

HNM-0003174 Dr. Mahalaxmi



**ESTIMATION SLIP**

Date : 6/6/20 UHID / IP No. : HNM-00003174 SI No. 1578  
 Name of Patient : Mrs. R. Subithi Age: 25yrs Gender: F  
 Father's / Husband's Name : MV. Veerendar Corporate / Occupation : \_\_\_\_\_  
 Address : \_\_\_\_\_ Phone : 9101886647 Email : \_\_\_\_\_  
 Procedure / Plan : ND/LSCS EDD/Dos: 6<sup>th</sup> June  
 MODE OF PAYMENT :  SELF  TPA : \_\_\_\_\_  GIPSA : \_\_\_\_\_  OTHER

**TARIFF INFORMATION :**

Particulars	Package Amounts (Rs.)	
	Normal Delivery	LSCS
Room Category		
Multi Shared Ward		
Shared Ward		
Twin Shared Ward →	<u>1.30k</u>	<u>1.6k</u>
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>9,000/-</u>	Pharmacy up to <u>12,000/-</u>
	Investigations up to <u>2,500/-</u>	Investigations up to <u>3,000/-</u>
Others	<u>will baby care</u>	<u>25k to 35k extra</u>

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

Initial Minimum Deposit : 80,000/- Advance

REMARKS : Neonatal vaccination, 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)

I R. Rabinath 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: Rathnad Signatory Relationship: Respected Brother Signature of the financial Counselor: [Signature]

**SURGERY DETAILS**



Sl. No.

Date 06/06/26

Patient Name

HNH-00003174 IP26-00006520  
Mrs R SAHITHI  
13-08-2000 25 Y 11 M 24 D (F)  
Dr. MAHALAKSHMI GOLI

Age : ..... Sex: .....

UHID No.



IP No: .....

Date of Surgery : .....

OT:  OT 1  OT 2  OT 3  
*WDR-I*

Name of the Surgery : .....

NVD

Time in : .....

1:00pm

Time Out : .....

2:00pm

	<u>NAME</u>	<u>AMOUNT</u>
1. Surgeon	: <u>Dr. Pamy a Haja</u>	.....
2. Anaesthetist	: <u>—</u>	.....
3. Asst. Surgeon	: <u>Dr. Nalweng</u>	.....
4. OT Technician	: <u>—</u>	.....
5. Circulating Nurse	: <u>Kaifusi</u>	.....
6. Asst. Nurse	: <u>Akati</u>	.....

Special Equipment :  Laparoscopy  Bronchoscope  Harmonic  Morcelator  C - ARM  Cystoscopy

Dr. Nalweng  
Signature of the Surgeon

Akati  
Signature of Circulating Nurse

Order No. : .....

26-000201741

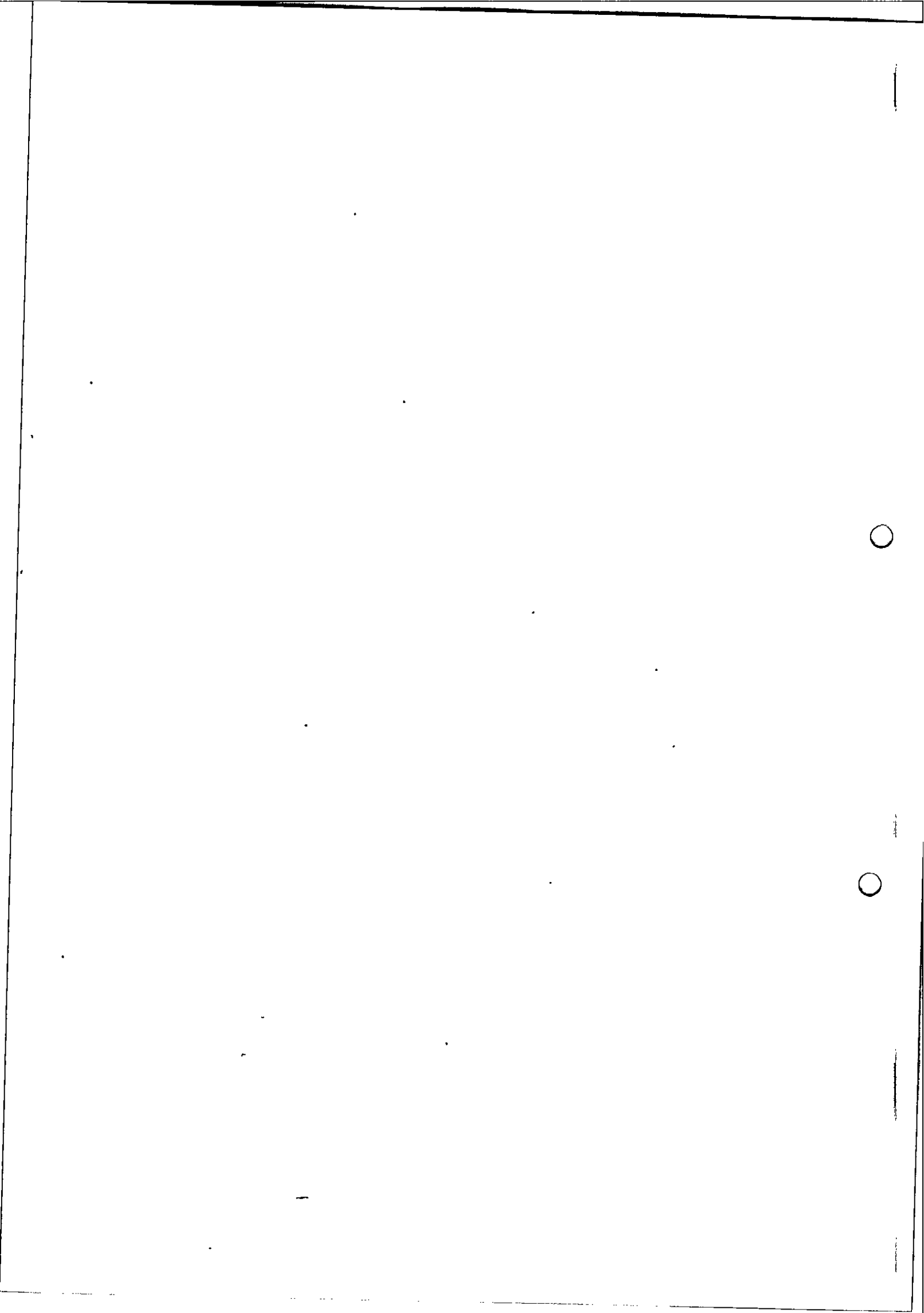
Ordered by : .....

Kaifusi



## 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	3			
7	Nursing plan of care and handover sheets	5			
8	Consultation sheet	1			
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	Anaesthesia notes (Pre Anaesthesia & post)	1			
22	Neonatal Admission/Delivery/Physical Exam	1			
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart	1			
30	Intake and Out take chart (fluid chart)	1			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart	1			
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			
	extras	6			
	<b>Total No. of Pages</b>	<b>33</b>			



**DISCHARGE SUMMARY**

<b>Name</b>	Mrs R SAHITHI	<b>UHID</b>	HNH-00003174
<b>Father/Guardian</b>	Mr N. VEERENDER	<b>Age/Gender</b>	25 Y 11 M 24 D/ Female
<b>Address</b>	VILLA NO: 90, FAROOQ NAGAR, SHADNAGAR., Shadnagar, Mahabubnagar, Telangana, INDIA, 509216		
<b>IP No</b>	IP26-00006520	<b>Admission Date</b>	06-06-2026
<b>Ref Doctor</b>	SELF		
<b>Discharge Date</b>	08.06.2026		

**DISCHARGE SUMMARY**

**Consultant:**  
**Dr. MAHALAKSHMI GOLI**  
MBBS , MD(OBG)  
AMC16257

**Diagnosis: G2P1L1 AT 37+4 WEEKS WITH PREVIOUS LOWER SEGMENT CESAREAN SCETION IN SECOND STAGE OF LABOUR FOR DELIVERY**

**SPONTANEOUS VAGINAL BIRTH AFTER CESAREAN (VBAC) DONE ON 06.06.2026**

**History:**

LMP: 15.08.2025  
EDD: 22.06.2026

Obstetric formula: G2P1L1  
Gestation at admission: 37+4 weeks

Name	Mrs R SAHITHI	UHID	HNH-00003174
IP No	IP26-00006520	Admission Date	06-06-2026

**Obstetric History:**

G1 - 2024- FTLSCS, (Indn : cord around neck), female, 2.7kg, uneventful, A&H  
 G2 - Present pregnancy Spontaneous conception.

Medical History : Nil

Surgical History: LSCS 2024

Allergies : Nil

Family History : Mother: hypothyroid, Father- DM type 2

**Antenatal Details:**

Mrs R SAHITHI was booked to Rainbow hospital at 15+1 weeks of gestation. She had regular antenatal checkups and investigations as advised. NT scan was normal. Quadruple marker was low risk. Diagnosed with gestational hypothyroidism at 20+6 weeks, started on Tab Thyronorm 75mcg OD. TIFFA was normal Fetal monitoring was done by serial growth scan. Scan done at 06.04.2026 showed SLIUP at 28+6 weeks with AFI 15.4 cm with Placenta anterior high with EFW 1.289gm (36%) with AC 18% with doppler normal. She was admitted at 37<sup>+4</sup> weeks with labour pains for delivery.

**Investigations:** Enclosed

Blood group : B positive

**Management: Course in hospital and Delivery Details:**

At admission on clinical examination the vitals were stable, uterus was acting, cervix was effaced and fully dilated, membrane absent with clear liquor draining at vertex +1 station. Fetal well being was confirmed by an admission CTG which was found to be reactive. Informed consent taken for vaginal birth

<b>Name</b>	Mrs R SAHITHI	<b>UHID</b>	HNH-00003174
<b>IP No</b>	IP26-00006520	<b>Admission Date</b>	06-06-2026

after cesarean (VBAC). As per hospital protocol she was started on IV. Taxim in view of ruptured membranes. Passive descent of fetal head was allowed. 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. At crowning of head episiotomy was given under local anesthesia (10 ml of 2 % xylocaine solution). 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. Episiotomy inspected. No extensions or additional vaginal tears found. Episiotomy sutured in layers. Instrument and swab count checked. 600 mcg of misoprostol given per rectally as prophylaxis against post partum hemorrhage. Vagina cleaned with betadine solution.

**\*1 loop of cord around neck**

**Delivery Details:**

Date : 06.06.2026  
Time of Delivery: 01:16pm  
Type of Labour : Spontaneous  
Type of Delivery: Spontaneous vaginal birth after cesarean (VBAC)

**Baby Details:**

Date : 06.06.2026  
Time of Delivery: 01:16pm  
Sex : Male  
Weight : 2.78kg  
Apgar : 9,10  
Gestational Age: 37+4 weeks

Name	Mrs R SAHITHI	UHID	HNH-00003174
IP No	IP26-00006520	Admission Date	06-06-2026

NICU Admission: Yes, Small anal opening

**Post-Partum Notes:** She was closely monitored for post partum hemorrhage. Breast feeding initiated. Vitals were stable; patient ambulated and was shifted to room. Baby was shifted to NICU for further evaluation in view of small anal opening to rule out VACTERAL causes. Baby in NICU at the time of discharge and planned for Anoplasty. Patient was encouraged for spontaneous voiding. Dietary advice given. Her postpartum period following that was uneventful. On first postpartum day episiotomy wound was healthy and intact. 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 11.06.2026 (8am-2pm-10pm) after food.
3. Tab. Pantodac (Pantoprazole - 40mg) 1 tablet twice daily till 12.06.2026 v(7am-7pm) before food.
4. Tab. Voveran 50 mg (Diclofenac 50mg) thrice daily till 11.06.2026 (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. Placentrix ointment for local application.
8. Syp. Duphalac 15 ml (Lactulose 3.33gm/5ml) at bed time for one week.
9. Ensure protein powder twice daily in one glass of milk for 1 month
9. Continue Tab thyronorm 50mcg once daily till further advise

<b>Name</b>	Mrs R SAHITHI	<b>UHID</b>	HNH-00003174
<b>IP No</b>	IP26-00006520	<b>Admission Date</b>	06-06-2026

10. Repeat FT3, FT4 and TSH after 6 weeks and review

Review with Dr. MAHALAKSHMI GOLI after **2 weeks** on **22.06.2026** at postnatal clinic with prior appointment.

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

Patient/ Attender

In case of emergency like bleeding, fever [please refer to postpartum book for further details - Chapter II page 6] kindly contact 9154865045 at Rainbow Himayathnagar 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](http://www.rainbowhospitals.in)

*Duva*  
**Registrar/Resident/C.M.O**



**Dr. MAHALAKSHMI GOLI**  
MBBS , MD(OBG)  
AMC16257

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006520 Admit Date : 06-Jun-2026 Admit Time : 12:45 PM UHID : HNH-00003174

Patient Details :

Patient Name : Mrs R SAHITHI Age : 25 Y 11 M 24 D  
Guardian : Mr N. VEERENDER DOB : 13-06-2000  
Gender : Female Religion :  
Occupation : Martial Status : Married  
Address (H) : VILLA NO: 90, FAROOQ NAGAR, SHADNAGAR. Phone No : 9390612127/ 9494886647  
Shadnagar Mahabubnagar Telangana INDIA E-mail : RATHODSAHITHI2000@GMAIL.COM  
509216

Admission Details :

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

Contact Details :

Name : Mr N. VEERENDER Relationship : Husband  
Contact Address : VILLA NO: 90, FAROOQ NAGAR, Phone No : 9494886647  
SHADNAGAR. Shadnagar Mahabubnagar  
Telangana INDIA 509216

  
Signature

Doctor Details :


Doctor Name : Dr. MAHALAKSHMI GOLI Specialisation : OBSTETRICS AND GYNECOLOGY  
Referral Doctor : SELF Phone No :  
Co-Consultant :

Payment Details :

Deposit Amount : 80000.00  
Payment Mode : DC/CC Card Payor Name : SELFPAY

# PATIENT TRANSFER FORM



Patient Name & UHID No. HNH-00003174 IP26-00006520 Mrs R SAHITHI 13-08-2000 25 Y 11 M 24 D (F) Dr. MAHALAKSHMI GOLI 		Date & Time of Admission 6/6/26 @ 12:45 PM	Date & Time of Transfer Order 6/6/26 @ 5 PM
		Transfer Ordered by DR. Naveena	Reason for Transfer Observation
From Unit 2DR	To Unit Room	Information to Attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Number of Sheets in Clinical File 28	Number of Imaging Films -1-	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Sis. Sujatha		Name of Person Ordered Transfer DR. Naveena	
Patient & Clinical Records Received by : Madhvi			
Date & Time of Patient Received : @ 6/6/26 5:10 PM			

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

- Unavailable Bed                     
  Nurse not Available                     
  Available Bed not ready

**ACTIVITY RECORD FOR BILLING**

Name : \_\_\_\_\_ HN-00003174 IP26-00008520  
 Mrs R SAHITHI  
 13-08-2000 25 Y 11 M 24 D (F)  
 Dr. MAHALAKSHMI GOLI

UHID No. : \_\_\_\_\_ Consultant: \_\_\_\_\_ Dept : \_\_\_\_\_

Date of Admission: \_\_\_\_\_ Date of Discharge : \_\_\_\_\_ Time: \_\_\_\_\_

Room / Bed No : \_\_\_\_\_ Ward : \_\_\_\_\_ Suggested Billable bed type : \_\_\_\_\_



**WARD TRANSFERS**

Date	Time	From	To	Signature of Nurse
6/6/26	5PM	Pre & Post	OT	Akshita / [Signature]
6/6/26	8:37pm	Pre & 2nd ward	3rd floor	Madh / [Signature]
6/6/26	10:40pm	3rd ward	gnd floor	[Signature]

**Cross Consultation Visit**

	Doctors Name	Date	Order No.	Signature
1	Dr. Sindhana	6/6/26	5071	[Signature]
2				
3				
4				
5				
6				
7				
8				
9				
10				





**PROCEDURE**

Date	Procedure	Quantity	Order No.	Signature
6/6	IV placement	①	209747	Li
<del>6/6/26</del>	<del>code location</del>	①		
	<del>code</del>			
6/6/26	NHA	①	4882	①

*Cross check done by  
Sr. Sandhya*

**ANY OTHER INFORMATION**

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
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# IP ADMISSION SHEET FOR OBSTETRICS

## Presenting Complaints

came clo pain abdomen  
∴ today morning.

## Obstetric Formula:

ML: Nov-2023, G2 P1 L1

## Obstetric History:

1st: FT USCS 2024, (undiagnosed  
fruit - 2.7kg around neck)  
female @ Rainbow

## Present Pregnancy Record:

2nd: PP, Spontaneous Conception  
NT-normal, FTS-low risk

## RISK FACTORS:

TIFPA normal

diagnosed = hypothyroidism  
@ 3moA and started  
on T. thyronaem  
75mcg

Height: ..... cm

Weight: ..... kg

Allergies: ..... Nil

Breast:  Normal  Abnormal

## General Examination:

Consciousness: c/c Pallor: no

Icterus: no Edema: ++

Temp: Afebrile PR: 91bpm

BP: 130/80mmHg. DTR: (N)

CVS: S/S & From umbilical RS B/L NUBS ⊕

Liver/Spleen: (N) Urine Output: Adequate

LMP: 15/8/2025

EDD:

Corrected EDD:

GA:

Menstrual History: Regular:  Yes  No

## Obstetric Examination

Fundal Height: term

Ut. Activity:  Relaxed  Mild  Mod  Severe

Liquor:  Adequate  Oligo  Poly

PP:  Cephalic  Breech Others \_\_\_\_\_

Head Fifths Palpable: 1/5<sup>th</sup>

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 fully

Membranes:  Present  Absent

Liquor:  Clear  Meconium  Blood Stained

Presenting Part:  Vertex  Breech  Others

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

Pelvis:  Adequate  Doubtful

## DIAGNOSIS

G2 P1 L1 with 37w 4 days POG with previous  
USCS came in 2nd stage labour



<p>Family History:</p> <p>Mother - hypothyroid Father - T<sub>2</sub>DM</p>	<p>Surgical History:</p> <p>LSCS - 2024</p>
<p>Medical History: Gestational Klebs hypothyroidism Eon T-thyronam. 75mcg</p>	<p>Medication History:</p> <p>T-IRON T-CALCIUM T-THYRONORM 75mcg</p>
<p>Plan of Care:</p> <p>Admission XIST iv Antibiotics Call paediatrician Pain preparation w/ POL strict FHR monitoring Monitor Vitals Inform SCS</p>	<p>Investigations: <u>BGT - B positive</u> <u>CBP 14/5/2026</u> Hb: 12.8 plt: 1.28 TLC: 15,100 PCV: 27.2% HIV HbsAg HCV VDRL } NR <u>USG (6/4/2026)</u> SLIUF Cephalic AFI - 15.4cm placenta - Ant high. EFW - 1.289 qms. (AC - 18%) Doppler - normal. 36%</p>

Doctor Name: Dr. Naveena.

Signature: @

Date & Time: 6/6/2026 @ 1:30pm

Consultant Name: Dr. Mahalakshmi

Signature: Mahalakshmi

Date & Time: 6/6/2026



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
06/06/2016 1:00 PM	SIB. Nareena / Dr Ranya	
	G2P4 prev W.D. @ 37 <sup>+</sup> 04 in active labor	
	clo learn down sensation	- Advice:
		- Mentals
	O/E: P= 80 bpm	→ Inform pediatrician
	BP - 110/80	
	PA not TS, up to 15 <sup>th</sup>	→ To shift to LR.
	RHSB Reg, no scar tenderness	for delivery
	3/10/30-40"	
	pv' is fully dilated	- Informed
	fully effaced	consent for
	Vx FM + 2 ↓ + 2	VBAC.
	OA	→ Inform AXON team
	- patient & relatives have been explained regarding present condition of the patient & risks of vaginal birth. after cesarean section like scar rupture, need of operative delivery, operative intervention, Excess blood loss. in the language they best understand. As patient is in full dilation, proceeding with VBAC delivery, <del>under</del> taking all necessary precautions.	

Dr Ranya (PTO)





**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
5/6/2026 4:00pm	cls by	Dr. Naveena
U- F-X S-X	all GC fair Alebnik Vitals - stable. PA: ut retracted well Soft, NT. IIE: PV bleeding wNL episiotomy wound clean & healthy Baby: mother's milk	Adv - Regular diet - Adequate hydration - drugs as charted - w/f PV bleeding - Ambulation - Monitor Vitals - In/Out SCS
	Kindly shift the patient to room	
5:10 PM	GC fair Temp @ PR 8 1/2 BP 110/76 w/HF Breasts @ Ut retracted well contour maintained urine passed Baby passed motion	Plenty of oral fluids Soft diet

Baby to be reviewed by Paed.



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/6/2020	C/S/Lb @	Momolu
7:30pm	PND-0	
		Adm
	CC for Afibrile	Regulen diet
	Vitals Stable	Adex hydration
<u>Baby</u> -new	P/A ut well retract	Drugs as clari
	AV Bleedy w/n	w/ vitals & BPV
uv		Ambulation
Sx	No complaints	Infum sm
		by Ananda
		noted by Sr. Sandhya
		6/6/20
		7:30pm
7/6/2020	C/S/Lb @ Momolu	
7am	PND-1	Adm
	CC for Afibrile	Regulen Diet / Adex Hydrat
	Vitals Stable	Drugs as clari
<u>Baby</u> -new	P/A ut well retract	w/ vitals & BPV
	AV Bleedy w/n	Ambulation
uv	Epistaxis intact	Infum sm
<u>Pv</u>		
Sx	No complaints	noted by Sr. Sandhya
		7/6/20
		7:30pm



**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
<del>7/6/26</del> <del>11:30 am</del> 11:30 am	c/s/B Dr. Mahalakshmi. G - Dr. G. Veena c/d/w Dr. Spandana	
u ✓ sx ✓	Pt is stable, No c/o o/e - GC fair Vitals - stable P/A - UT well retracted Wt - B.W.N.L. <u>Baby in NICU</u> ↓ - Planned for sx tomorrow - Requires stay of 1 week to 10 days	Adv ✓ Regular diet ✓ Drugs as charted ✓ Adequate hydration ✓ Ambulation. - Perform SOS ✓ - Plan for discharge tomorrow NB Saranda
<del>7/6/26</del> 9:30 pm	c/d/B Dr. Veena PND - 1 Pt is stable, No c/o o/e GC fair & Afebrile Vitals - stable P/A UT - well retracted BS (+) Wt - B.W.N.L. <u>Baby in NICU</u>	Adv - Regular diet - Drugs as charted - Adequate hydration - Ambulation - Dis tomorrow - Perform SOS
		noted by sr. Sandhya 7/6/26 @ 9:pm



HNH-0003174 IP26-0006520  
 Mrs R. SAMITHI  
 13-06-2000 25 Y 11 M 24 D (F)  
 Dr. MAHALAKSHMI GOLI



# DRUG CHART

Date of Admission: 6/6/26 Drug Allergies: N/A  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)

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

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

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

VERIFIED BY : Name ..... Signature



REGULAR PRESCRIPTIONS

Weight. .... Ward. ....

<b>DRUG :</b> INJ-CEFOTAXIME				Date/Time	6/6	7/6	8/6													
Dose	Route	Frequency	Start Date																	
1gm	iv	BD	6/6	6AM	X	(S)	(S)													
Name & Signature of the Doctor Starting the Drugs: Dr. Naveena																				
Additional Instructions: ATD for 24hrs				6pm to 8pm																
<b>Daily Doctor's Endorsement by a Sign</b>				1																

<b>DRUG :</b> T-PANTOPRAZOLE				Date/Time	6/6	7/6	8/6													
Dose	Route	Frequency	Start Date																	
40mg	PO	BD	6/6	6AM	+	(S)	(S)													
Name & Signature of the Doctor Starting the Drugs: Dr. Naveena																				
Additional Instructions: BEFORE FOOD				6pm to 8pm																
<b>Daily Doctor's Endorsement by a Sign</b>				2																

<b>DRUG :</b> T-DICLOFENAC				Date/Time	6/6	7/6	8/6													
Dose	Route	Frequency	Start Date																	
50mg	PO	TID	6/6	6AM	X	(S)	(S)													
Name & Signature of the Doctor Starting the Drugs: Dr. Naveena																				
Additional Instructions: AFTER FOOD				10pm																
<b>Daily Doctor's Endorsement by a Sign</b>				2																

<b>DRUG :</b> SYP-DUPHALAC				Date/Time	6/6	7/6														
Dose	Route	Frequency	Start Date																	
15mg	PO	OD	6/6																	
Name & Signature of the Doctor Starting the Drugs: Dr. Naveena				10pm																
Additional Instructions:																				
<b>Daily Doctor's Endorsement by a Sign</b>				2																



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 Dr. MAHALAKSHMI GOLI



Sheet No: .....

**REGULAR PRESCRIPTIONS**

Weight ..... Ward .....

<b>DRUG :</b> T. HYDROCOORM				Date Time	7/6	5/6															
Dose	Route	Frequency	Start Dt.																		
75mg	PO	OD	6/6																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					
<b>DRUG :</b> T. PARACETAMOL				Date Time	7/6	7/6	6/6														
Dose	Route	Frequency	Start Dt.																		
1g	PO	7/6	6/6																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					
<b>DRUG :</b>				Date Time																	
Dose	Route	Frequency	Start Dt.																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					
<b>DRUG :</b>				Date Time																	
Dose	Route	Frequency	Start Dt.																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					

Signature  
Verified By: Name



Date Time	Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.	
DRUG :	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route	Dose		Dose		Dose		Dose	
Start Date	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.	

Date Time	Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.	
<b>VARIABLE DOSE</b>								
DRUG :	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route	Dose		Dose		Dose		Dose	
Start Date	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
6/6	1:18pm	INS-OXYTOCIN	100	im	(Signature)	(Nurses)
6/6	1:30pm	ZETEN SUPPOSITORIES	1	PR	(Signature)	(Nurses)
6/6	1:30pm	INS. METHERGIN	0.2mg	iv	(Signature)	(Nurses)
6/6	1:30pm	INS. TRANEXAMIC ACID	1gm	iv	(Signature)	(Nurses)
6/6	1:30pm	T-MISOPROSTOL	600mcg	PR	(Signature)	(Nurses)

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



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Dr. MAHALAKSHMI GOLI



303

208

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

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Your Right to a Safe Delivery

## 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.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					

RO

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Blood group = B Positive						
HIV } NR						
HbsAg } NR						
HCV } NR						

Culture and Sensitivities : .....

.....

.....

.....

Radiology :      USG : .....

                    X-Ray : .....

                    ECHO : .....

                    CT : .....

                    MRI : .....

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

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 Dr. MAHALAKSHMI GOLI



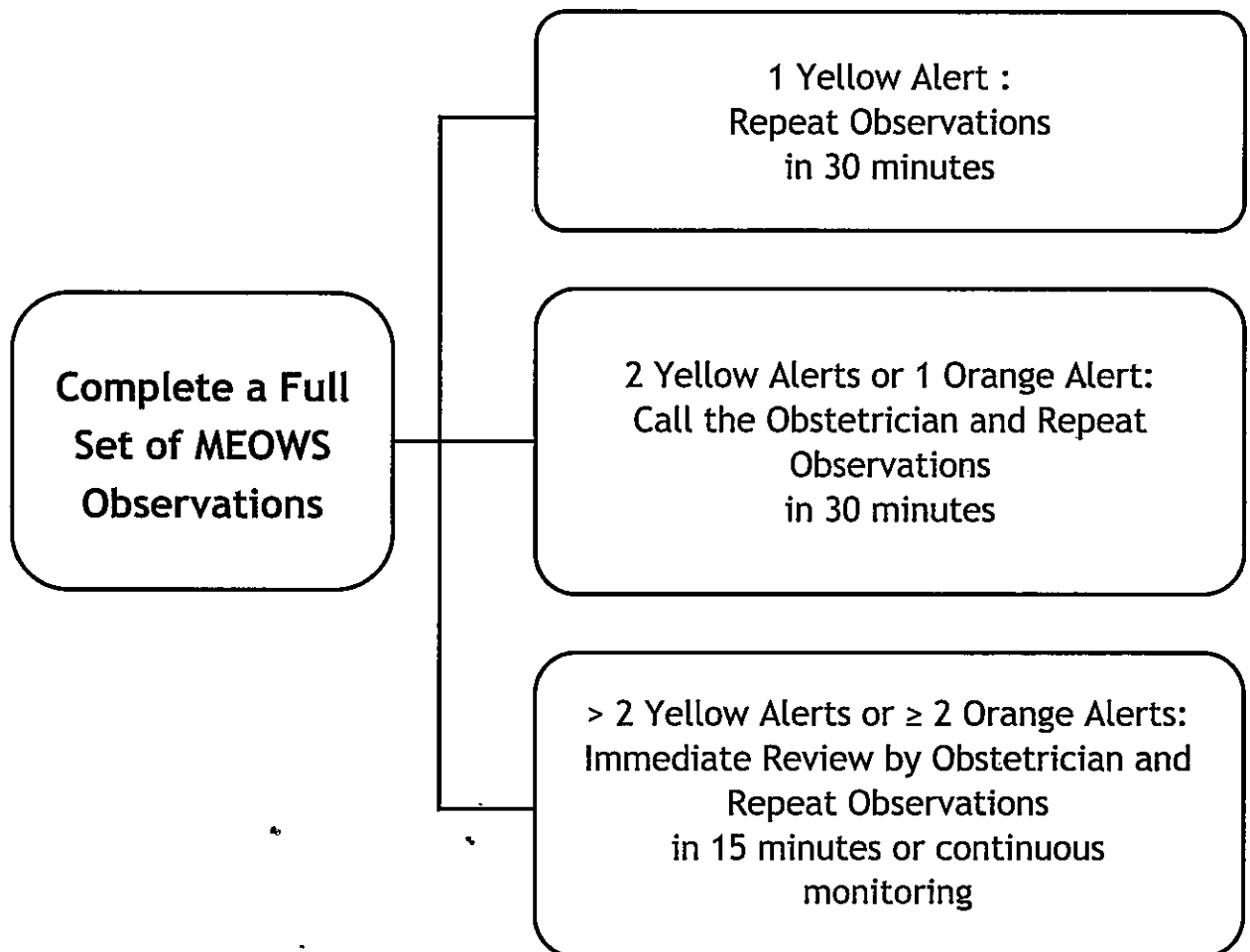
# Early Warning Observation Score Chart - Obstetrics

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

6/6/26

		Date																									
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	
RESP (write rate in corresp. box)	> 30																										
	21 - 30																										
	11 - 20							20	20	20	20	20	20	20			20				20					20	
	0 - 10																										
Saturations	94 - 100 %							99	99	99	99	99	99	99			99				99					99	
	< 94 %																										
Administered O <sub>2</sub> (L/min.)																											
Temp °C	40																										
	39																										
	38																										
	37																										
	36								98	98	98	98	98	98			98				98					98	
	< 35																										
Heart Rate	170																										
	160																										
	150																										
	140																										
	130																										
	120																										
	110																										
	100																										
	90																										
	80																										
	70								78	80	80	80	85			83				79					85		
60																											
50																											
40																											
Systolic Blood Pressure	190																										
	180																										
	170																										
	160																										
	150																										
	140																										
	130																										
	120																										
	110																										
	100																										
	90																										
80																											
70																											
60																											
50																											
40																											
Diastolic Blood Pressure	130																										
	120																										
	110																										
	100																										
90																											
80																											
70																											
60																											
50																											
40																											
NEURO RESPONSE [✓]	Alert																										
	Voice																										
	Pain																										
	Unresponsive																										
URINE mls / hour	> 30																										
	< 30																										
Proteinuria	Protein ++																										
	Protein > ++																										
Lochia	Normal																										
	Heavy / Foul																										
Liquor	Clear / Pink																										
	Green																										
TOTAL YELLOW SCORES								0	0	0	0	0	0			0				0					0		
TOTAL ORANGE SCORES								0	0	0	0	0	0			0				0					0		
Nurse Initial								S	S	S	S	S	S			S				S				S			

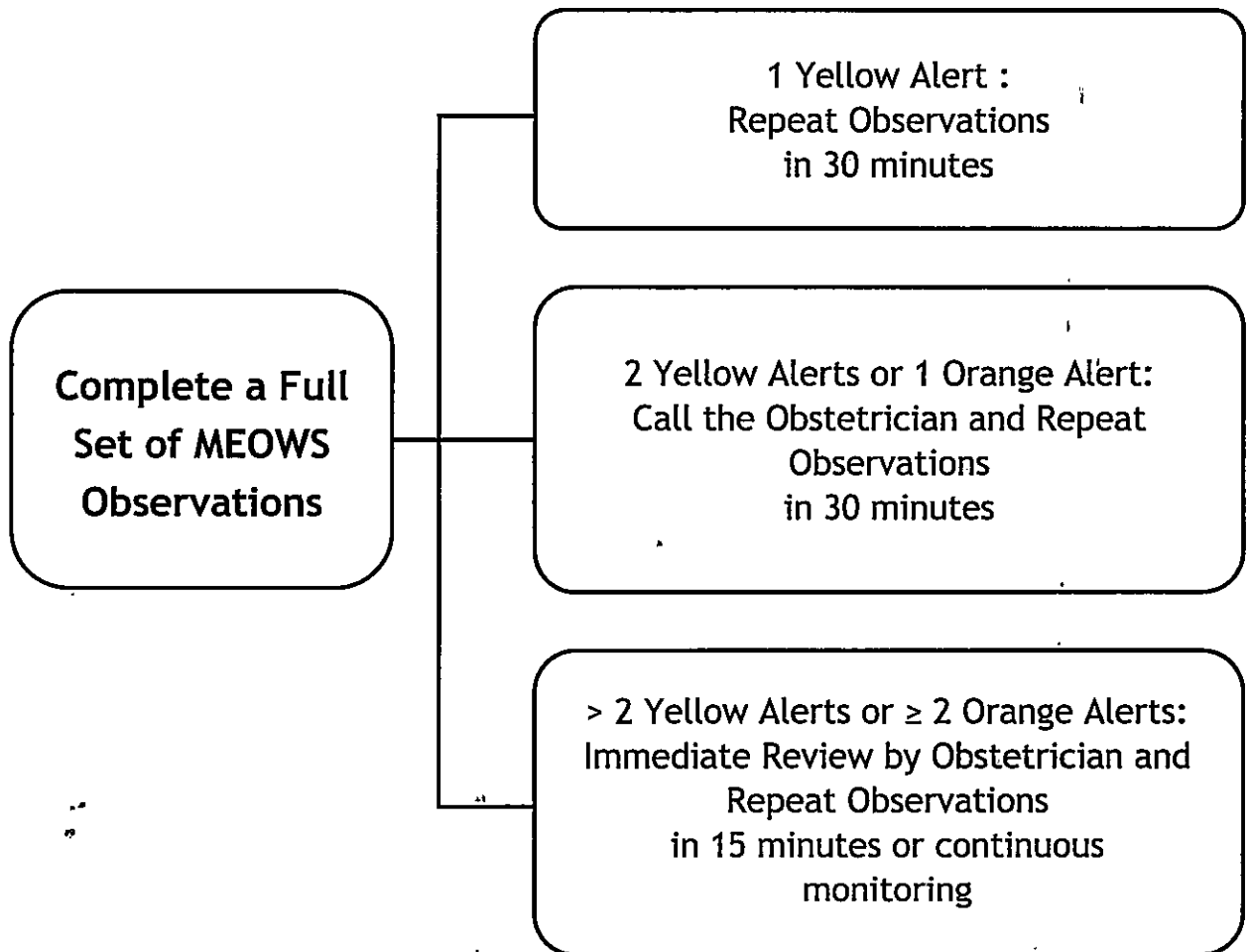
## Obstetrics and Gynaecology Early Warning Signs



\* The Modified Early Warning Score (MEOWS)



## Obstetrics and Gynaecology Early Warning Signs



\* The Modified Early Warning Score (MEOWS)

HNH-00003174  
 Mrs R SAHITHI  
 13-08-2000  
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 25 Y 11 M 24 D (F)



# FLUID CHART

Sheet No. : ①

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
6/6/26	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am	RL	RD										
	12:00 pm	RL	RD		100ml								
	01:00 pm	RL	RD		100ml								
<b>Total Intake :</b>			taken			<b>Total Output :</b>							
	02:00 pm												
	03:00 pm		idly										
	04:00 pm												
	05:00 pm		Ho										
	06:00 pm												
	07:00 pm												
<b>Total Intake :</b>			taken			<b>Total Output :</b>							
6/6/26	08:00 pm												
	09:00 pm		milk										
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
<b>Total Intake :</b>			taken			<b>Total Output :</b>							
6/6/26	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
<b>Total Intake :</b>			taken			<b>Total Output :</b>							

**Total 24 hrs. Intake**

**Total 24 hrs. Output**

# FLUID CHART

Sheet No. : .....

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

Date	Time	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
6/6/26			Mouth	I.V	N.G							
	08:00 am											
	09:00 am	lady										
	10:00 am	Rice										
	11:00 am											
	12:00 pm											
01:00 pm												
<b>Total Intake :</b>		Taken			<b>Total Output :</b> U-2 M-x							
7/6/26	02:00 pm	Rice										
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
<b>Total Intake :</b>		Taken			<b>Total Output :</b> U-2 M-x							
7/6/26	08:00 pm											
	09:00 pm											
	10:00 pm	Rice										
	11:00 pm	H2O										
	12:00 am											
	01:00 am											
<b>Total Intake :</b>		Taken			<b>Total Output :</b> U-2 M-x							
8/6/26	02:00 am											
	03:00 am											
	04:00 am	H2O										
	05:00 am											
	06:00 am											
	07:00 am											
<b>Total Intake :</b>		Taken			<b>Total Output :</b> U-3 M-							

**Total 24 hrs. Intake**

**Total 24 hrs. Output**

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 Mrs R SAHITHI 25 Y 11 M 24 D (F)  
 13-08-2000  
 Dr. MAHALAKSHMI GOLI



# CHECKLIST FOR THROMBOPHLEBITIS



S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	6/6 DAY-1			7/6 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	0	0	0	0					
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	-	-	-	-	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													

**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



## CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

Signature of Ward In Charge :

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

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

HNH-00003174

IP26-00006520

Mrs R SAHITHI

13-06-2000

25 Y 11 M 24 D (F)

Dr. MAHALAKSHMI GOLI



# BRADEN 'Q' SCALE



Date : 6/6/26  
Time : 06:30pm  
10am

Mobility	<b>1. Completely immobile:</b> Does not make even slight changes in body or extremity position without assistance.	<b>2. Very limited:</b> Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	<b>3. Slightly limited:</b> Makes frequent through slight changes in body or extremity position independently.	<b>4. No limitations:</b> Makes major and frequent changes in position without assistance.	4	4	4
"Activity The degree of physical activity"	<b>1. Bedfast :</b> Confined to bed	<b>2. Chairfast :</b> Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.*	<b>3. Walks occasionally:</b> Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	<b>4. All patients too young to ambulate; OR walks frequently:</b> Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4
Sensory Perception	<b>1. Completely limited:</b> 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.	<b>2. Very limited:</b> 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.	<b>3. Slightly limited:</b> 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.	<b>4. No impairment:</b> Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4
Moisture Degree to which skin is exposed to moisture	<b>1. Constantly moist:</b> Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	<b>2. Very moist:</b> Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	<b>3. Occasionally moist:</b> Skin is occasionally moist, requiring linen change every 12 hours.	<b>4. Rarely moist:</b> Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4
<b>FRICION-SHEAR</b> Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	<b>1. Significant problem:</b> Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	<b>2. Problem:</b> 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.	<b>3. Potential problem:</b> 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.	<b>4. No apparent problem:</b> Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times.*	4	4	4
Nutritional Usual food intake pattern	<b>1. Very Poor:</b> 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.	<b>2. Inadequate:</b> 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.	<b>3. Adequate:</b> 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.	<b>4. Excellent:</b> Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4
Tissue Perfusion & Oxygenation	<b>1. Extremely compromised:</b> Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	<b>2. Compromised:</b> Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	<b>3. Adequate:</b> Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	<b>4. Excellent:</b> Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4

**TOTAL SCORE** 28 28 28  
**Evaluator's Name** [Signature]

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

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

Risk Score	Category	Action	<b>Support Surfaces</b> (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"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	<ul style="list-style-type: none"> <li>• Use the Same Protocol as for “At Risk” Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> <li>• Follow the same protocol as for “Moderate Risk” Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>	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"> <li>• Use same protocol as for “High Risk” Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

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 Mrs R SAHITHI  
 13-08-2000 25 Y 11 M 24 D (F)  
 Dr. MAHALAKSHMI GOLI

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# Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	6/6/26	6/6	7/6	Fall Risk Grading		
		Score	mb	28M	10pm	Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25				Low Risk	0 - 24	Standard Fall Precaution
	No	0						
Secondary Diagnosis (more than one diagnosis)	Yes	15				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0	0	0	0			
Ambulatory Aid	Furniture	30				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0						
IV / Heparin Lock or Saline	Yes	20	20	20	20	Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0						
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0						
Total Morse Fall Scale Score:			20	20	20			
Signature								

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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Mrs R SAHITHI

13-06-2000

25 Y 11 M 24 D (F)

Dr. MAHALAKSHMI GOLI



# PAIN ASSESSMENT FORM

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

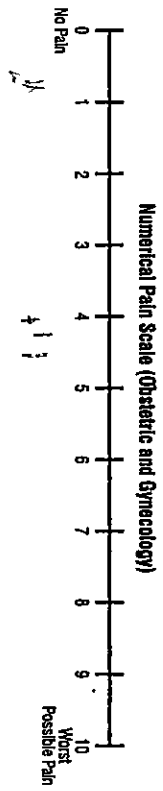
**Re-assessment Frequency:**

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

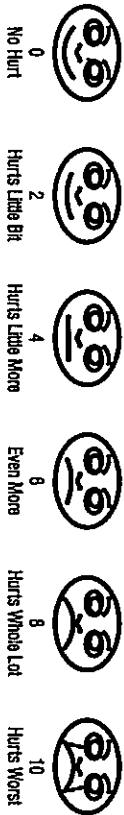
# PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdrawn, 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)	Means 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



Wong - Baker (Pediatrics) Above 7 Years



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

Assessment Criteria	Sedation			Normal	Pain / Agitation
	-2	-1	0		
Crying Irritability	No Cry with painful stimuli	Means 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	Arouses minimally to stimuli	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 <sub>2</sub>	No variability with stimuli	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO <sub>2</sub> 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO <sub>2</sub> less than or equal to 75% with stimulation - slow recovery Orit of sync or fighting ventilator



# NURSING CARE RECORD

Date: 6/6/26

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM 2PM	→ Assess the pt condition → monitor the vitals & record → Administration of medication → maintain I/O chart & record	8AM 2PM	→ Assessed the pt condition → monitored the vitals & recorded → Administered medication as per doctor's order → maintained I/O chart & recorded	Pt is stable	maintain I/O chart & record	Akuls @
Afternoon				day duty			
Night	8PM 8AM	→ Assess the patient general condition → monitor vitals → Administer medications as per doctor's orders.	8PM 8AM	→ Assessed the patient general condition → monitored vitals → Administered medications as per doctor's orders	Patient is stable	Rechecked vitals	Sh

HNH-00003174 26-00006520  
 Mrs P. MAHALAKSHMI  
 06-2000 25 Y 11 M 24 D (F)  
 Dr. MAHALAKSHMI GOLI



Patient Sticker

# NURSING CARE RECORD

Date: 7/5/26

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am 10 2pm	- Assess the pt condition - Monitor the v/s - maintain the I/O - Drug as per chart	8am 10 2pm	- Assess the pt condition - Monitor the v/s - maintain the I/O - Drug as per chart	- Now pt is stable	- Rechecked the v/s	(Signature)
Afternoon	2pm 8pm	-> Assess the pt condition -> monitor vitals. -> maintained I/O chart -> drug as per chart	2pm 8pm	-> Assessed the pt condition -> monitor vitals. checked & recorded -> I/O chart maintained -> All medication given as per chart	-> pt is stable	-> Rechecked the vitals.	(Signature)
Night	8pm	-> Assess the patient general condition -> monitor vitals -> Administer medications as per doctor's orders	8pm	-> Assessed the patient general condition -> Monitored vitals -> Administered medications as per doctor's orders	Patient is stable	-> Rechecked vitals	(Signature)

### NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: .....					
	Surgery / Procedure: <u>EMLSU</u>	Post OP Day:					
BACKGROUND	Date	<u>6/6</u>	<u>6/6/26</u>	<u>7/6/26</u>	<u>7/6/26</u>	<u>7/6/26</u>	
	Shift	<u>H6</u>	<u>N8</u>	<u>M6</u>	<u>E2</u>	<u>N8</u>	
	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
ASSESSMENT	Diet:	<u>NBM</u>	<u>Regular</u>	<u>Regular</u>	<u>Regular</u>	<u>Regular</u>	
	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, VENT):	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
	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:	<u>99.1°f</u>	<u>97.5°f</u>	<u>98.3°f</u>	<u>98.3°f</u>	<u>98.3°f</u>
		Res:	<u>20bmt</u>	<u>22b/m</u>	<u>22b/m</u>	<u>23b/m</u>	<u>23b/m</u>
	SpO <sub>2</sub> :	<u>99%</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>	
	Pulse:	<u>82bmt</u>	<u>85b/m</u>	<u>82b/m</u>	<u>79b/m</u>	<u>82b/m</u>	
	BP:	<u>110/70</u>	<u>119/70</u>	<u>113/62</u>	<u>106/64</u>	<u>109/80</u>	
	LOC:	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	
Fall Risk Score:	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>		
Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0</u>	<u>0</u>		
Skin Integrity	<u>good</u>	<u>-</u>	<u>good</u>	<u>intact</u>	<u>-</u>		
Recommendations	Safety Needs:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Physiotherapy:	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
	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:	<u>NBM</u>	<u>-</u>	<u>Regular</u>	<u>-</u>	<u>-</u>	
	Critical Lab Test / Values:	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	
	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	
	ADL (Dependent / Non Dependent):	<u>-</u>	<u>-</u>	<u>-</u>	<u>Dependent</u>	<u>-</u>	
Post Operative Procedure Special Orders:	<u>-</u>	<u>-</u>	<u>-</u>	<u>NA</u>	<u>NA</u>		
Handed Over By Name :	<u>Akhil</u>	<u>Sandhya</u>	<u>Sunand</u>	<u>Kushoban</u>	<u>Sandhya</u>		
Signature / ID :	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:	<u>6/6/26</u>	<u>7/6/26</u>	<u>7/6/26</u>	<u>7/6/26</u>	<u>8/6/26</u>		
Time:	<u>2pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>		
Taken Over By Name :	<u>Sandhya</u>	<u>Sunand</u>	<u>Kushuban</u>	<u>Sandhya</u>	<u>[Signature]</u>		
Signature / ID :	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:	<u>6/6/26</u>	<u>7/6/26</u>	<u>7/6/26</u>	<u>7/6/26</u>	<u>7/6/26</u>		
Time:	<u>8pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8pm</u>		

12  
12



# CONSENT FORM FOR TRIAL OF LABOR / REPEAT CESAREAN SECTION



Patient Name : Mrs R Sahiti Date of Birth: 13-06-2000  
 Husband's Name: Mv. N. Veerender UHID No. : HN70003174

You have had a previous cesarean section although "once a cesarean always a cesarean section" used to be the rule; some women may choose to attempt a "Trial of Labor" for Vaginal Birth after Cesarean section.

Your doctor will review the records of your cesarean section to determine whether or not you may attempt labor.

**Suitability for trial of labor for Vaginal Birth after Cesarean is assessed based on factors like:**

- When was the last caesarean done
- What is the type of scar on the uterus (Transverse / Vertical)
- Any complications during / after previous caesarean
- Where was it done
- Interval between pregnancies
- The course of your current pregnancy

You will have an opportunity to discuss this in detail with your doctor. Large studies have found a success rate of vaginal deliveries in 50 to 60% for women who have a trail of labor. The alternative to a trail of labor is to have a repeat cesarean section without labor.

If you qualify for a vaginal delivery after cesarean section, you need to understand the benefits and risks of a trial of labor. This will enable you to make an informed choice to either plan a trail of labor or a repeat cesarean section.

**Benefits, Risks, Alternatives for Trial of Labor for Vaginal Birth After Cesarean Section**

**Benefits:**

- Vaginal delivery after cesarean section include a shorter hospital stay and recovery period for you.
- A vaginal delivery is considered safer than a cesarean section for the mother, with less blood loss and less risk of infection.
- The baby may benefit from vaginal birth by less remaining lung fluid after the first breath.

**Risk:**

- May require a cesarean section during labor with a higher risk of infection
- There is a small (<1.2%) risk of the uterus opening in the area of the old incision. If this happens, it could cause distress, permanent injure or death to your baby, excessive bleeding and rarely may require a hysterectomy (removal of the uterus).

**Benefits and Risks with planned LSCS**

**Benefits:**

- No risk of uterine rupture in women undergoing Lower Cesarean Section
- Less risk of birth-related asphyxia for baby when compared with Vaginal Birth after Cesarean Section

**Risk:**

- Longer hospital stay and recovery period
- Increased risk of neonatal respiratory morbidity
- Increase the risk of serious complications in future pregnancies like adherent placenta, injury to bladder, bowel or ureter, hysterectomy; blood transfusion.

The risk of anesthetic complications in extremely low, irrespective of whether you opt for planned Vaginal Birth after Cesarean section or planner Lower Segment Cesarean Section.

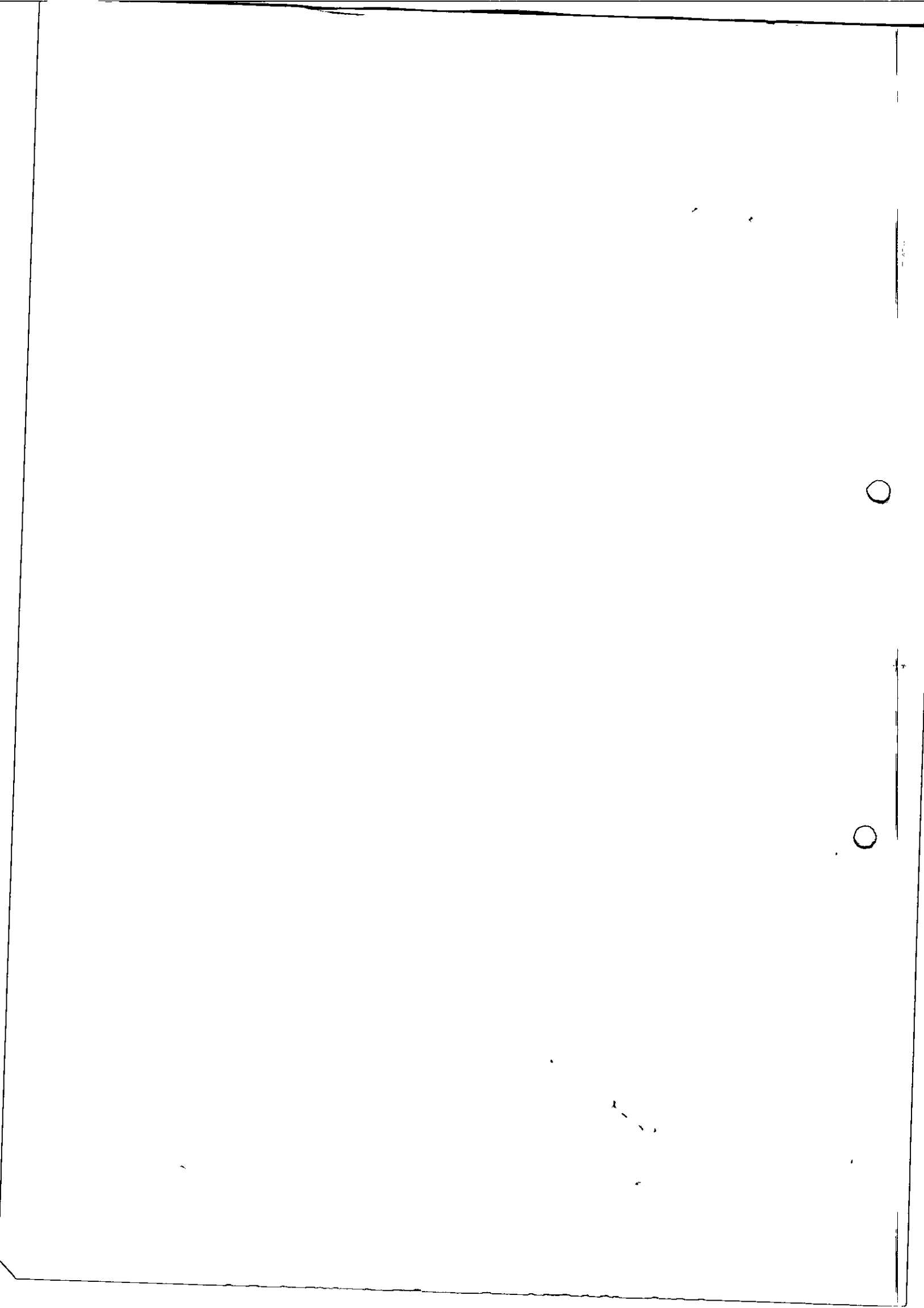
Your doctor will answer any further question that you may have.

**Please initial here that:**

I have read and understand the risk and benefits of each procedure. I have had the opportunity to have my questions answered and I elect for:  A trial of Labor for Vaginal Birth after Cesarean section  A repeat cesarean section

Name of the doctor who is performing the procedure: Dr Mahalaxmi Goli / Dr Ramya

<b>Patient Attendant</b> Signature : <u>[Signature]</u>	<b>Witness :</b>	<b>Doctor</b>
Name : .....	Signature : <u>R. Sahiti</u>	Signature : <u>[Signature]</u>
Relationship with Patient: <u>Husband</u>	Name : <u>Mrs R. Sahiti</u>	Name : <u>Dr Manisha</u>
Date & Time : <u>6/6/2020 @ 1pm</u>	Date & Time : <u>6/6/2020 @ 1pm</u>	Date & Time : <u>6/6/2020 @ 1pm</u>





DIETARY NOTES

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# NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 6/6/26 Time: 6pm

Origin: Indian Height: 155 cms Weight: 85 kg BMI:  ~ 26 kg/m<sup>2</sup>  
 ~ 28 kg/m<sup>2</sup>  
 ~ 30 kg/m<sup>2</sup>

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: [Signature]

Name: Sahithi

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

Dietician's

Signature: [Signature]

Name: Sabhwika G

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



HNH-00003174 IP26-00006520  
Mrs R SAHITHI  
13-06-2000 25 Y 11 M 24 D (F)  
Dr. MAHALAKSHMI GOLI

Patient Sticker



# CROSS CONSULTATION FORM

Doctor Name: Dr. Mahalakshmi Date: 6/6/26 Time: 6 PM

Diagnosis: Dr. Mahalakshmi NVD

Hospital: RCH - HMNR

Type of Referral :  
 Emergency  
 Urgent  
 Non Urgent

Referred for :  Opinion  Co-Management  Transfer of care

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

Signature:

### Findings and Recommendations :

Lactation care plan

- well formed breast & nipple's
- Advise for deep latch as demonstrated in cross cradle
- make baby suck 15-20 mins on each side every 2nd hly
- Colostrum seen

### Consultant :

Name : Sathya Signature : [Signature] Date & Time : 6/6/26 / 6 PM

# PARTOGRAPH

## 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:**  Nome  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:** .....  
**Duration of Instrumentation:** .....  
**No. of Pulls:** .....  
**Catherised :**  Yes  No  
**Type:**  Fileys  Plain  
**Perineum :**  Intact  Episiotomy  Tear  
**Suture Material Used:** Vicryl

## STAGE III

**Placenta:**  Normal  Abnormal  RP Clots  
 CCT  Retained  MRP  
**PPH :**  Atomic  Traumatic  None  
**Lacerations:** No  
**Cervical:** No  
**Perineal:** No  
**Others:** No  
**Prophylaxis:** Synocinon Prostodin  
**Blood Loss:** 300ml  
**Blood Transfusion:** -  
**Other Details (if any):** -  
**Ractal Examination:** normal

## DURATION OF LABOUR

**1st Stage:** .....  
**2nd Stage:** .....  
**3rd Stage:** .....  
**Duration of Active Pushing:** 1/2 hr  
**No. of VE'S:** .....

VBAC Delivery

## BABY DETAILS

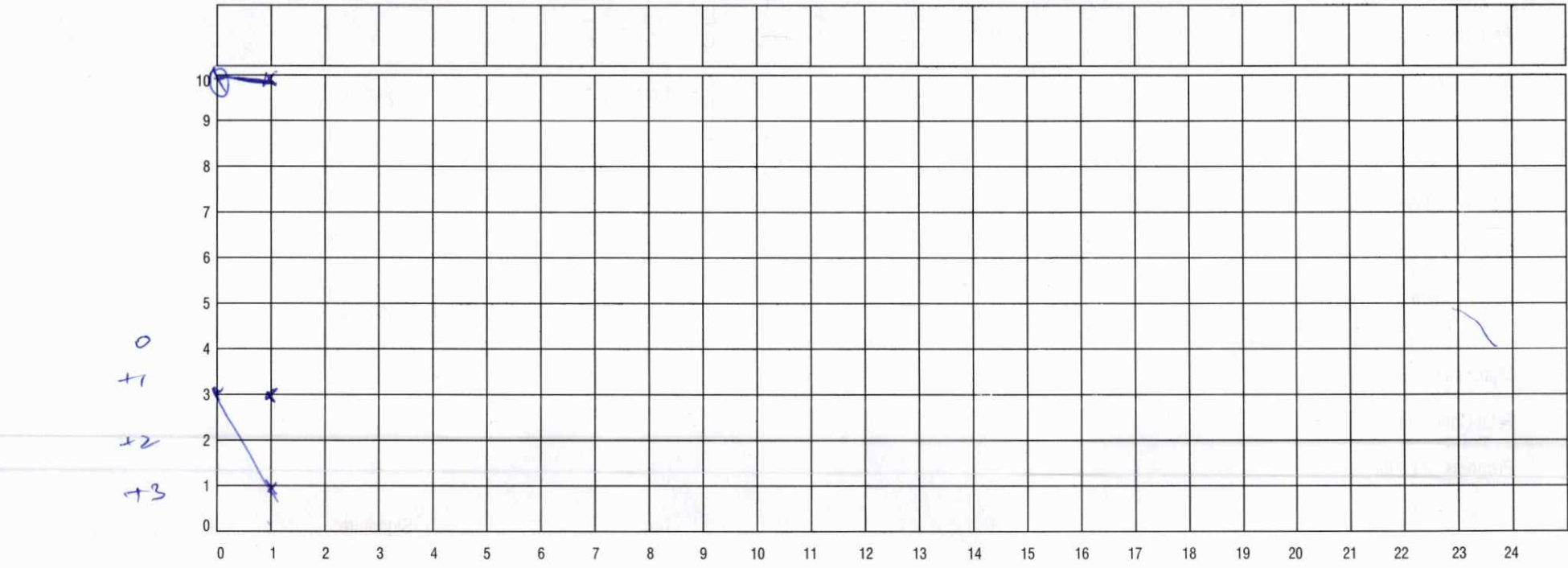
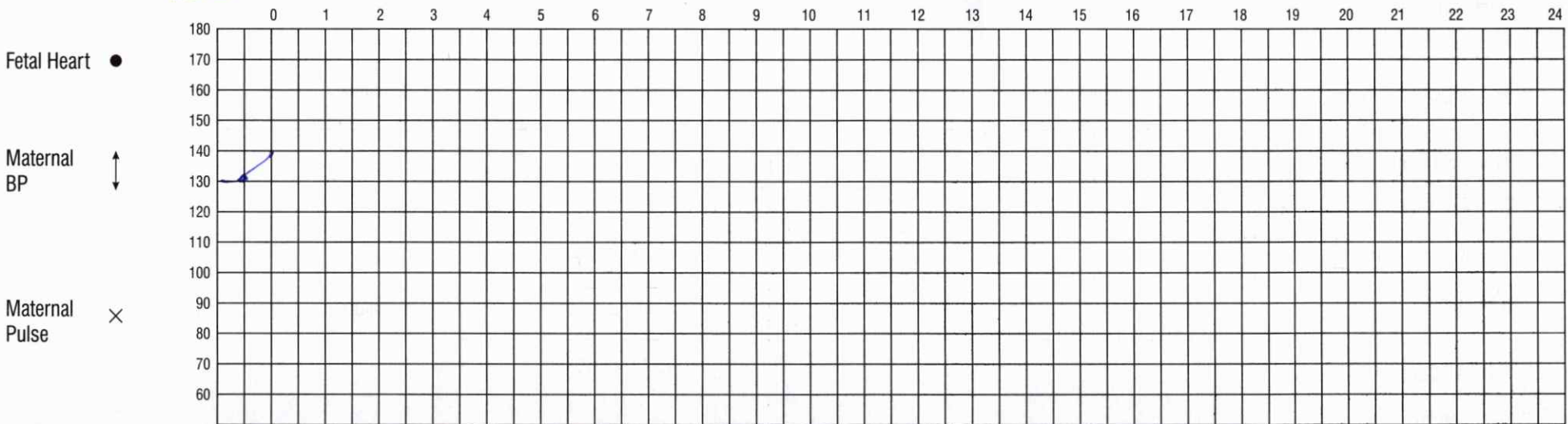
**Gender:** Male  
**Weight:** 2.78 kg  
**APGAR:** 9, 10  
**Date and Time of Delivery:** 6/6/2026 @ 1:16 pm  
**LW Doctor:** Dr. Ramya / Dr. Naveena  
**LW Sister:** Kasthuri Alathy



**PARTOGRAPH**

Name: Ms R Smith      Obstetrics Formula: G2P1      Blood Group Type: B+

Memb. Ruptured: SROM      PROM      ARM      Risk Factors: .....



0  
+1  
+2  
+3

**Record of Labor:**

Maternal Condition:

Vitals - stable.

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: .....

---

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

Time: ..... Signature: .....

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Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

Time: ..... Signature: .....

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HNH-00003174  
Mrs R SAHITHI  
13-08-2000  
Dr. MAHALAKSHMI GOLI  
IP26-00006520  
25 Y 11 M 24 D (F)

## 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: NO

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

9. Additional notes: .....

Continuity of Care:

Date: 6/6 .....

→ ASSESS the pt condition  
→ plan for vitals are checked &  
→ recorded  
→ 2nd hourly DBF given

Handover given by Luisa .....

Handover taken by Adunni .....

Signature Li .....

Signature Adunni .....

Date & Time: 6/6/26 @ 8pm .....

Date & Time: 6/6/26 @ 8pm .....

# OBSTETRIC TRIAGE ASSESSMENT FORM

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

1) Level of Consciousness:  Conscious  Semi-Conscious  Unconscious

2) Chief Complaint (Reason for Visit): (Circle the item as appropriate)

Severe Pain / Moderate Pain  Preterm rupture of Membranes / Leaking Water PV  
 Bleeding PV: Slight / Heavy  Preterm Labor/ Labor  
 Decreased Fetal Movement  Spontaneous Rupture of Membrane / Leaking Water PV  
 No Fetal Movement  Other Reason: .....

3) Vital Signs: Temperature: 99.8 Pulse: 92bmt RR: 20bmt SpO<sub>2</sub>: 99.1 BP: 110/70 Weight: .....

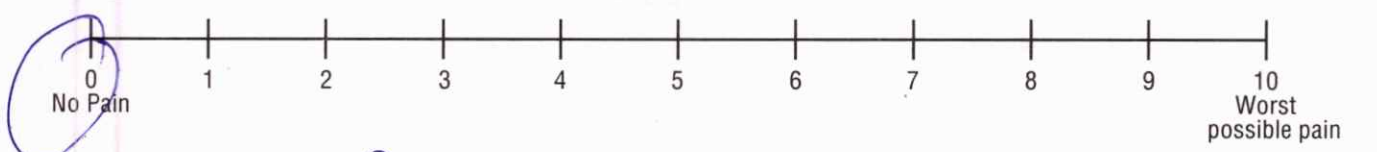
4) Gestational Criteria:

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

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

5) Pain Screening: Numerical Pain Scale (NPS)



• Location: .....  
 • Duration: ..... Days / Weeks/ Months (Strike out which is not applicable)  
 • Character: .....  
 • Frequency: will  
 • Interventions: .....

6) Past History:

a) Surgeries: .....  
 b) Medical: Di

HNH-00003174  
 Mrs R SAHITHI  
 13-08-2000  
 Dr. MAHALAKSHMI GOLI  
 IP26-00006520  
 25 Y 11 M 24 D (F)

No, If Yes : .....

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

9) **Prenatal Medical History:**

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

**Triage Category:** (Please tick on the category)

**Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)**

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

**OBCU Obstetrical Triage Acuity Scale (OTAS)**

OTAS	Level 1 (Resuscitative)	Level 2 (Emergent)	Level 3 (Urgent)	Level 4 (Less Urgent)	Level 5 (Non Urgent)
Level 1 (Resuscitative)	Immediate	≤ 15 minutes	≤ 30 minutes	≤ 60 minutes	≤ 120 minutes (2 Hours)
Re-Assessment	Continuous Nursing Care	Every 15 Minutes	Every 15 Minutes	Every 30 Minutes	Every 60 Minutes
Labour / Fluid	Imminent Birth	Suspected Pre-term Labour / PPROM < 37 Weeks	Signs of Active Labour > 37 weeks	Signs of Early Labour/ SROM > 37 weeks	Discomforts of Pregnancy
Bleeding	Active Vaginal bleeding with/ without abdominal pain	Bleeding associated with cramping (<spotting) <37 weeks	Bleeding associated with cramping (>spotting) >37 weeks	Spotting	
Hypertension	Seizure activity	Hypertension > 160/110 and / or headache, visual disturbance, RUQ pain	Mild hypertension > 140/90 with/without associated signs and symptoms		
Fetal Assessment	Abnormal FHR tracing Non-Fetal Movement	Atypical FHR tracing, abnormal dopplers Diseased fetal movement			
Others	<ul style="list-style-type: none"> <li>• Acute onsite severe abdominal pain</li> <li>• Altered level of consciousness</li> <li>• Cord prolapse</li> <li>• Severe respiratory distress</li> <li>• Suspected sepsis</li> </ul>	<ul style="list-style-type: none"> <li>• Major trauma</li> <li>• Shortness of breath</li> <li>• Unplanned and unattended birth</li> </ul>	<ul style="list-style-type: none"> <li>• Abdominal/back pain greater than expected in pregnancy</li> <li>• Flank pain / hematuria</li> <li>• Nausea /vomiting and /or diarrhea with suspected dehydration</li> </ul>	<ul style="list-style-type: none"> <li>• Ongoing assessment from out patient clinic (for hypertension, blood work)</li> <li>• Minor trauma (minor MVC/fall)</li> <li>• Nausea/Vomiting and /or diarrhea</li> <li>• Signs of infection (ie dysuria ,cough, fever, chills)</li> </ul>	<ul style="list-style-type: none"> <li>• Anything that does not seem to pose threat to mother or fetus</li> <li>• Cervical ripening</li> <li>• Out patient placenta previa protocols</li> <li>• Pre-booked visits (ie Rh and progesterone injections, NST</li> <li>• Assessment for version</li> <li>• Rashes</li> </ul>

Time seen by Doctor: .....

Nurse Name : AKWib Nurse Signature: [Signature]

Date: 6/6/26 Time: 3:30pm



## LABOUR AND DELIVERY NURSING ASSESSMENT

Date of Admission: 6/6/26

**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 Family members

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

**Chief Complaints:** ..... Doctor Notified on Admission:  Yes  No  
 Name of the Doctor: Dr. Veena  
 Time Notified: .....

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

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

**Blood Group:** ..... LMP: ..... EDD: ..... Gestational age during admission: .....  
 Contractions: ..... Vaginal Discharge: .....

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

Height: ..... Weight: ..... BMI: .....  
 Temp: 98.6 HR: 85 RR: 20 BP: 110/75 SpO<sub>2</sub>: 97.1

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

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



Abilities 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 0 (complete the Morse Fall Risk Assessment Sheet)

**Risk of Pressure Sore:**  Yes  No Score 0 (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 members

**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: ms.

Orientation not given Reason: .....

Nurse Signature: [Signature]  
Nurse Name: AKWp  
Date & Time: 6/6/26

# INFORMED CONSENT FOR VAGINAL BIRTH

Patient Name : Mrs. S. Sahithi UHID No : HNH - 6003174  
 Gender:  Male  Female Date : 6/6/2026 Time : 12:57pm

I hereby authorized the performance of the following procedure:

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

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

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

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

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

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

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

Name of the Doctor performing the procedure: DR. RAMYA

**Consentee :** S. Sahithi  
 Signature : [Signature]  
 Name : Sahithi  
 Date & Time : 6/6/2026 @ 12:57pm

**Patient Attendant :** Veeender  
 Signature : [Signature]  
 Name : Veeender  
 Relationship with Patient : Husband  
 Date & Time : 6/6/2026 @ 12:57pm

**Witness :** [Signature]  
 Signature : [Signature]  
 Name : [Name]  
 Date & Time : 6/6/26 @ 12:57pm

**Doctor (who is taking the consent) :** [Signature]  
 Signature : [Signature]  
 Name : Dr. Naveena  
 Date & Time : 6/6/2026 @ 12:57pm

### GENERAL CONSENT FOR TREATMENT

Patient Name: Mrs R SAHITHI Age : 25 Y 11 M 24 D  
IP No: IP26-00006520 Sex: Female  
Consultant: Dr. MAHALAKSHMI GOLI Ward/Bed No: 4F -OT/LDR-416

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: Rohmath

Relationship: Brother

Date: 06/06/2026

Witness Name:

Witness Signature: 

Time: 12:58 pm

Patient Address:

VILLA NO: 90, FAROOQ NAGAR,  
SHADNAGAR. Shadnagar  
Mahabubnagar Telangana INDIA  
509216

HNH-00003174 IP26-00006520  
Mrs R SAHITHI  
13-06-2000 25 Y 11 M 24 D (F)  
Dr. MAHALAKSHMI GOLI



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

BirthRight  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

25  
years  
of being the leading age  
honoring doctor, teaching hospital

## BILLING POLICY

- **Billing cycle:** - With effective from 1<sup>st</sup> 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 / Demand draft or online payment.
  - In 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 30% extra.
  - Patient Government ID proof is mandatory to submit during the admission.
  - TPA processing charges Rs.500 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

### INTERIM BILLING

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 enquire 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.5,000/- will be refund through NEFT in three Bank working days.

*Rohinath Radha*

Name & signature of Patient/Attendant

*Puja*

(Signature of Admission Desk executive)

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

### RAINBOW CHILDREN'S MEDICARE PRIVATE LIMITED

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