01

Parasthesia : Yes/No if yes details : -

Solution Composition : 0.1% Bupivacaine + 2mcg/ml Fentanyl

Any other issues :

a) -

b) -

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level		Maternal		FHR	Comments
			Left	Right	BP	Pulse		
<u>6:45 AM</u>		<u>6 ml</u>			<u>101/67</u>	<u>72</u>	<u>143</u>	<u>0.8% Lox 5000 given</u>
<u>7 AM</u>	<u>-</u>	<u>-</u>			<u>95/62</u>	<u>87</u>	<u>123</u>	<u>effect started</u>

Delivery Details : Time: 9:01 AM APGAR: 8-9 (SVD) Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected : Dr. SRINATH

Patient Satisfaction : Complete

Discharge / Shifting ordered by

Doctor Signature: Dr. SRINATH

Doctor Name: Dr. SRINATH

Date and Time : 6/6/16 9:01 AM

INDUCTION OF LABOR CONSENT

Name: Mrs Pooja Sanghi Age: Gender: Male Female
 UHID.No: HNH-00011469 Date: 5/6/2026

You are scheduled for an induction of labor on 5/6/2026 (date) at 39 (weeks of gestation).

The reason for your induction is near EDD.

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: [Signature]
 Name: POOJA SANGHI
 Date & Time: 05-06-2026 11:00PM

Patient Attendant:
 Signature: [Signature]
 Name: NAVEEN G
 Relationship with Patient: SPOUSE
 Date & Time: 05-06-2026 11:00PM

Doctor:
 Signature: [Signature]
 Name: Dr. Dna.
 Date & Time: 5/6/2026

Witness
 Signature: [Signature]
 Name: Amesh
 Date & Time: 5/6/26 @ 11pm

INFORMED CONSENT FOR VAGINAL BIRTH

Patient Name : Ms Pooja Sanghi UHID No : HNH - 000 11469
 Gender: Male Female Date : 5/6/2026 Time :

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:

Consentee :

Signature : pooja
 Name : POOJA SANGHI
 Date & Time : 05-06-2026 11:00pm

Patient Attendant :

Signature : G. Naveen
 Name : NAVEEN G
 Relationship with Patient: SPOUSE
 Date & Time : 05-06-2026 11:00pm

Witness :

Signature : Anusha
 Name : Anusha
 Date & Time : 5/6/26 @ 11pm

Doctor (who is taking the consent) :

Signature : [Signature]
 Name : Dr. Dug
 Date & Time : 5/6/26 11pm