

Dr. Romya



ESTIMATION SLIP

Date: 9/5/26 UHID / IP No.: HNH-00002333 SI No. 1507
Name of Patient: Mrs. Lalitika Trishadani Age: 24y Gender: F
Father's / Husband's Name: Mr. Rahul Corporate / Occupation:
Address: Khatapally Phone: 9500010611 Email: 8300331700
Procedure / Plan: ND/LSCS EDD/Dos: July-26
MODE OF PAYMENT: SELF TPA: New India GIPSA: OTHER
TARIFF INFORMATION: National Ins + M.A

Table with columns: Particulars, Package Amounts (Rs.), Normal Delivery, LSCS. Rows include Room Category (Multi Shared, Shared, Twin Shared, Private, Super Deluxe, Suite), Package includes, Length of Stay, Pharmacy, Investigations, and Others.

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


Initial Minimum Deposit: 20,000 Advance time of Admission
REMARKS: Vaccination, Neonatal SBR, BIG.

- 1. Room eligibility is purely subject to TPA approval...
2. Proportionate difference of bill amount is applicable...
3. Total baby charges are extra which include admission...
4. In Case the patient gets discharged earlier...
5. For Non-medicals, Disposables, Consumables, Taxes...
6. Difference if any between the final bill amount...
7. Two attendants are permitted with patients...
8. Tariffs are subject to revision
9. Kindly check your billing status...
10. Additional Charges on package are applicable...

DECLARATION

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

Signature of the Client Husband Signatory Relationship Signature of the financial Counselor

Patient ID: IP26-00006639
 HNH-00002333
 Mrs. LOLAKPURI TRISHALINI
 12-10-1996 29 Y 8 M 13 D (F)
 Dr. KADIYALA RAMYA THEJA




SURGERY DETAILS

Date : 25/06/26

Patient Name: Mrs. Lolakpuri Trishalini Date of Birth: 12-10-1996 Age: 29 Yr

Gender: Female Ward : OT UHID No.: HNH-00002333

Date of Surgery: 25/06/26 OT-1 OT-2 OT-3 OT-4 OBG OT-1 OBG OT-2


Name of the Surgery : ELECTIVE LOWER SEGMENT CESAREAN SECTION

Time in : 7:45 Am

Time Out : 8:45 Am

	<u>NAME</u>	<u>AMOUNT</u>
1. Surgeon	Dr. Ramya theja	
2. Anaesthetist	Dr. Shekhar	
3. Assistant Surgeon	Dr. Veena	
4. OT Technician	Br. Aravind	
5. Circulating Nurse	Sr.	
6. Assistant Nurse	Sr. Sangeetha	

- Special Equipment:
- | | | | |
|--------------------------------------|---------------------------------------|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Laparoscopy | <input type="checkbox"/> Bronchoscope | <input type="checkbox"/> Harmonic | <input type="checkbox"/> Morcelator |
| <input type="checkbox"/> C-ARM | <input type="checkbox"/> Cystoscopy | <input type="checkbox"/> Versa Point | <input type="checkbox"/> Liver Cusa |
| <input type="checkbox"/> Neuro Cusa | <input type="checkbox"/> Others | | |

For Dr. Ramya

 Signature of the Surgeon


 Signature of Circulating Nurse

Order No: 26-000020808-3

Order by: Archana 25/6/26 @ 9:38 Am



EL 1818



CONSUMABLES OF OT

Circulating staff : Technician : Arind, Saraswati Date : 25/6/26 Time :

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube			Major Pack <u>1 bag. 1 bag</u>			Inj Vit.K		<input checked="" type="checkbox"/>
LMA			Sutures <u>2306-2306</u>			Cord Clamp		<input checked="" type="checkbox"/>
ECG leads (A) P/N		<u>03</u>	<u>1326 4242</u>			Suction Catheter		
HME filter : A / P / N						Feeding Tube <u>5</u>		<input checked="" type="checkbox"/>
Syringes : 10 cc		<u>02</u>				Vaccum Suction Set		
05 cc		<u>02</u>	Gloves <u>546/2</u>			Surgical Gloves <u>1/2.59</u>		<input checked="" type="checkbox"/>
02 cc		<u>02</u>	<u>Encase 04/2</u>			Gauze Pack <u>Agnt</u>		
01 cc						Syringe 1ml / 2ml		<input checked="" type="checkbox"/>
Cautery plate (A) P/N		<u>01</u>	Surgical blade <u>22</u>			Surgical Blade # 20		<input checked="" type="checkbox"/>
IV set			NG tube			Koochies (S)		
RT Del Del			Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml		<u>02</u>	Koochies <u>XXL</u>			<u>Baby Said</u>		
<u>Atropine</u>		<u>01</u>	Ointments					
<u>Adrenaline</u>		<u>02</u>	Suction Catheter			<u>26-0000208091</u>		
Fentanyl		<u>01</u>	Cap, Mask					
Morphine			Gauze Pack					
Ketamine			Mop Pack					
Propofol			Steristrip					
<u>Recuronium Bupropion</u>		<u>01</u>	Underpad					
Glycopyrolate			Draw sheet					
<u>Myopyrolate oxytocin</u>		<u>03</u>	Abgel					
Ondansetron		<u>01</u>	Foleys catheter					
Pencan 250 Spinal Needle 22		<u>02</u>	Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)		<u>01</u>	Romodrain bag					
Antibiotics			Bandage					
<u>Tranexa</u>		<u>02</u>	Tegaderm					
Suppositories			Ioban <u>Arnav</u>					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg		<u>01</u>	Vaccum Suction set					
Justin : 12.5 mg / 25mg / 100mg		<u>04</u>	Plastic Bed Sheet					
Tab. Misoprost : 200mg		<u>01</u>	Betadine Solution					
Microshield 65		<u>01</u>	Microshield					
Gauze 75 x 75		<u>01</u>	Cotton Balls					
Latex gloves		<u>01</u>	Latex Gloves					
<u>Dextrose 5%</u>		<u>01</u>	Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician
 Order No. : 26-0000208090/89 Ordered by : Archana 25/6/26 @ 9.15 AM
 Doc. No. : RCH / FRM / GENERAL / 125



ELECTRONIC MEDICINE PRESCRIPTION

MRN : HNH-00002333 Name : Mrs LOLAKPURI TRISHALINI
 Age / Sex : 29 Y 8 M 13 D / Female Doctor : KADIYALA RAMYA THEJA
 Adm/Reg Date/Time : 25/06/2026 08:45 Payor : MEDI ASSIST INSURANCE TPA PVT LTD
 Order Date : 25/06/2026 09:51 Ordernumber : 26-0000208090
 Visit ID : IP26-00006639 Ward/Bed No : 4F -OT / LDR-415
 Patient Address : 4-11-3-4-716, Nimboladda, Hyderabad, Telangana, INDIA, 500027

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	MOPS 30X30 8PLY 5S X-RAY	MOPS 30X30 PLYDATT	1 Nos	/ Once Daily	3 Days		3 Nos	Dispensed
2	NS 500ML CLOSED BOTTLE		1 Bottle	External / Once Daily	1 Days		2 Bottle	Dispensed
3	ADROGLARE(ADRENALINE) INJ 1MG 1ML		1 Vial	Injection / Once Daily	1 Days		1 Vial	Dispensed
4	VICRYL 1-0 VP 2346	VICRYL 1-0 VP 2346	1 Nos	/ Once Daily	2 Days		2 Nos	Dispensed
5	PREGELLED SURGICAL PLATES(ADULT)	PREGELLED PLATED ADULT	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
6	DSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
7	JUSTIN SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
8	ADULT DIAPERS-XXL		1 Nos	External / 10 AM	1 Days		2 Nos	Dispensed
9	UNDER PAD 60X90 10's Pack -MEDICUBE		1 Nos	External / 10 AM	1 Days		2 Nos	Dispensed
10	ABGEL SURGI PAD (BIG) (GELSPON)	ABGEL	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
11	E C G ELECTRODES (ADULT)	ELECTRODES ADULT	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
12	Encore Micropic gloves-6 S		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
13	COTTON BALLS 2 GM 5 NOS		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
14	SUPRIDOL SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
15	PENCAN 25G*3 1 2	PENCAN 25G*3 1 2	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
16	ONDOKIND INJ 4 MG 2 ML		1 Nos	/ Once Daily	1 Days		1 Vial	Dispensed
17	BACYOPREP SOLUTIONS 100 ML		1 mL	/ Once Daily	1 Days		1 Nos	Dispensed
18	VICRYL 1-0 NW 2364	VICRYL 1-0 NW 2364	1 Nos	/ Once Daily	2 Days		2 Nos	Dispensed
19	SURGICAL BLADE 22	SURGICAL BLADE 22	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
20	CAUTERY PENCIL (ADVANCE)		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
21	DISPOSABLE APRONS STERILE XL	DISPOSABLE APRON STERILE XL	1 Nos	/ Once Daily	3 Days		3 Nos	Dispensed
22	BUPICAIN HEAVY 80MG INJ 4ML		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
23	TRUGUT CHROMIC CATGUT SN4242	TRUGUT CHROMIC CATGUT SN4242	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
24	BUPRIGESIC INJ AMP 0.3 MG 1 ML	BUPRENORPHINE 0.3 MG 1ML INJ	1 Ampule	Injection / Once Daily	1 Days		1 Ampule	Dispensed
25	BIOXAMIC 500 MG INJ		1 Ampule	/ Once Daily	1 Days		2 Ampule	Dispensed
26	EVATOCIN (OXYTOCIN) INJ 5IU 1 ML		1 Vial	Injection / Once Daily	1 Days		3 Vial	Dispensed
27	DSYRINGE 5ML(NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
28	DEXTROSE IV 5% 500 ML BOTTLE		1 Bottle	/ Once Daily	2 Days		2 Bottle	Dispensed
29	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
30	MONOCRYL 3-0 NW 1326	MONOCRYL 1326	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed

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.

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fc

Name Mrs LOLAKPURI TRISHALINI **UHID** HNH-00002333
Father/Guardian Mr RAHUL VARMA RUERAO **Age/Gender** 29 Y 8 M 13 D/ Female
Address 4-11-3-4-716, Nimboliadda, Hyderabad, Telangana, INDIA, 500027
IP No IP26-00006639 **Admission Date** 25-06-2026
Ref Doctor Self.
Discharge Date 28.06.2026

DISCHARGE SUMMARY

Consultant

Dr. KADIYALA RAMYA THEJA
MBBS/DNB
TSMC/FMR/01458

Diagnosis: G2P1L1 AT 37⁺⁵ WEEKS WITH PREVIOUS LOWER SEGMENT CAESAREAN SECTION FOR ELECTIVE LOWER SEGMENT CAESAREAN SECTION

ELECTIVE LOWER SEGMENT CAESAREAN SECTION DONE ON 25.05.2026

History:

LMP: 04.10.2025
EDD: 11.07.2026

Obstetric formula: G2P1L1
Gestation at admission: 37⁺⁵ weeks

Obstetric History:

Name

Mrs LOLAKPURI TRISHALINI UHID

HNH-00002333

IP No

IP26-00006639

Admission Date

25-06-2026

1 - Dec 2024 - Emergency FTLSCS (Ind - GDM OHA + Insulin - IOL at 38 weeks, MSL and cord round neck), boy, 2.66Kg, A&H, History of Dengue fever in pregnancy

2 - Present pregnancy, spontaneous conception

Medical History: Nil

Family History : Father - DM

+HTN

Surgical History: LSCS (2024)

Allergies : Nil

Antenatal Details:

Mrs LOLAKPURI TRISHALINI was booked to Rainbow hospital at 21⁺⁴ weeks of gestation. She had regular antenatal checkups and investigations as advised. Missed NT scan and FTS. TIFFA done was normal. Advised NIPS (non-invasive prenatal screening) as they has missed FTS, QSS. NIPS was low risk. At 33weeks, she presented with complaint of Shortness Of Breath occasionally, no cold/ cough, Physician opinion was sought- ECG and 2D echo - normal. Fetal growth monitoring was done by serial growth scan. Scan done (15-06-2026) showed SLIUF, 36⁺² weeks, cephalic, posterior high, AFI 18.7cm, EFW 2569gm 21%, AC 18%, Dopplers normal. She was admitted at 37⁺⁵ weeks with previous LSCS for EL LSCS.

Investigations: Enclosed.

Blood Group : "O" positive

Management: Course in hospital:

Fetal wellbeing confirmed by admission CTG which was normal. She was

Name Mrs LOLAKPURI TRISHALINI **UHID** HNH-00002333
IP No IP26-00006639 **Admission Date** 25-06-2026

prepared for elective C- section with indwelling Foley's catheter and IV canula under aseptic conditions. Written informed consent for surgery taken. Preanesthetic check up done. Anesthetic premedication (IV Pantop and Perinorm) given. Antibiotic prophylaxis with Inj. Taxim 1 gm IV given. Patient shifted to theatre.

Surgery Notes:

Under spinal anesthesia she was painted and draped as per hospital protocol. The previous scar excised. Abdomen opened in layers. The parietal and visceral peritoneum carefully opened after identifying the urachus. Bladder was reflected. A Lower segment curvilinear incision given on the uterus. Baby delivered. Cord clamped and cut and cord blood collected for blood grouping and Rh typing. Baby handed over to pediatrician. Placenta delivered with controlled cord traction. Uterus closed in layers. Hemostasis secured. Instruments and swab count checked. Rectus sheath closed. Skin closed with subcuticular sutures. Wound dressing done. Vagina cleaned with Betadine solution after expelling clots. Misoprostol 600 mcg given per rectum as prophylaxis against Postpartum hemorrhage. Patient was shifted out of theatre to post operative recovery room.

- * **LUS thinned out**
- * **Scar dehiscence noted**
- * **Bladder densely adherent to scar and LUS**

Delivery Details:

Date : 25.06.2026
Time of Delivery : 07:59 am

Name	Mrs LOLAKPURI TRISHALINI	UHID	HNH-00002333
IP No	IP26-00006639	Admission Date	25-06-2026

Type of Delivery : Elective lower segment caesarean section
Indication : Previous LSCS
Anaesthesia : Spinal

Baby Details:

Date : 25.06.2026
Time of Delivery : 07:59 am
Sex : Female
Weight : 3.16kg
Apgar : 7,9
Gestational Age : 37⁺⁵ weeks
NICU Admission : Yes (observation), Respiratory Distress

Post-Operative Notes:

She was closely monitored. Her vital signs remained stable. Uterus was well retracted with no postpartum hemorrhage. Breast feeding initiated. She was shifted to room. Her postoperative period following that was uneventful. On second postoperative day dressing was changed. On inspection wound was healthy. Her general condition was satisfactory and she was found to be fit for discharge. Wound care and medications were explained to patient supplemented by written information. She was given the postpartum book for further reference.

Advice:

1. Tab. Taxim O 200mg twice daily (9am-9pm) till 01.07.2026 after food.
2. Tab. Calpol (Paracetamol 500mg) 2 tablets thrice daily till 29.06.2026

Name Mrs LOLAKPURI TRISHALINI **UHID** HNH-00002333
IP No IP26-00006639 **Admission Date** 25-06-2026

- (8am-2pm-10pm) after food.
3. Tab. Voveran (Diclofenac-50mg) 1 tablet thrice daily till 29.06.2026 (9am-3pm-11pm) after food.
 4. Tab. Pantodac (Pantoprazole - 40mg) 1 tablet twice daily (7am-7pm) till 01.07.2026 before food.
 5. Tab. Livogen (Elemental Iron - 50mg, folic acid 1.5mg) once daily (7am) for three months before breakfast.
 6. Tab. Shelcal (Elemental Calcium 500mg, vitamin D3 250 IU) once daily (2pm) till breast feeding after food.
 7. Nebasulf Powder for local application.
 8. Birth spacing and contraceptive advise explained

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

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

Review with **Dr. KADIYALA RAMYA THEJA**, after **2 week** on **12.07.2026** at Rainbow Children's Hospital with prior appointment (**Review consultation will be charged**).

For Women Who Have Had a Caesarean Section Care of the wound:

1. You can bath and shower.

Name	Mrs LOLAKPURI TRISHALINI	UHID	HNH-00002333
IP No	IP26-00006639	Admission Date	25-06-2026

- 2.The wound can get wet during a bath or shower. Dry it thoroughly and gently by dabbing with a gauze piece. Do not rub the wound.
- 3.This gauze piece needs to be discarded after one use.
- 4.Prior to touching the wound clean hands thoroughly with Microshield solution and allow them to air dry or use disposable paper napkins.
- 5.Apply Nebasulf or Neomycin dusting powder on the wound after it is dry.
- 6.Do not touch the wound with unwashed hands.

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

Patient/ Attender

In case of emergency like bleeding, fever [please refer to postpartum book for further details - Chapter II page 6] kindly contact 9154865045 at Rainbow 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


Registrar/Resident/C.M.O

Consultant

Dr. KADIYALA RAMYA THEJA
MBBS/DNB
TSMC/FMR/01458

PATIENT TRANSFER FORM

Patient Name & UHID No.	Date & Time of Admission 25/6/26 @ 5:45 AM	Date & Time of Transfer Order 25/6/26 @ 12:15 PM
Treating Consultant Name	Transfer Ordered by DR. Manisha	Reason for Transfer observation
From Unit Pre-post	To Unit Room	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File 30	Number of Imaging Films - 1 -	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	RL - 500 ml	2
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes No

Name & Signature of Person who is Transferring Sis. Sujatha	Name of Person Ordered Transfer DR. Manisha
----------------------------------------------------------------	------------------------------------------------

Patient & Clinical Records Received by :

Sr. Sandhya

Date & Time of Patient Received : 25/6/26 @ 2:32

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

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006639 **Admit Date** : 25-Jun-2026 **Admit Time** : 05:45 AM **UHID** : HNH-00002333

Patient Details :

Patient Name : Mrs LOLAKPURI TRISHALINI	Age : 29 Y 8 M 13 D
Guardian : Mr RAHUL VARMA RUERAO	DOB : 12-10-1996
Gender : Female	Religion :
Occupation :	Martial Status :
Address (H) : 4-11-3-4-716 Nimboliadda Hyderabad Telangana INDIA 500027	Phone No : 8309731700/ 9500010611
	E-mail : trishalinidakpuri@gmail.com

Admission Details :

Bed Type : TWIN SHARING **Bed No** : LDR-415 **Ward Name** : 4F -OT
Room No : LDR-415 **Admission Type** : First Visit

Contact Details :

Name : Mr RAHUL VARMA RUERAO **Relationship** : Husband
Contact Address : 4-11-3-4-716 Nimboliadda Hyderabad
Telangana INDIA 500027 **Phone No** : 8309731700

[Handwritten Signature]
Signature

Doctor Details :



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

Payment Details :

Payment Mode : DC/CC Card **Deposit Amount** : 20000.00
Payor Name : MEDI ASSIST INSURANCE TPA PVT LTD

PATIENT TRANSFER FORM



Patient Name & UHID No. HNH-00002333 IP26-00006639 Mrs LOLAKPURI TRISHALINI 12-10-1996 29 Y 8 M 13 D (F) Dr. KADIYALA RAMYA THEJA 		Date & Time of Admission <i>25/6/2020 @ 5:45 AM</i>	Date & Time of Transfer Order <i>25/6/2020 @ 7:00 AM</i>
		Transfer Ordered by <i>DR Veena</i>	Reason for Transfer <i>EL-UCS</i>
From Unit <i>Pre-post</i>	To Unit <i>OP</i>	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File <i>55</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 type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	<i>re sound</i> → 		
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring <i>Srisaibhavi</i>		Name of Person Ordered Transfer <i>DR Veena</i>	
Patient & Clinical Records Received by : <i>Dangudela</i>			
Date & Time of Patient Received :			

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

- Unavailable Bed
 Nurse not Available
 Available Bed not ready

ACTIVITY RECORD FOR BILLING

Name : _____
HNH-00002333 IP26-00006639
 Mrs LOLAKPURI TRISHALINI
 12-10-1996 29 Y 8 M 13 D (F)
 UHID No. : _____
 Dr. KADIYALA RAMYA THEJA

Consultant: _____ Dept : _____



Date of Admi _____ Date of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
25/6/26	2:30 Am	Pre-post	OT	Alex / Srinatha
25/6/26	8:45 Am	OT	Pre-post	Alex / Srinatha
25/6/26	12:15 Pm	Pre-post	Room	Srinatha

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
25/6/20	Pv Placement	①	26-0800	<i>[Signature]</i>
25/6/20	Catheterisation	①	208056	<i>[Signature]</i>
22/6/20	PAC (op)	①	11440	<i>[Signature]</i>
25/6/20	NIAA	①	2877 8168	<i>[Signature]</i>
25/6/20 2:30pm				

ANY OTHER INFORMATION

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.....

Date :

Time :

Prepared By :

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

Presenting Complaints
 for E1-LSCS

LMP: 4/10/2025 EDD:
 Corrected EDD: 11/21/26 GA: 37⁺ 5 wks
 Menstrual History: Regular: Yes No

Obstetric Formula: G2P1
 1st preg (2024) :- FT-LSCS (GDM on OHA + Insulin)
 Obstetric History: msl & cord around neck.
 Present preg (2026) :- Sp. conceptn.

Obstetric Examination

ANC visit @ 29 wks - Booked case @ Rainbow

Fundal Height: U/L ~ 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

Present Pregnancy Record:
 FA - (N), NIPS - Low risk.
 OGTT - (N), HLOS @ 31 wks → Physician r/w
 Growth (N), ECG, 2d echo - (N)

Per Speculum Examination N/A

Draining: Present Absent Bleeding
 Colour of Liquor: Clear Meconium Blood Stained

RISK FACTORS:

~~Cholestasis~~
 - Prev. LSCS
 - Short ICP

Vaginal Examination N/A

Cervix: Long Partially effaced Effaced
 Os: Closed _____ 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: 150 cm
 Weight: 60 kg
 Allergies: Nil
 Breast: Normal Abnormal
 General Examination:
 Consciousness: (+) Pallor: (-)
 Icterus: (-) Edema: (+)
 Temp: 98.6 bit PR: 98 bpm
 BP: 90/62 mmHg DTR: (N)
 CVS: S2 (+) RS B/L NVBS
 Liver/Spleen: (N) Urine Output: (N)

DIAGNOSIS

G2P1L1 / 37⁺ 5 wks / prev. LSCS. for safe confinement



<p>Family History:</p> <p>father - DM + HTN</p>	<p>Surgical History:</p> <p>LSCS @ 2024</p>
<p>Medical History:</p> <p>Nil</p>	<p>Medication History:</p> <p>OT Fe / T.G.</p>
<p>Plan of Care:</p> <p><u>Elective LSCS</u></p> <ul style="list-style-type: none"> - Informed consent - Admission CTG - Prepare parts - Inform OT, Anesthetist & Pediatrician. - Shift to OT on call - Foley's catheterisation - PAC - CBP. 	<p>Investigations:</p> <p>Blood Group - "O positive"</p> <p>25/6/2026</p> <p>Hb - 11.0 Plt - 257 WBC - 1024</p> <p>HIV HBSAg RPR PCU] NR.</p> <p>USG (15/6/26) ~ 36⁺ wks</p> <p>Cephalic, Pl Post-high</p> <p>AFI - 18-2, EFW - 2589g (21%) AC - 18%, Doppler (N)</p> <p>Dr. RAMYA THEJA KADIYALA Reg. No: 01458</p>

Doctor Name: Dr. G. Veena
 Signature: [Signature]
 Date & Time: 25/6/26 @ 7pm

Consultant Name: Dr. Ramya Theja
 Signature: [Signature]
 Date & Time: 25/6/26 7:30 AM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/6/26 9:00 AM	<p>CS/B DI. DUA POD-0 B12</p>	
Baby @ NICU	<p>CC Fair Afekule BP: 145/80 mmHg PR: 91 bpm SpO₂: 99% on RA P/A Uterus Retracted well.</p>	<p><u>Adv</u> - NBM for 4-6 hours - Vital monitoring - I/O charting - IVFs, Analgesics & Thromboprophylaxis as per AXON.</p>
U/O - 250ml clear.	<p>U/E NAB.</p>	<p>- FU ABx for 24 hours - Foley's catheter for 24 hours - Inform SOs - w/o excessive bleeding P/V</p>
25/6/2026 11:30 AM	<p>CS/B DI Mause POD-0 P26</p>	
Baby Mithasulu	<p>CC Fair Afekule BP - 120/80 PR - 70 P/A ut well retracted BS (+) - sluggish PV - Bleeding WNL U/O - 80 cfm clear No complaints</p>	<p><u>Adv</u> Allow sips of water > 1:30pm vital monitoring - Drugs as charted Leg dext (if tolerate > 2:30pm) Foley's removal GAM cfm (26/6) I/O monitoring Inform SOs Shift to Room</p>

Handwritten signature/initials



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/6/26 3:30pm	<p>0-POD</p> <p>No complaints ic fair/ps/ob vitals (N) PA: soft, B(+) u/o: 100ml/hm.</p> <p>Reg. No. 01458 Dr. RAMYA THEJA KADIYALA Dr. R.D. RAMA Reg. No. 01458</p>	<p>Adv</p> <p>1) liquid diet 2) soft diet @ 4pm 3) Remove Foley's on 26/6/26 @ 8AM</p> <p>Banner DRAMYA THEJA</p>
25/6/2026 6:45pm	<p>cls by Dr. Naveena POD-0</p> <p>SLC GL-Fair A/ebnle Vitals - stable PA: soft, NT ut retracted well Dressing: dry Ectlean IIE: PV bleeding WNL clo: loomlthi clear</p> <p>S-L F-L</p> <p>Dr. Naveena</p>	<p>Adv</p> <p>- Soft diet - Adequate hydration - drug say charted - Ambulation - Foley's removed 26/6/26 @ 9am - Vase I/O charting - Monitor Vitals - Inform SUS</p> <p>Noted by [Signature]</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/6/26 8:30 AM	c/s/B Dr. Keena POD-1/P ₂ L ₂	
Baby @ ms f ✓ s ✓ U r	A is stable, No clo o/e GC-fair, -Afebrile Gallor ⊖ Nitals - stable. P/A - UtusM retracted BS ⊕ LE - BwNL U/O - 100ml/hr, clear	Adv - Soft diet. - Remove foley's catheter. - Ambulation - Adequate hydration - Vital monitoring. - Inform SOS
26/6/2026 12pm Bms U ✓ F ✓ S ✓	c/s/B Dr POD-0 GC Fair Afebrile BP 115/70 RR 89 P/A ut well retracted BS ⊕ LE Bleedly wNL	Adv Soft Diet (Adeq Hydration) Drugs as charted Ambulation vitals monitoring Inform SOS noted by Sr. Sandhya 26/6/26



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/6/26 3pm	G-POD	
baby null	No Complaints GC fair Vitals (N)	Adv
U: ✓	PA: soft, well	1) Remove IV cannula
S: ✓	UE: bleeding (N)	Dance
	Dr. RAMYA THEJA Reg. No. 01458	Dr. RAMYA THEJA
	Dr. RAMYA THEJA Reg. No. 01458	
26/6/2026 6:00pm	cls by Dr. Naveena	
	o/e GC-fair Afebrile Vitals - stable PA: ut - retracted well. Soft INT	Adv Regular diet Adequate hydration drugs as charted Ambulation w/o PV bleeding
	Dressing: dry & clean UE: PV bleeding wnl	Indent close dressing for TIM.
	Baby: Motherside.	Monitor Vitals Inform SCS
	Dr. Naveena	Noted by madhvi

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/06/2026 7:30am	<p>cls by Dr. Naveena</p> <p>O/E Gc-fair Afebrile Vitals-stable PA: ut-retracted well Soft I/M/T Dressing: dry & clean UE: PV bleeding w/ML</p> <p>Baby: Motherwde.</p>	<p>Adv</p> <ul style="list-style-type: none"> Regular diet Adequate hydration Drugs as charted Ambulation close dressng w/f PV bleeding Monitor Vitals Perform SOS
27/6/26 11am	<p>cls/B Dr. Veera</p> <p>Pt is stable, Nocto</p> <p>O/E Gc-fair Vitals-stable PA - Ut well retracted BS (+)</p> <p>UE - B/WNL</p> <p>BL Breasts - Soft, MS (+)</p>	<p>Adv</p> <ul style="list-style-type: none"> Regular diet Adequate hydration Drugs as charted Dressng (ASD) to do w/f excessive bleedng PL Ambulation Perform SOS
Baby @ ms Can be discharged	<p>noted by Sr. Sandhya 27/6/26 10:00</p>	<p>Dr. Naveena noted by mother 7:30pm</p>

HNH-00002333 IP26-00006639

Mrs LOLAKPURI TRISHALINI
12-10-1996 29 Y 8 M 13 D (F)
Dr. KADIYALA RAMYA THEJA



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RESULT SHEET

Date	(SR) 25/6				
Time	6:21 AM				
Hb	11.0				
PCV	31.3				
RBC	3.54				
WBC	10.24				
N/L	60.4/24.8				
Platelets	251				
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					

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Mrs LOLAKPURI TRISHALINI
12-10-1996 29 Y 8 M 13 D (F)

Dr. KADIYALA RAMYA THEJA



Early Warning Observation Score Chart - Obstetrics

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

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

25/10/26

5

20

100

96

N/A

92

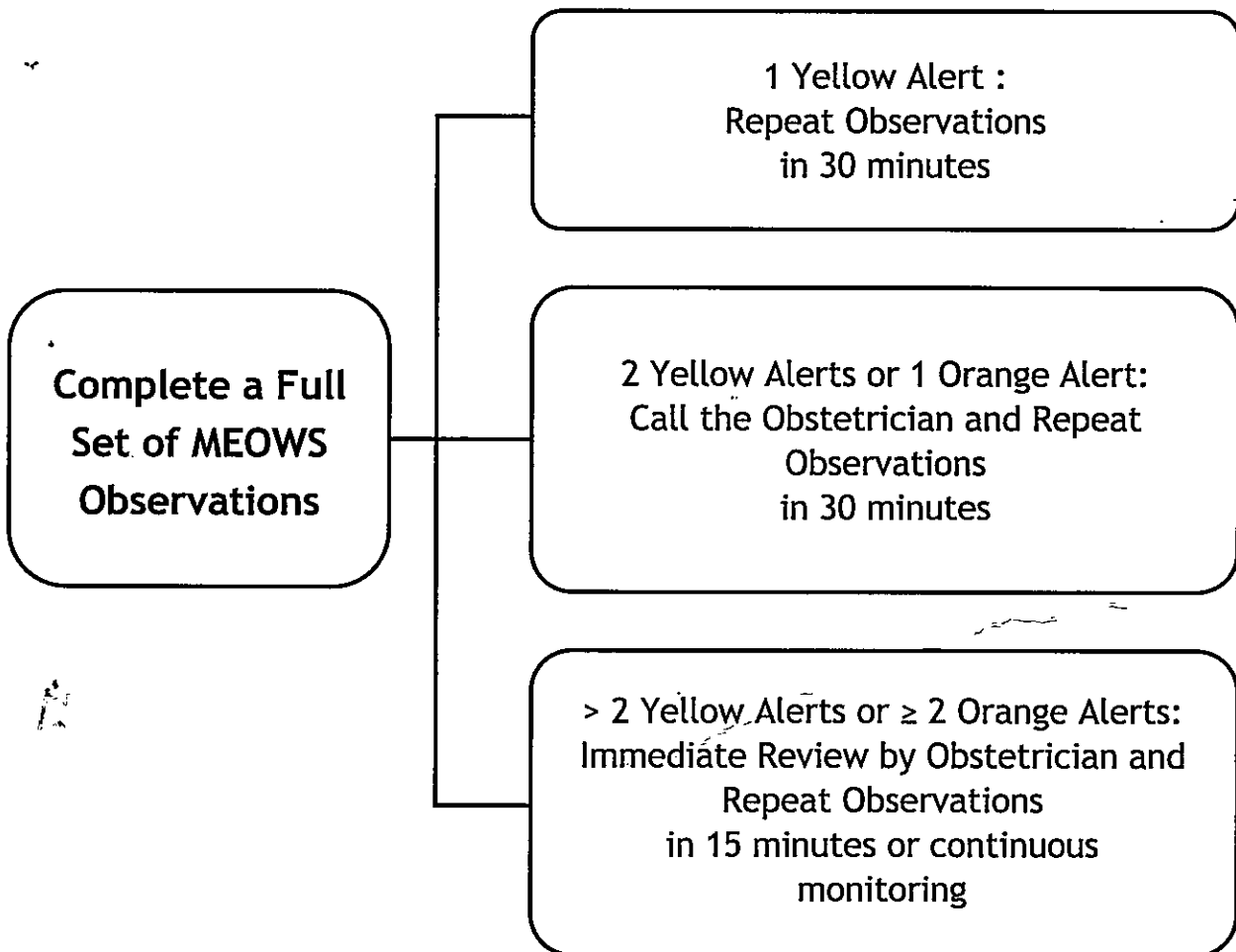
99

62

0

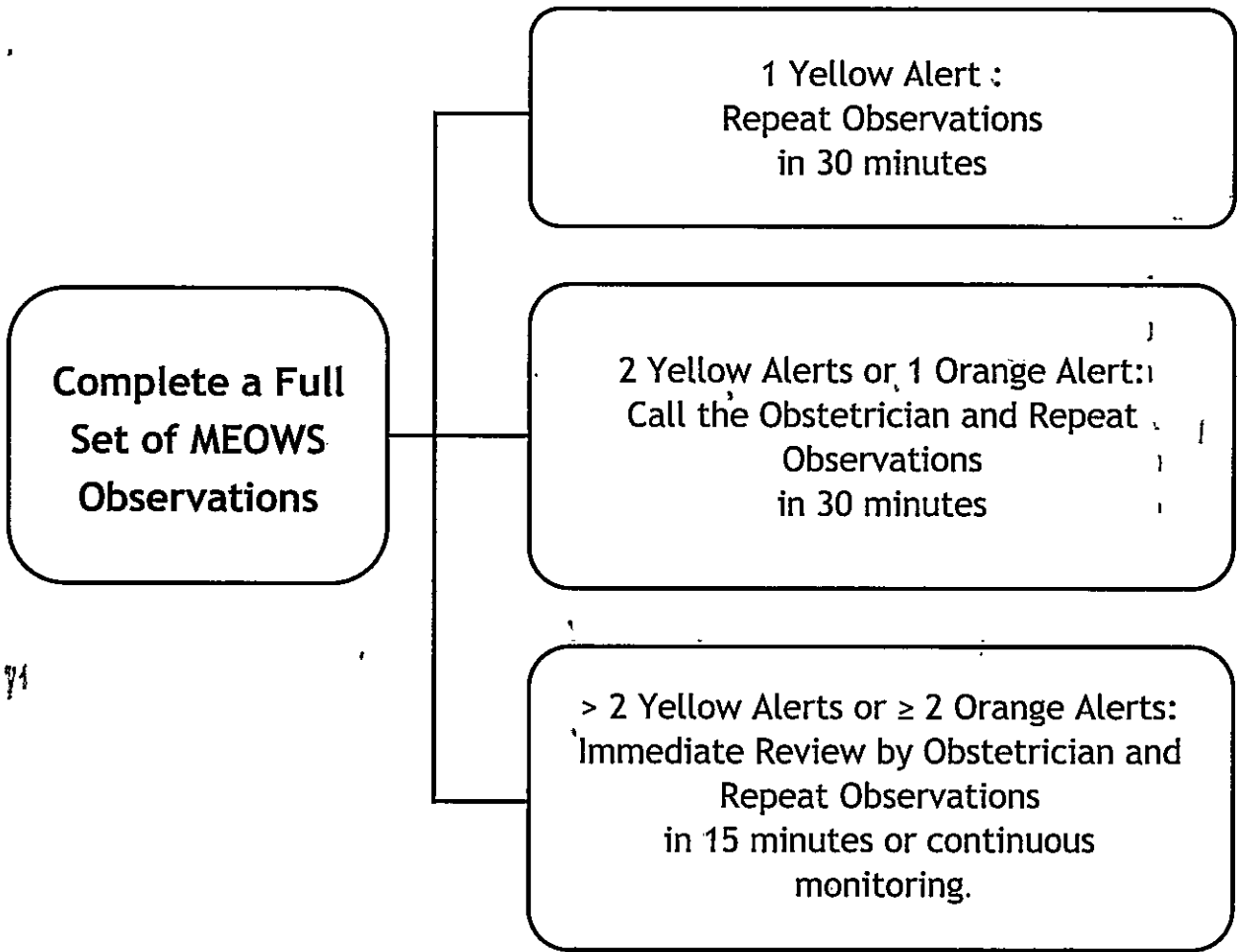
0

Obstetrics and Gynaecology Early Warning Signs



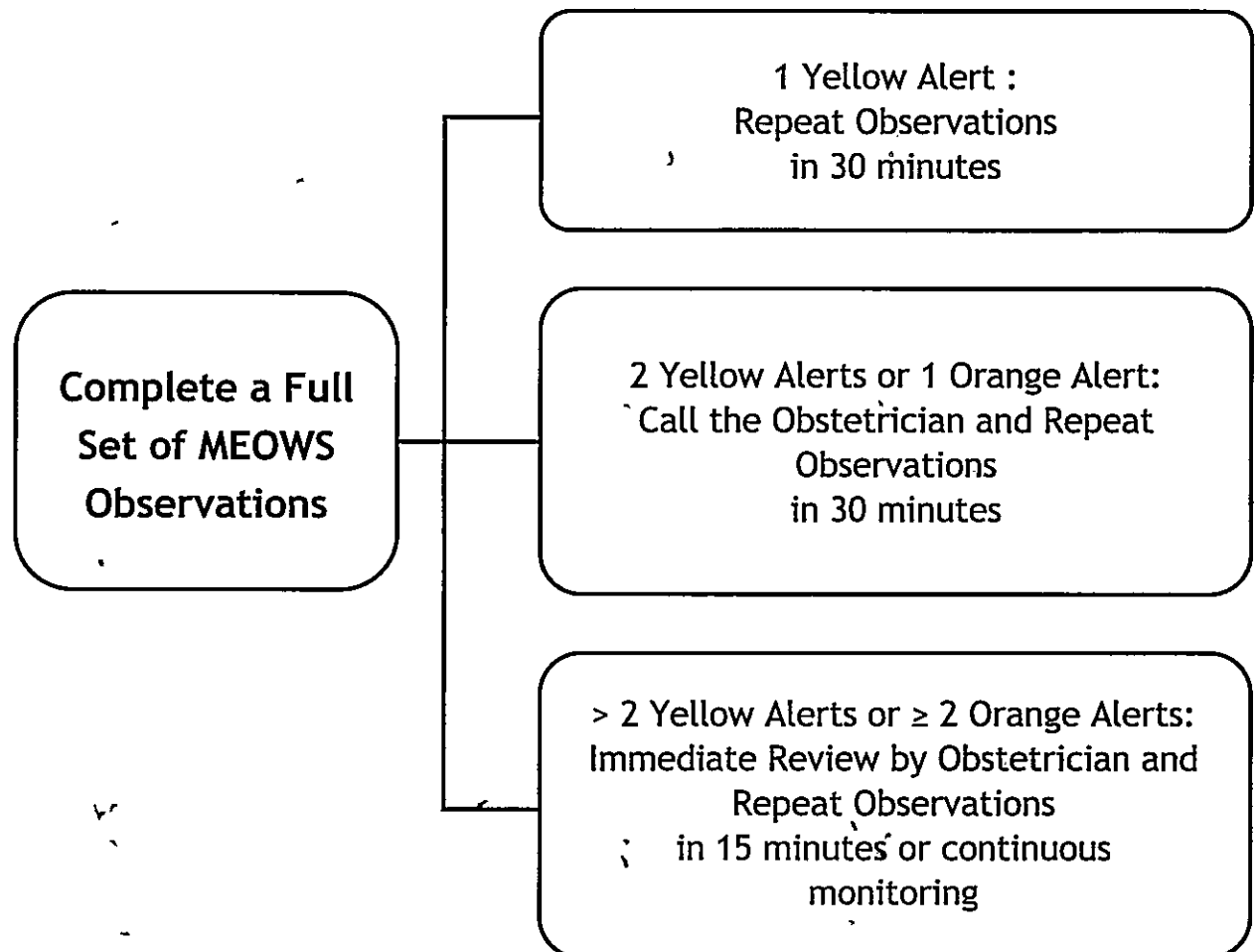
* The Modified Early Warning Score (MEOWS)

**Obstetrics and Gynaecology
Early Warning Signs**



* The Modified Early Warning Score (MEOWS)

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)



FLUID CHART

Sheet No. : (1)

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse		
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine				
	08:00 am													
	09:00 am													
	10:00 am													
	11:00 am													
	12:00 pm													
	01:00 pm													
Total Intake :						Total Output :								
	02:00 pm													
	03:00 pm													
	04:00 pm													
	05:00 pm													
	06:00 pm													
	07:00 pm													
Total Intake :						Total Output :								
	08:00 pm													
	09:00 pm													
	10:00 pm													
	11:00 pm													
	12:00 am													
	01:00 am													
Total Intake :						Total Output :								
	02:00 am													
	03:00 am													
	04:00 am													
	05:00 am	RL	3	100ml										
	06:00 am	RL	3	100ml										
	07:00 am	RL	3	100ml										
Total Intake :						Total Output :								

Total 24 hrs. Intake

Total 24 hrs. Output



FLUID CHART

Sheet No. : 2

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse						
			Route			NG	Diarrhoea	Vomit	Drainage	Urine								
			Mouth	I.V	N.G													
25/6/20	08:00 am	RL	N	100ml								empty 9AM						
	09:00 am	RL	B	100ml				250ml										
	10:00 am	RL	M	100ml														
	11:00 am	RL	M	100ml														
	12:00 pm	RL		100ml					300ml									
	01:00 pm	RL		100ml														
Total Intake : taken			Total Output :															
25/6/26	02:00 pm	RL	coconut water	100ml	NA	NA	NA	NA	NA	NA		Empty @ 6:40 pm						
	03:00 pm	RL		100ml												250ml		
	04:00 pm	RL		100ml														
	05:00 pm	RL		100ml														
	06:00 pm	RL	H2O	100ml														
	07:00 pm	RL	H2O	100ml													800ml	
Total Intake :			Total Output :															
25/6/16	08:00 pm	RL	Today	100ml								Empty 9pm						
	09:00 pm	RL		100ml				100ml										
	10:00 pm	RL	H2O	100ml														
	11:00 pm	RL	H2O	100ml														
	12:00 am	RL		100ml														
	01:00 am	RL		100ml					900ml									
Total Intake :			Total Output :															
26/6/16	02:00 am	RL		100ml								Empty 6:50am						
	03:00 am	RL		100ml														
	04:00 am	RL		100ml														
	05:00 am	RL		100ml														
	06:00 am	RL	H2O	100ml					600ml									
	07:00 am	RL		100ml														
Total Intake :			Total Output :															

Total 24 hrs. Intake

Total 24 hrs. Output



FLUID CHART

3

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		
26/6	08:00 am										6	Q
	09:00 am	0	Sally								0	
	10:00 am		H ₂ O								0	
	11:00 am										0	
	12:00 pm										0	
	01:00 pm										0	
Total Intake :						Total Output : 6-2 m-						
26/6/2	02:00 pm		Upma								1	Q
	03:00 pm		H ₂ O								0	
	04:00 pm										0	
	05:00 pm	0	Roti								0	
	06:00 pm										0	
	07:00 pm										0	
Total Intake : Taken						Total Output : 6-1 m-1						
26/6/2	08:00 pm										1	Q
	09:00 pm		upma								0	
	10:00 pm		H ₂ O								0	
	11:00 pm		Roti								0	
	12:00 am										0	
	01:00 am										0	
Total Intake :						Total Output : 6-3 M=0						
27/6	02:00 am										1	Q
	03:00 am										0	
	04:00 am										0	
	05:00 am		H ₂ O								0	
	06:00 am										0	
	07:00 am										0	
Total Intake :						Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output

NH-00002333 IP26-00006639

Ara LOLAKPURI TRISHALINI

2-10-1996 29 Y 8 M 13 D (F)

Jr. KADIYALA RAMYA THEJA



FLUID CHART

Sheet No. :

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

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

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

Total 24 hrs. Output	
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HNH-00002333 IP26-00006639

Mrs LOLAKPURI TRISHALINI

12-10-1996 29 Y 8 M 13 D (F)

Dr. KADIYALA RAMYA THEJA



NURSING CARE RECORD



Date: 25/6/26

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							
Afternoon				NA			
Night	8pm	- Assessed the patient condition - plan for vital x record - plan for IV fluids 8am - plan for vitals & record	8pm	- Assessed the patient condition - maintain vital - IV fluids continue 8am - maintain vitals	- patient stable	- vital normal	

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 Mrs LOLAKPURI TRISHALINI
 12-10-1996 29 Y 8 M 13 D (F)
 Dr. KADIYALA RAMYA THEJA



NURSING CARE RECORD



Date: 25/6/20

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	→ Assess the pt condition	8AM	→ Assessed the pt condition	No chart maintained	Patient is stable	Sri
	To	→ plan for vitals → plan for I/O chart	To	→ vital are checked & recorded → all medication given as per doctor's order			
	9AM	→ plan for medication	9AM				
Afternoon	2pm	Assess the pt condition	2pm	Assessed the pt condition	Patient is stable.	Re-checked vitals	S.
		<ul style="list-style-type: none"> - Monitor vitals & records - Maintain I/O chart - Give medication as prescribed by doctor 		<ul style="list-style-type: none"> - Monitor vitals & records - Maintain I/O chart - Given medication as prescribed by doctor 			
Night	8pm	→ Assess the pt condition	8pm	→ Assess the pt condition	Patient is stable	Re-checked vitals	S.
	To	→ monitor vitals	To	→ monitor vitals			
	8AM	→ Give medication prescribed by doctor	8AM	→ Give medication as prescribed by doctor			

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IP26-00006639

Mrs LOLAKPURI TRISHALINI
2-10-1996

29 Y 8 M 13 D (F)

Jr. KADIYALA RAMYA THEJA



NURSING CARE RECORD



Date: 26/6/26

- 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	8pm	- assessed the pt condition - checked the vital signs - maintained I/O chart - drug as per chart - soft diet - Ambulation	8pm	- assessed the pt condition - checked the vital signs - maintained I/O chart - drug as per chart - soft diet - Ambulation	- monitored vital signs - maintained I/O chart	- pt is stable	[Signature]
	2pm	- wt for bleeding	2pm				
Afternoon	2pm	- Assess the pt condition - monitor vitals - maintain I/O chart - medication given as per drug chart	2pm	- Assessed the pt condition - Monitored vitals - maintained I/O chart - medication given as per drug chart	pt is stable	Re-checked vitals	[Signature]
	8pm		8pm				
Night	8pm	-> Assess the pt condition -> monitored vitals -> maintained vital -> medication given	8pm	-> Assess the pt condition -> monitored vitals -> maintained vital -> medication given	pt is stable	Re-checked vitals	[Signature]
	8Am		8Am				

(NH-00002333 IP26-00006639
 Mrs LOLAKPURI TRISHALINI
 2-10-1996 29 Y 8 M 13 D (F)
 P. KADIYALA RAMYA THEJA



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							



CHECKLIST FOR THROMBOPHLEBITIS

25/6/26 28/6

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			26/6 DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			NA	NA	NA	NA	0	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			NA	NA	NA	NA	NA	NA	NA	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			NA	NA	NA	NA	NA	NA	NA	
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			NA	NA	NA	NA	NA	NA	NA	
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			NA	NA	NA	NA	NA	NA	NA	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			NA	NA	NA	NA	NA	NA	NA	
Signature of the Nurse				Aan's			E			E			NA

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 : Swathi

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 :

HNH-00002333 IP26-00006639
 Mrs. LOLAKPURI TRISHALINI
 12-10-1996 29 Y 8 M 13 D (F)
 Dr. KADIYALA RAMYA THEJA

Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	25/6	25/6	26/6	Fall Risk Grading		
		Score	5AM	8AM	8PM	Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25				Low Risk	0 - 24	Standard Fall Precaution
	No	0						
Secondary Diagnosis (more than one diagnosis)	Yes	15				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
Ambulatory Aid	Furniture	30				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0						
IV / Heparin Lock or Saline	Yes	20	20	20	20	Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0						
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0	0	0	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

HNH-00002333

IP26-00006639

Mrs LOLAKPURI TRISHALINI

12-10-1996 29 Y 8 M 13 D (F)

Dr. KADIYALA RAMYA THEJA



BRADEN 'Q' SCALE



Date: 25/6 25/6 25/6 25/6
 Time: 5:45 AM 8 AM 2 PM 2 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	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	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	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	4
FRICITION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	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 of 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	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	4

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

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

TOTAL SCORE	28	28	28	28
Evaluator's Name	AM	Si	R	AK

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

INH-00002333 IP26-00006639
 Ara LOLAKPURI TRISHALINI
 2-10-1996 29 Y 8 M 13 D (F)
 Jr. KADIYALA RAMYA THEJA



BRADEN 'Q' SCALE



					Date :	26/6	26/6	26/6	
					Time :	8pm	2	2/1	
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	
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					TOTAL SCORE	28	28	28	
					Evaluator's Name	[Signature]	[Signature]	[Signature]	

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PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
25/6/16	5 AM	0/10	None	<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	
25/6/16	8 AM	0/10	None	<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	
25/6	11 AM	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	
25/6	6 pm	0/10	NA	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input checked="" type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	
25/6	10 pm	0/10	NA	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input checked="" type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	
25/6	10 pm	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
26/6	9 AM	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
26/6/20	2 pm	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
26/6/20	8 pm	0/10	NA	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input checked="" type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	
26/6/20	10 pm	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Re-assessment Frequency:

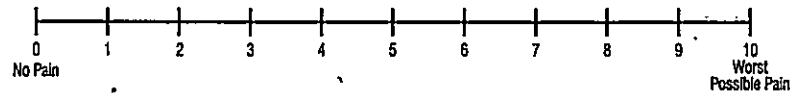
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 - a) At least every 2 hours for the first 24 hours
 - b) Then every 4 hours.
 - c) Prior to pain-relieving intervention.
 - d) Within 30 – 60 minutes after pain relief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



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
25/6/2		0/10	Normal	<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	
25/6/2	10pm	0/10	Normal	<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	
26/6	9am	0	Normal	<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	
26/6	10pm	0	Normal	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<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:

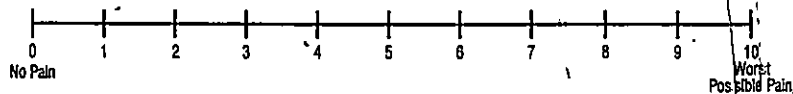
1. Every eight hours for all hospitalized patients.
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PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
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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
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Vital Signs HR, RR, BP, SaO ₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Even More 8 Hurts Whole Lot 10 Hurts Worst



URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 25/6/26 Date of Removal: 25/6/26

Parameters	Date	Shift Time	25/5/26 AM	25/6 E2	26/6.				
Need for the Catheter	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" 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
Hand Hygiene	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
Usage of Sterile Equipment	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the Collection bag below the level of bladder	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
Check the Tube for Obstruction (Free of Kinking)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is Catheter dated as policy	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
Collecting bag is been emptied regularly?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
Maintenance of closed system for the catheter	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dressing clean and dry?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the line removed as Policy?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Performance of Perineal Care	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
Onset of New Fever	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asses for the leakage at the site of insertion	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of the Nurse			<i>Aliya</i>	<i>Priyanka</i>					
Signature of the Nurse			<i>Aliya</i>	<i>Priyanka</i>					

Catheter removed at 8:20 AM
26/6/26



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis: <i>EL-LCS</i>	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:					
BACKGROUND	Area	<i>24/6/26</i>	<i>25/6</i>	<i>25/6</i>	<i>25/6</i>	<i>26/6</i>	
	Shift Time	<i>8pm</i>	<i>8AM</i>	<i>E2</i>	<i>NI</i>	<i>mb</i>	
	Medical Condition (Any special condition to be noted):	-	<i>NA</i>	-	-	-	
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Tubes/Drains/Catheter:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	<i>97.6</i>	<i>98.5</i>	<i>97.5</i>	<i>98</i>	<i>98.5</i>
		Res:	<i>20</i>	<i>20</i>	<i>20b/h</i>	<i>20b/h</i>	<i>20b/h</i>
		SpO ₂ :	<i>100</i>	<i>99.1</i>	<i>100%</i>	<i>100%</i>	<i>100%</i>
		Pulse:	<i>84</i>	<i>85</i>	<i>86b/h</i>	<i>86b/h</i>	<i>89b/h</i>
		BP:	<i>110/83</i>	<i>120/81</i>	<i>112/70</i>	<i>115/70</i>	<i>114/71</i>
Fall Risk Score:							
Pain Score:	<i>0/10</i>						
Recommendations	Safety Needs:	<i>yes</i>					
	Physiotherapy	<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	
	Others Specify:		<i>NA</i>				
	Special Diet:	<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	
	Other Special Orders / Medications:	<i>NA</i>	<i>NA</i>	<i>NA</i>	<i>NA</i>	<i>NA</i>	
Post Operative Procedure Special Orders:			<i>NA</i>	<i>NA</i>	<i>NA</i>	<i>NA</i>	
Handed Over By Name :		<i>Ala</i>	<i>Susha</i>	<i>Priyanka</i>	<i>Madhu</i>	<i>Sandhya</i>	
Signature :		<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	
Date:		<i>25/6/26</i>	<i>25/6</i>	<i>25/6/26</i>	<i>26/6/26</i>	<i>26/6/26</i>	
Time:		<i>8:10 AM</i>	<i>2PM</i>	<i>8pm</i>	<i>8AM</i>	<i>2pm</i>	
Taken Over By Name :		<i>Susha</i>	<i>Priyanka</i>	<i>Madhu</i>	<i>Sandhya</i>	<i>Susha</i>	
Signature :		<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	
Date:		<i>25/6</i>	<i>25/6/26</i>	<i>25/6/26</i>	<i>26/6</i>	<i>26/6/26</i>	
Time:		<i>8AM</i>	<i>2pm</i>	<i>8pm</i>	<i>8AM</i>	<i>2pm</i>	



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	26/6/20	N1	/	/	/	/	
	Shift Time							
	Medical Condition (Any special condition to be noted):	—						
ASSESSMENT	Allergy:	<input checked="" 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 checked="" 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:	98.3°					
		Res:	20b/m					
		SpO ₂ :	100%					
		Pulse:	98					
		BP:	116/89					
Fall Risk Score:	—							
Pain Score:	—							
Recommendations	Safety Needs:	—						
	Physiotherapy	<input checked="" 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 checked="" 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:	PO						
	Post Operative Procedure Special Orders:	NO						
	Handed Over By Name :	Madhul						
	Signature :	Madhul						
	Date:	26/6/20						
	Time:	8 AM						
	Taken Over By Name :							
	Signature :							
	Date:							
	Time:							

HNH-00002333 IP26-00006639
 Mrs LOLAKPURI TRISHALINI 29 Y 8 M 13 D (F)
 12-10-1996
 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	TAB-IRON	1tab	PO	OD	24/6/26	<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
2	TAB-CALCIUM	1tab	PO	OD	24/6/26	<input type="checkbox"/> C <input checked="" 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. Venka*

Date & Time : *25/6/26 @ 6:30 AM*

Nurse Name & Signature: *Alex Q Alex*

Date & Time : *25/6/26 @ 6:30 AM*

I.V. FLUIDS CHART

Weight 60kg Ward 102



Date	Time	Composition of I.V. Fluid (If infusion, mention ml/hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
25/6/26	6:00 AM	RINGER LACTATE	IV	1000 ml/hr	[Signature]	[Signature]	25/6	[Signature]	[Signature]
25/6/26	7:30	RINGER LACTATE	IV	1000 ml/hr	[Signature]	[Signature]	25/6	[Signature]	[Signature]
25/6	10 AM	RINGER LACTATE	IV	100 ml/hr	[Signature]	[Signature]	25/6	[Signature]	[Signature]
25/6	12 PM	RINGER LACTATE	IV	100 ml/hr	[Signature]	[Signature]	25/6	[Signature]	[Signature]
25/6/26	1:30 PM	RINGER LACTATE	IV	1000 ml/hr	[Signature]	[Signature]		[Signature]	[Signature]
25/6/26	8:15 PM	RINGER LACTATE	IV	1000 ml/hr	[Signature]	[Signature]		[Signature]	[Signature]
26/6/26	1 AM	RINGER LACTATE	IV	1000 ml/hr	[Signature]	[Signature]		[Signature]	[Signature]
STOP 26/6/26									

VERIFIED BY : Name Signature

0000, 100, 1000, 10000, 100000, 1000000

MNH-00002333 IP26-00006639
 Mrs LOKAPURI TRISHALINI
 12-10-1996 29 Y 8 M 13 D (F)
 Dr. KADIYALA RAMYA THEJA



REAN SECTION OPERATIVE NOTES

Surgeon's Name: DR. RAMYA THEJA	Date of Delivery: 25/6/2026
Assistant Surgeon: DR. VEENA	Time of Delivery: 7:59 AM
Anaesthetist's Name: DR. SHABANA	Gender of Baby: FEMALE
Type of Anaesthesia: SPINAL ANESTHESIA	Weight of Baby: 3.160 Kg
Neonatologist: DR. PRITESH	AGPAR Score: 7,9
Scrub Nurse: S/N SANGEETHA	NICU Admission: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <i>Greenly</i>

Pre-Operative Diagnosis: *G2P14 | 37th wks. | prev LSCS.*

Elective Emergency Indication: *Previous LSCS*

Urgency

- Immediate Threat to life of woman or fetus
- Maternal or fetal compromise not immediately life threatening
- No maternal or fetal compromise but needs early delivery
- Delivery timed to suit woman and staff

Decision time: *NA* Knief to rectus: *Smilis*

CTG Description: *Reactive*

If there was a delay give the reasons: *d -*

Surgical Procedure: *ELECTIVE LSCS*

Post Operative Diagnosis: *POD 0*

Peri-Operative Complications: *None*

Amount of Blood Loss: *300ml* Blood Transfused (in ML): *None*

Name and Number of Surgical Specimen sent for examination:

None

Examination Findings when Appropriate:

Presentation: Cephalic Breech Other Cervical Dilatation: 4 cm
 5th Palpable: S/S Fetal Position:
 Station: -3 -2 -1 0 +1 +2 Moulding: None + ++ +++
 Caput: + ++ +++ Meconium: None + ++ +++
 Bladder Catheterized: Yes No Urine: Clear Blood Stained

Skin Incision: Pfannenstiel Transverse Midline Other
 Uterine Incision: Lower Segment Classical Inverted T J Incision * LUS thinned out
 Previous Scar: Intact Thinned out Ruptured No Scar * Scar dehiscence noted
 Incision Through Placenta: Yes No * Bladder densely adherent to scar.
 Delivery of head: Manual Forceps
 Liquor: Clear Meconium: I II III Blood Offensive Not Offensive
 Delivery of Placenta: Manual CCT Complete Incomplete Piecemeal
 Cord Appearance: Intact & normal! Cord around the neck Yes No
 Appearance of placenta: Normal & complete. Cavity explored Yes No
 Uterus, tubes and ovaries: Normal Not Normal Sterilization: Yes No

Uterine Closure: One Layer Two Layers Nicryl No-1 Suture
 Peritoneal Closure: Pelvic Abdominal None Catgut Suture
 Sheath Closure: Nicryl 2-0 Suture
 Fat Closure: Yes No @ Catgut Suture
 Skin Closure: Subcuticular Mattress Monocryl 3-0 Suture
 Vaginal Evacuated Yes No
 Drain: Yes No Remove in days Await instructions
 Catheter Yes No Remove in 1 days Await instructions
 Swap & Instruments count correct? Yes No Post-op Antibiotics Yes No
 Intra-Operative Antibiotics Cover: Yes No Thromboprophylaxis Yes No

Post-Operative Notes:
 - NBM for 4-hours
 - Vital monitoring
 - IU ABx for 24 hours
 - Foley's catheter for 24 hours
 - w/ excessive bleedng PLU
 - IUF's, Analgesics & Thrombo prophylaxis as per Axou
 - Stochantle
 - Surform 50s

Doctor Name: Dr. Ranjitha Doctor Signature:
 Date & Time: 25/6/2011

SURGICAL SAFETY CHECKLIST

Surgeon: Dr. Ramya Theja
 Asst. Surgeon: Dr. Shubang Vena
 Anaesthetist: Dr. Shubang
 Scrub Nurse: Sr. Sangeetha

HNH-00002333 IP26-00006639
 Mrs. LOLAKPURI TRISHALINI
 12-10-1996 29 Y 8 M 13 D (F)
 Dr. KADIYALA RAMYA THEJA



Age: 29 Gender: F
 Primary Name:

Date: 25/06/26 In-time: 7:35 Am Out-time: 8:45 Am



Before Induction of Anaesthesia >>

SIGN IN	Time: <u>7:30am</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 checked="" type="checkbox"/> No <input type="checkbox"/> NA
Blood Units Reserved	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input 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>[Signature]</u>	
Name: <u>Dr. Shubang</u>	


Before Skin Incision >>

TIME OUT	Time: <u>7:35 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Correct Site	<input checked="" 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 type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Anaesthesia Team Reviews:	
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 checked="" 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
Power Supply, Earthing, Power Backup and functioning of equipment checked.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Signature: <u>[Signature]</u>	
Name: <u>Sangeetha</u>	

Before Patient Leaves Operating Room

SIGN OUT	Time: <u>8:45 Am</u>
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 type="checkbox"/> No <input checked="" type="checkbox"/> NA
The Specimen is Labelled (including patient name)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" 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>[Signature]</u>	
Name: <u>Dr. G. Vena</u>	

PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00002333 IP26-00006639 Mrs LOLAKPURI TRISHALINI 12-10-1996 29 Y 8 M 13 D (F) Dr. KADIYALA RAMYA THEJA 		Date & Time of Admission 25/06/26 @ 5:45 AM	Date & Time of Transfer Order 25/06/26 @ 8:45 AM
		Transfer Ordered by Dr. Shabana	Reason for Transfer Observation
From Unit OT	To Unit Pne Post	Information to Attendant Yes <input type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 40	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.	RC	1	
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Sangeetha		Name of Person Ordered Transfer Dr. Shabana	
Patient & Clinical Records Received by : Sriatha Dr			
Date & Time of Patient Received : 25/06/26 @ 9 AM			

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: 25/6/26 Time of Arrival: 5:45 AM Time Seen by Nurse: 5:50 AM

1) Level of Consciousness: Conscious Semi-Conscious Unconscious

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

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

3) Vital Signs: Temperature: 97.6 Pulse: 92 RR: 20 SpO₂: 100 BP: 110/70 Weight: 60kg

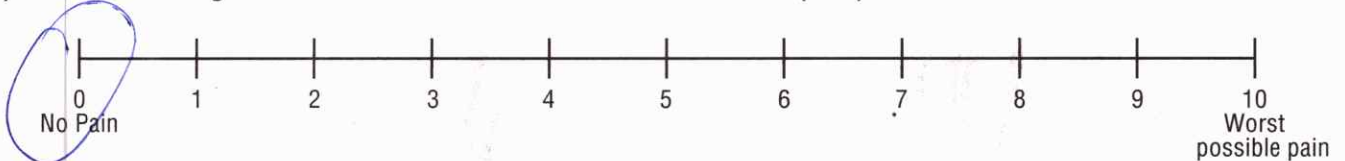
4) Gestational Criteria:

Gravida:	G <u>2</u>	P	L	A
----------	------------	---	---	---

LMP: 4/10/2025 EDD: 11/4/2028 Gestational Age: 37⁺ weeks

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

5) Pain Screening: Numerical Pain Scale (NPS)



- Location:
- Duration: 1 day Days / Weeks / Months (Strike out which is not applicable)
- Character:
- Frequency:
- Interventions:

6) Past History:

- a) Surgeries: 1st 2024
- b) Medical:



7) Allergy: Yes No, If Yes :

8) Current Medications: Prenatal Vitamin None Others:

9) Prenatal Medical History:

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

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

OTAS	Level 1 (Resuscitative)	Level 2 (Emergent)	Level 3 (Urgent)	Level 4 (Less Urgent)	Level 5 (Non Urgent)
Level 1 (Resuscitative)	Immediate	≤ 15 minutes	≤ 30 minutes	≤ 60 minutes	≤ 120 minutes (2 Hours)
Re-Assessment	Continuous Nursing Care	Every 15 Minutes	Every 15 Minutes	Every 30 Minutes	Every 60 Minutes
Labour / Fluid	Imminent Birth	Suspected Pre-term Labour / PPROM < 37 Weeks	Signs of Active Labour > 37 weeks	Signs of Early Labour/ SROM > 37 weeks	Discomforts of Pregnancy
Bleeding	Active Vaginal bleeding with/ without abdominal pain	Bleeding associated with cramping (<spotting) <37 weeks	Bleeding associated with cramping (>spotting) >37 weeks	Spotting	
Hypertension	Seizure activity	Hypertension > 160/110 and / or headache, visual disturbance, RUQ pain	Mild hypertension > 140/90 with/without associated signs and symptoms		
Fetal Assessment	Abnormal FHR tracing Non-Fetal Movement	Atypical FHR tracing, abnormal dopplers Diseased fetal movement			
Others	<ul style="list-style-type: none"> • 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: 6:30pm

Nurse Name : Alex

Nurse Signature: Alex

Date: 25/6/26 Time: 7pm

HNH-00002333 IP26-00006639
 Mrs LOKAPURI TRISHALINI
 12-10-1996 29 Y 8 M 13 D (F)
 Dr. KADIYALA RAMYA THEJA



OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 25/6/24

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
 EL-UCS Name of the Doctor: Dr veena
 Time Notified: 6:30 AM

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

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

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

Obstetric History: G 2 P 1 L 1 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: 97.6 HR: 92 RR: 20
 BP: 105/73 Weight: 60kg Height: 150 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 (complete the Morse Fall Risk Assessment Sheet)

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

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

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING: 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 *Family member*

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: *Mrs Trishalini*

Orientation not given Reason:

Nurse Signature: *[Signature]*

Nurse Name:

Date & Time: *25/10/2020 7AM*



BREAST FEEDING HANDOVER AND ASSESSMENT FORM

1. Breastfeeding initiated?

- a. Yes b. No

2. If No, Reason

3. Nipple condition:

- a. Nipple well formed
 b. Flat nipple
 c. Inverted nipple
 d. Short nipple

4. Milk flow:

- a. Good
 b. Drops of colostrums
 c. Dry

5. Steps for Positioning and attachment:

- a. Baby goes to the breast
 b. Mother always sits with a back support
 c. Ear-shoulder-hip should be in a straight line
 d. The baby takes a latch on the areola and not on the nipple



Feeding Positions:
Cross Cradle



Feeding Positions:
Football / Clutch

6. Was the position explained:

- a. Yes
- b. No

7. For Caesarian mothers:

- a. Mother is required sit and feed from the 4th feed
- b. Please explain football hold

8. NICU admission: yes

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

9. Additional notes:

Continuity of Care:

Date: 25/6.....

→ Assess the pt condition
→ vital are checked & recorded
→ D/o chart maintained
→ 2nd hourly DBF given

Handover given by Rintha.....

Handover taken by

Signature Li.....

Signature

Date & Time: 25/6 12.6 @ 2pm.....

Date & Time:

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE



Patient Name : Mrs. LOLAKPORI TRISHALINI Gender: Male Female Age : 29 yrs
 UHID No : HNH-00002333 Date : 25/6/26

Instruction:

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

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

ELECTIVE LOWER SEGMENT CAESAREAN SECTION
 upon MRS. LOLAKPORI TRISHALINI (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.

Excessive bleeding, post-partum hemorrhage, need for transfusion of blood or blood products, inadvertent injury to bowel, bladder or ureter, wound infection

My signature on this form indicates that

- I have read and understood the information provided in this form
- 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.
- I have had a chance to ask my surgeon questions.
- I have received all the information I desire concerning the operation or procedure and
- I authorize the consent to the performance of the operation or procedure.

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

Consentee :
 Signature : L. Trishalini
 Name : L. Trishalini
 Date & Time : 25/6/26 @ 6:30am

Patient Attendant :
 Signature : [Signature]
 Name : Rahul Varma
 Relationship with Patient: Husband
 Date & Time : 26/6/26 - 6:18 am

Witness :
 Signature : [Signature]
 Name : Ashwini
 Date & Time : 25/6/26 @ 6:30am

Doctor (who is taking the consent) :
 Signature : [Signature]
 Name : Dr. G. Veena
 Date & Time : 25/6/26 @ 6:30am

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE



Patient Name : L. TRISHAUNI Age : 29y Gender : Male Female

UHID NO: HNH-00002333 Surgeon Name: Dr Ramya Theja

Anaesthesiologist : Dr. Samir

Operative procedure planned : Elective caesarean

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 : hypotension, bradycardia, PDPH

Comments : laryngospasm, bronchospasm

- 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 L. Trishalini the above mentioned operation / Diagnostic / Therapeutic procedures Elective caesarean section

I authorize and give consent for anaesthesia (Regional / General Anesthesia / Monitored Anesthesia Care as considered appropriate by the anaesthetic team.

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, risk, benefits and alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anesthesia.

I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, asthmatic reactions, headaches.

I authorize the anaesthetic team to perform any additional procedures (for example, Central Venous Pressure line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter in need arises.

I understand that the above mentioned consultant anesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

- Pregnant : Yes No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

I declare that I have explained the nature of General Anaesthesia / Regional Anaesthesia / Monitored Anesthesia Care to be given and discussed the risks that particularly concern this patient.

I have given the patient an opportunity to ask questions and I have answered these.

Patient / Patient Attendant :

Signature : L. Poushalini

Name : L. Poushalini

Relationship with Patient: Self

Date & Time : 22/6/26 5:50pm

Witness :

Signature : Laxmi

Name : Laxmi (mother in law)

Date & Time 22/6/26 5:50pm

Doctor (who is taking the consent) :

Signature : Dr. Anurag

Name : Dr. Anurag K.

Date & Time : 22/6/26 5:50pm

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



Name: L. TRISHAUNI Age: 24y Sex: F UHID.No: HNH-00002333

Date: 22/6/26 Time: 5:40pm Proposed Operation: Elective Caesarian

Diagnosis: G2P1L1 37+2wks prev. LSCS.

B.P / CRT: 100/60 H.R: 98 Weight: 60.9kg ASA Physical Status: 1 2 3 4 5

3/26

Hgb: 11.5
PCV: 35
WBC: 8820
Plate: 314
PT:
PTT:
INR:

Glucose: 76
Urea:
Creat:
Na:
K:
Ca++:
Mg++:
Cl:

Laboratory Data:

Protein:
Alb:
Total Bill:
Dir. Bill:
LDH:
Alk phos:
Amylase:
SGOT/SGPT:

HIV:
HBS Ag: NR
HCV:
Blood group: o+ve
T3
T4
TSH 0.819

Allergies: - Nil -

Medical History: CVS: SOB NYHA III at 31wks of GA. evaluated by physician - related to pregnancy - subsided in 1 month
Diabetes: GDM in previous pregnancy - normal blood sugars in this pregnancy
Renal: Nil - significant
Hepatic / GE:
Others:
Physical Activity: active

Past Anaesthetic History: LSCS + SA Dec 2024 U/G.

Physical Exam: -

Airway: MP 1 (2) 3 4 Mouth Opening: 3FB Mentohyoid Distance: 3FB Neck: (N) Teeth: (M)

Lungs: BAE ⊕ chr

Heart: S1m ⊕

CNS: cl/c -

Pregnant: Yes No NA Venous Access Site: accessible Spine Exam for regional: well felt

Anaesthetic Plan: MAC REGIONAL GA-ETT LMA

Peri-Operative Plan Explained to the Patient: Yes No

CURRENT MEDICATIONS	DOSAGE
<u>Humatinites</u>	

- Pre-Operative Instructions:
- DVT Prophylaxis ✓
 - NIL ORAL $\left\{ \begin{array}{l} \text{Water / ORS 2 Hours} \\ \text{Others 6 Hours} \end{array} \right\}$ as per sx orders
 - Informed Consent: Standard High Risk
 - Post Operative Pain Management: Discussed with Patient
 - Other Instructions: → CBC on admission

Signature: (Signature) Name: Dr. Akhila-K.

HNH-00002333 IP26-00006639
 Mrs LOKAPURI TRISHALINI
 12-10-1996 29 Y 8 M 13 D (F)
 Dr. KADIYALA RAMYA THEJA



ANAESTHESIA CHART



Pre Induction Assessment:

Change in Patient Condition: Yes No Fasting Status: adequat

Physical Status: Patient Identified Consent Present Chart Reviewed

H.R: 92 B.P / CRT: 108 / 70 SpO₂: 100 R.R: 10 Last Feed: > 6 hr

Pre-OP Diagnosis: G2.P.I.I. Operation: Exelbu LSCS Date: 25/6/2028

Surgeon: Dr. Ramya Theja Anaesthesiologist: Dr. trishalin Technician: Mamh

TIME	7:45	8:00	8:15	8:30	8:45	9:00	9:15	9:30	9:45	10:00	10:15	10:30	10:45	11:00	11:15	11:30	11:45	12:00	
N ₂ O / AIR / O ₂ LPM																			
HALO / SO / SEVO																			
Drugs:																			
Antibiotic																			
Suppository																			
Blood Loss																			
FI _{O₂} / Sa _{O₂}	100	100	100	100															
ETCO ₂																			
ECG	SR	SR	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																			

LAB Values

ABG

GRBS

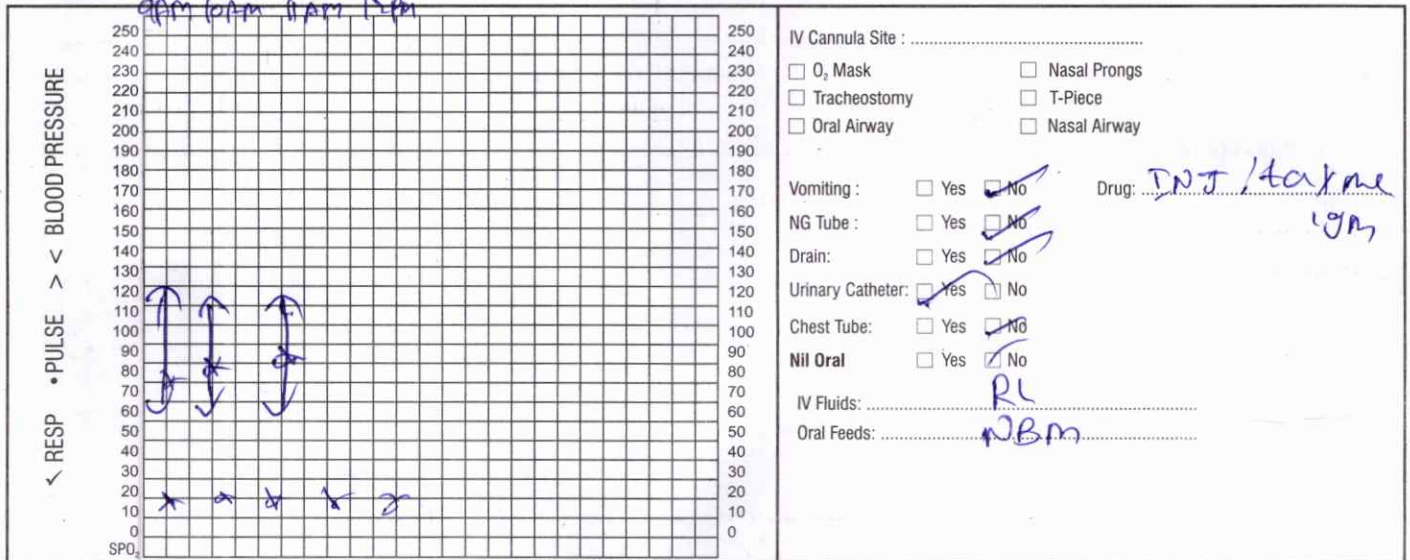
Others

<input checked="" type="checkbox"/> Equipment Checked and Functional <input checked="" type="checkbox"/> BP <input type="checkbox"/> Cuff Site: <u>Right</u> <input type="checkbox"/> Art Site: <input checked="" type="checkbox"/> EKG Lead <input type="checkbox"/> Temp Site <input type="checkbox"/> FIO ₂ Monitor <input type="checkbox"/> Agent Monitor <input type="checkbox"/> Pulse Oximeter <input type="checkbox"/> Capnograph <input type="checkbox"/> Ventilator <input type="checkbox"/> Nerve Stimulator Position: <u>Supine</u> <input checked="" type="checkbox"/> Pressure Points Checked Eye Care: <input type="checkbox"/> Oint <input type="checkbox"/> Tape <input type="checkbox"/> Padding <input checked="" type="checkbox"/> Awake	Temp: <input type="checkbox"/> HME <input type="checkbox"/> Fluid Warmer <input type="checkbox"/> Cling Film <input type="checkbox"/> OH Warmer <input type="checkbox"/> Hugger's <input type="checkbox"/> Cotton Wool <input type="checkbox"/> Other Times: Anaes Start: <u>7:45am</u> OP Start: OP End: Leave OR: <u>8:35am</u> Anaesthesia: <input 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>① hand 16g</u> <input type="checkbox"/> IV: <input type="checkbox"/> IV:	Induction <input type="checkbox"/> IV <input type="checkbox"/> Inhal <input type="checkbox"/> Pre O ₂ <input type="checkbox"/> RSI <input type="checkbox"/> Others <input type="checkbox"/> Mask <input type="checkbox"/> SGA <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 type="checkbox"/> Closed Circle <input type="checkbox"/> Other	Regional: Extremity Specify: <input checked="" type="checkbox"/> Spinal <input type="checkbox"/> Epidural <input type="checkbox"/> Caudal Others: Position: <u>sitting</u> Site: <u>L3-L4</u> Needle Size: <u>25g</u> Depth: Parasthesia <input type="checkbox"/> Yes <input type="checkbox"/> No Catheter at skin cm Drug Name & Conc: Bolus: <u>2ml of 0.5% bupivacaine</u> Infusion: <u>+ 25mg fentanyl</u> Block Level: <u>T4</u> 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. shalin</u> Signature of the Doctor:
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POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Sriyalha Time Received : 9 AM Time Discharged :



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	1	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	9	10	10	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
25/6	9 AM	0	NA	[Signature]
25/6	10 AM	0	NA	[Signature]
25/6	11 AM	0	NA	[Signature]
25/6	12 PM	0	NA	[Signature]

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:

PACU Nurse Name :

PACU Nurse Signature:

Date & Time: 26/6/26 @ 12 PM

Transferred to Unit by (PACU): 3rd Floor 314

Date & Time: 26/6/26 @ 12 PM

26-0000208053

**NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)**

Patient Name: Mrs Lolakpuri Trishadini Age: 29Y Gender: Female
 UHID No: HNH-00002333 IP No: IP 26-00006639 Date: 25/6/26 Time: 5:53 AM
 Diagnosis: HSCS (Ward - OT)

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/ML	100 mcg	01 AMP
2.	Morphine Sulphate Inj. 15mg/ML		
3.	Remifentanyl Hydrochloride Inj. 2MG		
	Remifentanyl Hydrochloride inj. 1MG		

Doctor Name: Dr. Amiga Doctor Registration No: 67529
 Signature: P. Amiga

**NARCOTIC DISPENSING FORM
APPENDIX 4 - FORM NO. 3E**

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

IP Registration No: IP 26-00006639 Date: 25/6/26

Aadhaar No. of the Patient (Optional):

1.	Name:	Mrs Lolakpuri Trishadini	Remarks
2.	Complete postal address (with contact number, if any)		4-11-3-4-716 Nimboliudda Hyderabad
3.	Brief description of the illness		HSCS
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		Fentanyl

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
25/6	INJ: Fentanyl	01	L. Trishadini	

Dispensed by (Name & ID No.): Sania (P18442) Signature: Sania

Received by (Name & ID No.): M Arvind Kumar (021957) Signature: AW

Time: