Dr. Padmaja / Dr. Nageshwari

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ESTIMATION SLIP

Date : 13/6/26 **UHID / IP No. :** HNH-00015726 **Sl No.** 1596

Name of Patient : Mrs. C. Jyothi Naga manjari **Age:** 29yr **Gender:** F

Father's / Husband's Name : Mr. Sai Sharath **Corporate / Occupation :**

Address : Himayathnagar **Phone :** [illegible] **Email :** 7799900 0729

Procedure / Plan : Secondary Suturing Surgical **EDD/Dos:** June-26

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

TARIFF INFORMATION :

Particulars	Package Amounts (Rs.)	
Room Category	Normal Delivery	LSCS
Multi Shared Ward		
Shared Ward		
Twin Shared Ward →	95k to 1.1ac	([illegible]) 1 Day
Private Room		
Super Deluxe Room		
Suite Room	+ Pharmacy & Investigation	Extra
Package includes (Package starts from the time of admission)	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee and Labour Ward Charges	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee Anesthetist's Fees and OT Charges
	Length of Stay for :	Length of Stay for :
	Pharmacy up to	Pharmacy up to
	Investigations up to	Investigations up to
Others		

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

Initial Minimum Deposit : 80% Advance time of Admission

REMARKS :

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 M. V. S. Sai Sharath 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.

Sai Sharath	Husband	[signature]
Signature of the Client	Signatory Relationship	Signature of the financial Counselor

HNH-00015726 IP26-00006588
Mrs G JYOTHIR NAGA MANJARI
20-10-1996 29 Y 7 M 26 D (F)
Dr. BANDARUGATTU N NAGESWARA

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SURGERY DETAILS

Date : 15/6/26

Patient Name: Mrs. G. Jyothir Naga Manjari Date of Birth: 20-10-1996 Age: 29 yrs

Gender: Female Ward : OT UHID No.: HNH-00015726

Date of Surgery: 15/6/26 ☑ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Secondary Suturing

Time in : 11:30 Am Time Out : 12:30 pm

		NAME	AMOUNT
1.	Surgeon	: Dr. Nageswara	
2.	Anaesthetist	: Dr. Samir, Dr. Akila	
3.	Assistant Surgeon	:	
4.	OT Technician	: Br. Saichandu	
5.	Circulating Nurse	: Sr. Natasha	
6.	Assistant Nurse	: Sr. Archana	

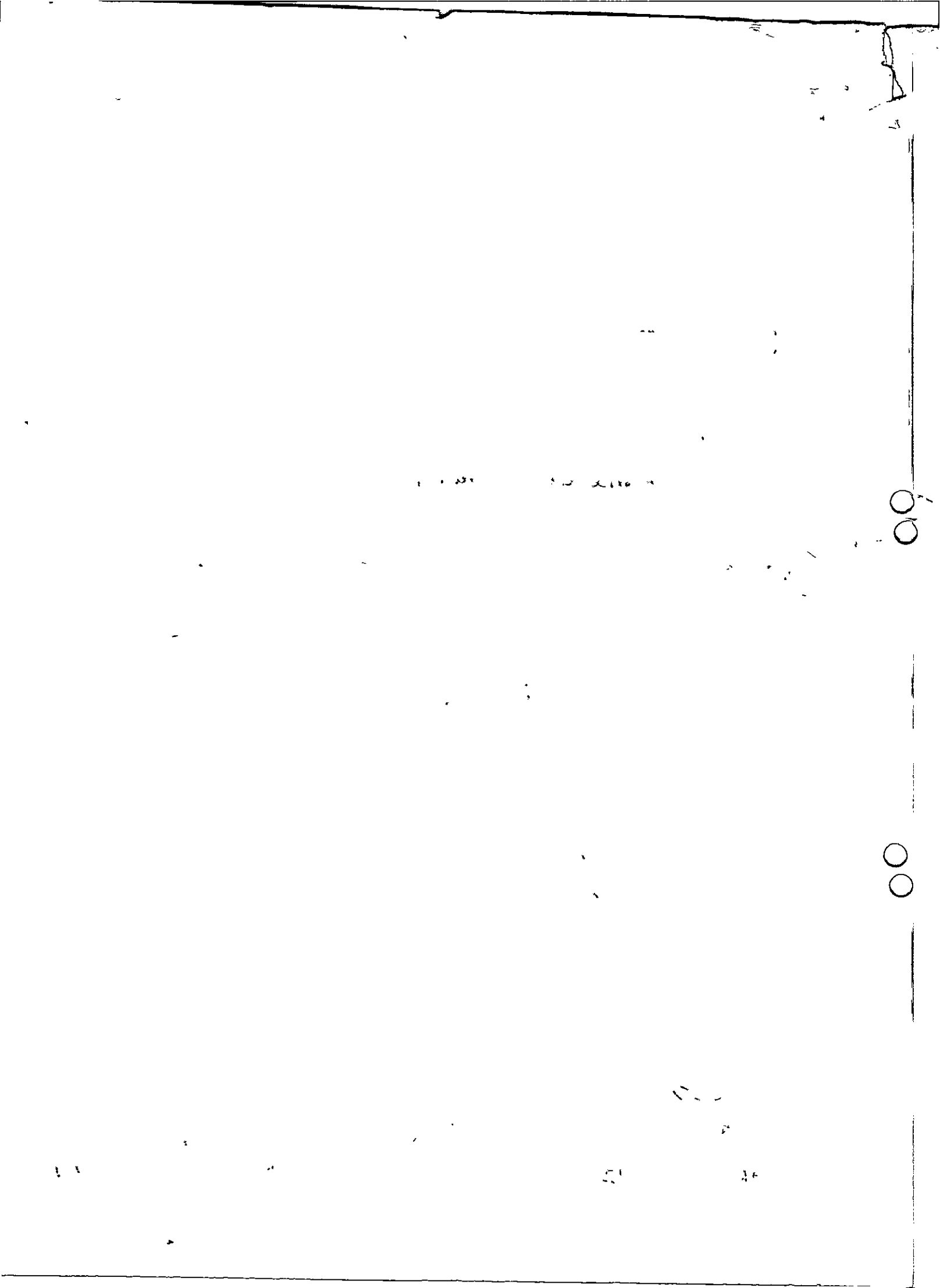
Special Equipment:
☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others .....

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 26-0000206802

Order by: Archana 15/6/26 @ 13:41 pm



HNH-00015726 IP26-00006588
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Secondary Suturing

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CONSUMABLES OF OT

Circulating staff : Natasha Technician : Sai Chandu Date : 15/6/26 Time :

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			~~Major~~ Pack General		01	Inj Vit.K		
LMA			Sutures ~~2/3/26~~ 3328.		01	Cord Clamp		
ECG leads : A / P / N		03			2	Suction Catheter		
HME filter : A / P / N						Feeding Tube		
Syringes : 10 cc		02				Vaccum Suction Set		
05 cc		03	Gloves S.G.G.L 7.0		03+1	Surgical Gloves		
02 cc		02	Encore 6 1/2		1	Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / P / N		01	Surgical blade 22		1	Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL		02	Cautery pencil	1				
NS : 10ml / 100ml / 500ml / 1000ml			Koochies					
Bupi Lox 2%		1	Ointments					
			Suction Catheter					
Fentanyl			Cap, Mask		10+10			
Morphine			Gauze Pack 7.5x7.5		2			
Ketamine			Mop Pack		1			
Propofol			Steristrip					
Rocuronium			Underpad					
Glycopyrolate			Draw sheet					
Myopyrolate			Abgel					
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22		01	Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)		01	Romodrain bag					
Antibiotics			Bandage					
			Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg		01	Vaccum Suction set	1				
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution	2				
Gauze		01	Microshield	2				
Encore Glove 6 1/2		01	Cotton Balls	1				
			Latex Gloves	10				
			Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 26-00002068 H 185 Ordered by : Archana 15/6/26 @ 13:25 pm

Doc. No. : RCH / FRM / GENERAL / 125

Rainbow Childrens Hospital-Himayatnagar

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

ELECTRONIC MEDICINE PRESCRIPTION

MRN	: HNH-00015726	**Name**	: Mrs G JYOTHIR NAGA MANJARI
Age / Sex	: 29 Y 7 M 26 D / Female	**Doctor**	: BANDARUGATTU N NAGESWARA RAO
Adm/Reg Date/Time	. 15/06/2026 09:33	**Payor**	: SELFPAY
Order Date	: 15/06/2026 13:24	**Ordernumber**	: 26-0000206816
Visit ID	: IP26-00006588	**Ward/Bed No**	: 4F -OT / PDA-414
Patient Address	: 502,tirumala deluxeapts, Himayathnagar, Hyderabad, Telangana, INDIA, 500029		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	RL 500 ML CLOSED SYSTEM	RINGER LACTATE 500ML CLOSED	1 Bottle	/ Once Daily	2 Days		2 Bottle	Dispensed
2	SURGICAL BLADE 22	SURGICAL BLADE 22	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
3	E.C.G ELECTRODES (ADULT)	ELECTRODES ADULT	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
4	COTTON BALLS 2 GM 5 NOS	COTTON BALLS 2G- 5 NOS	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
5	MOPS 30X30 8PLY 5S X-RAY	MOPS 30X308 PLYDATT	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
6	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
7	PREGELLED SURGICAL PLATES(ADULT)	PREGELLED PLATED ADULT	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
8	SUPRIDOL SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
9	GENERAL SURGICAL KIT (MEDITAKE)	GENERAL SURGICAL KIT	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
10	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
11	Encore Microptic gloves-6.5		1 Nos	/ Once Daily	1 Days		2 Nos	Dispensed
12	BACTOPREP SOLUTIONS 100 ML	CHLORHEXIDINE GLUCONATE2% &ALCOHOL80% 500	1 mL	/ Once Daily	2 Days		2 Nos	Dispensed
13	VACCUME SUCTION SET	VACCUME SUCTION SET	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
14	BUPICAIN HEAVY 80MG INJ 4ML	BUPIVACAINE 80MG INJ	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
15	PENCAN 25G*3 1 2	PENCAN 25G*3 1 2	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
16	POVINANZ SOLUTION 10% 100 ML		1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
17	THEMICAINE 2% 30ML INJ		1 Nos	Injection / Once Daily	1 Days		1 Nos	Dispensed

BANDARUGATTU N NAGESWARA RAO
GENERAL SURGERY
Reg No : 44101

* This document is just for reference purpose only. Not to be considered as primary report.

Note

*** This prescription is valid only for specified duration.**

*** Do not refill medicines.**

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040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	: HNH-00015726	**Name**	: Mrs G JYOTHIR NAGA MANJARI
Age / Sex	: 29 Y 7 M 26 D / Female	**Doctor**	: BANDARUGATTU N NAGESWARA RAO
Adm/Reg Date/Time	: 15/06/2026 09:33	**Payor**	: SELFPAY
Order Date	: 15/06/2026 13:24	**Ordernumber**	: 26-0000206815
Visit ID	: IP26-00006588	**Ward/Bed No**	: 4F -OT / PDA-414
Patient Address	: 502,tirumala deluxeapts, Himayathnagar, Hyderabad, Telangana, INDIA, 500029		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	SGLOVE # 7.0(SURGICARE)	SURGICAL GLOVES 7.0	1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
2	FACE MASK 3 LAYER - ELASTIC	FACE MASK 3 LAYER	1 Nos	External / Once Daily	1 Days		10 Nos	Ordered
3	NITRILE EXAMINATION GLOVES P F- MEDIUM	NITRILE GLOVES M	1 Nos	External / Once Daily	1 Days		10 Nos	Ordered
4	ETHILON 3-0 NW 3328	ETHILON 3-0 NW 3328	1 Nos	/ Once Daily	2 Days		2 Nos	Ordered
5	SURGEON CAP(FEMALE) (PROTECTCARE)		1 Nos	External / Once Daily	1 Days		10 Nos	Ordered
6	GAUZE 7.5X7.5 12 PLY (5 NOS)	GAUZE 7.5X7.5 12 PLY 5 NOS	1 Nos	External / Once Daily	1 Days		3 Nos	Ordered
7	DSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		2 Nos	Ordered
8	DSYRINGE 5ML.(NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		2 Nos	Ordered

BANDARUGATTU N NAGESWARA RAO
GENERAL SURGERY
Reg No : 44101

* This document is just for reference purpose only. Not to be considered as primary report.

Note

*** This prescription is valid only for specified duration.**

*** Do not refill medicines.**

INH-00015726 IP26-00006588
Mrs G JYOTHIR NAGA MANJARI
10-10-1996 29 Y 7 M 26 D (F)
Dr. BANDARUGATTU N NAGESWARA

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DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	1			
6	Doctors progress sheets	2			
7	Nursing plan of care and handover sheets	1			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaestesia notes (Pre Anaesthesia& post)				
22	Neonatal Admission/Delivery/Physical Exam	1			
23	Medication Reconciliation	1			
24	Emergency Triage record				
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart				
30	Intake and Out take chart (fluid chart)				
31	Drug chart (Regular Prescription)				
32	Investigation Values (result sheet)				
33	Nebulization chart				
34	Nutritional review chart				
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale				
38	Braden Q Scale				
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	Billing	1			
	Others	6			
	Total No. of Pages	18			

Doc. No. : RCH/ FRM / GENERAL / 126

Signature and Date : M. Das 15/6/26

(P.T.O)

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU / 2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

Name	Mrs G JYOTHIR NAGA MANJARI	**UHID**	HNH-00015726
Father/Guardian	Mr M V S SAI SHARATH	**Age/Gender**	29 Y 7 M 26 D/ Female
Address	502,tirumala deluxeapts, Himayathnagar, Hyderabad, Telangana, INDIA, 500029		
IP No	IP26-00006588	**Admission Date**	15-06-2026
Ref Doctor	SELF		
Discharge Date	15.06.2026		

DISCHARGE SUMMARY

Consultants :
Dr. BANDARUGATTU N NAGESWARA RAO
MBBS, DNB
44101

Diagnosis: P1L1 WITH POD- 21 OF LOWER SEGMENT CESAREAN SECTION WITH HYPOTHYROIDISM WITH WOUND GAPING.

SECONDARY SUTURING DONE ON 15.06.2026

History: Mrs. G Jyothi R Naga Manjari is POD- 21 (LSCS done on 25.05.2026). She came with complain of discharge from the wound. Swab C/S done outside on 29/5/26: E Coli growth .On examination: Uterus well involuting. Wound induration + pus discharge from the right side of the wound. Mattress sutures in situ. 4 cms gaping in the right side . Dressing done on alternate days.

Name	Mrs G JYOTHIR NAGA MANJARI	**UHID**	HNH-00015726
IP No	IP26-00006588	**Admission Date**	15-06-2026

Surgeon opinion was sought and pateint was planned for secondary suturing. She was admitted for secondary suturing.

Obstetric History: P1L1
Medical History: Hypothyroidism on Tab Thyronorm 100 mcg OD
Family History: Parents -DM
Surgical History: Adenectomy in 2000 , LSCS (25/05/2026)
Allergies: Nil

Investigations: Enclosed.
Blood group: "O positive"

Surgery Notes:
Operation performed:
Secondary Suturing done under Spinal Anaesthesia
.
Indication: Wound gaping

Operative findings:

- Previous skin suture (subcutaneous) removed.
- Thorough wound wash given.
- Inflamed and Indurated skin and subcutaneous tissue were excised and wound margin were freshened to healthy tissue.
- Rectus sheath sutures were found to have ?given way /came out .
- 16 Fr Romovac Drain was placed .
- Wound closure was done using mattress suture .
- Hemostasis secured and sterile dressing applied.
- Patient stood procedure well.

Name	Mrs G JYOTHIR NAGA MANJARI	**UHID**	HNH-00015726
IP No	IP26-00006588	**Admission Date**	15-06-2026

Post-Operative Notes: - Uneventful.

Advice:

1. Inj Magnex Forte 1.5 gm I.V. Twice daily (9am-9pm) till 19.06.2026 after food followed by Tab. Faropenem 200 mg twice daily (9am-9pm) for 7 days (20.06.2026 - 26.06.2026) after food.
2. Tab. Pantodac 40 mg (Pantoprazole 40mg) once daily (7am) before food till 26.06.2026
3. Tab. Calpol 500mg (Paracetamol 500mg) (2tabs)thrice daily till 17.06.2026 (7am-3pm-10pm) after food.
4. Tab Brufen 400 mg SOS (for pain)
5. Tab Chymoral Forte three times day after food for 5 days
6. Tab.LIVOGEN once daily before meals for three month.
7. Tab.Shelcal 500 mg once daily after food till breastfeeding.
8. Continue Tab Thyronorm 100 mcg OD
9. Dressing every 2 days
10. Romovac Drain removal after 1 week on 22.06.2026
11. Drain care explained

Review with Dr. Padmaja yelisetty , after 2 days on 18.06.2026 at his OPD clinic (**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

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Name	Mrs G JYOTHIR NAGA MANJARI	**UHID**	HNH-00015726
IP No	IP26-00006588	**Admission Date**	15-06-2026

In case of emergency like bleeding, fever kindly contact 9154865045. You can also take appointments at any time by going online to our website **www.rainbowhospital.in**

Rainbow Children's Medicare Himayathnagar 500029 Hyderabad

Registrar/Resident/C.M.O

Consultants :
Dr. BANDARUGATTU N NAGESWARA RAO
MBBS, DNB
44101

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital

BirthRight by Rainbow

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TEL NO :040-48873000
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006588 **Admit Date** : 15-Jun-2026 **Admit Time** : 09:33 AM **UHID** : HNH-00015726

Patient Details :

Patient Name	: Mrs G JYOTHIR NAGA MANJARI	**Age**	: 29 Y 7 M 26 D
Guardian	: Mr M V S SAI SHARATH	**DOB**	: 20-10-1996
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 502,tirumala deluxeapts Himayathnagar Hyderabad Telangana INDIA 500029	**Phone No**	: 7799900729/ 9849082588
		E-mail	: saisharoth555@gmail.com

Admission Details :

Bed Type : TWIN SHARING **Bed No** : PDA-414 **Ward Name** : 4F -OT

Room No : PDA-414 **Admission Type** : First Visit

Contact Details :

Name : Mr M V S SAI SHARATH **Relationship** : Husband

Contact Address : 502,tirumala deluxeapts Himayathnagar Hyderabad Telangana INDIA 500029 **Phone No** : 9515719849

Signature

Doctor Details :

Doctor Name : Dr. BANDARUGATTU N NAGESWARA RAO **Specialisation** : GENERAL SURGERY

Referral Doctor : SELF **Phone No** :

Co-Consultant :

Payment Details :

Deposit Amount : 80000.00

Payment Mode : DC/CC Card **Payor Name** : SELFPAY

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00015726 IP26-00006588 Mrs G JYOTHIR NAGA MANJARI 20-10-1996 29 Y 7 M 26 D (F) Dr. BANDARUGATTU N NAGESWARA	15/6/26 @	15/6/26 @ 11 PM
	Transfer Ordered by	Reason for Transfer
From Unit pre-past	To Unit OT	Information to Attendant Yes ☐ No ☐
Number of Sheets in Clinical File	Number of Imaging Films	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	1D
2.		
3.		
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer

Patient & Clinical Records Received by : Anthony

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-00015726 IP26-00006588
Mrs G JYOTHIR NAGA MANJARI
20-10-1996 29 Y 7 M 26 D (F)
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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
15/6/26	11:20pm	pre-post	OT	Manjula
15/6/26	1:40pm	OT	pre-post	Manjula

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
15/6	Cardiac monitor	12:30 pm	3:30 pm	206814	Moni
15/6	Infusion pump			206814	

Cross checked done

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
15/6/26	IV placement	(2)	6842	[illegible]
15/6/26	DAC	(1)	15408	[illegible]

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00015726 IP26-00006588
Mrs G JYOTHIR NAGA MANJARI
20-10-1996 29 Y 7 M 26 D (F)
Dr. BANDARUGATTU N NAGESWARA

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I.P. ADMISSION SHEET FOR GYNECOLOGY

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

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

PRESENTING COMPLAINTS :

P1L1 | 21 days Postnatal
LSCS done on 25/5/2026 @ FH
Lactating
~~Come for~~ wound discharge
Swab c/s (outside) on 29/5/2026 :- E Coli

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage :	Parity : ~~G1P1L1D0A0T~~ P1L1
Previous Periods :	Mode of Delivery :
LMP :	Last Child Birth : 25/5/2026
Contraception :	

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
K/C/O Hypothyroidism (Thyronorm 100 mcg OD)	Adenoidectomy @ Childhood (2000) LSCS (25/5/2026)

Mrs G JYOTHIR NAGA MANJARI
20-10-1996 29 Y 7 M 26 D (F)
Dr. BANDARUGATTU N NAGESWARA

FAMILY HISTORY:

Both parents: DM

MEDICATION HISTORY:

1. Thyronorm 100 mcg
2. Ibuprofen / Lexigan / Shelcal / Chymoral Forte

INITIAL ASSESSMENT :

Date 15/6/2026

Ht. ____ Wt. 81.1 kg

BMI ____

B.P ____

Pallor ____

CVR NAD

Respiratory System BAE(+)

Thyroid NAD

Breasts

(N)

Abdominal Examination

Ut well involuting, Wound induration (+) Pus discharge from right side 4cm Gaping (Rt side)

Local/Speculum Examination

not done

Bimanual Pelvic Examination

not done

PROVISIONAL DIAGNOSIS : P.L / Wound Gaping For Resuturing.

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT
B S7 · O (+ve) 30/5 Hb - 9.7 WBC - 11.9 Plt - 2.86	- NBM - Informed consent - Parts prepare - Drugs as charted - Shift to OT on call

Name of the Doctor : Dr Manisha

Signature of Doctor

Date & Time : 15/6/2026 @ 9:30 Am

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/6/2026	C/S/b Dr Mansha	
12:45pm	POD 0 - Secondary Suturing	
	GC - Fair Afebrile	Adv
	BP - 120/80mmHg	- NBM
	PR - 78bpm	- Vital monitoring
	P/A - Soft	- Drugs as chart
	L/E - NAD	- Drain x 7day
	D/O - nil	- Continue IV Ab x 5day
		- Repeat Dressing After every 2days
		- Inform SOS
		Dr Mansha
	[Attender were counselled regarding Future risk of Hernia by Dr Nageshwar rao Sir]	
15/6/26	c/s/B Dr. Veena	
3:30PM	POD-0/2° Resuturing	Adv
	Pt is stable, No c/o	- Oral sips from 4:30 pm
	O/E GC-fair	- Liquid diet today.
	BP - 120/70mmHg	- Drugs as charted
	PR - 75bpm	- Drain for 7 days
Can be discharged. Send file for processing	SpO_2 - 100% on RA	- IV Antibiotics for 5days
	P/A - Soft.	- ~~Alternate~~ Dressing
	Dressing (+)	
	DT - Nil	
	L/E - NAD.	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00015726 IP26-00008588
Mrs G JYOTHIR NAGA MANJARI
20-10-1996 29 Y 7 M 26 D (F)
Dr. BANDARUGATTU N NAGESWARA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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OPERATION THEATER NOTES

HNH-00015726 IP26-00006588
Mrs G JYOTHIR NAGA MANJARI
20-10-1996 29 Y 7 M 26 D (F)
Dr. BANDARUGATTU N NAGESWARA

.....Age : .....Gender : .....

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

Surgeon :	Asst. Surgeon :
Anesthetist :	OT Nurse :

Surgical Procedure : Secondary Suturing

Indications for Surgery : Wound Gaping

Date : 15/6/2026	Start Time : 11:30 Am	End Time : 12:30 pm

PRE-OPERATIVE PREPARATION :

↓AAP, Parts Painted & Draped

OPERATION NOTES:

- Previous skin (subcutaneous) suture removed
- Through wound wash given
- Inflamed & Indurated skin & subcutaneous tissue were excised and wound margin were freshened to healthy tissue
- Rectus Sheath sutures were found to have ? given way/ ? Come out.
- 16 Fr Romovac Drain was placed
- Wound closure was done using Mattress suture
- Hemostasis secured & sterile dressing applied
- pt stood procedure well

POST - OPERATIVE ORDERS :

- NBM ~~tdt~~
- Drugs as chart
- MJ Magnex Forte x 5day F/b Tab Faropenum BD x7d
- Drain Removal x 1wk
- Dressing ~~Alternate~~ every x 2days (Repeat)

Dr. Nageshwar Rao

Consultant Surgeon's Name

Consultant Surgeon's Signature

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

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Nageshwara Rao
Asst. Surgeon :
Anaesthetist : Dr. Akhila.
Scrub Nurse : Sr. Archana

HNH-00015726 IP26-00006588
Mrs G JYOTHIR NAGA MANJARI
20-10-1996 29 Y 7 M 26 D (F)
Dr. BANDARUGATTU N NAGESWARA

Age : 29 Gender F
Name :
Date : 15/6/26 In-time : 11:30 AM Out-time : 12:30 pm

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 11:20 AM

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

Site Marked ☐ Yes ☐ No ☑ NA

Anaesthesia Safety Check Completed ☑ Yes ☐ No

Pulse Oximeter on Patient & Functioning ☑ Yes ☐ No

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

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

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

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

Signature :
Name : Dr Akhila K

Before Skin Incision ➤➤

TIME OUT Time: 11:30 AM

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? ☐ Yes ☑ No ☐ NA

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

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

Signature :
Name : Akhila

Before Patient Leaves Operating Room

SIGN OUT Time: 12:30 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 :
Name :

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00015726 IP26-00006588 Mrs G JYOTHIR NAGA MANJARI 20-10-1996 29 Y 7 M 26 D (F) Dr. BANDARUGATTU N NAGESWARA	15/6/26 @ 9:33Am	15/6/26 @ 12:40pm
	Transfer Ordered by Dr. Akhila.	Reason for Transfer observation
From Unit OT	To Unit Pre-post	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File	Number of Imaging Films —	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 ☐

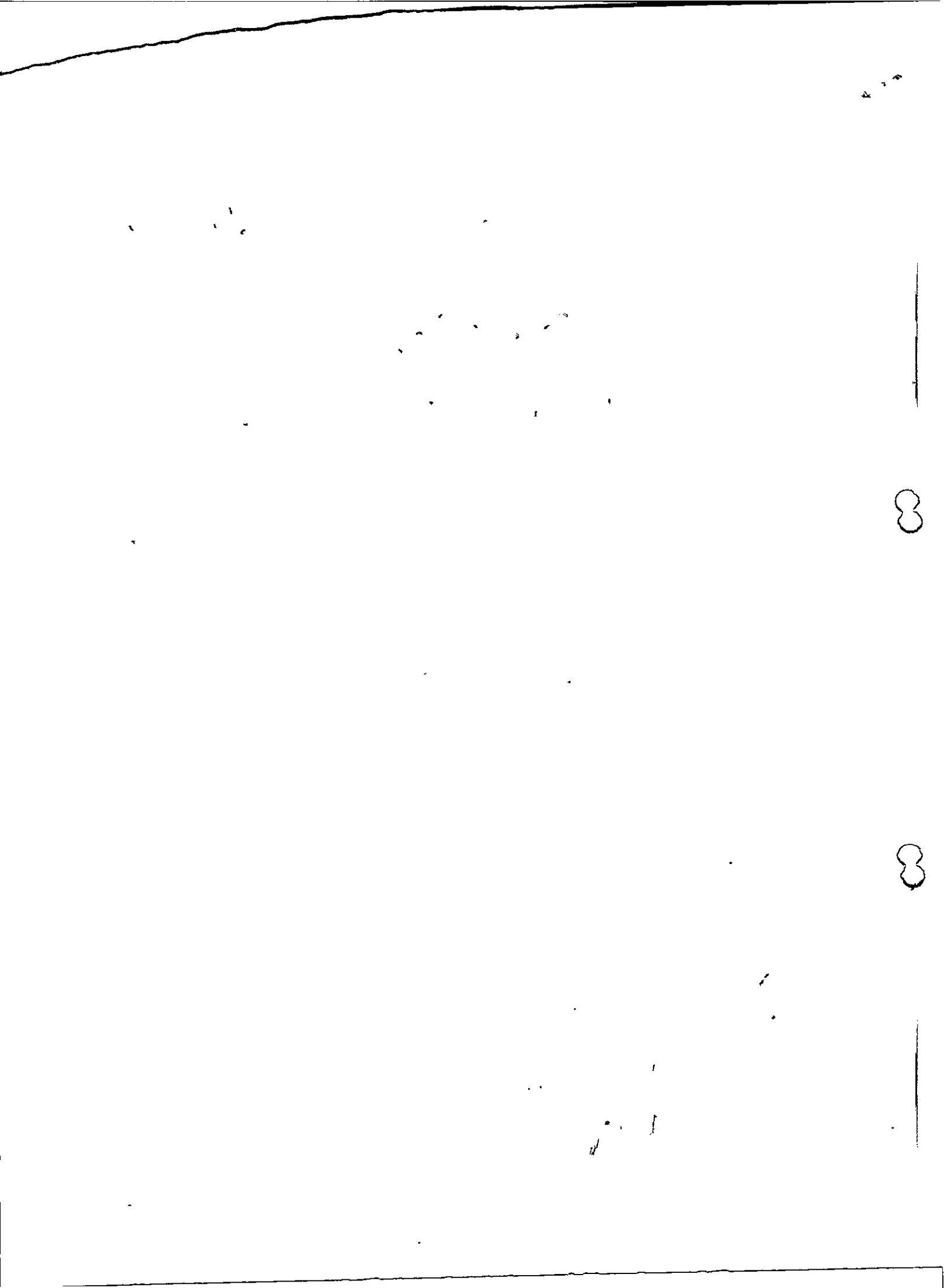
Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
	Dr. Akhila.

Patient & Clinical Records Received by :

Date & Time of Patient Received : 15/6/26 @

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



HNH-00015726 IP26-00006588
Mrs G JYOTHIR NAGA MANJARI
20-10-1996 29 Y 7 M 26 D (F)
Dr. BANDARUGATTU N NAGESWARA

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☑ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.
(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: NA Shifted to: NA

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	1-tab	P/O	OD	14/6/26.	☑ C ☑ DC
2	TAB. CALCIUM	2-tab	P/O	OD	14/6/26	☑ C ☐ DC
3	T. thyronorm	100mg	P/O	OD	14/6	☑ C ☐ DC
4	T Chymoral Forte	1 tab	P/O	TID	14/6	☑ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. G. Veena.

Date & Time : 15/6/26 @ 9am.

Nurse Name & Signature: .....

Date & Time : .....

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

Patient Sticker

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DRUG CHART

Date of Admission: 15/6/26 Drug Allergies: ..... ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

GENERAL - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.

DOCTOR
- Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line *I* through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

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

SOS / PRN (As Required Medication)

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

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

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

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

Mrs G JYOTHIR NAGA MANJARI
20-10-1996 29 Y 7 M 26 D (F)
Dr. BANDARUGATTU N NAGESWARA

Verified by
Dr. Dhakshayani

REGULAR PRESCRIPTIONS

Weight. 81 kg Ward. ....

DRUG : INJ. CEFPERAZONE + SULBACTAM.				Date ▸ / Time ▾
Dose	Route	Frequency	Start Date	
1.5g	IV	BD	15/6/26	10AM
Name & Signature of the Doctor Starting the Drugs: [signature]				
Additional Instructions: ATD x5d				10pm
Daily Doctor's Endorsement by a Sign				

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

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

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

Patient Sticker

Weight. 81.1 kg Ward. .....

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
15/6/26.	10 AM	INJ. PANTAPRAZOLE	40mg	IV		Mouni
15/6/26	10 AM	INJ. METOCLOPROMIDE	10mg	IV		Mouni

Verified by Dr. Dhakshayani

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

Patient Sticker

I.V. FLUIDS CHART

Weight. 81.1 kg Ward. .....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
15/6/26		RINGER LACTATE	IV	100ml/hr					
15/6/26	11:30 AM	RINGER LACTATE	IV	free flow					

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

HNH-00015726 IP26-00006588
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RESULT SHEET

Date							
Time							
Hb							
PCV							
RBC							
WBC							
N/L							
Platelets							
CRP							
ESR							
PCT							
RBS							
Na							
K							
Cl							
Ca/Mg							
Phosphate							
Urea							
Creatinine							
ALP							
SGPT							
SGOT							
T.Bil/Conj							
T.Protein							
S.Albumin							
S.Globulin							
A/G Ratio							
Uric Acid							
S.Amylase							
Sr.Lipase							
Blood Lactate							
S.Cholesterol							
PT/INR							
APTT							
CSF Protein / Sugar							
Cells							
N/L							

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Blood grouping						
HIV						
~~HBsAg~~						
HCV						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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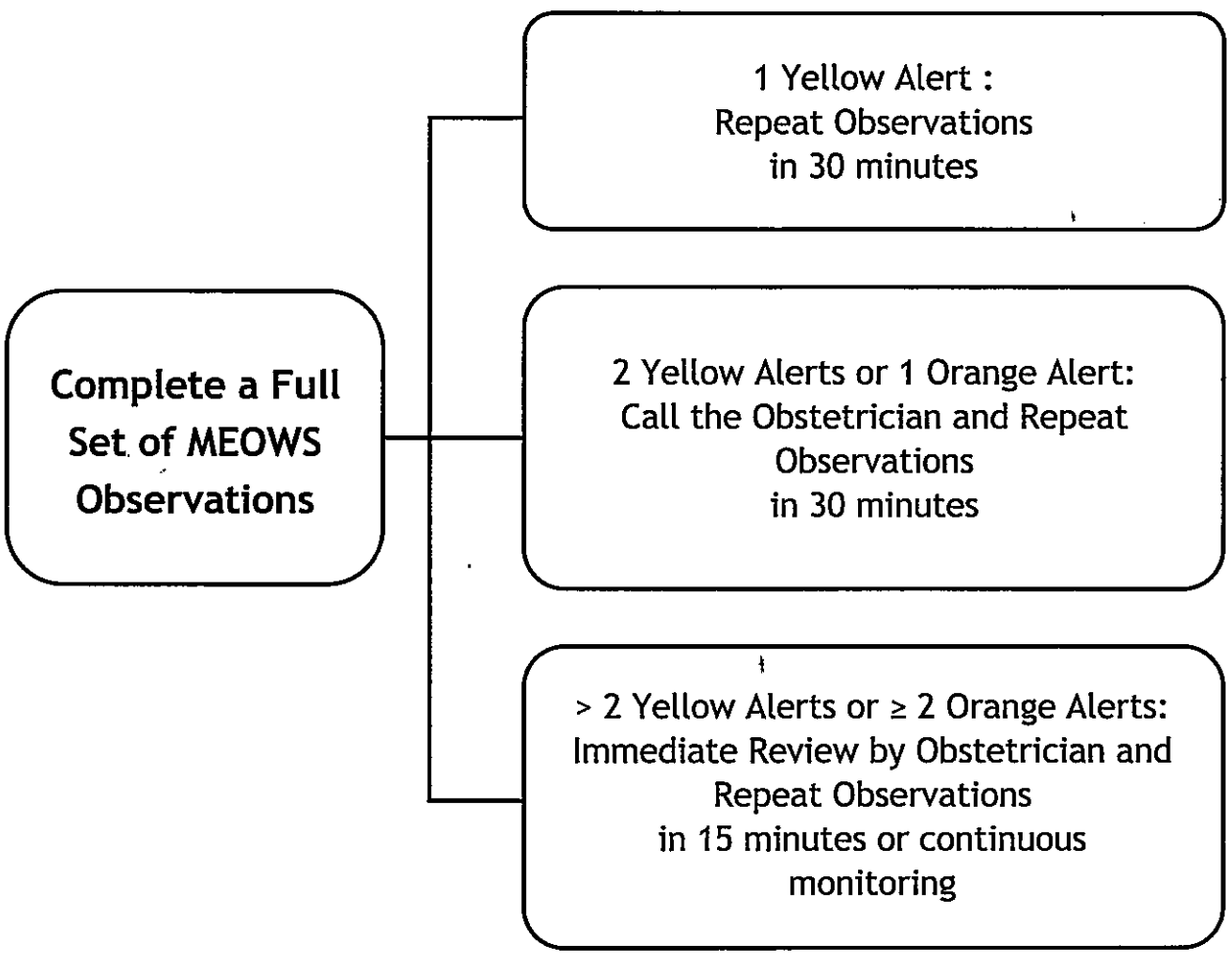
Early Warning Observation Score Chart - Obstetrics

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

		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																		
	0 - 10																									
Saturations	94 - 100 %							94																		
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37																									
	36							36																		
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70							75																		
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100							110																		
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60							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																		
TOTAL ORANGE SCORES																										
Nurse Initial																										

Obstetrics and Gynaecology Early Warning Signs



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

HNH-00015726 IP26-00006588
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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						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
15/6/26	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm	RL		100ml								
	01:00 pm	RL		100ml								
Total Intake :						**Total Output :**						
15/6/26	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	

Patient Sticker

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FLUID CHART

Sheet No. : .....

1. All measurements in ml.
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		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			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-00015726 IP26-00006588
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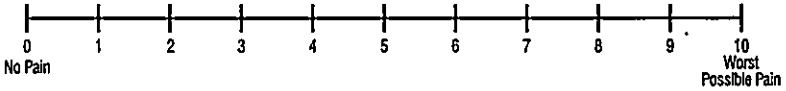
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
15/6/26	8AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ 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 brawn 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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BRADEN 'Q' SCALE

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				Date :	15/6			
				Time :	11m			
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4			
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4			
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4			
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen oply requires changing every 24 hours.	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			
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4			
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4			
				TOTAL SCORE	28			
				Evaluator's Name				

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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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	25/8/26			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						
Ambulatory Aid	Furniture	30				Low Risk	0 - 24	Standard Fall Precaution
	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	0					
GAIT / Transferring	Impaired	20	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					
		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

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CHECKLIST FOR THROMBOPHLEBITIS

15/6/26

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0									
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	WA									
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	WA									
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	WA									
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	WA									
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	WA									
			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 : .....

Patient Sticker

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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0										
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1										
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2										
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3										
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4										
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	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-00015726 IP26-00006588
Mrs G JYOTHIR NAGA MANJARI
20-10-1996 29 Y 7 M 26 D (F)
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NURSING CARE RECORD

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Date: .....

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am => Assess the patient condition. to => plan for vital 2pm => plan for Nebulization		8Am => Assessed the patient condition to => maintain vital & Record 2pm => maintain I/o. Chart		patient is stable	vital is normal	Cindy
Afternoon							
Night							

Patient Sticker

NURSING CARE RECORD

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Date: .....

Goals

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

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

HNH-00015726 IP25-00006588
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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area / Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature:							
Date:							
Time:							

Patient Sticker

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION	Diagnosis:				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
BACKGROUND	Area / Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : Mrs. JYOTHIR NAGA MANJARI Gender: ☐ Male ☐ Female Age : 29 years.

UHID No : HNH-00015726. Date : 15/6/26

Instruction:

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

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

SECONDARY RESURFACING upon

MRS. JYOTIR NAGA MANJARI (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.

Wound breakdown, wound infection, recurrence, requirement of further intervention.

My signature on this form indicates that

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

Name of the Doctor who is performing the Surgery / Procedure: Dr. Padmaja Yelisetty.

Consentee :

Signature : G Jyothir Naga Manjari

Name : Mrs Jyothir Naga

Date & Time :

Witness :

Signature :

Name :

Date & Time :

Patient Attendant :

Signature : Sk Shagata.

Name : M.V.S. Sai Shagata

Relationship with Patient: Husband

Date & Time : 15/06/2026 11.10AM.

Doctor (who is taking the consent) :

Signature :

Name : Dr. G. Veena

Date & Time : 15/6/26 @

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: Mrs. G. JYOTHIR NAGA MANJARI Age: 29y Sex: F UHID.No : HNH-0.0015726

Date: 13/6/26 Time: 2:46pm Proposed Operation: Secondary Suturing

Diagnosis: S/P LSCS POD-20, P1L1 C Inbound Surgical Infection

B.P / CRT: ..... H.R: ..... Weight: 81.1kg ASA Physical Status: ☐1 ☐2 ☐3 ☐4 ☐5

30/5/26

Laboratory Data:

Hgb: 10.8 9.7/12.0	Glucose:	Protein:	HIV: Ag NR	X-Ray:	
PCV: 38.2	Urea:	Alb:	HBS Ag:	ECG:	
WBC: 11900 | 6200	Creat:	Total Bill:	HCV:	2D Echo:	
Plate: 2.86 lakh | 643	Na:	Dir. Bill:	Blood group: B Positive (O +ve)	Stress/Anglo:	
PT:	K:	LDH:	T3	Other:	
PTT:	Ca++:	Alk phos:	T4		
INR:	Mg++:	Amylase:	TSH		
	Cl -:	SGOT/SGPT:			

Allergies: FOOD ALLERGY (+) (Itching & Rash)

Medical History: CVS : NIL SIGNIFICANT

RESP : Diabetes :

CNS :

Renal :

Hepatic / GE : Physical Activity: METS >4

Others : K/c/o HYPOTHYROID, HYN

Past Anaesthetic History: ADENOIDECTOMY @ childhood, LSCS (25/5/26) ↓ EA ↓ SAB, VE @ Fernandez.

Physical Exam:

Airway: MP 1 (2) 3 4 Mouth Opening: Adequate Mentohyoid Distance: (N) Neck: (N) Teeth: fixed denture (N) Alignment

Lungs : BAE (+), Clear

Heart: S_1S_2 (+)

CNS: NAD

Pregnant: ☐ Yes ☑ No ☐ NA Venous Access Site : Peripheral access (+) Spine Exam for regional : Midline

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

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

CURRENT MEDICATIONS	DOSAGE
ON T. THYRONORM	100mcg OD
T. IBUPROFEN	TID
T. ZIVOCIEN	OD
T. SHELCAL	OD
T. CHYMORAL FORTE	TID

Pre-Operative Instructions:

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

Signature: ..... Name: Dr. Sk. Ayesha

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

Patient Sticker

ANAESTHESIA CHART

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Pre Induction Assessment: 11:30AM

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

H.R: 90	B.P / CRT: 112/68	SpO_2: 100%	R.R: 18/min	Last Feed: 7hrs

Pre-OP Diagnosis: Surgical wound infection Operation: Secondary suturing Date: 15/6/26

Surgeon: Dr. Nageshwar Rao Anaesthesiologist: Dr. Akhila. K Technician: Sai Chandu

TIME	1130	1200	1230
N_2O /AIR /O_2 LPM			
HALO /SO /SEVO			
Drugs:			
FIO_2 (SaO_2)	100	99	99	100
ETCO$_2$				
ECG	SR	SR	SR	SR
Temperature				
Urine Output				
Fluids: RL	→	→	→	→
Blood				

Antibiotic

Suppository –

Blood Loss –

NOTES

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

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

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

LAB Values

ABG

GRBS

Others

☑ Equipment Checked and Functional
☑ BP (R) UL
☐ Cuff Site: .....
☐ Art Site: .....
☑ EKG 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

Times:
Anaes Start: 11:30AM
OP Start: .....
OP End: .....
Leave OR: 12:30pm

Anaesthesia:
☐ GA
☐ Monitored Anaesthesia Care
☑ Regional

Line (Size & Location)
☐ CVP: .....
☐ ART: .....
☑ IV: (L) UL 18G
☐ 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: L3 L4
Needle Size: 25 Gauge Depth: 5 cm
Parasthesia ☐ Yes ☑ No
Catheter at skin ..... cm
Drug Name & Conc: 0.5% Bupivacaine heavy
Bolus: 2 cm.
Infusion: .....
Block Level: T6
Comments: Adequate
Transportation to
☐ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☑ NA
Name of the Doctor: Dr. Akhila. K
Signature of the Doctor: (Signature)

Patient Sticker

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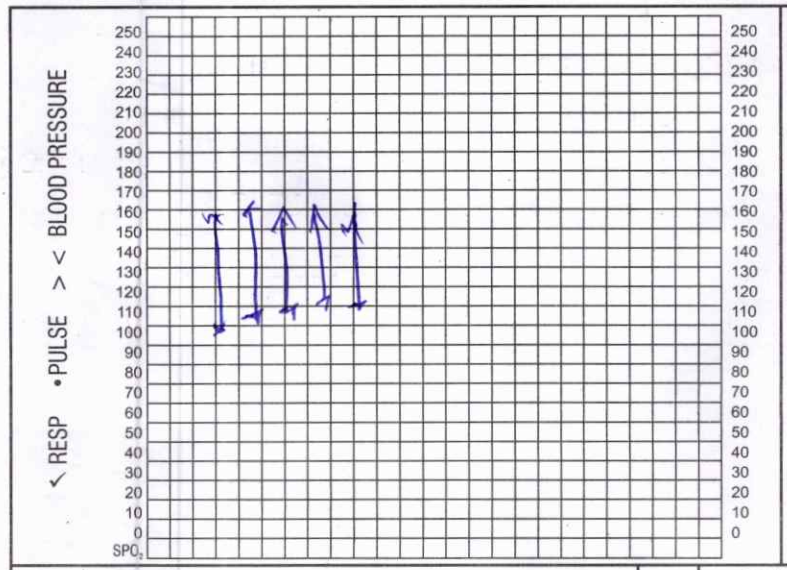
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Manik Time Received : 12:30pm Time Discharged : 2:30pm



IV Cannula Site : left side

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

Vomiting : ☐ Yes ☐ No Drug: Kpinic

NG Tube : ☐ Yes ☐ No

Drain: ☐ Yes ☐ No

Urinary Catheter: ☐ Yes ☐ No

Chest Tube: ☐ Yes ☐ No

Nil Oral ☐ Yes ☐ No

IV Fluids: RL load

Oral Feeds:

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
15/12/16	12:30p	0|10	Normal	
15/12/16	1pm	0|10	Normal	
15/12/16	1:30p	0|10	Normal	
15/12/16	2p	0|10	Normal	

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

Reassessment Frequency:

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

Anaesthesiologist Name : .....

Anaesthesiologist Signature: .....

Date & Time: .....

PACU Nurse Name : .....

PACU Nurse Signature: .....

Date & Time: .....

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

Date & Time: .....

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 Left Right	Maternal BP	Maternal Pulse	FHR	Comments

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

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

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : Jyothir Naga Manjari Age : 24y Gender : Male ☐ Female ☑

UHID NO: AHVH-0000157725 Surgeon Name: Dr. Padmaja / Dr. Nageshwara Rao

Anaesthesiologist : Dr. Samir / Dr. Akhila. K

Operative procedure planned : Secondary suturing

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 : hypotensions, Bradycaedia

Comments : .....

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

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient Jyothir Naga Manjari the above mentioned operation / Diagnostic / Therapeutic procedures Secondary Suturing

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 : G. Jyothir Naga Manjari.

Name : G. Jyothir Naga Manjari

Relationship with Patient: Self

Date & Time : 15/6/26 10:20 AM

Witness :

Signature : Sai Sharath.

Name : Sai Sharath

Date & Time : 15/6/26 10:20 AM

Doctor (who is taking the consent) :

Signature : Dr. Akhila

Name : Dr. Akhila. K

Date & Time : 15/6/26 10:20 AM

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

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Mrs G JYOTHIR NAGA MANJARI**	**Age :**	**29 Y 7 M 26 D**
IP No:	**IP26-00006588**	**Sex:**	**Female**
Consultant:	**Dr. BANDARUGATTU N NAGESWARA RAO**	**Ward/Bed No:**	**4F -OT/PDA-414**

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned also consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science and that no guarantee have been made to me as the results of my evaluation and I or treatment.

I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal items and valuables.

"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process as per evidence based guidelines".

Note:
1 We do not allow use of medication brought from outside by the patient.
2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.
(Receivers Signature:.....)

3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.
4 Financial and billing counseling has been done to me.

Signature of Patient/Relative:

Name: M.V.S.Sai Sharath

Relationship: Husband

Date: 15-06-2026 Time: 9:45 AM

Witness Name:

Witness Signature:

Patient Address:

502,tirumala deluxeapts
Himayathnagar Hyderabad Telangana
INDIA 500029

HNH-00015726 IP26-00006588
Mrs G JYOTHIR NAGA MANJARI
20-10-1996 29 Y 7 M 26 D (F)
Dr. BANDARUGATTU N NAGESWARA

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BILLING POLICY

- Billing cycle: - With effective from 1st January 2020, Our billing cycle to be start from 12 PM to 12 PM, Settlement post 12 PM, room rent will be charge for half day extra & post 6 pm, it will be charge for full day. Less than 24 hours stay will be considered as one day.
- As per the GOI guidelines, we can collect Rs 1,99,999/- only in cash mode, balance patient can pay through Card tpaln the event of TPA/ Cashless denial or approval not received due to any reason then hospital tariff will be applicable and any discount or special rates given to TPA's / corporates won't be applicable.
- If the surgery / scans performed in Emergency hours (8pm - 7am), public holiday and on Sunday will be charged TPA processing charges Rs.720 for every TPA route cases.
- All charges vary as per Room category, except Pharmacy and consumables.
- We follows a "No Discounts Policy" kindly cooperate.
- No Duplicate/Second copy of OP OR IP bill is issued.
- ICU/Ward Charges DO NOT INCLUDE - Air Mattress, Monitor, Consultants/ Specialty Doctors Visit, Infusion/syringe pump, Ventilator/C pap, Oxygen, Investigations, Procedures, Consumables, Medicines or any other bedside equipment's/devices etc. (Detailed list can be taken from billing department).

Patient attendant can collect for Interim/provisional bill of the patient from the billing section on daily basis. Interim Bill shall be based on the acknowledged services in HIS. Final Bill of the patient may vary from the Interim bill based on actual update taken on the day of discharge. It is requested that patients/attendants inquire daily about the bill amount from billing section and pay the outstanding as on that day.

Patient bill outstanding should not be increase more than 10,000/-

You are requested to clear your outstanding amount on daily basis before 12 PM.

MODE OF PAYMENT & REFUNDS

- We accept payments by cash (up to Rs 1,99,999/- only), cards, online transfer and Demand Drafts.
- All refund more than Rs.2,000/- will be refund through NEFT in three Bank working days.

Name & signature of Patient/Attendant

(Signature of Admission Desk executive)

NOTE: Self - attested Govt. ID proof is mandatory whosoever is signing the undertaking.

RAINBOW CHILDREN'S MEDICARE PRIVATE LIMITED

Registered Office: Road No.2, Banjara hills, Near Hotel Park Hyatt, Hyderabad - 500 034, T: +91 40 2233 4455.
Corporate Office: 8-2-19/1/A, Daulet Arcade, Karvy Line, Road No.11, Banjara Hills, Hyderabad - 500 034.
Branches : BANJARA HILLS - T: 2233 4455 | VIKRAMPURI - T: 4246 2200 | KONDAPUR - T: 4246 2400 | MADHAPUR - T: 6464 2020 |KUKATPALLY - T: 4246 2300 | L B NAGAR - T: 7111 1333 | MARATHAHALLI, BENGALURU - T: +91 80 7111 2345 | BANNERGHATTA ROAD, BENGALURU - T: +91 80 2551 2345, HIMAYATNAGAR- T:- 40 48873000

CIN: U85110 TG1998 PTC029914 email : info@rainbowhospitals.in www.rainbowhospitals.in

HNH-00015726 IP26-00006588
Mrs G JYOTHIR NAGA MANJARI
20-10-1996 29 Y 7 M 26 D (F)
Dr. BANDARUGATTU N NAGESWARA

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UNDERTAKING FOR BALANCE DEPOSIT

To

The Management,

Rainbow Children's Hospital, Himayatnagar

Hyderabad-500029

Sub:- **Undertaking Balance Deposit**

I Mr./Mrs./Ms. M.V.S. Sai Sharath (~~Father~~/ ~~Mother~~/ ~~Other~~ Husband) of ~~Master~~/ ~~Baby~~/ ~~Baby of~~/ Mrs./ ~~Ms.~~ G. Jyothir Naga Manjari was bought to your hospital on 15-06-2026 at 09:33 AM. Admitted in 4F-OT. Approximate charges deposit details were explained by the Front office/ Billing executive on duty.

I have to pay the amount of 1.20 L as a caution deposit but for now I'm depositing 80000. The remaining amount I'll deposit on _____ at _____.

Thanking You

M.V.S. Sai Sharath

~~Signature~~

Name:- M.V.S. Sai Sharath

Ph. No.:- 7799900729.