

Dr. Ramya



ESTIMATION SLIP

1591

Date : 12/6/26 UHID / IP No. : HNH-00015523 SI No.

Name of Patient : Mrs. T. Deepa Age: 23y Gender: F

Father's / Husband's Name : Mr. Vamsi Corporate / Occupation :

Address : Abids Phone : 9182721123 Email : 9461056006

Procedure / Plan : SRPC EDD/Dos:

MODE OF PAYMENT : SELF TPA : GIPSA : OTHER

TARIFF INFORMATION :

| Particulars | Package Amounts (Rs.) | |
|---|--|--|
| | Normal Delivery | LSCS |
| Multi Shared Ward | | |
| Shared Ward | | |
| Twin Shared Ward → | <u>SRPC</u> <u>65k (Daycare)</u> | <u>JV 1200</u> <u>15k</u> |
| Private Room | | |
| Super Deluxe Room | <u>+ Pharmacy & Investigation Extra</u> | |
| 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 : | 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 :

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

DECLARATION

I Vamsi 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.

Deepa
13/6/26
Signature of the Client

husband
Signature Relationship

[Signature]
Signature of the financial Counselor

HNH-00015523 IP26-00006575
 Mrs T DEEPA
 02-10-2002 23 Y 8 M 11 D (F)
 Dr. KADIYALA RAMYA THEJA



SURGERY DETAILS

Date : 13-06-26

Patient Name: Mrs. T. Deepa Date of Birth: 02-10-2002 Age: 23 yrs.

Gender: Female Ward : OT UHID No.: HNH-00015523

Date of Surgery: 13-06-26 OT-1 OT-2 OT-3 OT-4 OBG OT-1 OBG OT-2

Name of the Surgery : SERPE ↓ SGA

Time in : 10:30 Am

Time Out : 11 Am

| | <u>NAME</u> | <u>AMOUNT</u> |
|----------------------|-----------------------------------|---------------|
| 1. Surgeon | : <u>Dr. Kadiyala Ramya Theja</u> | |
| 2. Anaesthetist | : <u>Dr. Samir</u> | |
| 3. Assistant Surgeon | : <u>Dr. Veena</u> | |
| 4. OT Technician | : <u>Dr. Arvind</u> | |
| 5. Circulating Nurse | : <u>Sr. Natarsha</u> | |
| 6. Assistant Nurse | : <u>Sr. Archana Sandhya</u> | |

Mrs T DEEPA (23 Y 8 M 11 D/ F)

TISSUE

NNV04329
HN26009751020

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

(for Dr. Ramya)
 Signature of the Surgeon

Natarsha
 Signature of Circulating Nurse

Order No: 26-0000206405

Order by: Sandhya 13/6/26 @ 11:40 am
(or record saved)



SEPPC

CONSUMABLES OF OT

Circulating Staff: Natasha Technician: Arunid, pallavi Date: 13/11/26 Time:

| Anaesthesia Disposables | Qty | | Surgical Disposables | Qty | | Disposables (Baby Side) | Qty | |
|--|--------|------------|--|--------|--------------|-------------------------|--------|------|
| | Issued | Used | | Issued | Used | | Issued | Used |
| ET tube <u>7 gel 4</u> | | <u>101</u> | Major Pack <u>General</u> | | <u>1</u> | Inj Vit.K | | |
| LMA | | | Sutures | | | Cord Clamp | | |
| ECG leads <u>(A) P / N</u> | | <u>03</u> | | | | Suction Catheter | | |
| HME filter: A / P / N | | | <u>Themicain Jelly</u> | | <u>1</u> | Feeding Tube | | |
| Syringes : 10 cc | | <u>04</u> | | | | Vaccum Suction Set | | |
| 05 cc | | <u>03</u> | Gloves <u>S.G 6 1/2</u> | | <u>3</u> | Surgical Gloves | | |
| 02 cc | | <u>02</u> | <u>Enode 6</u> | | <u>1</u> | Gauze Pack | | |
| 01 cc | | | <u>Hand Case</u> | | <u>3</u> | Syringe 1ml / 2ml | | |
| Cautery plate: <u>(A) P / N</u> | | | Surgical blade | | | Surgical Blade # 20 | | |
| IV set | | | NG tube | | | Koochies (S) | | |
| RL | | <u>01</u> | Cautery pencil | | | | | |
| NS : 10ml / 100ml / 500ml / 1000ml | | <u>01</u> | Koochies <u>Saral</u> | | <u>4</u> | | | |
| <u>MIDazolam</u> | | <u>01</u> | ointments <u>Nelol cat no 10</u> | | <u>1</u> | | | |
| | | | Suction Catheter | | | | | |
| Fentanyl | | <u>01</u> | Cap, Mask | | <u>10/10</u> | | | |
| Morphine | | | Gauze Pack <u>7.5 x 7.5</u> | | <u>5</u> | | | |
| Ketamine | | | Mop Pack | | | | | |
| Propofol | | <u>02</u> | Steristrip | | | | | |
| Rocuronium | | | Underpad | | | | | |
| Glycopyrolate | | <u>01</u> | Draw sheet | | | | | |
| Myopyrolate <u>oxystoun</u> | | <u>04</u> | Abgel | | | | | |
| Ondansetron | | <u>01</u> | Foleys catheter | | | | | |
| Pencan 25g/ Spinal Needle 22 | | | Urobag | | | | | |
| Bupivacaine 0.25% | | | Chest Drainage Catheter | | | | | |
| Bupivacaine 0.25%(Heavy) | | | Romodrain bag | | | | | |
| Antibiotics | | | Bandage | | | | | |
| Suppositories | | | Tegaderm | | | | | |
| Anamol : 80mg / 250mg / 170 mg | | | tohan <u>Easy grip cannula no 7</u> | | <u>1</u> | | | |
| Supridol : 100mg | | <u>01</u> | Double J Stent | | | | | |
| Justin : 12.5 mg / 25mg / 100mg | | <u>01</u> | Vaccum Suction set | | <u>4</u> | | | |
| Tab. Misoprost : 200mg | | <u>01</u> | Plastic Bed Sheet <u>APRON</u> | | <u>03</u> | | | |
| <u>Vaccum Suction</u> | | <u>01</u> | Betadine Solution | | <u>1</u> | | | |
| <u>O2 mask (A)</u> | | <u>01</u> | Microshield | | <u>1</u> | | | |
| <u>braxmil</u> | | <u>02</u> | Cotton Balls | | <u>1</u> | | | |
| <u>methergin</u> | | <u>01</u> | Latex Gloves | | <u>10</u> | | | |
| | | | Ramdione Scrub | | | | | |
| | | | Saral | | | | | |

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ELECTRONIC MEDICINE PRESCRIPTION

MRN : HNH-00015523 Name Mrs T DEEPA
Age / Sex 23 Y 8 M 11 D / Female Doctor KADIYALA RAMYA THEJA
Adm/Reg Date/Time : 13/06/2026 08:32 Payor SELFPAY
Order Date : 13/06/2026 11:24 Ordernumber : 26-0000206422
Visit ID : IP26-00006575 Ward/Bed No : 4F -OT / PPO-419
Patient Address : 1-126 ,GEESUGONDA, Dharmaram, Warangal, Telangana, INDIA, 506330

| 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 | 1 Days | | 1 Bottle | Ordered |
| 2 | E.C.G ELECTRODES (ADULT) | ELECTRODES ADULT | 1 Nos | External / Once Daily | 1 Days | | 3 Nos | Ordered |
| 3 | ENCORE MICROPTIC GLOVES-6 PF | | 1 Nos | External / Once Daily | 1 Days | | 1 Nos | Ordered |
| 4 | SGLOVE # 6.5 (SURGICARE) | SURGICAL GLOVES 6.5 | 1 Nos | External / Once Daily | 1 Days | | 3 Nos | Ordered |
| 5 | EASY GRIP (MTP CANULA)-7 | EASYGRIP 7 | 1 Nos | External / Once Daily | 1 Days | | 1 Nos | Ordered |
| 6 | COTTON BALLS 2 GM 5 NOS | COTTON BALLS 2G- 5 NOS | 1 Nos | External / Once Daily | 1 Days | | 1 Nos | Ordered |
| 7 | THEMICAINE 30GM JELLY | | 1 On Application | / Once Daily | 1 Days | | 1 Nos | Ordered |
| 8 | METHERGIN INJ 1 ML | | 1 Vial | / Once Daily | 1 Days | | 1 Vial | Ordered |
| 9 | VACCUME SUCTION SET | VACCUME SUCTION SET | 1 Nos | External / Once Daily | 1 Days | | 2 Nos | Ordered |
| 10 | JUSTIN SUPPOSITORIES 100 MG 5 S | | 1 Nos | External / Once Daily | 1 Days | | 1 Nos | Ordered |
| 11 | SUPRIDDL SUPPOSITORIES 100 MG 5 S | | 1 Nos | External / Once Daily | 1 Days | | 1 Nos | Ordered |
| 12 | ONDOKIND INJ 4 MG 2 ML | ONDANSETRON 4MG 2ML INJ | 1 Nos | / Once Daily | 1 Days | | 1 Vial | Ordered |
| 13 | BACTOPREP SOLUTIONS 100 ML | CHLORHEXIDINE GLUCONATE 2% & ALCOHOL 80% 500 | 1 mL | / Once Daily | 1 Days | | 1 Nos | Ordered |
| 14 | BIOXAMIC 500 MG INJ | | 1 Ampule | External / Once Daily | 1 Days | | 2 Ampule | Ordered |
| 15 | POVINANZ SOLUTION 10% 100 ML | | 1 Nos | External / Once Daily | 1 Days | | 1 Nos | Ordered |
| 16 | EVATOCIN (OXYTOCIN) INJ 5 IU 1 ML | | 1 Vial | External / Once Daily | 1 Days | | 4 Vial | Ordered |
| 17 | MEZOLAM INJ 5 MG 5 ML | | 1 Vial | External / Once Daily | 1 Days | | 1 Vial | Ordered |
| 18 | GENERAL SURGICAL KIT (MEDITAKE) | GENERAL SURGICAL KIT | 1 Nos | / Once Daily | 1 Days | | 1 Nos | Ordered |
| 19 | MCT-ROF 100MG 10ML | | 1 Nos | External / Once Daily | 1 Days | | 2 Nos | Ordered |
| 20 | DISPOSABLE APRONS STERILE XL | DISPOSABLE APRON STERILE XL | 1 Nos | / Once Daily | 3 Days | | 3 Nos | Ordered |
| 21 | 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 |
| 22 | NELTON CATHETER-10 POLYMED | | 1 Nos | External / 10 AM | 1 Days | | 1 Nos | Ordered |
| 23 | OxygenMask With Tubing - Adult ROMSONS-FC | | 1 Nos | External / Once Daily | 1 Days | | 1 Nos | Ordered |
| 24 | HAND CARE GLOVE | HAND CARE GLOVE | 1 Nos | External / Once Daily | 1 Days | | 3 Nos | Ordered |

KADIYALA RAMYA THEJA

Reg No : TSMC/FMR/01458

* 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.

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-00015523 Name : Mrs T DEEPA
Age / Sex : 23 Y 8 M 11 D / Female Doctor : KADIYALA RAMYA THEJA
Adm/Reg Date/Time : 13/06/2026 08:32 Payor : SELFPAY
Order Date : 13/06/2026 11:24 Ordernumber : 26-0000206421
Visit ID : IP26-00006575 Ward/Bed No : 4F -OT / PPO-419
Patient Address : 1-126 ,GEESUGONDA, Dharmaram, Warangal, Telangana, INDIA, 506330

| S.No | Description | Generic Name | Dosage | Route / Frequency | Duration | Instruction | Qty | Status |
|------|---|-------------------|--------|-----------------------|----------|-------------|--------|---------|
| 1 | SURGEON CAP(FEMALE) (PROTECTCARE) | | 1 Nos | External / Once Daily | 1 Days | | 10 Nos | Ordered |
| 2 | THEMIPYRRNOM 0.2MG INJ | | 1 Nos | Injection / 10 AM | 1 Days | | 1 Nos | Ordered |
| 3 | DSYRINGE 10ML (NIPRO) | SYRINGE 10ML | 1 Nos | External / Once Daily | 1 Days | | 4 Nos | Ordered |
| 4 | DSYRINGE 5ML.(NIPRO) | SYRINGE 5ML | 1 Nos | External / Once Daily | 1 Days | | 3 Nos | Ordered |
| 5 | IGEL NO 4.0 | IGEL 4.0 | 1 Nos | / Once Daily | 1 Days | | 1 Nos | Ordered |
| 6 | DSYRINGS 2.5ML(NIPRO) | SYRINGE 2ML | 1 Nos | External / Once Daily | 1 Days | | 2 Nos | Ordered |
| 7 | NITRILE EXAMINATION GLOVES P F- MEDIUM | NITRILE GLOVES M | 1 Nos | External / Once Daily | 1 Days | | 10 Nos | Ordered |
| 8 | FACE MASK 3 LAYER - ELASTIC | FACE MASK 3 LAYER | 1 Nos | External / Once Daily | 1 Days | | 10 Nos | Ordered |
| 9 | NS 100ML ACCULIFE - EH | | 1 mL | External / 10 AM | 1 Days | | 1 mL | Ordered |

KADIYALA RAMYA THEJA

Reg No : TSMC/FMR/01458

* 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.



Rainbow Childrens Hospital-Himayatnagar

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

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006575 Admit Date : 13-Jun-2026 Admit Time : 08:32 AM UHID : HNH-00015523

Patient Details :

| | | | |
|--------------|--|----------------|--------------------------|
| Patient Name | : Mrs T DEEPA | Age | : 23 Y 8 M 11 D |
| Guardian | : Mr T VAMSHI | DOB | : 02-10-2002 |
| Gender | : Female | Religion | : |
| Occupation | : | Martial Status | : |
| Address (H) | : 1-126 ,GEESUGONDA Dharmaram Warangal Telangana INDIA 506330 | Phone No | : 9441054006/ 9182721123 |
| | | E-mail | : XANDARVOLDY@GMAIL.COM |

Admission Details :

Bed Type : TWIN SHARING Bed No : PPO-419 Ward Name : 4F -OT
Room No : PPO-419 Admission Type : First Visit

Contact Details :

Name : Mr T VAMSHI Relationship : W/O
Contact Address : 1-126 ,GEESUGONDA Dharmaram Warangal Phone No :
Telangana INDIA 506330


Signature


Doctor Details :

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

Payment Details :

Deposit Amount : 55000.00
Payment Mode : DC/CC Card Payor Name : SELFPAY

PATIENT TRANSFER FORM

| Patient Name & UHID No. HNH-00015523 Mrs T DEEPA 02-10-2002 Dr. KADIYALA RAMYA THEJA 23 Y 8 M 11 D (F) IP26-00006575  | | Date & Time of Admission 13/6/26 @ 8:32Am | Date & Time of Transfer Order 13/6/26 @ 10:10Am |
|---|----------------------------------|---|--|
| From Unit PHE - Post | | Transfer Ordered by DR - Naveena | Reason for Transfer SERPC |
| To Unit PHE OT | | Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| Number of Sheets in Clinical File (30) | Number of Imaging Films — | 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. | RL 500ml | 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. Priyanka | | Name of Person Ordered Transfer DR. Naveena | |
| Patient & Clinical Records Received by : Natarsha Natarsha | | | |
| Date & Time of Patient Received : 13/06/26 10:10Am. | | | |

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: ----- HNH-00015523 IP26-00006575 -----
 Mrs T DEEPA
 UHID No: ----- IP No: ----- 02-10-2002 23 Y 8 M 11 D (F) ----- Dept: -----
 Dr. KADIYALA RAMYA THEJA
 Date of Admission: -----  Discharge: ----- Time: -----
 Room / Bed No: ----- Ward: ----- Suggested Billable bed type: -----

WARD TRANSFERS

| Date | Time | From | To | Signature of Nurse |
|---------|----------|------------|------------|--------------------|
| 13/6/26 | 10:10 AM | PRE - POST | OT | Sujatha / Nataraj |
| 13/6/26 | 11:00 AM | OT | PRE - POST | Nataraj / Sujatha |
| | | | | |
| | | | | |

Cross Consultation Visit

| | Doctors Name | Date | Order No. | Signature |
|-----|--------------|------|-----------|-----------|
| 1. | | | | |
| 2. | | | | |
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| 10. | | | | |

PROCEEDURE

| Date | Proceedure | Quantity | Order No. | Signature |
|---------|-------------------------|----------|--------------------|-----------------------------|
| 13/6/26 | IV placement | | 206411 | Lij |
| | PAC PAC (OP) | | 00526-00 119646 | Lijatha |
| 13/6/26 | IV IRON therapy | | 26-000020 6432 | Lij |
| | | | | |
| | | | | |
| | | | | |
| | | | | cross checked by sujatha |
| | | | | 13/6/26 @ |
| | | | | 2/10 |
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ANY OTHER INFORMATION

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Date :

Time :

Prepared By :

| | | | |
|-------------|--------------|-------------------|--------------------|
| Staff Nurse | Shift / Ward | Billing Assistant | Billing Supervisor |
|-------------|--------------|-------------------|--------------------|



P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 13/06/2020 Time of Admission :

Allergies: Nil Not know any drug allergies

PRESENTING COMPLAINTS :

Prim / 8th week / mild Anemia (+hb 8.5g/dl)
 USG (18/05/2020) - SIUGS = yolk sac, no Fetal pole
 v Size inst normal.
 Wishes to go ahead = TOP
 Tab Mifepristone 200mg stat given 12/06/2020

| MENSTRUAL HISTORY | OBSTETRIC HISTORY |
|--|--|
| Year of Marriage : 2026 off - NCM. Previous Periods : Regular LMP : 13/04/2020 Contraception : - | Parity : Prim - Sp concepta Mode of Delivery : - Last Child Birth : - MC - Smante / NCM |

| PAST MEDICAL HISTORY | PAST SURGICAL HISTORY |
|----------------------|-----------------------|
| Nd | Nd |



MEDICATION HISTORY:

Nil

Nil

INITIAL ASSESSMENT :

| | | |
|--|---|---|
| Date <u>13/06/2022</u> Ht. <u>154</u> Wt. <u>45.80</u> BMI <u>19.31</u> B.P. <u>106/76mmHg</u> Pallor <u>(+)</u> CVR <u>NAD</u> Respiratory System <u>BMCP</u> Thyroid <u>NAD</u> | Breasts (N) Abdominal Examination Soft | Local/Speculum Examination Not done Bimanual Pelvic Examination Not done |
|--|---|---|

PROVISIONAL DIAGNOSIS: Painful B⁺ve / mild Anemia / for SERPC

| INVESTIGATIONS ORDERED | PLAN OF MANAGEMENT |
|---|---|
| Allergy - Nil BGT - 0 Positive CBP Hb - 8.5 g/dl WBC - 7180 PLT - 2.86 | NBM Informed consent Pains prepare Drugs as charted Inform Anesthetist Shift to OT on call Rescue IO PRBC |
| <p><u>Plan</u> - IV Iron (Daycare) Post-op</p> | |

Name of the Doctor: Dr Mansha

Signature of Doctor: [Signature]

Date & Time: 13/06/2022

[Signature]
 DR. KADIYALA RAMYA THEJA

Pa



PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|---|---|--|
| <p>13/6/26 11 AM</p> | <p style="text-align: right;">c/s/B. Dr. Veena</p> <p><u>POD-0 / SERPC / mild anemia</u></p> <p>Pt. is stable, N <u>O/E</u> GC fair BP- 108/73 mmHg PR- 71 bpm SpO₂- 100% on RA P/A - UT well retracted UE - BWNL Pad - Dry</p> | <p><u>Adv</u></p> <ul style="list-style-type: none"> - NBM for 4 hours. - Drugs as charted - Vital monitoring - I/O charting - Inj. PCM 1g in 100ml NS @ 12pm - Inform SOS |
| | <p>d/s advise → T. Paracetamol 200mg BD x 5 days T. Pan 40mg OD x 5 days. T. Misoprostol 200mcg 1-1 x 2 days T. Dolo 650mg P/O 1-1 x 3 days. - R/w after 1 month (D4) 2 RPOC scan.</p> | <p style="text-align: right;"><i>[Signature]</i></p> |
| <p>13/6/26 1 PM</p> <p>U: yet to void</p> <p><u>Can be discharged</u></p> | <p>O/E pt clear GC fair/epistaxis RR: 8/min BP: 112/61 mmHg SpO₂: 98% PA: IFT AV: no active bleeding</p> | <p><u>Adv</u></p> <p>Inj. Ferric Carboxy Maltoate 1gm IV plus repeat but dose in 100ml NS</p> <p>↓</p> <p>No allergic reaction.</p> <p><u>Ramya</u> IRAMYA THEJA</p> |

HNH-00015523

IP26-00006575

Mrs T DEEPA

02-10-2002

23 Y 8 M 11 D

(F)

Dr. KADIYALA RAMYA THEJA



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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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 | | | | | |

| | | | | | | |
|-----------------|-------------|--|--|--|--|--|
| Date | | | | | | |
| Time | | | | | | |
| CUE - Alb | | | | | | |
| CUE - Sugar | | | | | | |
| CUE - Ketones | | | | | | |
| CUE - PUS Cells | | | | | | |
| CUE - RBC Cells | | | | | | |
| CUE | | | | | | |
| | | | | | | |
| | | | | | | |
| Stool Pus Cell | | | | | | |
| OVA / Cyst | | | | | | |
| Occult Blood | | | | | | |
| | | | | | | |
| Blood Grouping | O' positive | | | | | |
| AIV | } NR | | | | | |
| Hbs 174 | | | | | | |
| HCV | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc..) :

HNH-00015523

IP26-00006575

Mrs T DEEPA

02-10-2002

23 Y 8 M 11 D (F)

Dr. KADIYALA RAMYA THEJA



MEDICATION RECONCILIATION FORM

Drug Allergies: Not known any Drug Allergies

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

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

Shifting From: Shifted to:

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : *Dr. G. Veena*

Date & Time : *13/6/26 @ 9am*

Nurse Name & Signature: *Sunitha S*

Date & Time : *13/6/26 @ 9AM*

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

HNH-00015523

Mrs T DEEPA

02-10-2002

Dr. KADIYALA RAMYA THEJA

IP26-00008575

23 Y 8 M 11 D

(F)



REGULAR PRESCRIPTIONS

Weight. Ward.

| 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 | | | | |
| 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 | | | | |



| | | | | | |
|-----|------------|------------|------------|------------|------------|
| ate | | | | | |
| me | Nurse Sig. | 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 |
|------|----------|-----------------------------|-----------------------------|-------|-----------|---------------------|
| 13/6 | 10 AM | INJ CEFOTAXIME | 1g (ASB) | IV | A | Sujatha Anusha K |
| 13/6 | 9:30 AM | INJ PANTOPRAZOLE | 40mg | IV | A | Sujatha Anusha K |
| 13/6 | 9:30 AM | INJ METOCLOPRAMIDE | 10mg | IV | A | Sujatha Anusha K |
| 13/6 | 9 AM | Tab. MISOPROSTOL | 400mcg | PV | M | Sujatha Anusha K |
| 13/6 | 10:45 AM | TAB. MISOPROSTOL | 600mcg | P/R | S. Jay | Nataha Anusha K |
| 13/6 | 10:50 AM | INJ. FERROUS CARBOXYMALTOSE | 1g (in 100ml NS) | IV | S. Jay | Nataha Anusha K |
| 13/6 | 10:30 AM | PARACETAMOL | 1gm | IV | M | Nataha Anusha K |
| 13/6 | 10:45 AM | METHERGINE | 0.2mg | IV | Mi | Nataha Anusha K |
| 13/6 | 10:45 AM | ONDANSETRON | 4mg | IV | M | Nataha Anusha K |

Signature

VERIFIED BY: Name



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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

OPERATION THEATER NOTES

HNH-00015523 IP26-00006575

Mrs T DEEPA

02-10-2002 23 Y 8 M 11 D (F)

Dr. KADIYALA RAMYA THEJA



Patient's Name

Age : 23 yrs Gender : Female

UHID :

I.P.No. 26-00006575 Weight :

Surgeon : DR. RAMYA Asst. Surgeon : DR. VEENA

Anesthetist : DR. SAMIR OT Nurse : DR. SANDHYA

Surgical Procedure : SURGICAL EVACUATION OF ~~REPRODUCTIVE~~ PRODUCTS OF CONCEPTION.

Indications for Surgery : MEDICAL TERMINATION OF PREGNANCY

Date : 13/08/2026 Start Time : 10:30 Am End Time : 11:00 Am.

PRE-OPERATIVE PREPARATION :

- Patient kept in lithotomy position.
- Parts painted & draped.

OPERATION NOTES:

- Posterior vaginal wall retracted & Sims speculum
- Anterior lip of cervix held & vulsellum
- Cervix dilated w/
- Oterocervical length noted to be 10 cms
- Cervical os dilated & No. 7 dilator.
- Cannula (No. 6) inserted and suction of products of conception done - Sample sent for HPE. use guidance
- No active bleeding noted.
- Patient tolerated the procedure well
- Shifted out in stable condition.
- Scan at the end of procedure: Cervix appears empty
- Minimal blood loss.

POST - OPERATIVE ORDERS :

- NBM for 4 hours
- Drugs as charted
- Vital monitoring
- 500mg FCM 1g IV (in 100ml NS) @ 12pm
- Inform SOS

..... Dr. Ranuja Theja

Consultant Surgeon's Name

..... 

Consultant Surgeon's Signature

Date : 13/6/26 Time : 10:45 AM

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Ramya
 Asst. Surgeon : Dr. Vena
 Anaesthetist : Dr. Samir
 Scrub Nurse : Sr. Sandhya

HNH-00015523 IP20-00000375
 Mrs T DEEPA 23 Y 8 M 11 D (F)
 Dr. KADIYALA RAMYA THEJA
 Barcode
 Date : 13/6/26 In-time : 10:30 AM Out-time : 11:00 AM

Age : 23 yrs Gender : F
 Primary Name :



Before Induction of Anaesthesia ➤ ➤

| SIGN IN | Time: <u>10:25 AM</u> |
|--|---|
| Patient Has Confirmed | |
| Identity | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| Site | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| Procedure | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| Consent | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| Site Marked | <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA |
| Anaesthesia Safety Check Completed | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| Pulse Oximeter on Patient & Functioning | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| Does Patient have a: | |
| Known Allergy? | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| Difficult Airway / Aspiration Risk? | |
| Yes, & Equipment / Assistance Available | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| Risk of > 500ml Blood Loss (7ml/kg In Children)? | |
| Yes, and Adequate Intravenous Access and Fluids Planned | <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA |
| Blood Units Reserved | <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA |
| Has Antibiotic Prophylaxis been given within the last 60 minutes? | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |
| Signature : <u>Dr. Samir</u> | |
| Name : | |

Before Skin Incision ➤ ➤

| TIME OUT | Time: <u>10:31 AM</u> |
|---|--|
| Confirm all team members have introduced themselves by Name and Role | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| Surgeon, Anaesthesia Professional and Nurse Verbally Confirm | |
| Correct Patient (Check ID Band) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Correct Site | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Correct Procedure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anticipated Critical Events | |
| Surgeon Reviews: | |
| What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? | <input checked="" type="checkbox"/> <u>Chronic Bleeding</u> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |
| Anaesthesia Team Reviews: | <u>Aspiration</u> |
| Are There Any Patient-specific Concerns? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |
| Nursing Team Reviews: | |
| Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |
| Is Essential Imaging Displayed? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |
| Signature : <u>Natasha</u> | |
| Name : <u>Natasha @ 10:31 AM</u> | |

Before Patient Leaves Operating Room

| SIGN OUT | Time: |
|---|---|
| Nurse Verbally Confirms with the Team: | |
| The Name of the Procedure Recorded | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| That Instrument, Sponge and Needle Counts are Correct (or Not Applicable) | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA |
| The Specimen is Labelled (including patient name) | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |
| Whether there are any Equipment Problems to be addressed | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA |
| To Surgeon, Anaesthetist and Nurse: | |
| What are the key concerns for recovery and management of this patient? | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| Signature : <u>Dr. Vena</u> | |
| Name : <u>D. G. Vena</u> | |

PATIENT TRANSFER FORM

HNH-00015523 IP26-00006575

Mrs T DEEPA
02-10-2002 23 Y 8 M 11 D (F)
Dr. KADIYALA RAMYA THEJA



| | | |
|---|---|--|
| Date & Time of Admission <i>13/6/26 @ 8:32 Am</i> | | Date & Time of Transfer Order <i>13/6/26 @ 10:25 am</i> |
| Treating Consultant Name | Transfer Ordered by <i>Dr. Samir</i> | Reason for Transfer <i>Observation</i> |
| From Unit <i>OT</i> | To Unit <i>Pre-Post</i> | Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| Number of Sheets in Clinical File <i>30</i> | Number of Imaging Films <i>1</i> | Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what ? |
| Medications / Consumables / Surgicals / Hand over | | |
| Sl.No. | Item Name | Quantity |
| 1. | <i>RL</i> | <i>1</i> |
| 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 <i>Natesha</i> | | Name of Person Ordered Transfer <i>Dr. Samir</i> |
| Patient & Clinical Records Received by : | | |
| Date & Time of Patient Received : <i>13/6/26</i> | | |

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



OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 13/6/20 Time of Arrival: 8:32 AM 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: 97.8 Pulse: 85 RR: 20 SpO₂: 99.1 BP: 110/75 Weight:

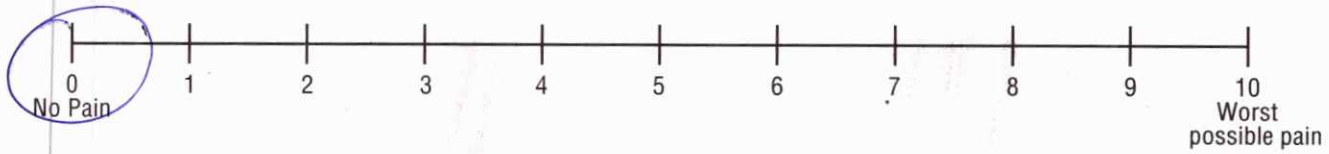
4) **Gestational Criteria:**

| | | | | |
|----------|---|---|---|---|
| Gravida: | G | P | L | A |
|----------|---|---|---|---|

LMP: EDD: Gestational Age:

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

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



• Location:

• Duration: Days / Weeks/ Months (Strike out which is not applicable)

• Character:

• Frequency: NTA

• Interventions: NTA

6) **Past History:**

a) Surgeries:

b) Medical:



Energy: Yes No, If Yes :

8) Current Medications: Prenatal Vitamin None Others:

9) Prenatal Medical History:

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

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

| OTAS | Level 1 (Resuscitative) | Level 2 (Emergent) | Level 3 (Urgent) | Level 4 (Less Urgent) | Level 5 (Non Urgent) |
|-------------------------|--|---|--|---|--|
| Level 1 (Resuscitative) | Immediate | ≤ 15 minutes | ≤ 30 minutes | ≤ 60 minutes | ≤ 120 minutes (2 Hours) |
| Re-Assessment | Continuous Nursing Care | Every 15 Minutes | Every 15 Minutes | Every 30 Minutes | Every 60 Minutes |
| Labour / Fluid | Imminent Birth | Suspected Pre-term Labour / 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"> • Acute onsite severe abdominal pain • Altered level of consciousness • Cord prolapse • Severe respiratory distress • Suspected sepsis | <ul style="list-style-type: none"> • Major trauma • Shortness of breath • Unplanned and unattended birth | <ul style="list-style-type: none"> • Abdominal/back pain greater than expected in pregnancy • Flank pain / hematuria • Nausea /vomiting and /or diarrhea with suspected dehydration | <ul style="list-style-type: none"> • Ongoing assessment from out patient clinic (for hypertension, blood work) • Minor trauma (minor MVC/fall) • Nausea/Vomiting and /or diarrhea • Signs of infection (ie dysuria ,cough, fever, chills) | <ul style="list-style-type: none"> • Anything that does not seem to pose threat to mother or fetus • Cervical ripening • Out patient placenta previa protocols • Pre-booked visits (ie Rh and progesterone injections, NST • Assessment for version • Rashes |

Time seen by Doctor: Dr. maini

Nurse Name : Chandee Nurse Signature: [Signature]

Date: 13/6/20 Time:

HNH-00015523

IP26-00006575

Mrs T DEEPA

02-10-2002

23 Y 8 M 11 D

(F)

Dr. KADIYALA RAMYA THEJA



OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 13/6/20

Baseline Information:

Admission From: ER OPD Admission Desk Others, specify

Primary Language: Telugu English Hindi Others, specify

Do you require an interpreter? Yes No if Yes specify

Source of Information: Patient Family Others, specify

Allergies: Yes No Medications Blood Transfusion Food Other:

If yes, identify

Chief Complaints: Doctor Notified on Admission: Yes No

..... Name of the Doctor: Dr. Manish

..... Time Notified: 13/6/20

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

| Past Medical History | Past Surgical History | Previous Hospital Admission |
|---|---|---|
| — | — | — |
| Gynecology Assessment: <input type="checkbox"/> Not Applicable Menstrual History: Onset of Menarche: Menstrual Cycle: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular Last Menstrual Period: | Gynecology Surgical History: Caesarean Section: <input type="checkbox"/> No <input type="checkbox"/> Yes Cervical Cerclage: <input type="checkbox"/> No <input type="checkbox"/> Yes Ectopic Pregnancy: <input type="checkbox"/> No <input type="checkbox"/> Yes Myomectomy: <input type="checkbox"/> No <input type="checkbox"/> Yes Others: | Gynecological History: Contraceptives: <input type="checkbox"/> No <input type="checkbox"/> Yes Vaginal Discharge: <input type="checkbox"/> No <input type="checkbox"/> Yes Post-Coital Bleeding: <input type="checkbox"/> No <input type="checkbox"/> Yes Infertility: <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes Type: <input type="checkbox"/> Primary <input type="checkbox"/> Secondary |

Obstetric History: G P L A

Previous LSCS:

Current Medication: None Yes, If Yes, Fill the reconciliation form

Family History: No Abnormalities Detected

Heart Disease Hypertension Diabetes Stroke Seizures Kidney disease
 Liver disease Other

Vital Signs / Measurements: Temp: 97.8 HR: 90 RR: 20
 BP: 110/70 Weight: Height: BMI:

Pain Assessment: Pain: Yes No (If Yes, complete the Pain Assessment / Reassessment Form)



PHYSICAL ASSESSMENT

General Appearance: Healthy ill looking Anxious Agitated Others:

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: No Abnormality Detected

- Overweight
- Poor Appetite > 3 Days
- Needs Therapeutic Diet.
- Under Weight
- Diabetes Mellitus
- Hyperemesis Gravidarum

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

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: self

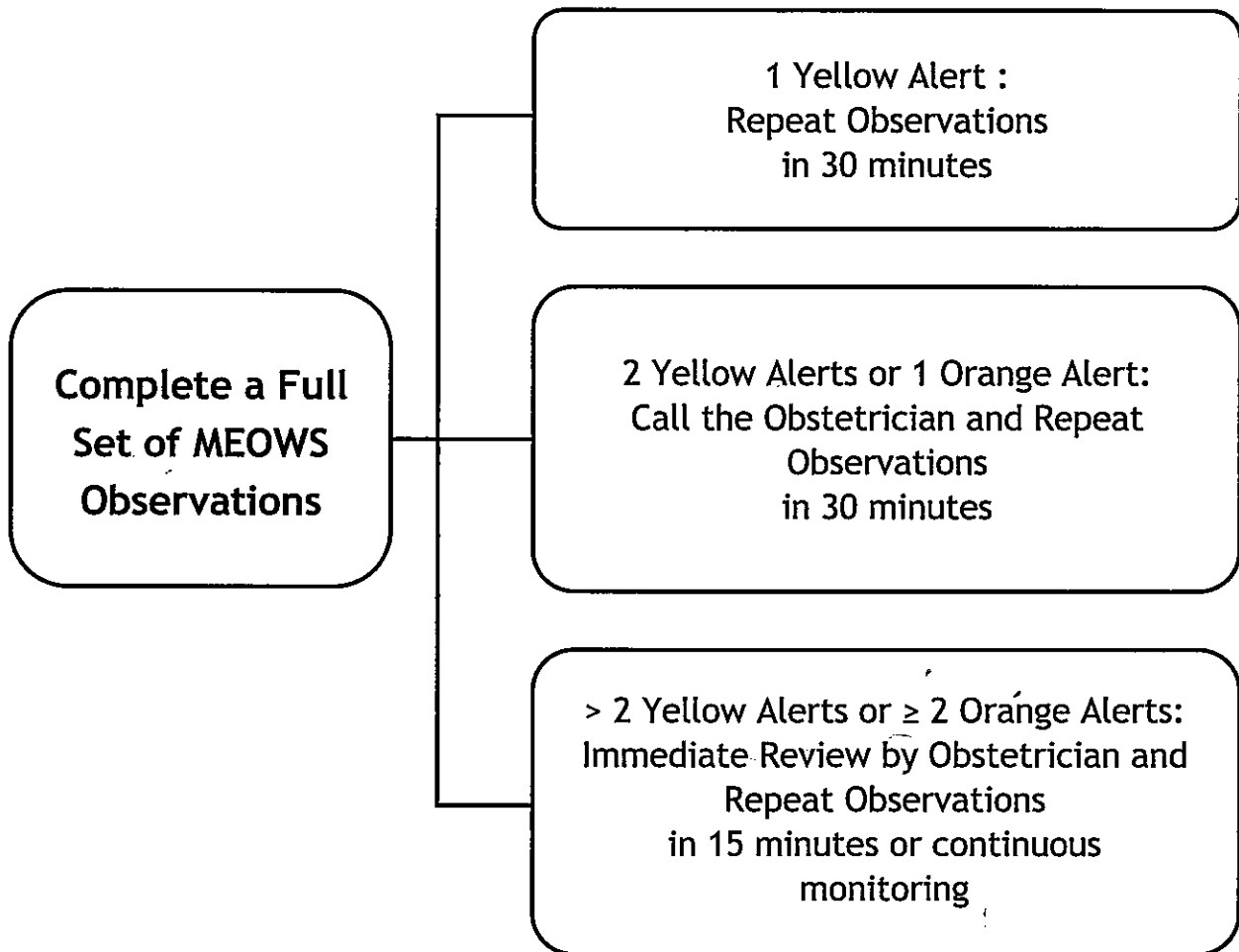
Orientation not given Reason:

Nurse Signature: *CF*

Nurse Name: *Chandras*

Date & Time: *13/6/20*

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)



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.

| 13/6/26 | | Intake | | | | Output | | | | | IV Site Thrombophlebitis Score | Sign. Nurse |
|-----------------------|----------|-----------------|--------|-------|-----|-----------------------|-----------|-------|----------|-------|--------------------------------|-------------|
| Date | Time | Nature of Fluid | Route | | | NG | Diarrhoea | Vomit | Drainage | Urine | | |
| | | | Mouth | I.V | N.G | | | | | | | |
| | 08:00 am | RL | N | 100ml | | | | | | | | |
| | 09:00 am | RL | B | 100ml | | | | | | | | |
| | 10:00 am | RL | M | 100ml | | | | | | | | |
| | 11:00 am | RL | | 100ml | | | | | | | | |
| | 12:00 pm | RI | | 100ml | | | | | | | | |
| | 01:00 pm | RI | | 100ml | | | | | | | | |
| Total Intake : | | | tawker | | | Total Output : | | | | | | padder |
| | 02:00 pm | | | | | | | | | | | |
| | 03:00 pm | | | | | | | | | | | |
| | 04:00 pm | | | | | | | | | | | |
| | 05:00 pm | | | | | | | | | | | |
| | 06:00 pm | | | | | | | | | | | |
| | 07:00 pm | | | | | | | | | | | |
| Total Intake : | | | | | | Total Output : | | | | | | |
| | 08:00 pm | | | | | | | | | | | |
| | 09:00 pm | | | | | | | | | | | |
| | 10:00 pm | | | | | | | | | | | |
| | 11:00 pm | | | | | | | | | | | |
| | 12:00 am | | | | | | | | | | | |
| | 01:00 am | | | | | | | | | | | |
| Total Intake : | | | | | | Total Output : | | | | | | |
| | 02:00 am | | | | | | | | | | | |
| | 03:00 am | | | | | | | | | | | |
| | 04:00 am | | | | | | | | | | | |
| | 05:00 am | | | | | | | | | | | |
| | 06:00 am | | | | | | | | | | | |
| | 07:00 am | | | | | | | | | | | |
| Total Intake : | | | | | | Total Output : | | | | | | |

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

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

Patient Sticker



FLUID CHART

Sheet No. :

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

| Date | Time | Nature of Fluid | Intake | | | Output | | | | | IV Site Thrombo-phlebitis Score | Sign. Nurse | |
|-----------------------|-----------------------|-----------------|--------|-----|-----|-----------------------|-----------------------|-------|----------|-------|---------------------------------|-------------|--|
| | | | Mouth | I.V | N.G | NG | Diarrhoea | Vomit | Drainage | Urine | | | |
| | 08:00 am | | | | | | | | | | | | |
| | 09:00 am | | | | | | | | | | | | |
| | 10:00 am | | | | | | | | | | | | |
| | 11:00 am | | | | | | | | | | | | |
| | 12:00 pm | | | | | | | | | | | | |
| | 01:00 pm | | | | | | | | | | | | |
| | Total Intake : | | | | | | Total Output : | | | | | | |
| | 02:00 pm | | | | | | | | | | | | |
| | 03:00 pm | | | | | | | | | | | | |
| | 04:00 pm | | | | | | | | | | | | |
| | 05:00 pm | | | | | | | | | | | | |
| | 06:00 pm | | | | | | | | | | | | |
| | 07:00 pm | | | | | | | | | | | | |
| Total Intake : | | | | | | Total Output : | | | | | | | |
| | 08:00 pm | | | | | | | | | | | | |
| | 09:00 pm | | | | | | | | | | | | |
| | 10:00 pm | | | | | | | | | | | | |
| | 11:00 pm | | | | | | | | | | | | |
| | 12:00 am | | | | | | | | | | | | |
| | 01:00 am | | | | | | | | | | | | |
| Total Intake : | | | | | | 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-00015523 IP26-00006575
 Mrs T DEEPA
 02-10-2002 23 Y 8 M 11 D (F)
 Dr. KADIYALA RAMYA THEJA



CHECKLIST FOR THROMBOPHLEBITIS



| S. No. | SITE OBSERVATION | STAGE / ACTION | SCORE | DAY-1 | | | DAY-2 | | | DAY-3 | | | Remarks |
|------------------------|--|---|-------|--------------------|---|---|-------|---|---|-------|---|---|---------|
| | | | | M | E | N | M | E | N | M | E | N | |
| 1 | IV site appears healthy | No signs of phlebitis / Observe cannula | 0 | 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 | | | | <i>[Signature]</i> | | | | | | | | | |

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

Signature of Shift In Charge :

Signature : *[Signature]* Name : *[Signature]*

Signature of Ward In Charge :

Signature : *[Signature]* Name : *[Signature]*

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 :



BRADEN 'Q' SCALE

Date: 13/10
 Time: 2:30 PM

| | | | | | | | | |
|---|--|--|---|--|---|--|--|--|
| Mobility | 1. Completely immobile: Does not make even slight changes in body or extremity position without assistance. | 2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently. | 3. Slightly limited: Makes frequent through slight changes in body or extremity position independently. | 4. No limitations: Makes major and frequent changes in position without assistance. | 4 | | | |
| "Activity The degree of physical activity" | 1. Bedfast: Confined to bed | 2. Chairfast: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair." | 3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair. | 4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours. | 4 | | | |
| Sensory Perception | 1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface. | 2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body. | 3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities. | 4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort. | 4 | | | |
| Moisture Degree to which skin is exposed to moisture | 1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned. | 2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours. | 3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours. | 4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours. | 4 | | | |
| FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another | 1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction. | 2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. | 3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down. | 4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times." | 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 meat 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 | | | |

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

| | | | |
|-------------------------|-------------|--|--|
| TOTAL SCORE | 28 | | |
| Evaluator's Name | [Signature] | | |

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

HNH-00015523
 Mrs T DEEPA
 02-10-2002
 Dr. KADIYALA RAMYA THEJA (F)
 23 Y 8 M 11 D
 IP26-0006575



Morse Fall Risk Assessment Form

| Choose Highest Applicable Score from each Category | | Date / Time | Fall Risk Grading | | |
|--|-------------------------------|-------------|-------------------|------------------------|--------------------------|
| | | Score | Risk Level | Morse Fall Score (MFS) | Action |
| History of Falling (Immediately or w/in 3 months) | Yes | 25 | | | |
| | 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 | | | |
| | No | 0 | | | |
| GAIT / Transferring | Impaired | 20 | | | |
| | Weak (uses touch for balance) | 10 | | | |
| | Normal /On Bed Rest /Immobile | 0 | | | |
| Mental Status | Forgets limitations | 15 | | | |
| | Oriented to own ability | 0 | | | |
| Total Morse Fall Scale Score: | | | 20 | | |
| | | Signature | CF | | |

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

HNH-00015523
Mrs T DEEPA
IP26-00006575

02-10-2002 23 Y 8 M 11 D (F)
Dr. KADIYALA RAMYA THEJA



PAIN ASSESSMENT FORM

| Date | Time | Frequency (0/10) | Location | Duration | Acuity | Character | Modifying Factors | Patient / Family Educated | Intervention | Sign |
|---------|------|------------------|----------|--|--|--|--|---|--------------|------|
| 13/6/26 | 9AM | 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 | S |
| 13/6/26 | 1PM | 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 | S |
| | | | | <input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute <input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | | <input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute <input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | | <input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute <input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | | <input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute <input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | | <input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute <input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | | <input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute <input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | | <input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute <input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Re-assessment Frequency:

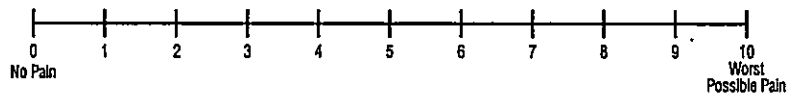
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

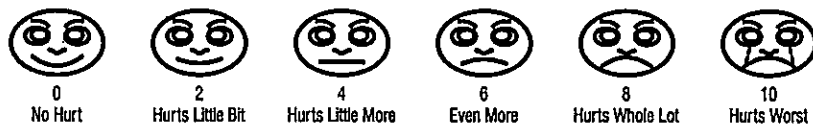
Numerical Pain Scale (Obstetric and Gynecology)



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

| Assessment Criteria | Sedation | | Normal | Pain / Agitation | |
|--|---|---|---|--|---|
| | -2 | -1 | 0 | 1 | 2 |
| Crying Irritability | No Cry with painful stimuli | Moans or cries minimally with painful stimuli | Appropriate crying Not Irritable | Irritable or crying at intervals consolable | High-pitched or silent-continuous cry Inconsolable |
| Behavior State | No arousal to any stimuli No spontaneous movement | Arouses minimally to stimuli Little spontaneous movement | Appropriate for gestational age | Restless, squirming Awakens frequently | Arching, kicking constantly awake or Arouses minimally / no movement (not sedated) |
| Facial Expression | Mouth is lax No expression | Minimal expression with stimuli | Relaxed Appropriate | Any pain expression intermittent | Any pain expression continual |
| Extremities Tone | No grasp reflex Flaccid tone | Weak grasp reflex decreased muscle tone | Relaxed hands and feet Normal Tone | Intermittent clenched toes, fists or finger splay Body is not tense | Continual clenched toes, fists, or finger splay Body is tense |
| Vital Signs HR, RR, BP, SaO₂ | No variability with stimuli Hypoventilation or apnea | Less than 10% variability from baseline with stimuli | Within baseline or normal for gestational age | Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery | Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator |

Wong - Baker (Pediatrics) Above 7 Years



HNH-00015523 IP26-00006575
 Mrs T DEEPA 23 Y 8 M 11 D (F)
 Dr. KADIYALA RAMYA THEJA



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

| | | | | | | | |
|--|---|---|---|--|--|--|--|
| SITUATION | Diagnosis: | Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: | | | | | |
| BACKGROUND | Area | Shift Time | 13/6 8AM | / | / | / | / |
| | Medical Condition (Any special condition to be noted): | | NA | | | | |
| ASSESSMENT | Allergy: | | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Tubes/Drains/Catheter: | | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Vital Signs: | | Temp: | 97F | | | |
| | | | Res: | 20 | | | |
| | | | SpO ₂ : | 99.1 | | | |
| | | | Pulse: | 85 | | | |
| | | | BP: | 110/75 | | | |
| | | Fall Risk Score: | - | | | | |
| | | Pain Score: | - | | | | |
| Recommendations | Safety Needs: | | NA | | | | |
| | Physiotherapy | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Others Specify: | | NA | | | | |
| | Special Diet: | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Other Special Orders / Medications: | | NA | | | | |
| Post Operative Procedure Special Orders: | | Surgery | | | | | |
| Handed Over By Name : | | Sj | | | | | |
| Signature : | | [Signature] | | | | | |
| Date: | | 13/6/20 | | | | | |
| Time: | | 2PM | | | | | |
| Taken Over By Name : | | | | | | | |
| Signature : | | | | | | | |
| Date: | | | | | | | |
| Time: | | | | | | | |

Patient Sticker



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

| | | | | | | | | |
|------------------------|---|---|--|--|--|--|--|--|
| SITUATION | Diagnosis: | Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: | | | | | | |
| BACKGROUND | Area . | | | | | | | |
| | Shift Time | | | | | | | |
| | Medical Condition (Any special condition to be noted): | | | | | | | |
| ASSESSMENT | Allergy: | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Tubes/Drains/Catheter: | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Vital Signs: | Temp: | | | | | | |
| | | Res: | | | | | | |
| | | SpO ₂ : | | | | | | |
| | | Pulse: | | | | | | |
| | | BP: | | | | | | |
| Fall Risk Score: | | | | | | | | |
| Pain Score: | | | | | | | | |
| Recommendations | Safety Needs: | | | | | | | |
| | Physiotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Others Specify: | | | | | | | |
| | Special Diet: | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Other Special Orders / Medications: | | | | | | | |
| | Post Operative Procedure Special Orders: | | | | | | | |
| | Handed Over By Name : | | | | | | | |
| | Signature : | | | | | | | |
| | Date: | | | | | | | |
| | Time: | | | | | | | |
| | Taken Over By Name : | | | | | | | |
| | Signature : | | | | | | | |
| | Date: | | | | | | | |
| | Time: | | | | | | | |

HNH-00015523 IP26-00006575
 Mrs T DEEPA
 02-10-2002 23 Y 8 M 11 D (F)
 Dr. KADIYALA RAMYA THEJA

NURSING CARE RECORD

Date: 13/6

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 To 2PM | → ASSESS the pt condition → plan for vitals + plan for I/O chart → plan for medication | 8AM To 2PM | → ASSESS the pt condition → vitals are checked & recorded → all medication given as per doctor orders | I/O chart maintained | patient is stable | Sri Sujatha |
| Afternoon | | | | | | | |
| Night | | | | | | | |

Patient Sticker

NURSING CARE RECORD

Date:

Goals

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

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

CONSENT FORM FOR MEDICAL TERMINATION OF PREGNANCY

Patient Name : T. Deepa Age : 23yrs

UHID No : ANH-00015523 Date : 13/6/26

I, the undersigned (Mrs./Miss) T. Deepa W/o, D/o, C/o T. Vamsi aged 23yrs years and residing at Marayal, Telangana request to terminate my pregnancy.

Reason for Undergoing Medical Term of Pregnancy : (Tick whichever applicable)

- The continuance of the pregnancy would involve a risk to my life due to serious medical disease.
- In order to prevent injury to my physical or mental health.
- The continuance of the pregnancy has a substantial risk of the newborn being born with serious physical / mental handicap.
- This pregnancy has resulted from me being raped.
- This pregnancy has occurred as a result of failure of contraceptive techniques -Intrauterine Device/ Oral Pills/ Condoms/ Coitus Interruptus/ periodic abstinence/ tubectomy/ vasectomy.
- In order to prevent a risk of injury to my physical or mental health by reason of my actual/ reasonably foreseeable environment.

I have been explained in the language known and understood by me about all the options available, counseled about the procedure, its risks, and costs & care to be taken after the procedure. Thus, I give my full valid consent as an act of my own free will to undergo the above-mentioned procedure to terminate my pregnancy.

I have been explained also the risks, benefits and alternatives of the procedure.

The future consequence of infertility has been explained to me in view of the voluntary termination of pregnancy and I am willing to accept the risk.

I also indemnify the Doctor and Rainbow Hospitals & its staff of any liability arising because of undergoing the above-mentioned procedure.

Name of the Doctor performing the procedure : Dr. Ranjya Thirja

Patient :

Signature : [Signature]

Name : T. Deepa

Date & Time : 13-06-2026 @ 8:30AM

Patient Attendant / Guardian :

Signature : T. Vamsi [Signature]

Name : Vamsi

Relationship with Patient : Husband

Date & Time : 13-06-2026 @ 8:30AM

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. G. Veena

Date & Time : 13/6/26 @ 9:45AM

Witness :

Signature : [Signature]

Name : Dr. Ranjya Thirja

Date & Time : 13/6/26 @ 8:30AM

*Guardian consent & signature needed in case of patient being less than 18 years or mentally unstable.

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE



Patient Name : Ms T Deepa Gender: Male Female Age : 23f
 UHID No : HNH0001523 Date : 13/06/2026

Instruction:

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

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

SURGICAL EVACUATION OF PRODUCT OF CONCEPTION
(SERPC) upon Ms T Deepa
 (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.

Bleeding, Infection, inadvertent injury to bowel, bladder or omentum (if perforation of uterus), chances of Blood or Blood Product transfusion

My signature on this form indicates that

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

Name of the Doctor who is performing the Surgery / Procedure: Dr Ramya Theja

Consentee :

Signature : [Signature]
 Name : T. Deepa
 Date & Time : 13-06-2026 @ 8:30AM

Patient Attendant :

Signature : [Signature]
 Name : T. Vamsi
 Relationship with Patient: husband
 Date & Time : 13-06-2026 @ 8:30AM

Witness :

Signature : [Signature]
 Name : RAMYA THEJA
 Date & Time : 13/6/26 @ 8:30AM

Doctor (who is taking the consent) :

Signature : [Signature]
 Name : Dr. G. Venna
 Date & Time : 13/6/26 @ 9:45AM

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE



Patient Name : Mrs. T. DEEPA Age : 23y Gender : Male Female

UHID NO: 1444 Surgeon Name: Dr. RANYA THEJA

Anaesthesiologist : Dr. COMILA

Operative procedure planned : SEAPL

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 and 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 Acidosis
- Incapacitating Chronic Obstructive Pulmonary Disease
- Others :

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 Mrs. T. DEEPA the above mentioned operation / Diagnostic / Therapeutic procedures SEAPL

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 anaesthesia.

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 anaesthesiologist 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 : Deepa

Name : T. Deepa

Relationship with Patient : self

Date & Time : 12-06-2021 5:30pm

Witness :

Signature : Self

Name : T. Varma ki

Date & Time : 12-06-2021

Doctor (who is taking the consent) :

Signature : Dr. Sarain

Name : Dr. SARAIN

Date & Time : 12/06/2021 5:30pm

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



Name: Mrs. T. DEEPA Age: 23yrs Sex: female UHID.No: HNH-0015523
 Date: 12/06/2026 Time: 5:30pm Proposed Operation: SEAPC
 Diagnosis: MTP
 B.P./CRT: 109/64 H.R: 79/min Weight: 46.5 ASA Physical Status: 1 2 3 4 5

Laboratory Data:

Hgb: 8.5 ↓ Glucose: Protein: HIV: X-Ray:
 PCV: 26.7 Urea: Alb: HBS Ag: NA ECG:
 WBC: 7180 Creat: Total Bill: HCV: 2D Echo:
 Plate: 2186 Na: Dir. Bill: Blood group: B+ve Stress/Angio:
 PT: K: LDH: T3 Other:
 PTT: Ca++: Alk phos: T4 HbA1c - 4.8
 INR: Mg++: Amylase: TSH
 Cl-: SGOT/SGPT:

Allergies: NEDA

Medical History: CVS: —
 RESP: Diabetes: —
 CNS:
 Renal: NAD
 Hepatic/GE: Physical Activity:
 Others:

Past Anaesthetic History: NIL

Physical Exam: Thinly built & emaciated

Airway: MP 1 2 3 4 Mouth Opening: 3/8 Mentohyoid Distance: 3/8 Neck: Ⓟ Teeth: No loose teeth

Lungs: Clear

Heart: S1 S2

CNS: NAD

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

Anaesthetic Plan: MAC REGIONAL GA-ETT LMA

Peri-Operative Plan Explained to the Patient: Yes No

| CURRENT MEDICATIONS | DOSAGE |
|---------------------|--------|
| | |
| | |
| | |
| | |

- Pre-Operative Instructions:**
- DVT Prophylaxis :
 - NIL ORAL
 → Water / ORS 2 Hours
 → Others 6 Hours .
 - Informed Consent: Standard High Risk.
 - Post Operative Pain Management: Discussed with Patient
 - Other Instructions:

Signature: [Signature] Name: Dr. SARADIN

HNH-00015523 IP26-00006575
 Mrs T DEEPA
 02-10-2002 23 Y 8 M 11 D (F)
 Dr. KADIYALA RAMYA THEJA

ANAESTHESIA CHART



Pre Induction Assessment:

Change in Patient Condition: Yes No Fasting Status: adequate

Physical Status: Patient Identified Consent Present Chart Reviewed

H.R: 89/m B.P / CRT: 101/64 SpO₂: 100% R.R: 18/m Last Feed: 6 hrs.

Pre-OP Diagnosis: R/Oc Operation: CEPC Date: 13/6

Surgeon: Dr RT/Vera Anaesthesiologist: Sanu Technician: Pavan

| TIME | 1030 | 1100 | | | | | | | | | | | | | | | | | | |
|---|---------------|---------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| N ₂ O/AIR O ₂ LPM | 2/1/min | 2/1/min | | | | | | | | | | | | | | | | | | |
| HALO /SO (SEVO) | MAC 1.0 | MAC 1.0 | | | | | | | | | | | | | | | | | | |
| Drugs: | | | | | | | | | | | | | | | | | | | | |
| MIDAZOLAM | 2mg | | | | | | | | | | | | | | | | | | | |
| FENTANYL | 100mcg | | | | | | | | | | | | | | | | | | | |
| PROPOFOL | 100 + 40mg IV | | | | | | | | | | | | | | | | | | | |
| PARACETAMOL | 1gm | | | | | | | | | | | | | | | | | | | |
| METHEMLINE | 0.2mg | | | | | | | | | | | | | | | | | | | |
| TRANEXAMIC ACID | 1gm IV | | | | | | | | | | | | | | | | | | | |
| FI ₀₂ / SaO ₂ | 100 / 100 | | | | | | | | | | | | | | | | | | | |
| ETCO ₂ | 35 35 | | | | | | | | | | | | | | | | | | | |
| ECG | SR SR | | | | | | | | | | | | | | | | | | | |
| Temperature | | | | | | | | | | | | | | | | | | | | |
| Urine Output | | | | | | | | | | | | | | | | | | | | |
| Fluids | | | | | | | | | | | | | | | | | | | | |
| Blood | | | | | | | | | | | | | | | | | | | | |
| B.P | | | | | | | | | | | | | | | | | | | | |
| V Systolic | | | | | | | | | | | | | | | | | | | | |
| A Diastolic | | | | | | | | | | | | | | | | | | | | |
| X Mean | | | | | | | | | | | | | | | | | | | | |
| • Heart Rate | | | | | | | | | | | | | | | | | | | | |
| Tourniquet on Time | | | | | | | | | | | | | | | | | | | | |
| Tourniquet off Time | | | | | | | | | | | | | | | | | | | | |
| Throat Pack In | | | | | | | | | | | | | | | | | | | | |
| Throat Pack Out | | | | | | | | | | | | | | | | | | | | |

Antibiotic
Zmer
 Suppository
DICLOFENAC 100mg
TRAMADOL
 Blood Loss 00/4
ISML
 NOTES

LAB Values

ABG

GRBS

Others

| | | | |
|--|---|---|---|
| <input checked="" type="checkbox"/> Equipment Checked and Functional <input type="checkbox"/> BP <u>20/90</u> <input type="checkbox"/> Cuff Site: <u>20/90</u> <input type="checkbox"/> Art Site: <u>3lead</u> <input checked="" type="checkbox"/> EKG Lead <u>3lead</u> <input type="checkbox"/> Temp Site <input checked="" type="checkbox"/> FIO ₂ Monitor <input checked="" type="checkbox"/> Agent Monitor <input checked="" type="checkbox"/> Pulse Oximeter <input checked="" type="checkbox"/> Capnograph <input checked="" type="checkbox"/> Ventilator <input type="checkbox"/> Nerve Stimulator Position: <u>litro</u> <input type="checkbox"/> Pressure Points Checked Eye Care: <input type="checkbox"/> Oint <input checked="" type="checkbox"/> Tape <input type="checkbox"/> Padding <input type="checkbox"/> Awake | Temp: <input type="checkbox"/> HIME <input type="checkbox"/> Fluid Warmer <input type="checkbox"/> Cling Film <input type="checkbox"/> OH Warmer <input checked="" type="checkbox"/> Hugger's <input type="checkbox"/> Cotton Wool <input type="checkbox"/> Other <u>sheet</u> Times: Anaes Start: <u>1030</u> OP Start: <u>11:00</u> OP End: <u>11:00</u> Leave OR: <u>11:00</u> Anaesthesia: <input checked="" type="checkbox"/> GA <input type="checkbox"/> Monitored Anaesthesia Care <input type="checkbox"/> Regional Line (Size & Location) <input type="checkbox"/> CVP: <input type="checkbox"/> ART: <input checked="" type="checkbox"/> IV: <u>20g @ ul</u> <input type="checkbox"/> IV: <input type="checkbox"/> IV: | Induction <input checked="" type="checkbox"/> IV <input checked="" type="checkbox"/> Inhal <input type="checkbox"/> Pre O ₂ <input type="checkbox"/> RSI <input type="checkbox"/> Others <input type="checkbox"/> Mask <input checked="" type="checkbox"/> SGA <u>IAEL #4</u> <input type="checkbox"/> Airway <input type="checkbox"/> Oral <input type="checkbox"/> Nasal ETT# at cm <input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Cuff <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Topical <input type="checkbox"/> Drug: <input type="checkbox"/> Awake <input type="checkbox"/> Direct Vision <input type="checkbox"/> Video Laryngoscopy <input type="checkbox"/> Stylette / Bougie <input type="checkbox"/> Fiberoptic Blade# Attempts: Difficulty Why? <input type="checkbox"/> Bilat = BS <input type="checkbox"/> Semi-Closed Circle <input checked="" type="checkbox"/> Closed Circle <input type="checkbox"/> Other | Regional: Extremity Specify: <input type="checkbox"/> Spinal <input type="checkbox"/> Epidural <input type="checkbox"/> Caudal Others: Position: Site: Needle Size: Depth: Parasthesia <input type="checkbox"/> Yes <input type="checkbox"/> No Catheter at skin cm Drug Name & Conc: Bolus: Infusion: Block Level: Comments: Transportation to <input checked="" type="checkbox"/> PACU <input type="checkbox"/> ICU <input type="checkbox"/> Other Relaxant Reversed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA Name of the Doctor: <u>Dr. Sanu</u> Signature of the Doctor: <u>[Signature]</u> |
|--|---|---|---|

HNH-00015523
 Mrs T DEEPA
 02-10-2002
 Dr. KADIYALA RAMYA THEJA

IP26-00006575

23 Y 8 M 11 D (F)

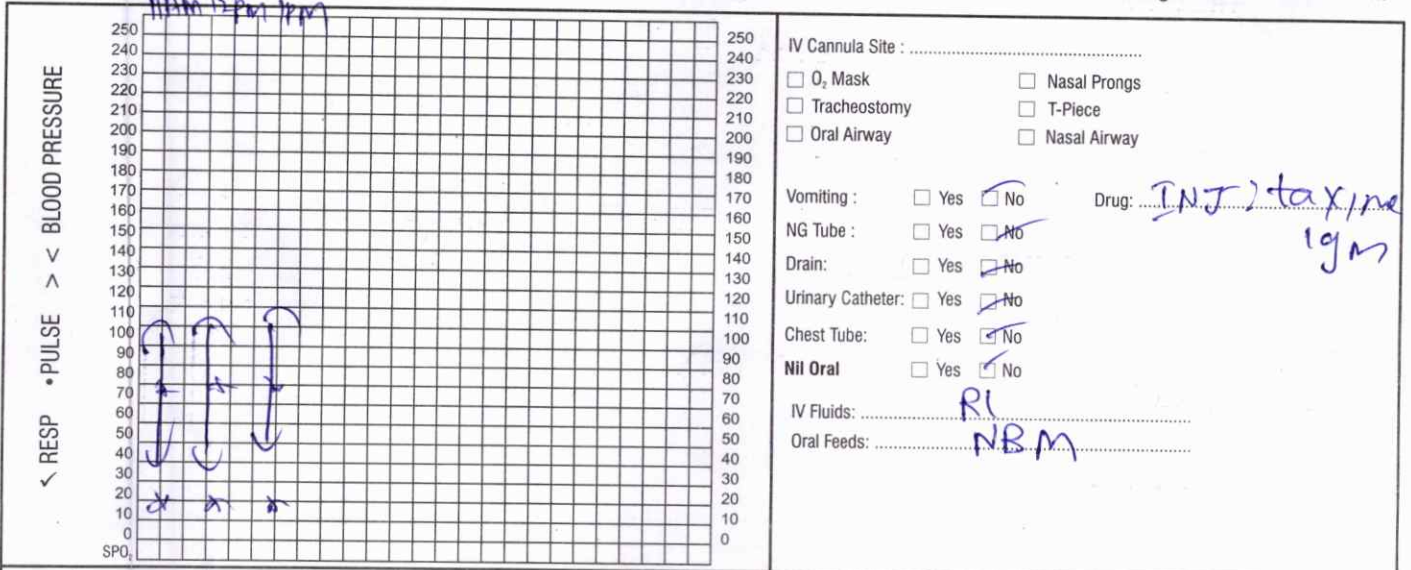


Rainbow Children's Hospital
 It takes a lot to treat the little.

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

POST ANAESTHESIA CARE UNIT RECORD

Received in PACU by: Sujatha Time Received: 11 AM Time Discharged: _____



IV Cannula Site : _____
 O₂ Mask Nasal Prongs
 Tracheostomy T-Piece
 Oral Airway Nasal Airway

Vomiting : Yes No Drug: INJ Taxime 1gm
 NG Tube : Yes No
 Drain: Yes No
 Urinary Catheter: Yes No
 Chest Tube: Yes No
 Nil Oral Yes No
 IV Fluids: RI
 Oral Feeds: NBM

| POST ANAESTHESIA SCORE (Modified Aldrete Score) | IN | MINUTES | | | OUT | SCORING INTERPRETATION |
|--|---------------|---------|----|----|-----|--|
| | | 30 | 60 | 90 | | |
| Able to move 4 extremities voluntary or on command = 2 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 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 = 2 Dyspnea or limited breathing = 1 Apneic = 0 | RESPIRATION | 2 | 2 | 2 | 2 | |
| BP ± 20 of Pre Anaesthetic level = 2 BP ± 20-50 of Pre Anaesthetic level = 1 BP ± 50 of Pre Anaesthetic level = 0 | CIRCULATION | 2 | 2 | 2 | 2 | |
| Fully awake = 2 Arousable on calling = 1 Not responding = 0 | CONSCIOUSNESS | 2 | 2 | 2 | 2 | |
| Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0 | COLOR | 2 | 2 | 2 | 2 | |
| TOTAL | | 9 | 10 | 10 | 10 | |

PAIN ASSESSMENT AND MANAGEMENT FORM

| Date | Time | Pain Score | Intervention | Signature |
|------|-------|------------|--------------|-----------|
| 13/6 | 11 AM | 0 | NA | Si |
| 13/6 | 12 PM | 0 | NA | Si |
| 13/6 | 1 PM | 0 | NA | Si |
| 13/6 | 2 PM | 0 | NA | Si |

Pain Tool Used: N PASS FLACC Wong Baker NPS

Reassessment Frequency:

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

Anaesthesiologist Name : _____

Anaesthesiologist Signature: _____

Date & Time: 13/6/26 @ 2 PM

PACU Nurse Name : _____

PACU Nurse Signature: _____

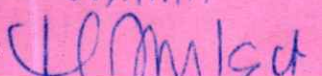
Date & Time: 13/6/26 @ 2 PM

Transferred to Unit by (PACU): _____

Date & Time: 13/6/26 @ 2 PM

26-0000140303

NARCOTIC PRESCRIPTION FORM (PATIENT COPY)

| Patient Name: | Mrs T Deepa | Age: | 33Y | Gender: | Female |
|---|-------------------------------------|--|-------------|-------------------------------|---------|
| UHID No: | HNA-00015597 | IP No: | 26-00006575 | Date: | 13/6/26 |
| Diagnosis: | SERPC | | (W:OT) | Time: | 9:03 |
| PRESCRIPTION DETAILS (Tick only one of the following) | | | | | |
| S.No | Drug Name | Dosage | Remarks | | |
| 1. | Fentanyl Citrate Inj. 50mcg/ML | 100mcg | 01 AMP | | |
| 2. | Morphine Sulphate Inj. 15mg/ML | --- | --- | | |
| 3. | Remifentanyl Hydrochloride Inj. 2MG | --- | --- | | |
| 4. | Remifentanyl Hydrochloride inj. 1MG | --- | --- | | |
| Doctor Name: | | Dr. Amir | | Doctor Registration No: 67529 | |
| Signature: | |  | | | |

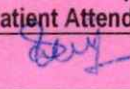
NARCOTIC DISPENSING FORM APPENDIX 4 - FORM NO. 3E

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

IP Registration No: 26-00006575

Date: 13/6/26

Aadhaar No. of the Patient (Optional):

| 1. | Name: | Mrs. T. Deepa | Remarks | |
|------|---|---------------------------------|--|-----------------|
| 2. | Complete postal address (with contact number, if any) | 675090nda Dhamgram Waranagar | | |
| 3. | Brief description of the illness | SERPC | | |
| 4. | Whether registered with any other registered medical practitioner / recognized medical institution (If yes, details of the recorded) | NO | | |
| 5. | Details of essential Narcotic drug dispensed | INJ: Fentanyl | | |
| Date | Name of the Essential Narcotic Drugs | Quantity | Signature / Thumb Impression of the patient / Patient Attender | Remarks, if any |
| 13/6 | INJ: Fentanyl | 01 |  | |

Dispensed by (Name & ID No.): Sania (018442) Signature: Sania
 Received by (Name & ID No.): M Arvind Kumar (091257) Signature: AKO

Time: