

Name	Mrs ALUR ARAVINDA	UHID	HNH-00012139
Father/Guardian	Mr L P GOUTHAM PRATAPA	Age/Gender	27 Y 0 M 12 D/ Female
Address	3RD FLOOR, SRI SARADA NILYAM, 2-1-565/4/4, Nallakunta, Hyderabad, Telangana, INDIA, 500044		
IP No	IP26-00006513	Admission Date	05-06-2026
Ref Doctor	Self.		
Discharge Date	06.06.2026		

DISCHARGE SUMMARY

Consultants :
Dr. Swathi H V
MBBS/MS
TSMC/FMR/15501

Diagnosis: PRIMIGRAVIDA WITH 32⁺³ WEEKS WITH REDUCED FETAL MOVEMENTS WITH THREATENED PRETERM LABOR

History:

LMP: 21.10.2025

EDD: 28.07.2026

admission:32⁺³weeks

Obstetric formula: PRIMI

Gestation at

Obstetric History:

G1 - Present pregnancy, Spontaneous conception.

Medical History: Nil

Name	Mrs ALUR ARAVINDA	UHID	HNH-00012139
IP No	IP26-00006513	Admission Date	05-06-2026

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

Antenatal Details:

Mrs ALUR ARAVINDA was booked to Rainbow hospital at 4⁺⁴ weeks of gestation. .She had regular antenatal checkups and investigations as advised. NT scan normal. FTS low risk. MTAS normal. She had an uneventful antenatal period. Scan done at 32⁺³ weeks showed single live intrauterine fetus with cephalic presentation with Placenta-anterior,high,EFW-2.073kg(54%),AC-23%,AFI-9.4 cm with normal dopplers. She was admitted at 32⁺³weeks with complaints of pain abdomen and decreased fetal movements .

Investigations: Enclosed
 Blood Group : ' O positive '

Management: Patient came with complaints of pain abdomen and decreased fetal movements. At admission on clinical examination the vitals were stable, uterus was irritable, cervix was uneffaced, os closed. Fetal well being was confirmed by an admission CTG which was found to be reactive. Tocolysis done with Depin 10mg thrice daily. Antenatal steroid coverage done with 2 doses of Inj. Betamethasone 12mg on 05.06.2026.and 06.06.2026 for fetal lung maturity in view of anticipated preterm delivery. Scan done on 05.06.2026 showed single live fetus with cephalic presentation, Placenta-anterior and high,AFI-9.4cm(lower limit of normal),EFW-2.073kg(54%),AC- 23%.Arginine sachets were advised in view of low liquor. CUE showed 8-10 pus cells , 20-25 epithelial cells .Urine Culture and sensitivity report to be traced. She has no further symptoms and found fit to be discharged.

Name	Mrs ALUR ARAVINDA	UHID	HNH-00012139
IP No	IP26-00006513	Admission Date	05-06-2026

Advice:

1. Arginine sachets thrice daily with 1 glass of water (8am- 2pm-8pm) .
2. Cap.Depin 10 mg thrice daily (6am-2pm-10pm) till 09.06.2026 after food
3. Tab Livogen once daily before lunch.
4. Tab Shelcal XT once daily after dinner.
5. Cap Uprise 2000 IU once daily.
6. Cap Suport once daily after breakfast.
7. Cap MGD3 once daily for 7 days.
8. Plenty of oral fluids.
9. Strict fetal kick count.

Review consultation with **Dr. Swathi H V**, on **12.06.2026** with **AFI scan** in Rainbow Children's Hospital (**Review consultation will be charged**).

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


Patient/ Attender

In case of emergency like bleeding, fever kindly contact 9154865045 at Rainbow Children's Hospital just dial one toll free number - 18002122. You can also take appointments at any time by going online to our website **www.rainbowhospitals.in**

Name	Mrs ALUR ARAVINDA	UHID	HNH-00012139
IP No	IP26-00006513	Admission Date	05-06-2026



Registrar/Resident/C.M.O

Consultants :
Dr. Swathi H V
MBBS/MS
TSMC/FMR/15501

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006513 Admit Date : 05-Jun-2026 Admit Time : 02:22 PM UHID : HNH-00012139

Patient Details :

Patient Name : Mrs ALUR ARAVINDA Age : 27 Y 0 M 12 D
Guardian : Mr L P GOUTHAM PRATAPA DOB : 24-05-1999
Gender : Female Religion :
Occupation : Martial Status :
Address (H) : 3RD FLOOR, SRI SARADA NILYAM, 2-1-565/4/4 Nallakunta Hyderabad Telangana INDIA 500044 Phone No : 8985007024/ 8985928679
E-mail : ALURARAVINDA24@gmail.com

Admission Details :

Bed Type : TWIN SHARING Bed No : PPO-418 Ward Name : 4F -OT
Room No : PPO-418 Admission Type : First Visit

Contact Details :

Name : Mr L P GOUTHAM PRATAPA Relationship : W/O
Contact Address : 3RD FLOOR, SRI SARADA NILYAM, 2-1-565/4/4 Nallakunta Hyderabad Telangana INDIA 500044 Phone No : 8985007024

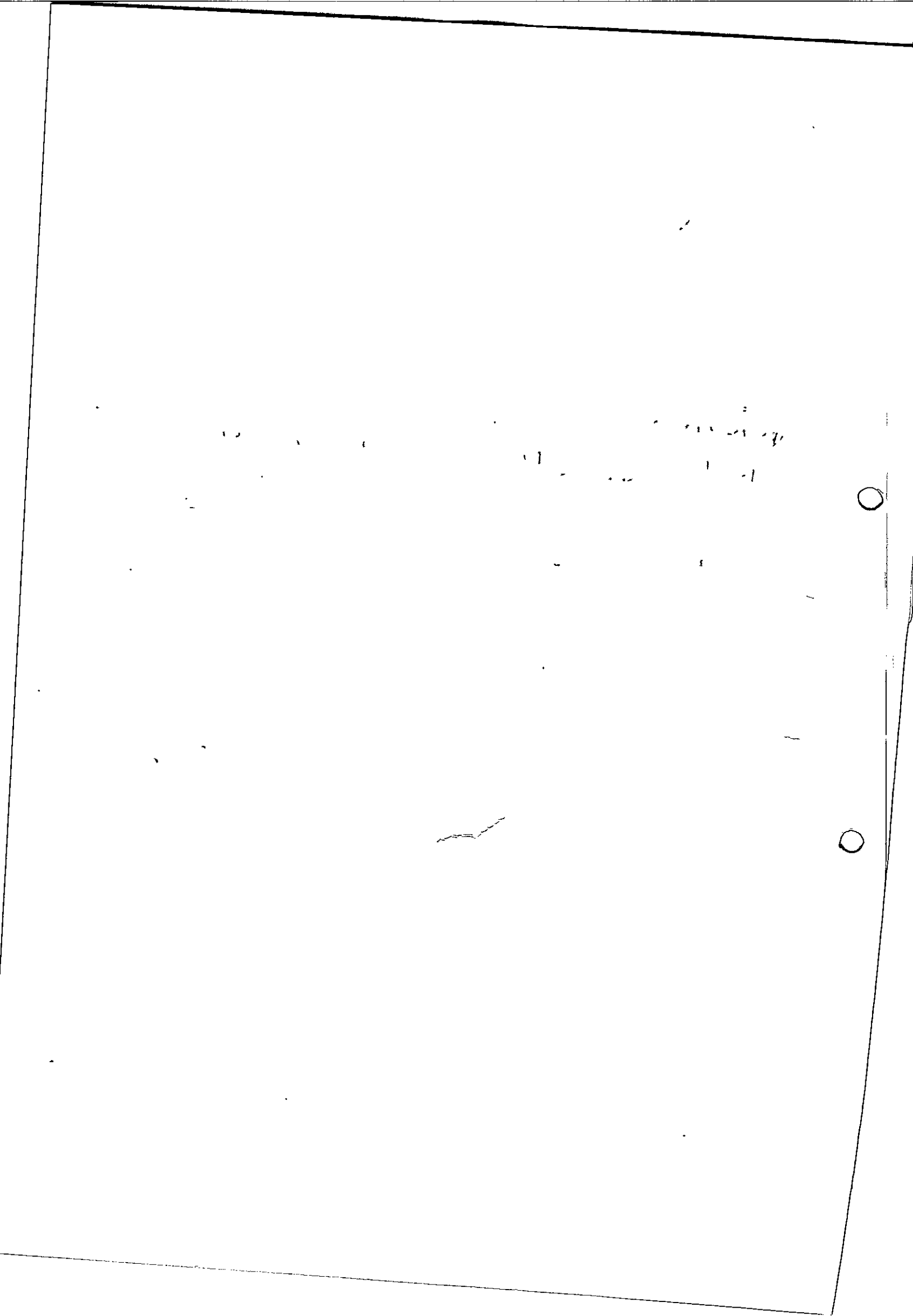

Signature

Doctor Details :

Doctor Name : Dr. SWATHI H V Specialisation : OBSTETRICS AND GYNECOLOGY
Referral Doctor : Self. Phone No :
Co-Consultant :

Payment Details :

Payment Mode : DC/CC Card Deposit Amount : 10000.00
Payor Name : SELFPAY





DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	01			
2	Discharge Summary	01			
3	Nursing Initial assessment	01			
4	Patient Transfer form	01			
5	In-patient Medical record	01			
6	Doctors progress sheets	02			
7	Nursing plan of care and handover sheets	01			
8	Consultation sheet	01			
9	General consent for treatment	01			
10	Consent for Surgery	01			
11	Consent for blood transfusion	01			
12	Consent for chemotherapy	01			
13	Consent for high risk	01			
14	Consent for Restraint	01			
15	LAMA consent	01			
16	Consent for special procedure / Sedation	01			
17	Consent for Formula feed	01			
18	Consent for MTP	01			
19	Consent for Radiological Investigations	01			
20	Consent for HIV test	01			
21	Anaesthesia notes (Pre Anaesthesia & post)	01			
22	Neonatal Admission/Delivery/Physical Exam	01			
23	Medication Reconciliation	01			
24	Emergency Triage record	01			
25	Pre operative check list	01			
26	Surgical safety checklist	01			
27	Operation Theatre notes	01			
28	Nurses clinical Presentation	01			
29	TPR & BP chart	01			
30	Intake and Out take chart (fluid chart)	01			
31	Drug chart (Regular Prescription)	01			
32	Investigation Values (result sheet)	01			
33	Nebulization chart	01			
34	Nutritional review chart	01			
35	Intensive care unit (ICU Charts)	01			
36	Consent for Admission in PICU / NICU	01			
37	The Humpty dumpty scale	01			
38	Braden Q Scale	01			
39	Bed side check list	01			
40	PICU bed formula Dilution feeds	01			
41	Gastro monitoring chart	01			
42	Rch ED doctors note	01			
43	BP Monitoring chart	01			
44	RBS monitoring chart	01			
	<i>extra pages</i>	10			
	Total No. of Pages	25			

ERROR LOG

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

OBSERVATION :


DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No: **HNH-00012139** **IP26-00006513**
Dr. ALUR ARAVINDA **24-05-1999** **27 Y 0 M 12 D** (F) **Consultant:** _____ **Dept :** _____
Dr. SWATHI HV

Date of :  **Date of Discharge :** _____ **Time:** _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

Cross Consultation Visit

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

.....
.....
.....
.....
.....
.....
.....

Date :

Time :

Prepared By :

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

Presenting Complaints

clt pain abdomen: morning
 clt decreased FM

Obstetric Formula: Primi

Obstetric History: Spontaneous conceptⁿ.

Booked @ 4th wks, NT - (N)

FTS - Low risk.

Present Pregnancy Record:

TIFFA - (N), Growth - (N)

LMP: 21/10/25

EDD: ...

Corrected EDD: 28/7/26.

GA: 32⁺3 wks

Menstrual History: Regular: Yes No

Obstetric Examination

Fundal Height: Ut ~ Term

Ut. Activity: Relaxed Mild Mod Severe

Liquor: Adequate Oligo Poly

PP: Cephalic Breech Others _____

Head Fifths Palpable: 5/5

FHS: Normal Tachy Brady Absent

RISK FACTORS:

Preterm.

Per Speculum Examination

Draining: Present Absent Bleeding

Colour of Liquor: Clear Meconium Blood Stained

Vaginal Examination

Cervix: Long Partially effaced Effaced

Os: Closed cb Dilated _____

Membranes: Present Absent

Liquor: Clear Meconium Blood Stained

Presenting Part: Vertex Breech Others

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

Pelvis: Adequate Doubtful

Height: 152 cm

Weight: 71 kg

Allergies: Nil

Breast: Normal Abnormal

General Examination:

Consciousness: (+)

Pallor: (-)

Icterus: (-)

Edema: (-)

Temp: Afebrile

PR: 100

BP: 111/71

DTR: (+)

CVS: SS2 (+)

RS: B/LN VBS

Liver/Spleen: (N)

Urine Output: (N)

DIAGNOSIS

Primi / 32⁺3 wks / ↓ FM
 for observation.



<p>Family History:</p> <p>Father - DM Mother - HTN.</p>	<p>Surgical History:</p> <p>Nil</p>
<p>Medical History:</p> <p>Nil</p>	<p>Medication History:</p> <p>On 7. Fe / T. Ca.</p>
<p>Plan of Care:</p> <p>Ⓟ</p> <ul style="list-style-type: none"> - Admission NST - NST X 6th hourly - Tab Depin 10mg 710 - Antenatal steroid (Tab Betamethasone 12mg 24 hour Apart 2 dose) - W/F vitals - FHS monitoring - Inform surg - Serial CUB - Growth scan stat 	<p>Investigations:</p> <p>BCT - "Positive"</p> <p><u>GRBS</u> -</p> <p>fcu HbSAg uDel] NR.</p> <p>Ab - Pt - uRbc -</p> <p><u>USG (5/5/26)</u> ~ 28 weeks SLR, Cephalic Pl - Ant. high, AFI - 17.4cm EFW - 1.1kg (48%) AC @ 15% Dopplers - (N)</p>

Doctor Name: Dr. G. Veena
 Signature: *[Signature]*
 Date & Time: 5/6/26 @ 2:30pm

Consultant Name: Dr. Swathi HV
 Signature: *[Signature]*
 Date & Time: 5/6/26



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		c/s/B Dr. Veena - c/D/w Dr. Swathi
5/6/26 4:30pm	Primi / 32 ³ wks - Threatened preterm	
	Pt is stable, No clo	Adv
	o/f GC fair	- Regular diet
1st dose steroid given ✓	BP - 116/74 mmHg	- Vital monitoring
	PR - 79 bpm	- Drugs as charted
	SpO ₂ - 100% on RA	- CUE - send E trace.
	PLA - U/W term	- NST 6th hourly.
	Relaxed, Cephalic	- w/ hypotension,
	FHS (+)	tachycardia, Tsd pain,
Growth scan done (USG) - SLF, Cephalic	AFI - 9.4 cm (lower limit)	decreased movements
	Pl - Ant E high, EFW - 2.07 kg (54%)	- ARG 9 SACHETS - TID
	AC @ 23%	
	Dopplers - (N)	
		Noted by Amrha. S.



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/6/26 8pm	C/S/B Dr. Dva Primi @ 32 ⁺³ week - Threatened preterm No complaints GC Fair Afebrile vitals - Normal P/A ut = 32wks cephalic NST - Reactive @ 5:30pm Relaxed FHR ⊕	Adv - Regular diet - Rest in left lateral position - DFMC - FHR Monitoring 2nd hour - NST 6th hourly - Drugs as charted - 2nd dose Betnasol @ 2:30pm
6/6/26 6AM	C/S/B Dr. Dva Primi @ 32 ⁺⁴ wk - threatened preterm No complaints GC Fair Afebrile vitals - Normal P/A ut = 32wk cephalic Relaxed FHR ⊕	Adv - Regular diet - Rest in left lateral position - DFMC - FHR 2nd hourly monitoring - NST 6th hourly - Drugs as charted - 2nd dose Betnasol @ 2:30pm



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/6/2026 10:00am	cls / by Dr. Naveena / Dr. Keena cls / by Dr. Swathi H V	
	<p>o/e GC-fair Afebrile PR: 75bpm BP: 105/74mmHg. Cus/RS: NAD PA: ut \approx 30-32wks</p>	<p>Ado - Regular diet - Adequate hydration - LLP Rest - DFMC - strict FHR monitoring 2hrly.</p>
	<p>Cephalic FHR (+) 150bpm</p>	<p>- NST 6th hrly - drugs as charted</p>
	<p>patient can be discharged</p>	<p>- Inj. Betnesol. 12mg im 2nd dose @ 2:30pm</p>
	<p>Dr. Naveena</p>	<p>- Monitor Vitals - Inj. SO S.</p>

HNH-00012139 IP26-00006513
 Mrs ALUR ARAVINDA
 24-05-1999 27 Y 0 M 12 D (F)
 Dr. SWATHI H V



RESULT SHEET

Date	5/6/26				
Time					
Hb					
PCV					
RBC					
WBC					
N/L					
Platelets					
CRP					
ESR					
PCT					
RBS	97 mg/dl				
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	5/6/26					
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones	negative					
CUE - PUS Cells	8-10					
CUE - RBC Cells	4-6					
CUE						
Neutrophils	Present +					
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities :

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Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :



LABOUR AND DELIVERY NURSING ASSESSMENT

Date of Admission: 5/6/2020

Baseline Information:

Admission From: ER OPD Admission Desk Others: specify

Primary Language: Telugu English Hindi Others

Do you require an interpreter? Yes No

Source of Information: Patient Family Others

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

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

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

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

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

Blood Group: O +ve LMP: 21/10/15 EDD: 28/7/26 Gestational age during admission:
 Contractions: Vaginal Discharge:

Obstetric History: G 1 P L A Previous LSCS

Height: 162 Weight: 71 BMI:
 Temp: 98.1° HR: 96 RR: 20 BP: 114/96 SpO₂: 99%

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

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



History: NO Abnormalities Detected

- Heart Disease
- Hypertension
- Diabetes
- Stroke
- Seizures
- Kidney disease
- Liver disease
- Other

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

Fall Assessment: Yes No Score 0 (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore: Yes No Score 0 (complete the Braden Q Sheet)

FUNCTIONAL SCREENING: If a patient needs assistance with any of the following inform consultant

- Mobility problem
- Walking Problem
- No Abnormality Detected
- Developmental Delay
- Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

- Overweight
- Poor Appetite > 3 Days
- Needs Therapeutic Diet.
- Under Weight
- Diabetes Mellitus
- No Abnormality Detected

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

- Calm & Cooperative
- Restless
- Depressed
- Agitated
- Confused
- Others

Inform consultant for positive criteria

SOCIAL SCREENING:

1. Marital Status: Single Married Divorced Widow
2. Special Habits: Smoker: Yes No Alcohol Abuse: Yes No Drug Abuse: Yes No

Social History: Lives With

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: Arun Aravinda

Orientation not given Reason:

Nurse Signature: *[Signature]*

Nurse Name:

Date & Time: 05/06/2026 @

HNH-00012139 IP26-00006513
 Mrs ALUR ARAVINDA
 24-05-1999 27 Y 0 M 12 D (F)
 Dr. SWATHI H V



DRUG CHART

Date of Admission: 5/6/2020 Drug Allergies: Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
 - Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
 - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
 - AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name _____ Signature _____



REGULAR PRESCRIPTIONS

Weight. Ward.

DRUG : <u>TAB DEPIN</u>				Date Time																
Dose	Route	Frequency	Start Date																	
10mg	PO	710	5/6																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG : <u>TAB LIVOREN</u>				Date Time																	
Dose	Route	Frequency	Start Date																		
1tab	PO	00	5/6																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					

DRUG : <u>T. SHELCAL XT</u>				Date Time																	
Dose	Route	Frequency	Start Date																		
1tab	PO	00	5/6																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					

DRUG : <u>CAP. SUPORT</u>				Date Time																	
Dose	Route	Frequency	Start Date																		
1 Cap	PO	00	5/6																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					



Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

DRUG : CAP UPRISE				Date Time															
Dose	Route	Frequency	Start Dt.																
2000iv	P/O	OD	5/6																
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			
DRUG : ARGININE SACHETS				Date Time															
Dose	Route	Frequency	Start Dt.																
1sachet	P/O	TID	5/6/26	7 AM	5/6/6	X													
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			
DRUG :				Date Time															
Dose	Route	Frequency	Start Dt.																
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			
DRUG :				Date Time															
Dose	Route	Frequency	Start Dt.																
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			

Signature
VERIFIED BY / Name

HNH-00012139 IP28-00008513
 Mrs ALUR ARAVINDA
 24-05-1999 27 Y 0 M 12 D (F)
 Dr. SWATHI HV



Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

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

Signature

VERIFIED BY Name



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
5/6	3 PM	6p DEPIN	20mg	P/O	ny	A 8
5/6	2:30 pm	INS 24 BETAMETHASONE	12mg	IM	lb	headmistress
6/6/26	2:30 PM	INS BETAMETHASONE	12mg	IM	lb	

Signature Name

FHR chart 6/6/26

5/6/26

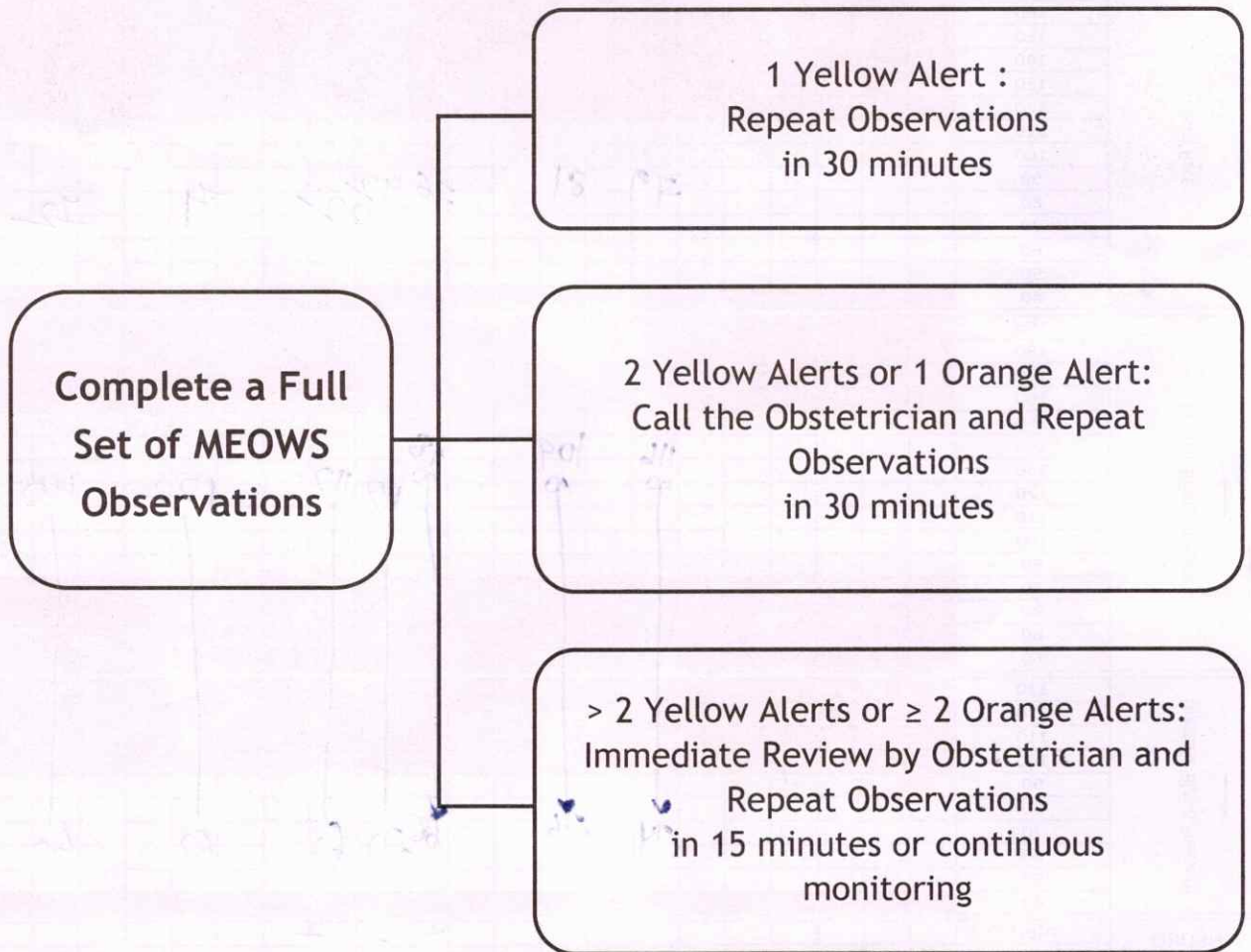
10pm \Rightarrow 148 bnt

2AM \Rightarrow 152 bnt

4AM \Rightarrow 138 bnt

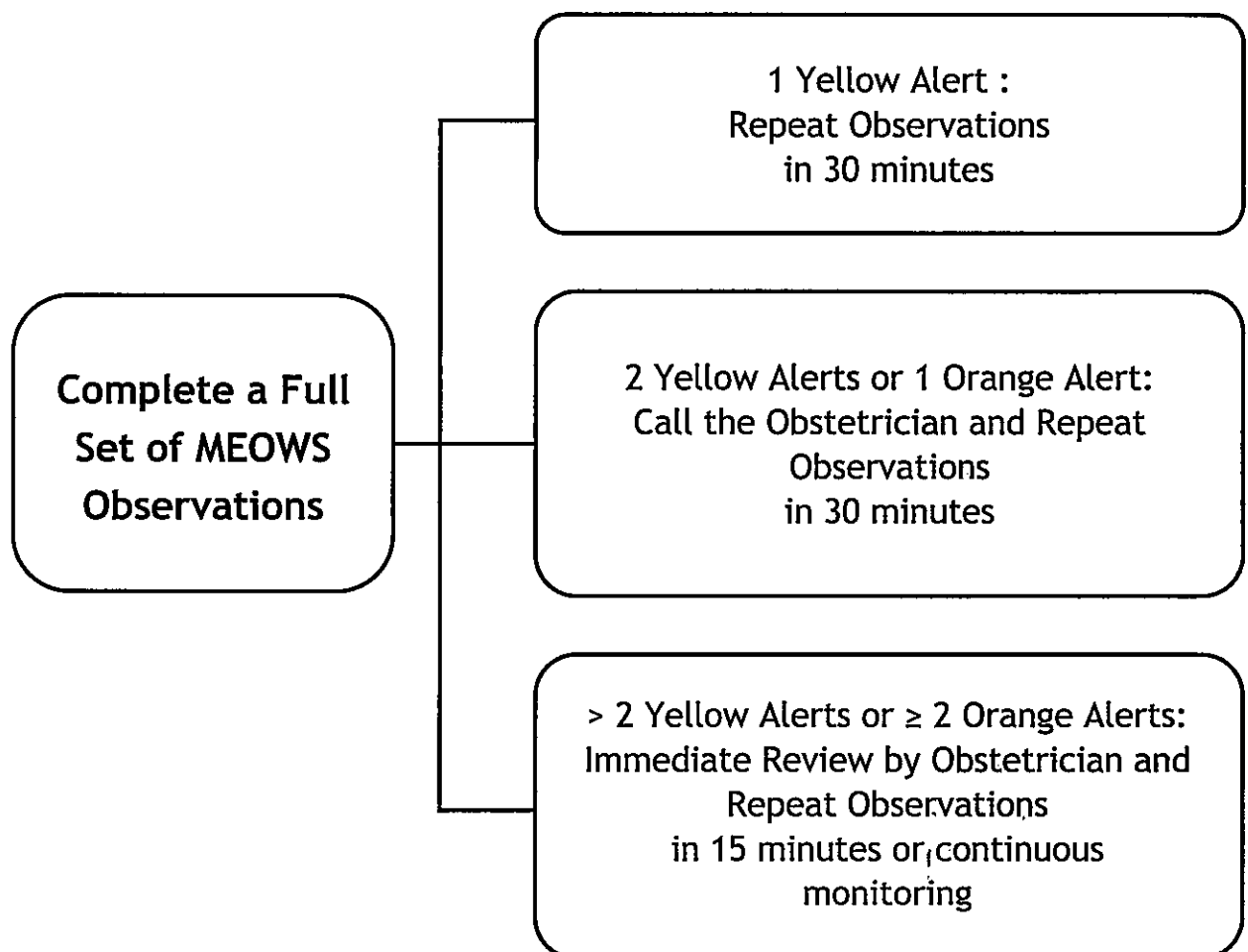
6AM \Rightarrow 142 bnt.

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

HNH-00012139 IP26-00006513
 Mrs ALUR ARAVINDA
 24-05-1999 27 Y 0 M 12 D (F)
 Dr. SWATHI H V



FLUID CHART

Sheet No. :

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

Date	Time	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	Meals											
	04:00 pm	Milk											
	05:00 pm	H ₂ O											
	06:00 pm												
	07:00 pm	Meals											
Total Intake : Taken						Total Output : passed							
	08:00 pm												
	09:00 pm	H ₂ O											
	10:00 pm												
	11:00 pm												
	12:00 am	H ₂ O											
	01:00 am												
Total Intake : Taken						Total Output : passed							
	02:00 am												
	03:00 am	H ₂ O											
	04:00 am												
	05:00 am	H ₂ O											
	06:00 am												
	07:00 am												
Total Intake : Taken						Total Output : passed							

Total 24 hrs. Intake

Total 24 hrs. Output

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FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine				
6/6/26			Mouth	I.V	N.G								
	08:00 am		Tea										
	09:00 am												
	10:00 am		Water										
	11:00 am						NA						
	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	
-----------------------------	--

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NURSING CARE RECORD

Date: 5/06/2016

- 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				NA			
Afternoon	2pm	→ Assess the pt condition → check the vitals → Echo chest done → Dujic Betnigel - 12mg/lin given 2:30pm 1st dose done	3pm	→ Assessed pt condition → checked vital's & found → Maintained Echo chest → done	pt is stable	vital's is Normal	Ausha
Night	8pm	→ cap: Depine give 3pm	8pm	→ 1st dose			
Night	8pm	→ Assess the pt condition → monitor vitals → plan for FHR/NST	8pm	→ Assessed pt condition → vitals Normal. → NST done. → FHR checked	stable	Normal	Ausha

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NURSING CARE RECORD



Date: 6/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8 AM 2 PM	→ Assess the pt condition → monitor the vitals & record → Administration of medication → ASST @ Hbny → maintain Kooluvely	8 AM 2 PM	→ Assessed the pt condition → monitored the vitals & recorded → Administered medication → maintain Kooluvely → n of th monitoring & ambly	pt is stable	maintain Kooluvely chart & record	Aklis @
Afternoon							
Night							



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
5/6	3pm	0/10	—	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	<i>[Signature]</i>
5/6	9pm	0/10	—	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	<i>[Signature]</i>
6/6	8AM	0/10	—	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	<i>[Signature]</i>
6/6	2pm	0/10	—	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	<i>[Signature]</i>
				<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:

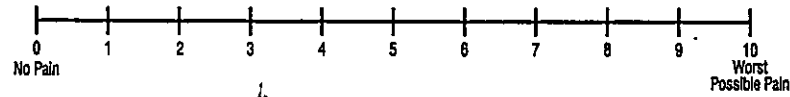
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 - a) At least every 2 hours for the first 24 hours
 - b) Then every 4 hours.
 - c) Prior to pain pain-relieving intervention.
 - d) Within 30 – 60 minutes after pain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

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

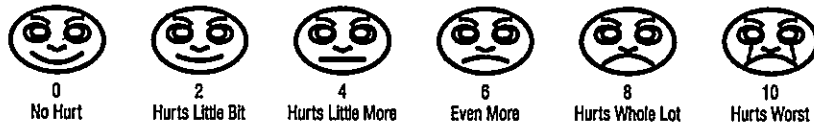
Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	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



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BRADEN 'Q' SCALE



Date : 5/6 5/6 6/6
 Time : 5 12 12

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

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

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

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

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	5/6/2026	5/6/26	6/6/26	Fall Risk Grading		
		Score	E2	N		Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25				Low Risk	0 - 24	Standard Fall Precaution
	No	0						
Secondary Diagnosis (more than one diagnosis)	Yes	15				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0	0	0	0			
Ambulatory Aid	Furniture	30						
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0	0	0			
IV / Heparin Lock or Saline	Yes	20	20	20	20	High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	No	0	0	0	0			
GAIT / Transferring	Impaired	20				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0						
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0						
Total Morse Fall Scale Score:			20	20	20			
Signature			[Signature]	[Signature]	[Signature]			

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

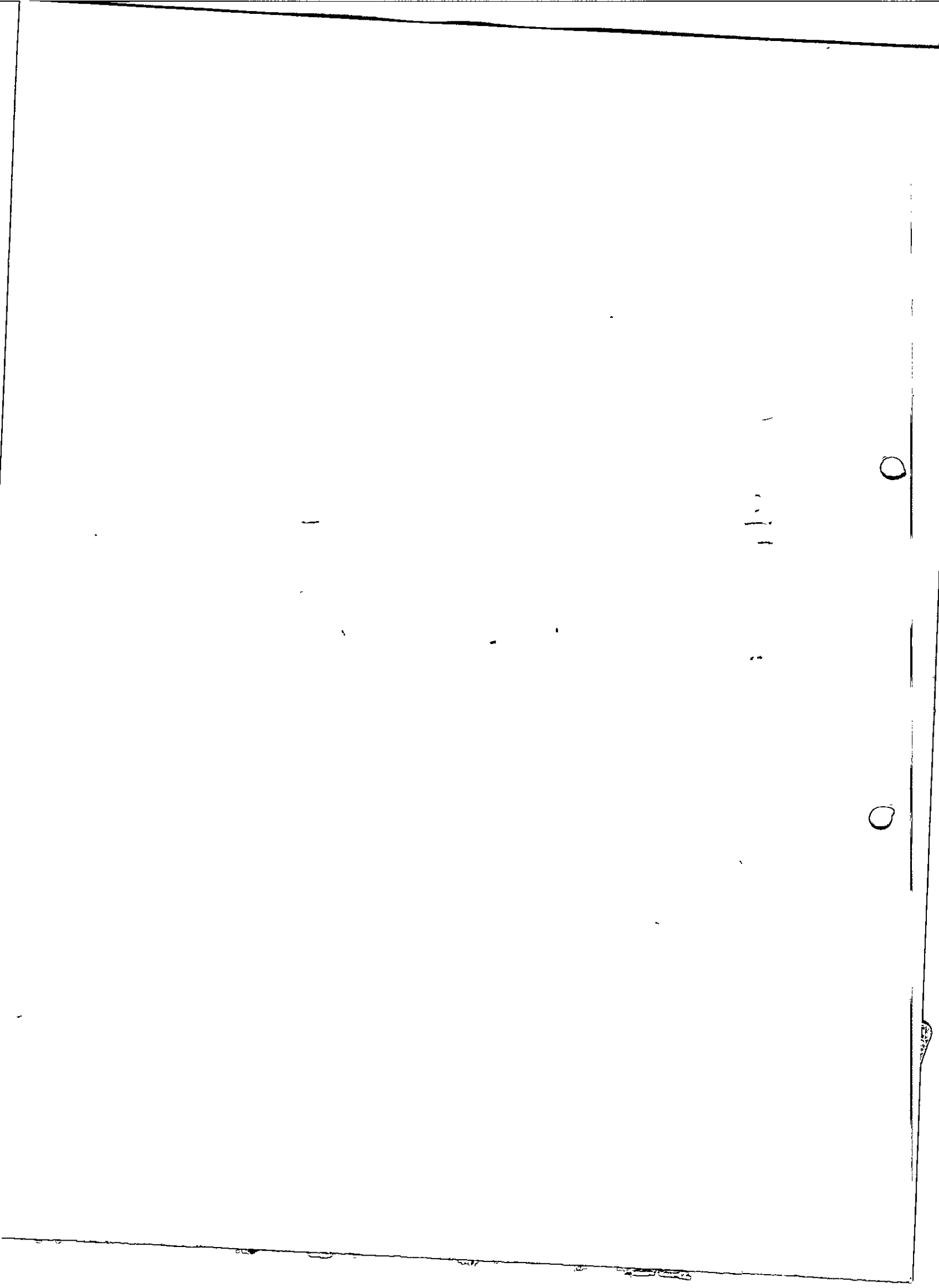
- Ensure patients use their prescribed eye glasses if any, in the hospital
- Use chairs with arm rests
- Use safety straps on stretchers and wheelchairs while transporting patients

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

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

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

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



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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <i>00 pome 32 weeks</i>	Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known					
	Surgery / Procedure: <i>↓ FM for observation</i>	If Yes Specify:					
BACKGROUND	Date	<i>5/6/26</i>	<i>5/6/26</i>	<i>6/6/26</i>			
	Shift	<i>Br</i>	<i>N</i>	<i>mb</i>			
	Medical Condition (Any special condition to be noted):		<i>NA</i>				
ASSESSMENT	Diet:	<i>Normal diet</i>	<i>NR</i>	<i>NR</i>			
	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Vital Signs:	Temp: <i>98.1 F</i>	<i>98.7</i>	<i>98.1 F</i>			
	Res:	<i>20</i>	<i>20</i>	<i>20bnt</i>			
	SpO ₂ :	<i>99%</i>	<i>99%</i>	<i>99%</i>			
	Pulse:	<i>76</i>	<i>70</i>	<i>75bnt</i>			
	BP:	<i>110/66</i>	<i>121/62</i>	<i>112/72</i>			
	LOC:	<i>-</i>	<i>good</i>	<i>-</i>			
Recommendations	Fall Risk Score:	<i>-</i>	<i>-</i>	<i>-</i>			
	Pain Score:	<i>-</i>	<i>-</i>	<i>0/10</i>			
	Skin Integrity:	<i>good</i>	<i>good</i>	<i>-</i>			
	Safety Needs:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Physiotherapy:	<i>-</i>	<i>-</i>	<i>-</i>			
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Special Diet:	<i>Normal</i>	<i>NR</i>	<i>-</i>			
	Critical Lab Test / Values:						
Post Operative Procedure Special Orders:	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	ADL (Dependent / Non Dependent):	<i>-</i>	<i>-</i>	<i>-</i>			
	ADL (Dependent / Non Dependent):	<i>-</i>	<i>-</i>	<i>-</i>			
Handed Over By Name :	Signature / ID :	<i>Anusha</i>	<i>Anusha</i>	<i>Akhil</i>			
	Date:	<i>5/6/26</i>	<i>5/6/26</i>	<i>6/6/26</i>			
	Time:	<i>5pm</i>	<i>8:07</i>	<i>2pm</i>			
	Taken Over By Name :	<i>Anusha</i>	<i>Akhil</i>				
	Signature / ID :	<i>Anusha</i>	<i>Akhil</i>				
	Date:	<i>5/6/26</i>	<i>5/6/26</i>				
Time:	<i>8AM</i>						

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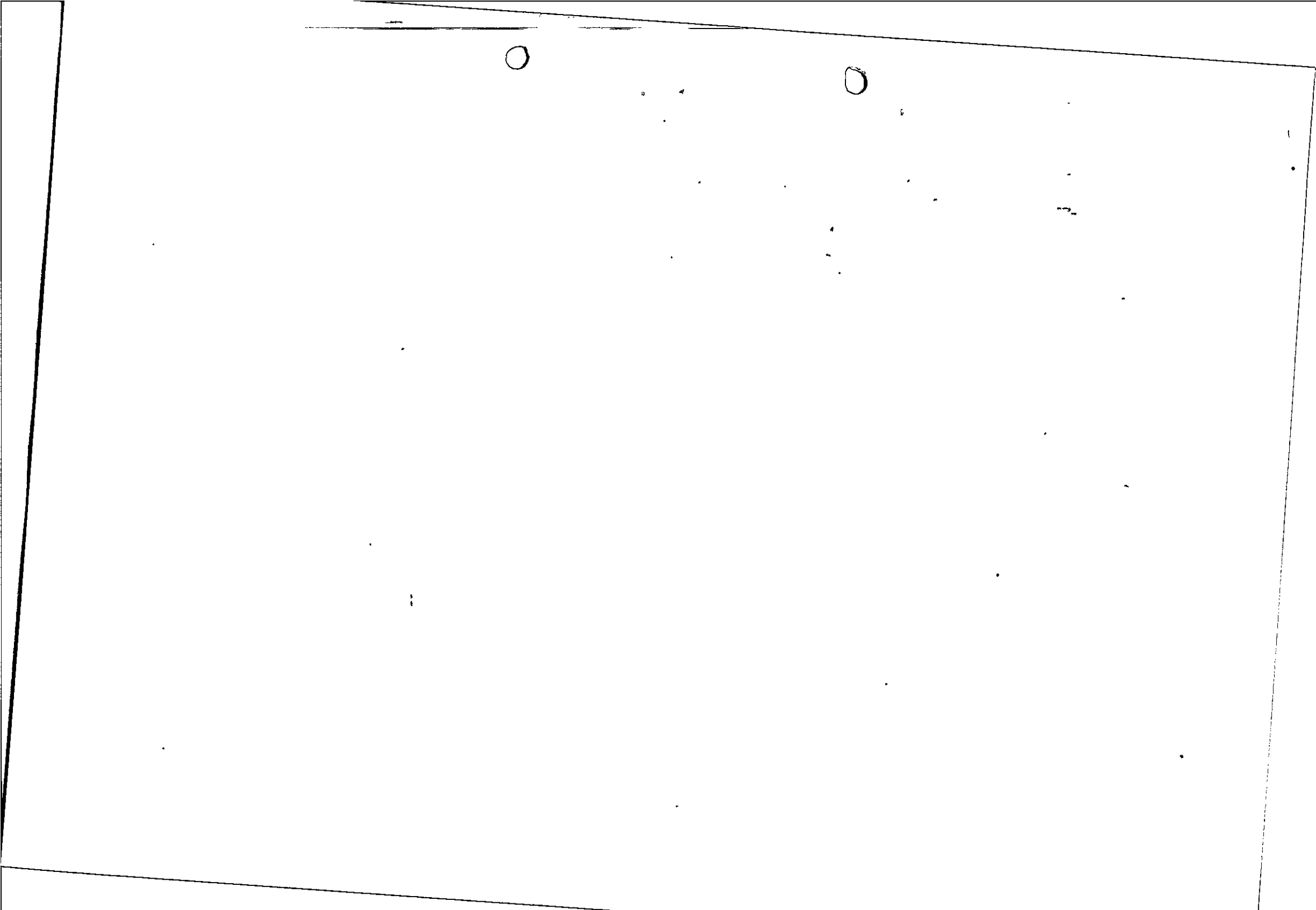
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BILLING POLICY

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

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

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

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

MODE OF PAYMENT & REFUNDS

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


Name & signature of Patient/Attendant


(Signature of Admission Desk executive)

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

RAINBOW CHILDREN'S MEDICARE PRIVATE LIMITED

Registered Office: Road No.2, Banjara hills, Near Hotel Park Hyatt, Hyderabad - 500 034, T: +91 40 2233 4455.

Corporate Office: 8-2-19/1/A, Daulet Arcade, Karvy Line, Road No.11, Banjara Hills, Hyderabad - 500 034.

Branches : BANJARA HILLS - T: 2233 4455 | VIKRAMPURI - T: 4246 2200 | KONDAPUR - T: 4246 2400 | MADHAPUR
- T: 6464 2020 | KUKATPALLY - T: 4246 2300 | L B NAGAR - T: 7111 1333 | MARATHAHALLI, BENGALURU - T: +91 80
7111 2345 | BANNERGHATTA ROAD, BENGALURU - T: +91 80 2551 2345, HIMAYATNAGAR- T:- 40 48873000

