

306  
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Name	Mrs P. SHIRISHA	UHID	HNH-00010982
Father/Guardian	Mr RUPESH	Age/Gender	28 Y 2 M 17 D/ Female
Address	9-68/B/5 EAST HANUMAN NAGAR, Boduppal, Hyderabad, Telangana, INDIA, 500092		
IP No	IP26-00006607	Admission Date	18-06-2026
Ref Doctor	Self.		
Discharge Date	20.06.2026		

### DISCHARGE SUMMARY

#### Consultant:

Dr. SWAPNA SAMUDRALA  
MBBS, MS (OBG)  
69924

**Diagnosis:PRIMI AT 37<sup>+6</sup> WEEKS WITH GESTATIONAL DIABETES MELLITUS ON ORAL HYPOGLYCEMIC AGENTS FOR INDUCTION OF LABOUR**

**SPONTANEOUS VAGINAL DELIVERY ON 19.06.2026**

#### History:

LMP:23.09.2025  
EDD:04.04.2026  
weeks

Obstetric formula: Primigravida  
Gestation at admission: 37<sup>+6</sup>

#### Obstetric History:

G1 - Present pregnancy Spontaneous conception.

**Medical History :** Nil

**Family History :** Parents HTN + DM

**Surgical History:** Nil

**Allergies :** Nil

#### Antenatal Details:

Mrs P. SHIRISHA was booked with Dr.Swapna Samudrala at 13<sup>+2</sup>weeks of gestation. She had regular antenatal checkups and investigations as advised elsewhere.NT scan normal.FTS low risk.MTAS normal.OGTT done at 25<sup>+3</sup> weeks deranged(102/241/217).Physician opinion sought and advised to start on

1/4

Name	Mrs P. SHIRISHA	UHID	HHH-00010982
IP No	IP26-00006607	Admission Date	18-06-2026

T.Metformin 500mg twice daily.Regular home blood sugar monitoring done.At 34<sup>+5</sup> weeks OHAs titrated to T.Metformin 500mg thrice daily. Fetal surveillance done by serial growth scans. Last scan done on 11.05.2026 showed single live fetus corresponding to 36<sup>+5</sup> weeks with cephalic presentation,placenta-posterior,high with AFI-19.5cms,EFW-2915g(45%), AC-33% with normal dopplers.She was admitted at 37<sup>+6</sup> weeks for induction of labour.

**Investigations:** Enclosed  
Blood group- "B" Positive

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

At admission on clinical examination the vitals were stable, uterus was relaxed, cervix was 3cm dilated and partially effaced. Fetal well being was confirmed by an admission CTG which was found to be reactive. Informed consent taken for Induction of labour. Labour induced with 2 doses of PGE1. Artificial rupture of membranes done at 3 cms dilatation revealing clear liquor. As per hospital protocol she was started on IV. Taxim in view of ruptured membranes. Partographic monitoring of labour was done. Patient opted for epidural analgesia at 3cms dilatation for pain relief. The same was sited by an anesthetist after informed consent. Further augmentation was done by oxytocin infusion. She progressed to full dilatation. Passive descent of fetal head was allowed for 25mins post full dilatation. She was put into position for vaginal birth at 3:45pm. Parts painted with betadine solution and draped to ensure full asepsis. She was encouraged to bear down. At crowning of head episiotomy was given under local anaesthesia (10 ml of 2 % xylocaine solution). Baby was delivered by spontaneous vaginal delivery, Cord clamped and cut and baby handed over to pediatrician. Cord blood collected for blood grouping and Rh typing. Placenta and membranes delivered completely with controlled cord traction. Prophylactic syntocinon given. Episiotomy inspected. No extensions or additional vaginal tears found. Episiotomy sutured in layers. Instrument and swab count checked. 600 mcg of misoprostol given per rectally as prophylaxis against post partum hemorrhage. Vagina cleaned with betadine solution.

**Delivery Details:**

Date : 19.06.2026  
Time of Delivery: 3:56PM  
Type of Labour : Induced  
Type of Delivery: Spontaneous  
Analgesia : Epidural  
Indication : GDM on OHA

**Baby Details:**

Name Mrs P. SHIRISHA UHID HNH-00010982  
IP No IP26-00006607 Admission Date 18-06-2026

Date : 19.06.2026  
Time : 3:56PM  
Sex : Male  
Weight : 3.140grams  
Apgar : 7,8  
Gestational Age: 37<sup>+6</sup> weeks  
NICU Admission: Yes

**Post-Partum Notes:** She was closely monitored for post partum hemorrhage. Breast feeding initiated. Vitals were stable; patient ambulated and was shifted to room. Patient was encouraged for spontaneous voiding. Dietary advice given. Her postpartum period following that was uneventful. On first postpartum day episiotomy wound was healthy and intact. On first post natal day, FBS/PPBS 100/188 mg/dl .Physician opinion sought and advised to start on T.Metformin 500mg OD.Her general condition was satisfactory and she was found to be fit for discharge. Wound care and medications were explained to patient supplemented by written information. She was given the postpartum book for further reference.

**Advice:**

1. Tab. Taxim - O 200mg (Cefixime 200mg) twice daily till 24.06.2026 (9am-9pm) after food.
2. Tab. Calpol 500mg (Paracetamol 500mg) (2tabs) thrice daily till 22.06.2026(8am-2pm-10pm) after food.
3. Tab. Pantodac (Pantoprazole - 40mg) 1 tablet twice daily till 24.06.2026(7am-7pm) before food.
4. Tab. Voveran 50 mg (Diclofenac 50mg) thrice daily till 22.06.2026 (9am-3pm-11pm) after food.
5. Tab. Livogen (Elemental iron - 50mg, folic acid 1.5mg) once daily (7am) for three months before breakfast.
6. Tab. Shelcal (Elemental Calcium 500 mg, vitamin D3 250 IU) once daily (2pm) till breast feeding after food.
7. Betadine ointment for local application.
8. Syp. Duphalac 15 ml (Lactulose 3.33gm/5ml) at bed time for one week.
9. Tab. Glycomet 500 mg once daily after breakfast .
10. **Review with FBS and PPBS after 2 weeks**

Home Blood pressure monitoring to be done **twice daily** for **two weeks**.

<b>Name</b>	Mrs P. SHIRISHA	<b>UHID</b>	HNH-00010982
<b>IP No</b>	IP26-00006607	<b>Admission Date</b>	18-06-2026

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. SWAPNA SAMUDRALA**, after **2 weeks** weeks on **04.07.2026** at Rainbow Children's Hospital with prior appointment (**Review consultation will be charged**).

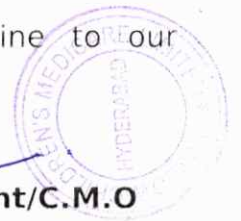
The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, when and how to obtain emergency care etc also have been explained by doctor ..... in a language that I can understand and I acknowledge.

Patient/ Attender

In case of emergency like bleeding, fever [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. SWAPNA SAMUDRALA  
MBBS, MS (OBG)  
69924

**ADMISSION SHEET**

**Registration Details :**



Admission No : IP26-00006607      Admit Date : 18-Jun-2026      Admit Time : 10:42 PM      UHID : HNH-00010982

**Patient Details :**

<b>Patient Name</b> :	Mrs P. SHIRISHA	<b>Age</b> :	28 Y 2 M 16 D
<b>Guardian</b> :	Mr RUPESH	<b>DOB</b> :	02-04-1998
<b>Gender</b> :	Female	<b>Religion</b> :	
<b>Occupation</b> :		<b>Martial Status</b> :	
<b>Address (H)</b> :	9-68/B/5 EAST HANUMAN NAGAR Boduppal Hyderabad Telangana INDIA 500092	<b>Phone No</b> :	9121828064/ 9959994454
		<b>E-mail</b> :	siripulipalunula241998@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 RUPESH      Relationship : W/O  
Contact Address : 9-68/B/5 EAST HANUMAN NAGAR Boduppal      Phone No : 9121828064  
Hyderabad Telangana INDIA 500092

*[Handwritten Signature]*  
18-06-26  
**Signature**

**Doctor Details :**

Doctor Name : Dr. SWAPNA SAMUDRALA      Specialisation : OBSTETRICS AND GYNECOLOGY  
Referral Doctor : Self.      Phone No :  
Co-Consultant :

**Payment Details :**

Payment Mode : Cash      Deposit Amount : 80000.00  
Payor Name : SELFPAY

# PATIENT TRANSFER FORM



Patient Name & UHID No. HNH-00010982 IP26-00006607 Mrs P. SHIRISHA 02-04-1998 28 Y 2 M 17 D (F) Dr. SWAPNA SAMUDRALA 		Date & Time of Admission 19/6/26 @ 10:42 pm	Date & Time of Transfer Order 19/6/26 @ 7:30 pm
		Transfer Ordered by DR. veena	Reason for Transfer observation
From Unit WPA	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 5	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Sis. Sujathe		Name of Person Ordered Transfer DR. veena	
Patient & Clinical Records Received by : Apin @ 19/6/26 7:40 pm			
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 : \_\_\_\_\_

UHID No. : \_\_\_\_\_ HNH-00010982 IP26-00006607 Consultant: \_\_\_\_\_ Dept : \_\_\_\_\_  
Mrs P. SHIRISHA

Date of Admission: \_\_\_\_\_ 02-04-1998 28 Y 2 M 16 D (F) Date of Discharge : \_\_\_\_\_ Time: \_\_\_\_\_  
Dr. SWAPNA SAMUDRALA



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

**WARD TRANSFERS**

Date	Time	From	To	Signature of Nurse
19/6	7:30pm	LDR	Room	Swalpa

**Cross Consultation Visit**

	Doctors Name	Date	Order No.	Signature
1	Dr. Tejaswee	20/6/26	7546	[Signature]
2				
3	<del>cross checked stone by Supanya</del>			
4				
5				
6				
7				
8				
9				
10				



HNH-00010982 IP26-00006607  
Mrs P. SHIRISHA  
02-04-1998 28 Y 2 M 17 D (F)  
Dr. SWAPNA SAMUDRALA



### SURGERY DETAILS

Date : 19/6/26

Patient Name: Mrs. Shirisha Date of Birth: 2-4-1998 Age: 28Y

Gender: Female Ward: LDR UHID No.: HNH-00010982

Date of Surgery:  OT-1  OT-2  OT-3  OT-4  OBG OT-1  OBG OT-2

Name of the Surgery : Normal delivery with epidural

Time in : 3:30pm

Time Out : 4:30pm

	NAME	AMOUNT
1. Surgeon	DR. Swapna Samudrala	
2. Anaesthetist		
3. Assistant Surgeon	DR. DVA	
4. OT Technician		
5. Circulating Nurse	Kasthuri	
6. Assistant Nurse	Sujatha	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 26-0000207429

Order by: Sujatha

Dr. Swapna



# ESTIMATION SLIP

Date : 17/6/26 UHID / IP No. : 11111-00010982 SI No. **1611**  
 Name of Patient : \_\_\_\_\_ Age: 28yrs Gender: F  
 Father's / Husband's Name : Mrs. P. Sridisha Corporate / Occupation: \_\_\_\_\_  
Mr. P. Puresh  
 Address : \_\_\_\_\_ Phone : 9849968565 Email : 9897234890  
 Procedure / Plan : \_\_\_\_\_ EDD/Dos: June-26  
 MODE OF PAYMENT :  SELF  TPA: LSCS  GIPSA : \_\_\_\_\_ OTHER \_\_\_\_\_

## TARIFF INFORMATION :

Particulars	Package Amounts (Rs.)	
	Normal Delivery	LSCS
Room Category		
Multi Shared Ward		
Shared Ward		
Twin Shared Ward		
Private Room →		
Super Deluxe Room →	1.45L	1.55L
Suite Room →	1.65L	1.75L
Package includes (Package starts from the time of admission)	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee and Labour Ward Charges	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee Anesthetist's Fees and OT Charges
	Length of Stay for : <u>2 Days</u>	Length of Stay for : <u>3 Days</u>
	Pharmacy up to <u>9,000/-</u>	Pharmacy up to <u>12,000/-</u>
	Investigations up to <u>2,500/-</u>	Investigations up to <u>3,000/-</u>
Others <u>1057, CBP</u>	<u>Well baby Care</u>	<u>211 to 35L</u>

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

Initial Minimum Deposit : 80% Advance time of Admission

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

### DECLARATION

I \_\_\_\_\_ 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 \_\_\_\_\_  
 Signature of the Husband \_\_\_\_\_  
 Signature of the financial Counselor \_\_\_\_\_

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Name	Mrs P. SHIRISHA	UHID	HNH-00010982
Father/Guardian	Mr RUPESH	Age/Gender	28 Y 2 M 17 D/ Female
Address	9-68/B/5 EAST HANUMAN NAGAR, Boduppal, Hyderabad, Telangana, INDIA, 500092		
IP No	IP26-00006607	Admission Date	18-06-2026
Ref Doctor	Self.		
Discharge Date	20.06.2026		

### DISCHARGE SUMMARY

#### Consultant:

Dr. SWAPNA SAMUDRALA  
MBBS, MS (OBG)  
69924

**Diagnosis:PRIMI AT 37<sup>+6</sup> WEEKS WITH GESTATIONAL DIABETES MELLITUS ON ORAL HYPOGLYCEMIC AGENTS FOR INDUCTION OF LABOUR**

**SPONTANEOUS VAGINAL DELIVERY ON 19.06.2026**

#### History:

LMP:23.09.2025  
EDD:04.04.2026  
weeks

Obstetric formula: Primigravida  
Gestation at admission: 37<sup>+6</sup>

#### Obstetric History:

G1 - Present pregnancy Spontaneous conception.

**Medical History :** Nil

**Family History :** Parents HTN + DM

**Surgical History:** Nil

**Allergies :** Nil

#### Antenatal Details:

Mrs P. SHIRISHA was booked with Dr.Swapna Samudrala at 13<sup>+2</sup>weeks of gestation. She had regular antenatal checkups and investigations as advised elsewhere.NT scan normal.FTS low risk.MTAS normal.OGTT done at 25<sup>+3</sup> weeks deranged(102/241/217).Physician opinion sought and advised to start on

1/4

Name	Mrs P. SHIRISHA	UHID	HNH-00010982
IP No	IP26-00006607	Admission Date	18-06-2026

T.Metformin 500mg twice daily.Regular home blood sugar monitoring done.At 34<sup>+5</sup> weeks OHAs titrated to T.Metformin 500mg thrice daily. Fetal surveillance done by serial growth scans. Last scan done on 11.05.2026 showed single live fetus corresponding to 36<sup>+5</sup> weeks with cephalic presentation,placenta-posterior,high with AFI-19.5cms,EFW-2915g(45%), AC-33% with normal dopplers.She was admitted at 37<sup>+6</sup> weeks for induction of labour.

**Investigations:** Enclosed  
Blood group- "B" Positive

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

At admission on clinical examination the vitals were stable, uterus was relaxed, cervix was 3cm dilated and partially effaced. Fetal well being was confirmed by an admission CTG which was found to be reactive. Informed consent taken for Induction of labour. Labour induced with 2 doses of PGE1. Artificial rupture of membranes done at 3 cms dilatation revealing clear liquor. As per hospital protocol she was started on IV. Taxim in view of ruptured membranes. Partographic monitoring of labour was done. Patient opted for epidural analgesia at 3cms dilatation for pain relief. The same was sited by an anesthetist after informed consent. Further augmentation was done by oxytocin infusion. She progressed to full dilatation. Passive descent of fetal head was allowed for 25mins post full dilatation. She was put into position for vaginal birth at 3:45pm. Parts painted with betadine solution and draped to ensure full asepsis. She was encouraged to bear down. At crowning of head episiotomy was given under local anaesthesia (10 ml of 2 % xylocaine solution). Baby was delivered by spontaneous vaginal delivery, Cord clamped and cut and baby handed over to pediatrician. Cord blood collected for blood grouping and Rh typing. Placenta and membranes delivered completely with controlled cord traction. Prophylactic syntocinon given. Episiotomy inspected. No extensions or additional vaginal tears found. Episiotomy sutured in layers. Instrument and swab count checked. 600 mcg of misoprostol given per rectally as prophylaxis against post partum hemorrhage. Vagina cleaned with betadine solution.

**Delivery Details:**

Date : 19.06.2026  
Time of Delivery: 3:56PM  
Type of Labour : Induced  
Type of Delivery: Spontaneous  
Analgesia : Epidural  
Indication : GDM on OHA

**Baby Details:**

<b>Name</b>	Mrs P. SHIRISHA	<b>UHID</b>	HNH-00010982
<b>IP No</b>	IP26-00006607	<b>Admission Date</b>	18-06-2026

Date : 19.06.2026  
Time : 3:56PM  
Sex : Male  
Weight : 3.140grams  
Apgar : 7,8  
Gestational Age: 37<sup>+6</sup> weeks  
NICU Admission: Yes

**Post-Partum Notes:** She was closely monitored for post partum hemorrhage. Breast feeding initiated. Vitals were stable; patient ambulated and was shifted to room. Patient was encouraged for spontaneous voiding. Dietary advice given. Her postpartum period following that was uneventful. On first postpartum day episiotomy wound was healthy and intact. On first post natal day, FBS/PPBS 100/188 mg/dl .Physician opinion sought and advised to start on T.Metformin 500mg OD.Her general condition was satisfactory and she was found to be fit for discharge. Wound care and medications were explained to patient supplemented by written information. She was given the postpartum book for further reference.

**Advice:**

1. Tab. Taxim - O 200mg (Cefixime 200mg) twice daily till 24.06.2026 (9am-9pm) after food.
2. Tab. Calpol 500mg (Paracetamol 500mg) (2tabs) thrice daily till 22.06.2026(8am-2pm-10pm) after food.
3. Tab. Pantodac (Pantoprazole - 40mg) 1 tablet twice daily till 24.06.2026(7am-7pm) before food.
4. Tab. Voveran 50 mg (Diclofenac 50mg) thrice daily till 22.06.2026 (9am-3pm-11pm) after food.
5. Tab. Livogen (Elemental iron - 50mg, folic acid 1.5mg) once daily (7am) for three months before breakfast.
6. Tab. Shelcal (Elemental Calcium 500 mg, vitamin D3 250 IU) once daily (2pm) till breast feeding after food.
7. Betadine ointment for local application.
8. Syp. Duphalac 15 ml (Lactulose 3.33gm/5ml) at bed time for one week.
9. Tab. Glycomet 500 mg once daily after breakfast .
10. **Review with FBS and PPBS after 2 weeks**

Home Blood pressure monitoring to be done **twice daily** for **two weeks**.

Name	Mrs P. SHIRISHA	UHID	HNH-00010982
IP No	IP26-00006607	Admission Date	18-06-2026

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. SWAPNA SAMUDRALA**, after **2 weeks** weeks on **04.07.2026** at Rainbow Children's Hospital with prior appointment (**Review consultation will be charged**).

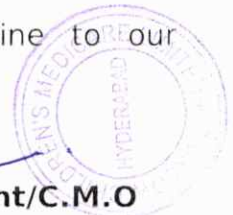
The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, when and how to obtain emergency care etc also have been explained by doctor ..... in a language that I can understand and I acknowledge.

Patient/ Attender

In case of emergency like bleeding, fever [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. SWAPNA SAMUDRALA  
MBBS, MS (OBG)  
69924

**ADMISSION SHEET**

**Registration Details :**



**Admission No** : IP26-00006607      **Admit Date** : 18-Jun-2026      **Admit Time** : 10:42 PM      **UHID** : HNH-00010982

**Patient Details :**

<b>Patient Name</b> : Mrs P. SHIRISHA	<b>Age</b> : 28 Y 2 M 16 D
<b>Guardian</b> : Mr RUPESH	<b>DOB</b> : 02-04-1998
<b>Gender</b> : Female	<b>Religion</b> :
<b>Occupation</b> :	<b>Martial Status</b> :
<b>Address (H)</b> : 9-68/B/5 EAST HANUMAN NAGAR Boduppall Hyderabad Telangana INDIA 500092	<b>Phone No</b> : 9121828064/ 9959994454
	<b>E-mail</b> : siripulipalunula241998@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 RUPESH      **Relationship** : W/O  
**Contact Address** : 9-68/B/5 EAST HANUMAN NAGAR Boduppall  
Hyderabad Telangana INDIA 500092      **Phone No** : 9121828064

*[Handwritten Signature]*  
18-06-26

**Signature**

**Doctor Details :**


**Doctor Name** : Dr. SWAPNA SAMUDRALA      **Specialisation** : OBSTETRICS AND GYNECOLOGY  
**Referral Doctor** : Self.      **Phone No** :  
**Co-Consultant** :

**Payment Details :**

**Payment Mode** : Cash      **Deposit Amount** : 80000.00  
**Payor Name** : SELFPAY

# PATIENT TRANSFER FORM



Patient Name & UHID No. HNH-00010982      IP26-00006607 Mrs P. SHIRISHA 02-04-1998      28 Y 2 M 17 D (F) Dr. SWAPNA SAMUDRALA 		Date & Time of Admission 19/6/26 @ 10:42 PM	Date & Time of Transfer Order 19/6/26 @ 7:30 PM
		Transfer Ordered by DR. Veeena	Reason for Transfer observation
From Unit WPA	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 5	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.	⊙    D		
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor :    Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Sis. Sujathe		Name of Person Ordered Transfer DR. Veeena	
Patient & Clinical Records Received by : Apin @ 19/6/26 7:40 PM			
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 : \_\_\_\_\_

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

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

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

HNH-00010082 IP26-00006607  
Mrs P. SHIRISHA  
02-04-1998 28 Y 2 M 16 D (F)  
Dr. SWAPNA SAMUDRALA



### WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
19/6	7:30pm	LDR	Room	Swialha

### Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Tejaswi	20/6/20	7546	
2				
3	<del>cross checked done by Supriya</del>			
4				
5				
6				
7				
8				
9				
10				









# IP ADMISSION SHEET FOR OBSTETRICS

**Presenting Complaints**

Came here safe confinement

LMP: 23/9/2025 EDD: 4/07/2026  
 Corrected EDD: 4/7/2026 GA: 37w 5days

**Obstetric Formula:**

Primigravida

ML: 2 Sys Menstrual History: Regular:  Yes  No

**Obstetric History:**

1st: PP, Sport. Conception

**Obstetric Examination**

Fundal Height: Term

**Present Pregnancy Record:**

NT - (N) FTS - low risk  
 T1PPA - (N)  
 Fetal 2D echo - WNL

Ut. Activity:  Relaxed  Mild  Mod  Severe

Liquor:  Adequate  Oligo  Poly

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

Head Fifths Palpable: 4/5<sup>th</sup>

**RISK FACTORS:**

FHS:  Normal  Tachy  Brady  Absent

O&TT @ 25w 2day - 16/2/24/1/2/17  
 diagnosed = GDM & on OHA @ 26wks

**Per Speculum Examination** *not done*

Draining:  Present  Absent  Bleeding

Colour of Liquor:  Clear  Meconium  Blood Stained

**Vaginal Examination**

Cervix:  Long  Partially effaced  Effaced

Os: Closed \_\_\_\_\_ Dilated 3cm

Membranes:  Present  Absent

Liquor:  Clear  Meconium  Blood Stained

Presenting Part:  Vertex  Breech  Others

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

Pelvis:  Adequate  Doubtful

Height: 158 cm

Weight: 76 kg

Allergies: \_\_\_\_\_

Breast:  Normal  Abnormal

**General Examination:**

Consciousness: clc Pallor: -ve

Icterus: No Edema: -ve

Temp: Afebrile PR: 98bpm

BP: 112/60mmHg DTR: (N)

CVS: S2 (+) normal murmur RS: B/L LUBS (+)

Liver/Spleen: (N) Urine Output: Adequate

**DIAGNOSIS**

Primigravida with 37w 5days POG with GDM on OHA for IOL



<p>History: Parents - HTN + T2DM  <del>Med</del></p>	<p>Surgical History:          Nil.</p>
<p>Medical History:          Nil.</p>	<p>Medication History:          T-IRON          T-CALCIUM          T-GLYCOMET 500mg TID</p>
<p>Plan of Care:          Admission NST          Pains preparation          Informed Consent          POL to T-miscprostil 25mg          Start FHR monitoring 4th hrly          NST 4th hrly          w/f POL / PV leak / PV bleeding          Monitor Vitals          Infirm SOS.</p>	<p>Investigations: <u>BGT : 'B' Positive.</u>  <u>CBP (18/6/2026)</u>          Hb - 11.9          plt - 1.57          TLC - 10.22          PCV - 34.3          HIV          HbsAg          HCV          VDRL } MR.  <u>USG (11/06/2026)</u>          SCIPUF 36w Scleros          Cephalic          AFI - 19.5cm          placenta - fundopost high.          EFW - 2915gm (45%)          AC - 33%          Dopplers - (N)</p>

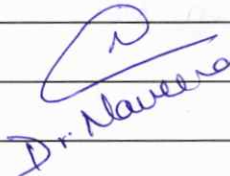
Doctor Name: Dr. Naveena  
 Signature:   
 Date & Time: 18/6/2026 @ 11:00pm

Consultant Name: Dr. Swapna S.  
 Signature:   
 Date & Time: 18/6/2026 @ 10:30am

Dr. Swapna S. Samudrala  
 Consultant Obstetric  
 Reg. No.



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/06/2026 12:00am	cls/by	Dr Naveena
	<p>ole GC-fair            Alebnile.            Vitals-stable            PA: ut-term size            Relaxed            FHR(+)            PV: Gx 3cm.            40-50% effaced            Vrat - 2 station.            membranes present</p>	<p>Ado            - Soft diet            - Adequate hydration.            - wlf. PCL            - strict FHR monitoring            2holy            - NST. 4th holy.            - wlf PV. bleedings            PCL leak            - drugs as charted            - Monitor Vitals            - Inform SCS</p>
	 Dr. Naveena	
19/06/2026 6:00am	cls/by	Dr. Naveena
	<p>ole GC-fair            Alebnile            Vitals-stable            PA: ut-term size            Relaxed            FHR(+)            PV: Gx 3-4cm            50-60% effaced            Vrat - 2 station            mem present</p>	<p>Ado            - Early breakfast P/b            liquid diet            - Adequate hydration            - drugs as charted            - Ambulation            - T. Misoprostol 25mcg PV.            P/b 25mcg PO @ 10am.            - wlf PCL/PV leak (P.T.O) PV bleed            - monitor Vitals/ Inform SCS</p>

  
 Dr. Naveena

HNH-00010982  
 Mrs P. SHIRISHA  
 02-04-1998 28 Y 2 M 16 D (F)  
 Dr. SWAPNA SAMUDRALA

IP26-00006607



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/6/2026	C/S/B Dr. Dwa	
9:30 AM	Preni is 37 <sup>+6</sup> wk. c/DM on OHA. ↓ SOL.	
	c/o Low back ache	
	p <sup>o</sup> PET.	Adv
	AC Fair	- Liquid diet
	Afebrile	- Adequate hydration
	vitals. (N)	- Drugs as charted
	P/A = uterus + G.	- Ambulation
	cephalic	Monitor vitals
NST-Reactive.	FHR (N)	Infuse ser
	1-2   10-15 sec / 10.	and doc
	Head 3/5 palpable	T. Misoprostol 25mcg
	P/V - ca. 60% effaced	PO @ 10A
	os - 3cm (N)	
	PPMx	- WFPOL
	-2 ↓ -1	PR



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/6/2026	C/S/B. Dr. Swapna.	
11:00 AM	Primigravida / 37 <sup>th</sup> wks / GDM on OHA / clo mild pains, FM (+) G/A - Pt (9:40 AM)	Oxytocin 100 / Po @ 10:10 AM
	O/E - Gc spec uterine O <sub>2</sub> sat - 99 L RA Vitals - @ PR - 80 bpm B.P - 100/60 mmHg F/H - uterine activity 1-2 / 15-20 / 10' Ceph 2, HR - good VLS - Ex 3 cm, 90% Vx - 2. memb (+) ABM - lig clear	Adv - Digoxin 1 gm IV Stat (AHS) - IV + Oral hydralazine - Oxy as charted - C/S 3 <sup>rd</sup> luly - W/F prep - HR monitoring - Epidural 80 - Short Synto @ 12:10 pm - Oxy 100
		Dr. Swapna Samudrala Consultant Obstetrics and Gynecology Reg. No: 69924 (A. Samudrala)

## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/6/2026 1:40pm	C/S/B Dr. Swapna	
	Ac Fev, Afebrile vitals ⊕	Adv
	P/A uterine acting cephalic FHS ⊕	- RILP. - FHRM.
NSI-Reactive	2-3/20/10	- IV + oral hydration. - CTG 3rd hourly
	V/E ca 80-1 efface 4-cm ME drainy clear liquor PR <sup>2</sup> PS <sup>1</sup> -2-1 Δ	- WFPOL - Inj Syntocinon in 100 RL titrate accordingly
19/6/26	PND - 0 (P, L, S)	
11:30pm	No comp OIB - Ac Fev afebrile	vitals
Baby - well	O <sub>2</sub> sat - 99% RA PR - 102 bpm	- Papuan Diet - Oral hydration
Baby ⊕	B.P - 115/69 mmHg	- Drugs as charted
Baby ⊕	P/A - uterine contracting	- monitor vitals
Baby ⊕	ME - MATS	- w/f excessive PR bleeding
17:30/17:38 on 20/6/20		Dr. Swapna Consultant Obstet. Reg. .... Dr. Swapna



**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
<u>19/6/26</u>		C/S/B Dr. Veena
Ipm	PND-0/P.L.U	
	Pt is stable, Noct o/e GC fair BP- 112/67wally PR- 88bpm SpO <sub>2</sub> - 98% on RA. P/A - Ut well retracted P/U - Episiotomy intact Bleeding wNL.	Adv - Soft diet - Drugs as charted - Adequate hydration - Encourage to void - w/f excessive bleeding Plu - Base Shift to Room - FBS/PPBS c/m.
Foley's removed @ 6:30pm		N/B Supriya @ 7pm (Signature)
<u>20/6/26</u>		C/S/B Dr. Veena
8Am	PND-0/P.L.U	
U/S SX.	c/o pain in lower back. o/e GC fair &afebrile Vitals - stable Billos (-)	Adv - Regular diet - Drugs as charted - Adequate hydration - PPBS to Follow-up - w/f excessive bleeding Plu - Ambulation - Perform S/Ds
Baby @ wico	P/A - Ut well retracted BS (+)	
FBS - 100mg/dl	L/E - BwNL P/U - Episiotomy intact	(Signature)



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/6/26	C/S/B Dr. Dwa	
12pm	PND-1 (P/L) GDM	
	c/o pain over buttocks	
	GC Fair	Adv
Baby @ NICU.	afebrile	- Regular diet
	BP: 114/73 mmHg	- Oral Antibiotics
U ✓	PR: 50 bpm.	- Drugs as charted
F ✓	SpO <sub>2</sub> : 99% on RA.	- Adequate hydration.
	P/A ulcers retracted	- Ambulation.
	well	w/f excessive bleeding PV
FBS - 100 mg/dl	L/E - NAB.	- Monitor vitals
PPBS - 188 mg/dl		
	On call. Physician opinion	
	taken i/v/o ↑ PPBS.	
	Adv - Tab Glycomet 500mg OD	A can be discharged
		N/A - Supine
		1pm @ 20/6/26

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IP26-00006607

Mrs P. SHIRISHA

28 Y 2 M 18 D (F)

02-04-1998

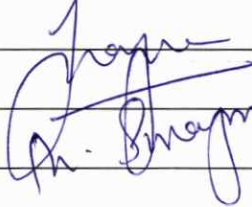
Dr. SWAPNA SAMUDRALA



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

BirthRight  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

### PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/6/26 2pm	C/S/B Dr. Swapna  PND-1 P <sub>1</sub> L <sub>4</sub> = CDM.	
Baby @ NICU  U ✓ F ✓ Sx.	Cic Face - Afebrile BP: 118 / 70 mmHg. PR: 86 / min SpO2: 97% on RA P/A Uterus retracted well L/E NAB.	<div style="border: 1px solid black; padding: 5px;"> <del>Adv</del>  <del>- Regular diet</del>  <del>- Drugs as charted</del>  <del>- Adequate hydration</del>  <del>- Ambulation</del>  <del>- w/f excessive PV bleed</del>  <del>- Monitor vitals</del>  <del>- Infection</del> </div>
Can be discharged on 21/6/26 20/6/26 2pm		<p style="text-align: right;">   An. Srinivas </p>
		<p style="text-align: right;"> N/B - Supriya  2:05pm @ 20/6/26 </p>



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 Mrs P. SHIRISHA  
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 Dr. SWAPNA SAMUDRALA



## RESULT SHEET

Date	(TP) 18/6/26				
Time					
Hb	11.9				
PCV	34.3				
RBC	4.24				
WBC	10.22				
N/L	60.6/32.1				
Platelets	1.57				
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 P. SHIRISHA 28 Y 2 M 16 D (F)  
02-04-1998  
Dr. SWAPNA SAMUDRALA



# MEDICATION RECONCILIATION FORM

Drug Allergies: Nil  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	T-IRON	1TAB	PO	OD	18/6	<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
2	T-CALCIUM	1TAB	PO	DD	18/6	<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
3	T-METFORMIN	500mg	PO	TID	18/6	<input type="checkbox"/> C <input checked="" 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. Naveena @

Date & Time: 18/6/2026 @ 11:00pm

Nurse Name & Signature: Anhe D

Date & Time: 18/6/26 @ 11PM

HNH-00010982  
 Mrs P. SHIRISHA  
 02-04-1998  
 Dr. SWAPNA SAMUDRALA  
 28 Y 2 M 16 D (F)  
 IP26-00006607



# DRUG CHART

Date of Admission: 18/6/26 Drug Allergies: .....  Not known any Drug Allergies

## FOR THE SAFETY OF THE PATIENT

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

## SOS / PRN (As Required Medication)

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

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

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

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



REGULAR PRESCRIPTIONS

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

**DRUG:** Inj TRANEXAMIC ACID

Date/Time: 19/6/2016

Dose: 1g Route: IV Frequency: BD Start Date: 19/6

Name & Signature of the Doctor Starting the Drugs: Dr. Dna [Signature]

Additional Instructions: 2nd dose after shower

Daily Doctor's Endorsement by a Sign

6pm Inj medicine

STOP 20/6/2016

**DRUG:** Inj CEFOTAXIME

Date/Time: 19/6

Dose: 1g Route: IV Frequency: BD Start Date: 19/6

Name & Signature of the Doctor Starting the Drugs: Dr. Dna [Signature]

Additional Instructions: 1 dose / 16 oral

Daily Doctor's Endorsement by a Sign

10AM ✓

STOP 20/6/2016

**DRUG:** T. PARALLETAMOL

Date/Time: 19/6/2016

Dose: 1g Route: PO Frequency: TID Start Date: 19/6

Name & Signature of the Doctor Starting the Drugs: Dr. Dna [Signature]

Additional Instructions:

Daily Doctor's Endorsement by a Sign

7AM x

3pm x

11pm

**DRUG:** Tab PANTOPRAZOLE

Date/Time: 20/6

Dose: 40mg Route: PO Frequency: OD Start Date: 19/6

Name & Signature of the Doctor Starting the Drugs: Dr. Dna [Signature]

Additional Instructions:

Daily Doctor's Endorsement by a Sign

5AM

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 Mrs P. SHIRISHA 28 Y 2 M 16 D (F)  
 02-04-1998  
 Dr. SWAPNA SAMUDRALA



Sheet

**REGULAR PRESCRIPTIONS**

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

<b>DRUG :</b> T. DICLOFENAC				Date Time	19/6/2016																		
Dose	Route	Frequency	Start Dt.																				
50mg	P/O	BD	19/6/26	7AM	x																		
Name & Signature of the Doctor Starting the Drugs:				[Signature]																			
Additional Instructions:				7pm ✓																			
<b>Daily Doctor's Endorsement by a Sign</b>																							
<b>DRUG :</b> SXP-DUHPAEC				Date Time	19/6																		
Dose	Route	Frequency	Start Dt.																				
10ml	P/O	OD	19/6/26																				
Name & Signature of the Doctor Starting the Drugs:				[Signature]																			
Additional Instructions:				Bedtime																			
<b>Daily Doctor's Endorsement by a Sign</b>																							
<b>DRUG :</b> OINT. POU IDONE. IODINE				Date Time	19/6	20/6																	
Dose	Route	Frequency	Start Dt.																				
1g	L/A	BD	19/6/26	6AM																			
Name & Signature of the Doctor Starting the Drugs:				[Signature]																			
Additional Instructions:				6pm 10pm [Signature]																			
<b>Daily Doctor's Endorsement by a Sign</b>																							
<b>DRUG :</b> T. TRAMADOL				Date Time	19/6	20/6																	
Dose	Route	Frequency	Start Dt.																				
100mg	P/O	BD	19/6/26	10AM	x																		
Name & Signature of the Doctor Starting the Drugs:				[Signature]																			
Additional Instructions:				10pm [Signature]																			
<b>Daily Doctor's Endorsement by a Sign</b>																							

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

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 Mrs P. SHIRISHA  
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 Dr. SWAPNA SAMUDRALA



Sheet No: .....

### REGULAR PRESCRIPTIONS

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

<b>DRUG :</b> T. CEFEXIME				Date Time																
Dose	Route	Frequency	Start Dt.																	
200mg	P/O	BD	20/6/25	10AM																
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

<b>DRUG :</b> T. METFORMIN HYDROCHLORIDE				Date Time																	
Dose	Route	Frequency	Start Dt.																		
500mg	PO	OD	20/6	1PM																	
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					

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

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

Signature  
VERIFIED BY : Name

HNH-00010982 IP26-00006607  
 Mrs P. SHIRISHA  
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 Dr. SWAPNA SAMUDRALA

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



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
19/6	6am	T.MISO PROSTOL	25mcg	PV	@	Archana
19/6	8:45am	PROCTOGLYSIS ENEMA	1 PACK	PR	@	Chand
19/6	10am	T.MISO PROSTOL	25mcg	PO	@	Alakh
19/6	10:40am	Inj CEFOTAXIM	1g	IV	HL	Chand
19/6	11:50am	Inj HYOSCINE BUTYLBROMIDE	20mg	IV	HL	Alakh
19/6	12pm	Inj DROPERIDONE	4mg	IV	HL	Alakh
19/6	2:15pm	Inj HYOSCINE BUTYLBROMIDE	20mg	IV	HL	Chand
19/6	4pm	Inj OXYTOCIN	10 unit	IM	HL	Sujatha Kasthuri
19/6	4pm	MISO PROSTOL	600 mcg	P/R	HL	Sujatha Kasthuri

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

Verified by





# PARTOGRAPH

## LABOUR

Labour:  Spont  IOL-PGE 1  E2  Others

Indications for IOL-Accel:  None  Oxytocin

Memb. Repture Type:  SRM  PROM  ARM

Presentation:  Vertex  Breech  Others

## INTRA PARTUM COMPLICATION

Maternal:  None  Pyrexia  HTN  Others

Liquor:  Adequate  Oligo  Poly  Clear

Blood  Meconium  Cord: ..... Cord loop

Shoulder Dystocia:  Yes  No

## DELIVERY DETAILS

Anesthesia:  None  Epidural

Non-epi:  Local  Spinal  General

Del. Type:  SVD  Asst. Breech  Twins

AVD:  Outlet  Low Forceps  Ventouse  
 Trails of Forceps

Indications: .....

Application, Locking & Traction: .....

Duration of Instrumentation: .....

No. of Pulls: .....

Catherised:  Yes  No

Type:  Fileys  Plain

Perineum:  Intact  Episiotomy  Tear

Suture Material Used: Rapid Vicryl 2/0

## STAGE III

Placenta:  Normal  Abnormal  RP Clots

CCT  Retained  MRP

PPH:  Atomic  Traumatic  None

Lacerations: .....

Cervical: .....

Perineal: .....

Others: .....

Prophylaxis:  Synocinon  Prostin

Blood Loss: ~ 300 ml

Blood Transfusion: Nil

Other Details (if any): Cord & needle count

Ractal Examination: Peranal mass observed without

## DURATION OF LABOUR

1st Stage: .....

2nd Stage: 26 mins

3rd Stage: 5 min

Duration of Active Pushing: 15 mins

No. of VE'S: 3-4

## BABY DETAILS

Gender: MALE

Weight: 3.140 kg

APGAR: 2, 8

Date and Time of Delivery: 3:56 pm

LW Doctor: Dr. Srinivas / Dr. Dhe

LW Sister: In theatre



PARTOGRAPH

Name: Mrs. Sivisha

Obstetrics Formula: P<sub>1</sub>M<sub>1</sub>

Blood Group Type: B+ve

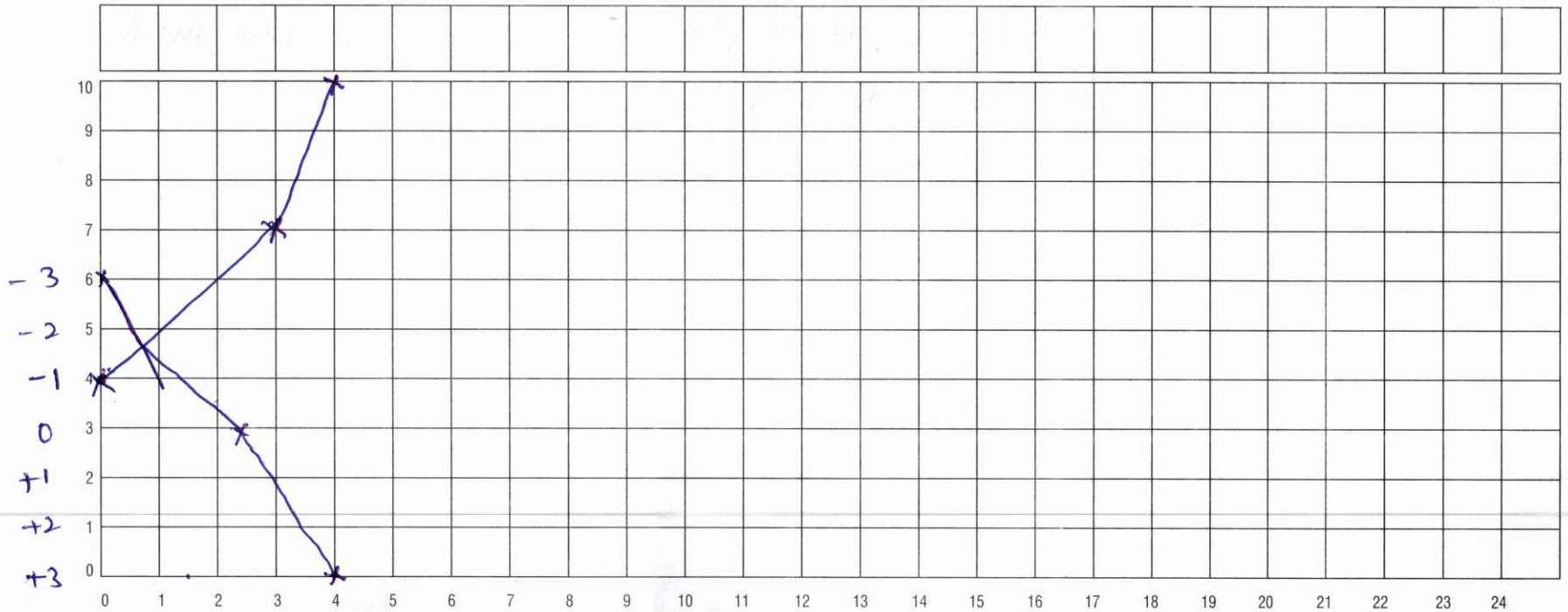
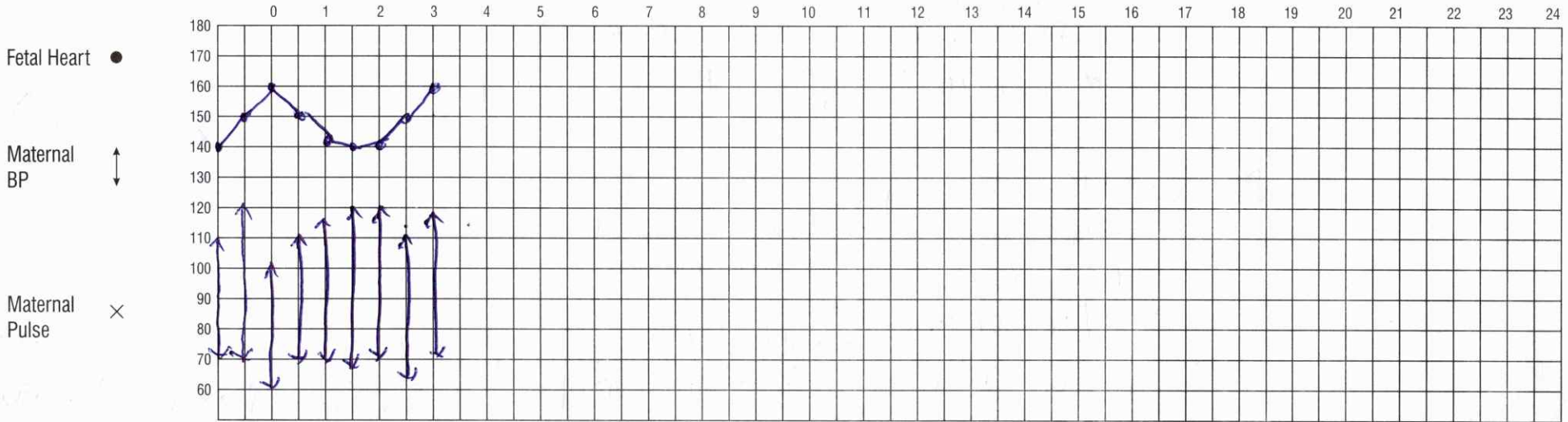
Memb. Ruptured:

SROM

PROM

ARM

Risk Factors:



1:45pm 3p. 3  
2:45

On Synto @ 32 ml/hr.

Christy D. Swagman

**Record of Labor:**

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

P/A ut = +G; active  
cephalic  
FNS ⊕ Good  
2-3/20/10

P/v ca 80% effaced  
4-5 cm M ⊕  
deamy clear hv  
ppx  
2 ↓ + A

Time: 1:45 pm Signature: \_\_\_\_\_

Christy D. Swagman

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

P/A ut = +G active  
cephalic  
FNS ⊕ Good  
3-4/20-30/10

P/v ca. 80% effaced  
5-6-7 cm M ⊕  
deamy clear hv  
ppx  
2 ↓ + A

Time: 3:10 pm Signature: \_\_\_\_\_

Christy D. Swagman

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

P/v - ut active, 3-4/25-30"/10'  
Ceph. FHR - good  
V/E - ca fully dilated  
Vx + ⊕ 85%

Adv  
- Allow passive Descent  
- FHR monitoring  
Signature: \_\_\_\_\_  
Christy D. Swagman

Time: 3:30 pm Signature: \_\_\_\_\_

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

Time: \_\_\_\_\_ Signature: \_\_\_\_\_

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

Time: \_\_\_\_\_ Signature: \_\_\_\_\_



# OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 18/6/2026

**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: *DOZ* Doctor Notified on Admission:  Yes  No  
Name of the Doctor: *Dr. Naveena*  
Time Notified: *10:30 AM*

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<i>-</i>	<i>-</i>	<i>-</i>

<b>Gynecology Assessment:</b> <input type="checkbox"/> Not Applicable Menstrual History: ..... Onset of Menarche: <i>regular</i> Menstrual Cycle: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular Last Menstrual Period: <i>23/9/2025</i>	<b>Gynecology Surgical History:</b> Caesarean Section: <input type="checkbox"/> No <input type="checkbox"/> Yes Cervical Cerclage: <input type="checkbox"/> No <input type="checkbox"/> Yes Ectopic Pregnancy: <input type="checkbox"/> No <input type="checkbox"/> Yes Myomectomy: <input type="checkbox"/> No <input type="checkbox"/> Yes Others: .....	<b>Gynecological History:</b> Contraceptives: <input type="checkbox"/> No <input type="checkbox"/> Yes Vaginal Discharge: <input type="checkbox"/> No <input type="checkbox"/> Yes Post-Coital Bleeding: <input type="checkbox"/> No <input type="checkbox"/> Yes <b>Infertility:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <b>If Yes Type:</b> <input type="checkbox"/> Primary <input type="checkbox"/> Secondary
--	---	---

Obstetric History: G *1* P *0* L *0* A *0*

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: *98.2* HR: *79* RR: *20*  
BP: *113/81* Weight: *76* Height: *158* 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 .....

**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. Shirisha .....  
Orientation not given Reason: .....

Nurse Signature: .....  
Nurse Name: .....  
Date & Time: ..... 18/06/2016

HNH-00010982 IP26-00006607  
 Mrs P. SHIRISHA  
 02-04-1998 28 Y 2 M 16 D (F)  
 Dr. SWAPNA SAMUDRALA



## 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 <sub>2</sub> (L/min.)																											
Temp <sup>o</sup> 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																											

18/6/26

10 2 6

20 20 20  
99 99 99

90 84 87

113 105 116

81 70 72

0 0 0

18/6/2026

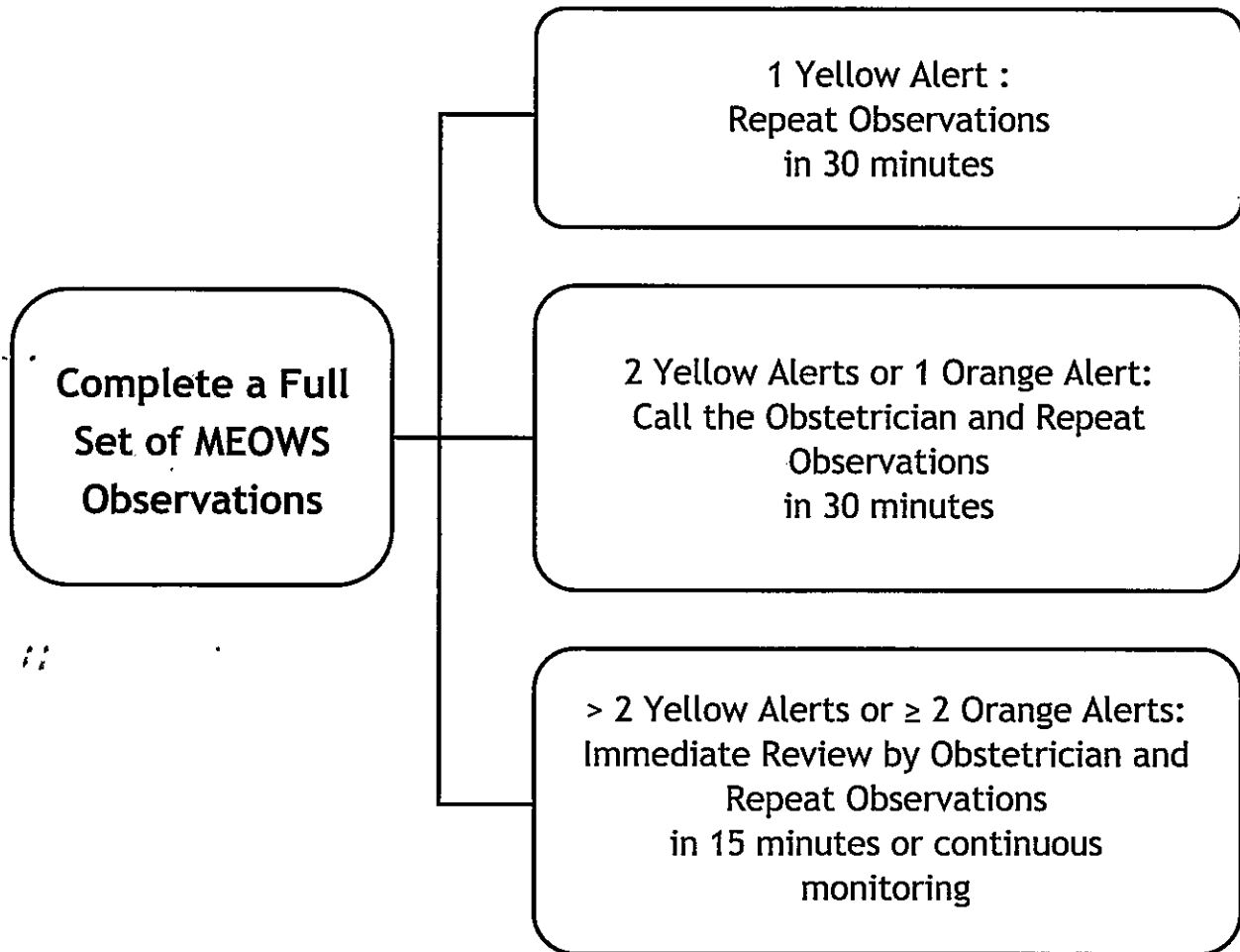
11pm  $\Rightarrow$  145 count

19/6/26  
9am  $\Rightarrow$  149 count

3am  $\Rightarrow$  160 count

6am  $\Rightarrow$  150 count

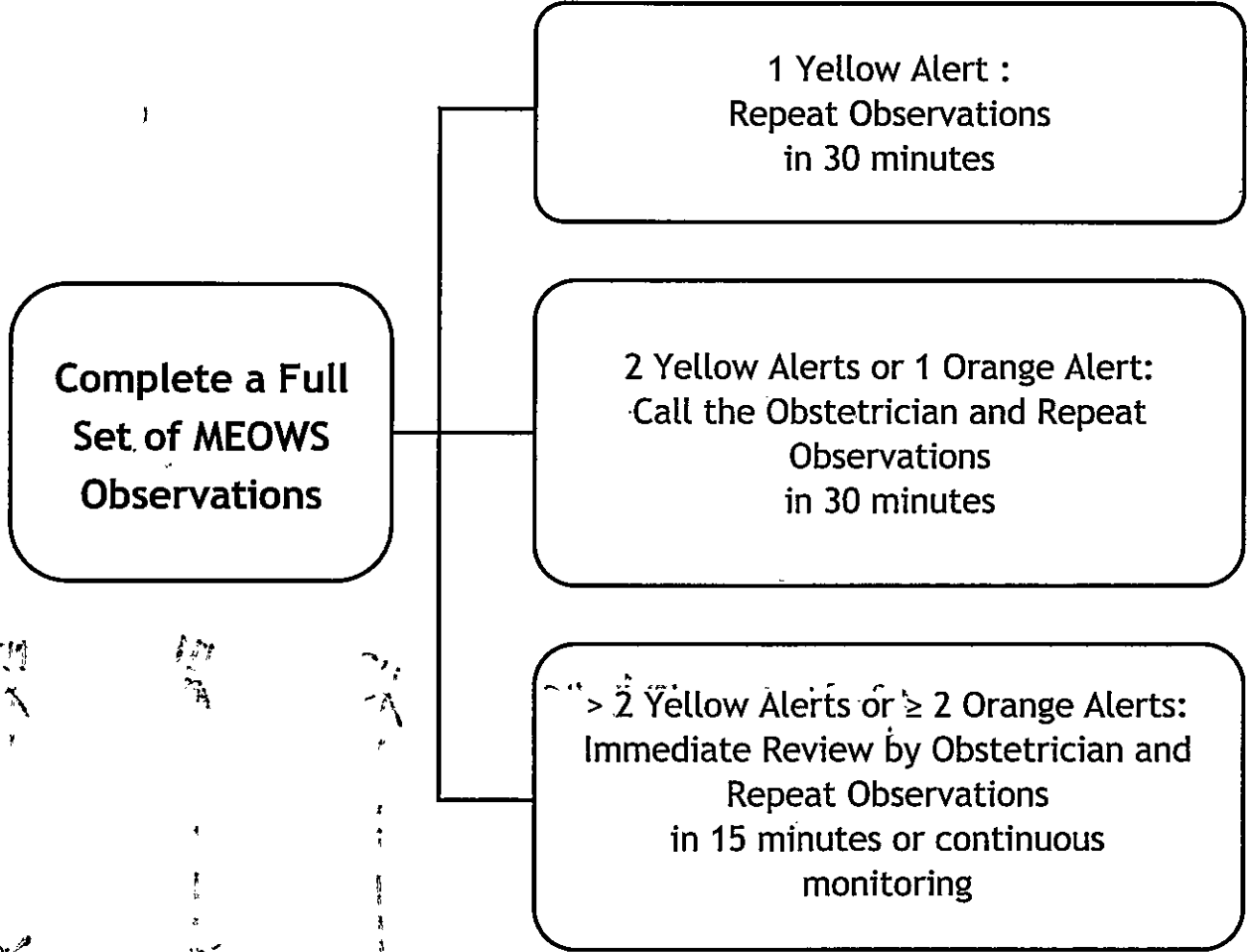
**Obstetrics and Gynaecology**  
**Early Warning Signs**



\* The Modified Early Warning Score (MEOWS)



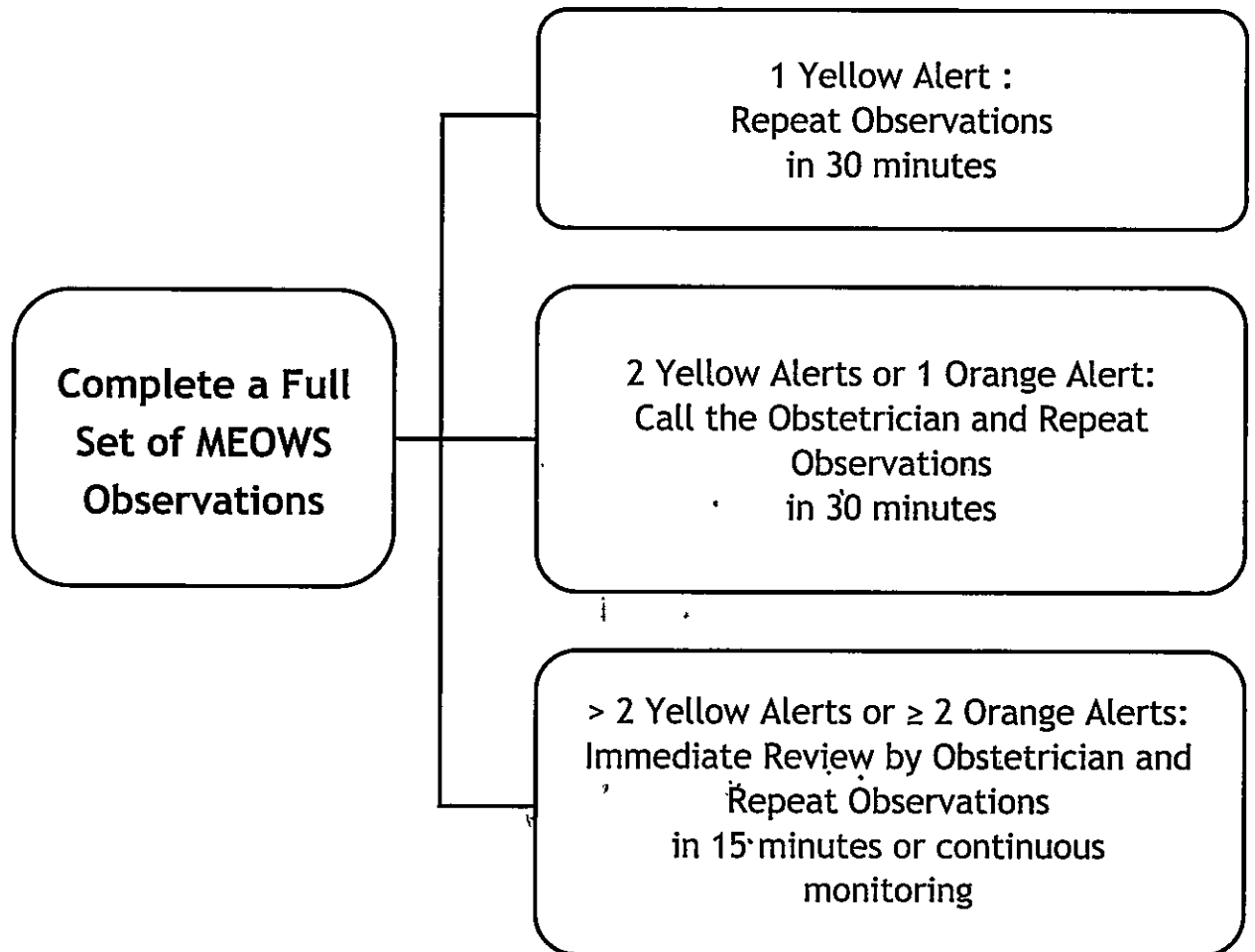
**Obstetrics and Gynaecology  
Early Warning Signs**



\* The Modified Early Warning Score (MEOWS)



## Obstetrics and Gynaecology Early Warning Signs



\* The Modified Early Warning Score (MEOWS)

HNH-00010982 IP26-00006607  
 Mrs P. SHIRISHA 28 Y 2 M 16 D (F)  
 02-04-1998  
 Dr. SWAPNA SAMUDRALA



# 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													
<b>Total Intake :</b>						<b>Total Output :</b>								
	02:00 pm													
	03:00 pm													
	04:00 pm													
	05:00 pm													
	06:00 pm													
	07:00 pm													
<b>Total Intake :</b>						<b>Total Output :</b>								
	08:00 pm													
	09:00 pm													
	10:00 pm													
	11:00 pm													
	12:00 am													
	01:00 am													
<b>Total Intake :</b> <i>taken</i>						<b>Total Output :</b> <i>passed</i>								
	02:00 am													
	03:00 am													
	04:00 am													
	05:00 am													
	06:00 am													
	07:00 am													
<b>Total Intake :</b> <i>Taken</i>						<b>Total Output :</b> <i>passed</i>								
<b>Total 24 hrs. Intake</b>						<b>Total 24 hrs. Output</b>								

HNH-00010082 IP26-00006607

Mrs P. SHIRISHA

02-04-1998

28 Y 2 M 17 D

(F)

Dr. SWAPNA SAMUDRALA



# 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	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse		
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage			Urine	
			Mouth	I.V	N.G								
18/6/26	08:00 am	H <sub>2</sub> O											
	09:00 am	H <sub>2</sub> O											
	10:00 am												
	11:00 am	RL	H <sub>2</sub> O	FF									
	12:00 pm	RL		100ml						✓			
	01:00 pm	RL		100ml									
<b>Total Intake :</b>			taken			<b>Total Output :</b>						passed	
19/6/26	02:00 pm	RL		60ml									
	03:00 pm	RL	H <sub>2</sub> O	100ml									
	04:00 pm	RL		100ml						500ml			
	05:00 pm	RL	H <sub>2</sub> O	100ml									
	06:00 pm	RL		100ml									
	07:00 pm	RL											
<b>Total Intake :</b>			taken			<b>Total Output :</b>							
19/6/26	08:00 pm												
	09:00 pm												
	10:00 pm	0	Idly	0									
	11:00 pm		H <sub>2</sub> O							✓	0		
	12:00 am												
	01:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>						U I R	
20/6/26	02:00 am												
	03:00 am												
	04:00 am	6											
	05:00 am			6									
	06:00 am												
	07:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>						U R	

**Total 24 hrs. Intake**

**Total 24 hrs. Output**



# 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			
20/6/20	08:00 am	↓											
	09:00 am	↓	Jelly							✓		00	
	10:00 am	↓	Jelly									00	
	11:00 am	↓	Jelly									00	
	12:00 pm	↓										00	
	01:00 pm	↓										00	
<b>Total Intake :</b>			Taken			<b>Total Output :</b>							
20/6/20	02:00 pm	↓											
	03:00 pm	↓	Jelly										
	04:00 pm	↓	Jelly										
	05:00 pm	↓											
	06:00 pm	↓											
	07:00 pm	↓											
<b>Total Intake :</b>			Taken			<b>Total Output :</b>							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							

**Total 24 hrs. Intake**

**Total 24 hrs. Output**

Patient Sticker



# FLUID CHART

Sheet No. : .....

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

Date	Time	Intake				Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
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<b>Total Intake :</b>						<b>Total Output :</b>							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							
<b>Total 24 hrs. Intake</b>													
<b>Total 24 hrs. Output</b>													

HNH-00010982 IP26-00006607  
 Mrs P. SHIRISHA 28 Y 2 M 16 D (F)  
 02-04-1998  
 Dr. SWAPNA SAMUDRALA

# NURSING CARE RECORD



Date: 18/6/2020

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning				NA			
Afternoon		✓					
Night	8pm	→ Assess the pt condition → Check the vital's → Go chart Mantue → plan NST	8pm	→ Assessed pt condition → checked vital's → Mantue go chart → Admission NST done	vital's is Normal	patient is stable	Anurupa [Signature]

HNH-00010982 IP26-00006607  
 Mrs P. SHIRISHA  
 02-04-1998 28 Y 2 M 17 D (F)  
 Dr. SWAPNA SAMUDRALA



# NURSING CARE RECORD



Date: 19/5/26

**Goals**

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8pm to 2pm	=> Assess the patient condition => plan for vitals => plan for Biochart	8pm to 2pm	=> Assessed the pt condition => maintain vitals & record => maintain p/o chart	patient is stable	vitals is normal	Cmudy
Afternoon	<div style="border: 1px solid black; width: 100%; height: 100%; display: flex; align-items: center; justify-content: center;"> <span style="font-size: 2em;">/</span> </div>						
Night	8pm /	-> Assess the general condition of pt. -> Monitor vitals -> Maintain Biochart -> Administer medication	8pm /	-> Assess the general condition of pt. -> Monitor vitals -> Maintain p/o chart. -> Administer medication	pt is SA	Re-assess vitals	

Patient Sticker


# NURSING CARE RECORD



Date: 20/6/26

**Goals**

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am 2pm	<ul style="list-style-type: none"> <li>- Assess the Patient condition</li> <li>- Maintain vital</li> <li>- Maintain Tlo</li> </ul>	8am 2pm	<ul style="list-style-type: none"> <li>- Assesed the patient condition</li> <li>- Maintain vital</li> <li>- maintain Tlo</li> </ul>	- patient stable	- vital Normal	
Afternoon							
Night							

Patient Sticker

# NURSING CARE RECORD



Date: .....

**Goals**

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

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

HNH-00010982

IP26-00006607

Mrs P. SHIRISHA

02-04-1998

28 Y 2 M 16 D (F)

Dr. SWAPNA SAMUDRALA



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

BirthRight™  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

# CHECKLIST FOR THROMBOPHLEBITIS

18/6/26 19/6 20/6/26

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			-	-	NA	NA	NA			
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			
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			-	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			
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			
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			
Signature of the Nurse													

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

Signature of Shift In Charge :

Signature :  Name : Anushe

Signature of Ward In Charge :

Signature :  Name : Kustur

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-00010982 IP26-00006607  
 Mrs P. SHIRISHA  
 02-04-1998 28 Y 2 M 16 D (F)  
 Dr. SWAPNA SAMUDRALA

# Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	18/6/2019 / 6/20 / 27/6/20			Fall Risk Grading		
		Score		2pm	10pm			
History of Falling (immediately or w/in 3 months)	Yes	25				Risk Level	Morse Fall Score (MFS)	Action
	No	0						
Secondary Diagnosis (more than one diagnosis)	Yes	15				Low Risk	0 - 24	Standard Fall Precaution
	No	0						
Ambulatory Aid	Furniture	30				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0	0	0			
IV / Heparin Lock or Saline	Yes	20	20	20	20	High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	No	0	0	0	0			
GAIT / Transferring	Impaired	20				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0						
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0						
Total Morse Fall Scale Score:			20	20	20			
Signature								

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

# Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	Fall Risk Grading				
		Score	Risk Level	Morse Fall Score (MFS)	Action		
History of Falling (immediately or w/in 3 months)	Yes	25					
	No	0	0				
Secondary Diagnosis (more than one diagnosis)	Yes	15					
	No	0					
Ambulatory Aid	Furniture	30					
	Crutches, Cane(S), Walker	15					
	None /Bed Rest /Nurse Assist	0					
IV / Heparin Lock or Saline	Yes	20	20				
	No	0					
GAIT / Transferring	Impaired	20					
	Weak (uses touch for balance)	10					
	Normal /On Bed Rest /Immobile	0					
Mental Status	Forgets limitations	15					
	Oriented to own ability	0					
Total Morse Fall Scale Score:			20				
		Signature	<i>Ali</i>				

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

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

HNH-00010982  
 Mrs P. SHIRISHA  
 02-04-1998 28 Y 2 M 16 D (F)  
 Dr. SWAPNA SAMUDRALA

IP26-00006607



### PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
18/6	11 PM	0/20	-	<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	PL
19/6	10 AM	0/10	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	CD
19/6	3 PM	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	SL
19/6/20	10 PM	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	⊕
20/6/20	2 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	⊕
				<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		
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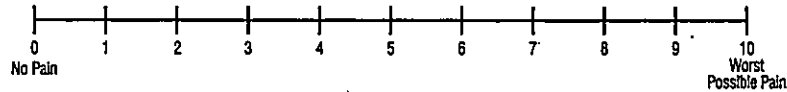
**Re-assessment Frequency:**  
 1. Every eight hours for all hospitalized patients.  
 2. For post-surgical patients, patients with chronic pain, patient with severe pain:  
 a) At least every 2 hours for the first 24 hours      b) Then every 4 hours.  
 c) Prior to pain pain-relieving intervention.      d) Within 30 – 60 minutes after pain relief intervention.

# PAIN ASSESSMENT TOOLS

## FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

## Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
<b>Crying Irritability</b>	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
<b>Behavior State</b>	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)
<b>Facial Expression</b>	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
<b>Extremities Tone</b>	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
<b>Vital Signs HR, RR, BP, SaO<sub>2</sub></b>	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 <sub>2</sub> 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO <sub>2</sub> less than or equal to 75% with stimulation - slow recovery 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

# PAIN ASSESSMENT FORM

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**Re-assessment Frequency:**

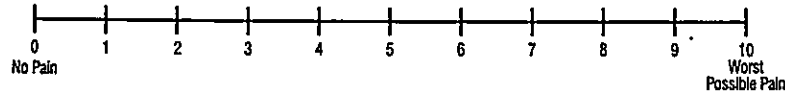
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## Wong - Baker (Pediatrics) Above 7 Years



HNH-00010982 IP26-00006607  
 Mrs P. SHIRISHA  
 02-04-1998 28 Y 2 M 16 D (F)  
 Dr. SWAPNA SAMUDRALA



# BRADEN 'Q' SCALE



Date : 18/6 19/6 19/6 20/6  
 Time : 7:30 am 2pm 10 pm 8 am

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

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

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

# BRADEN 'Q' SCALE

Patient ID

					Date :				
					Time :				
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Moisture Degree to which skin is exposed to moisture	<b>1. Constantly moist:</b> Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	<b>2. Very moist:</b> Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	<b>3. Occasionally moist:</b> Skin is occasionally moist, requiring linen change every 12 hours.	<b>4. Rarely moist:</b> Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.					
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					<b>TOTAL SCORE</b>				
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Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

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## NURSING SHIFT HAND OVER FORM - WARD

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

SITUATION	Diagnosis: <u>JOL</u>	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: .....				
BACKGROUND	Area	<u>18/6/2026</u>	<u>19/6</u>	<u>19/6</u>	<u>20/6/26</u>	<u>20/6</u>
	Shift Time	<u>N1</u>	<u>MP</u>	<u>2PM</u>	<u>N1</u>	<u>8:30 AM</u>
ASSESSMENT	Medical Condition (Any special condition to be noted):	<u>-</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>-</u>
	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Vital Signs:	Temp: <u>98.1°F</u>	<u>98.0°F</u>	<u>97.8°F</u>	<u>97.4°F</u>	<u>97.6°F</u>
		Res: <u>20</u>	<u>20</u>	<u>20</u>	<u>20</u>	<u>20bpm</u>
		SpO <sub>2</sub> : <u>99%</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>
		Pulse: <u>79</u>	<u>86</u>	<u>85</u>	<u>84</u>	<u>86</u>
		BP: <u>113/81/90</u>	<u>113/70</u>	<u>110/75</u>	<u>110/76</u>	<u>101/68</u>
	Fall Risk Score:	<u>0</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
	Pain Score:	<u>0</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>101</u>
Recommendations	Safety Needs:	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>yes</u>
	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:	<u>-</u>	<u>-</u>	<u>NA</u>	<u>NA</u>	<u>-</u>
	Special Diet:	<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
	Other Special Orders / Medications:	<u>-</u>	<u>-</u>	<u>NA</u>	<u>NA</u>	<u>-</u>
	Post Operative Procedure Special Orders:	<u>-</u>	<u>-</u>	<u>NA</u>	<u>NA</u>	<u>-</u>
	Handed Over By Name :	<u>Anusha</u>	<u>Chud</u>	<u>Sriath</u>	<u>Mounish</u>	<u>Sapanya</u>
	Signature :	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
	Date:	<u>19/6/2026</u>	<u>19/6</u>	<u>19/6</u>	<u>20/6/26</u>	<u>20/6/20</u>
	Time:	<u>8:30 AM</u>	<u>2PM</u>	<u>8PM</u>	<u>9AM</u>	<u>2PM</u>
	Taken Over By Name :	<u>Chud</u>	<u>Sriath</u>	<u>Mounish</u>	<u>[Signature]</u>	
	Signature :	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
	Date:	<u>19/6</u>	<u>19/6</u>	<u>19/6</u>	<u>20/6/26</u>	
	Time:	<u>8AM</u>	<u>2PM</u>	<u>8PM</u>	<u>8:30 AM</u>	

Patient Sticker



## NURSING SHIFT HAND OVER FORM - WARD

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

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

# INFORMED CONSENT FOR VAGINAL BIRTH



Patient Name : MRS. P. SHIRISHA UHID No : HMH - 00010982

Gender:  Male  Female Date : 18/06/2026 Time : 11:10pm

I hereby authorized the performance of the following procedure:

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

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

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

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

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

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

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

Name of the Doctor performing the procedure: Dr. SWAPNA. S

Consentee :  
Signature : [Signature]

Name : MRS. P. Shirisha

Date & Time : 18/06/2026 @ 11:10pm

Patient Attendant :  
Signature : [Signature]

Name : Roopesh

Relationship with Patient : Husband

Date & Time : 11:10 PM, 18/6/2026

Witness :  
Signature : .....

Name : .....

Date & Time : .....

Doctor (who is taking the consent) :  
Signature : [Signature]

Name : Dr. Nayeena

Date & Time : 18/6/2026 @ 11:10pm

## INDUCTION OF LABOR CONSENT

Name: MRS. P. SHIRLISHA Age: 27 YRS Gender: Male  Female   
 UHID.No: HNH-00010982 Date: 18/06/2026

You are scheduled for an induction of labor on 18/06/2026 (date) at 37 wsdays (weeks of gestation).

The reason for your induction is .....

The goal of induction of labor is to achieve vaginal delivery by starting uterine contractions before the spontaneous start of labor.

Induction of labor for a medical indication is done when continuation of pregnancy is considered detrimental to the health of the mother or fetus. This can be done at any stage of pregnancy irrespective of fetal maturity if there is a valid indication.

Elective induction of labor (scheduled induction without a medical indication) may not be done until you are at least 39 weeks. This is important so that your newborn does not have complications due to possible prematurity.

The alternative to induction of labor is to wait for labor to start spontaneously.

I have read the information provided and also discussed the process with my doctor.

I understand the risks and benefits of this procedure and wish to proceed.

Patient  
Signature: [Signature]  
Name: MRS-P. Shirlisha  
Date & Time: 18/06/2026 @ 11:10pm

Patient Attendant:  
Signature: [Signature] 18-06-26  
Name: Rupesh  
Relationship with Patient: Husband  
Date & Time: 11:10 PM

Doctor:  
Signature: [Signature]  
Name: Dr. Navneeta  
Date & Time: 18/06/2026 @ 11:10pm

Witness  
Signature: .....  
Name: .....  
Date & Time: .....

# CONSENT FOR SPECIAL PROCEDURES

Patient Name : Mrs. P. SIRISHA Gender:  Male  Female

UHID No : HNH-10982 Department : ANAESTHESIA Date : 19/6/26

I P. ROOPESH S/D/W/O P. RAMDAS

Here by give consent for procedure of : LABOR EPIDURAL

For my patient, Named : Mrs. P. SIRISHA

The doctors have clearly explained to me that the procedure has following possible complications:  
Hypotension, Bradycardia, Prolonged labor.

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :  
i.v. fluids, Antidote.

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure: Dr. AYESHA

**Patient Attendant :**  
Signature : [Signature]  
Name : P. ROOPESH  
Relationship with Patient: Husband  
Date & Time : 19-06-26

**Witness :**  
Signature : [Signature]  
Name : \_\_\_\_\_  
Date & Time : 19/06/26

**Doctor (who is taking the consent) :**  
Signature : [Signature]  
Name : DR. M. VINETHA  
Date & Time : 19/06/26

# ప్రత్యేక విధానాలకు సమ్మతి



రోగి పేరు ..... లింగం  పురుషుడు  స్త్రీ

యు.పాచ్.ఐ.డి ..... విభాగం ..... తేదీ .....

నేను ..... S/D/W/O .....

ఇక్కడ ప్రక్రియ కోసం సమ్మతి ఇవ్వడం ద్వారా .....

నా రోగికి, పేరు: .....

ఈ ప్రక్రియ కోసం ప్రత్యామ్నాయాలు, నష్టాలు మరియు ప్రయోజనాలు గురించి డాక్టర్ నాకు తెలిసిన భాషలో వివరించా

.....

.....

నాకు తెలిసిన భాషలో పైన పేర్కొన్న విషయాన్ని నేను అర్థం చేసుకున్నాను మరియు ప్రక్రియకు సమ్మతిని తెలియజేస్తున్నాను.

ప్రక్రియ చేస్తున్న వైద్యుని పేరు: .....

సహాయకుడు(అటెండెంట్)

సాక్షి

సంతకము .....

సంతకము .....

పేరు .....

పేరు .....

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

తేదీ మరియు సమయము .....

సంతకము .....

పేరు .....

**Department of Anaesthesiology**  
**PRE-ANAESTHETIC EVALUATION**



Name: Mrs. P. Kirishan Age: 28 yr Sex: female UHID.No: HNH-00010982  
 Date: 19/06/26 Time: 11:41 am Proposed Operation: Epidural labor analgesia  
 Diagnosis: Primi @ 27<sup>th</sup> wks @ GDM on OHA  
 B.P./CRT: ..... H.R.: ..... Weight: ..... ASA Physical Status:  1  2  3  4  5

19/6

19/6 GRBS-154

**Laboratory Data:**

Hgb: <u>11.9</u>	Glucose: .....	Protein: .....	HIV: .....	X-Ray: .....
PCV: <u>34.3</u>	Urea: .....	Alb: .....	HBS Ag: <u>NR</u>	ECG: .....
WBC: <u>10.22</u>	Creat: .....	Total Bill: .....	HCV: <u>NR</u>	2D Echo: .....
Plate: <u>1.57</u>	Na: .....	Dir. Bill: .....	Blood group: <u>B positive</u>	stress/Angio: .....
PT: .....	K: .....	LDH: .....	T3: .....	Other: .....
PTT: .....	Ca++: .....	Alk phos: .....	T4: .....	
INR: .....	Mg++: .....	Amylase: .....	TSH: .....	
	Cl-: .....	SGOT/SGPT: .....		

Allergies: NKDA

**Medical History:** CVS: no active cardio respiratory complaints Diabetes: GDM (+) Placenta fundopositor, High  
 RESP: .....  
 CNS: .....  
 Renal: Nil significant  
 Hepatic / GE: ..... Physical Activity: Active  
 Others: .....

**Past Anaesthetic History:**

**Physical Exam:**

Airway: MP 1 2 3 4 Mouth Opening: Adequate Mentohyoid Distance: (N) Neck: (N) Teeth: Intact  
 Lungs: BAE (+), clear  
 Heart: S1S2 (+)  
 CNS: NAD  
 Pregnant:  Yes  No  NA Venous Access Site: (+) Spine Exam for regional: (h)

Anaesthetic Plan:  MAC  REGIONAL  GA-ETT  LMA

Peri-Operative Plan Explained to the Patient:  Yes  No

CURRENT MEDICATIONS	DOSAGE
<u>T. HYALOMET</u>	<u>500mg TID.</u>

**Pre-Operative Instructions:**

- DVT Prophylaxis :
- NIL ORAL  $\left\{ \begin{array}{l} \text{Water / ORS 2 Hours} \\ \text{Others 6 Hours} \end{array} \right.$
- Informed Consent  Standard  High Risk
- Post Operative Pain Management:  Discussed with Patient
- Other Instructions:

Signature: [Signature] Name: DR. M. VINI PETHA





Department of Anaesthesiology

# EPIDURAL ANALGESIA RECORD

Date: 19/6/26 Time: 12:00pm Procedure done by D. Sr. Ayesha

CSE / Spinal / Epidural  Position: Sitting Space: L3-L4 Technique (LOR/LOS)

Depth: 4 cm Catheter at Skin: 9 cm Attempts: 1

Parasthesia: Yes/No if yes details: .....

Solution Composition: 0.1% BUPIVACAINE + 2mcg/ml FENTANYL

Any other issues:

a) .....

b) .....

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level		Maternal		FHR	Comments
			Left	Right	BP	Pulse		
12:04		8 ml			105/65	100/min	172/min	0.8% DICLOFENAC + ADRENALINE
12:20pm	10 ml/hr	0	T <sub>10</sub>	T <sub>8</sub>	105/60	102/min	135/min	0.1% BUPIVACAINE + 2mcg/ml FENTANYL
2:00pm	8 ml/hr		T <sub>10</sub>	T <sub>10</sub>	101/70	90/min	138/min	"
3:00pm	8 ml/hr		T <sub>8</sub>	T <sub>8</sub>	104/60	110/min	140/min	"
3:50pm	8 ml/hr		T <sub>8</sub>	T <sub>8</sub>	102/62	114/min	146/min	"
4:00pm	8 ml/hr		T <sub>8</sub>	T <sub>8</sub>				"
5:00pm	6 ml/hr		T <sub>10</sub>	T <sub>10</sub>	107/65	104/min	-	"

Delivery Details: Time: 3:56pm APGAR: ..... SVD / Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected: Dr. Ayesha, 7:10pm

Patient Satisfaction: Comfortable

Discharge / Shifting ordered by  
Doctor Signature: Ayesha

Doctor Name: Dr. Sr. Ayesha

Date and Time: 19/6/26, 7:10pm

26-0000207374

**NARCOTIC PRESCRIPTION FORM  
(PATIENT COPY)**

Patient Name: Mrs P. Shiresha Age: 28y Gender: F  
 UHID No: HNH-00010977 IP No: 26-00006607 Date: 19/6/26 Time: 11:45 AM  
 Diagnosis: Premigrasda with 3 days 5 days pain with vom OHA for 10L LDR

PRESCRIPTION DETAILS (Tick only one of the following)

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

Doctor Name: Dr. Samir Doctor Registration No: 67529  
 Signature: [Signature]

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

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

IP Registration No: 26-00006607 Date: 19/6/26  
 Aadhaar No. of the Patient (Optional):

1.	Name : Mrs. P. Shiresha	Remarks
	Complete postal address (with contact number, if any)	7-68-1-15 East (A number) near Boduppal Hyderabad Telangana India 500092
3.	Brief description of the illness	20L
4.	Whether registered with any other registered medical practitioner / recognized medical institution ( If yes, details of the recorded)	NO
5.	Details of essential Narcotic drug dispensed	inj Fentanyl

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
19/6/26	inj Fentanyl	01	[Signature]	
19/6/26				

Dispensed by (Name & ID No.): Sania (018462) Signature: [Signature]  
 Received by (Name & ID No.): Alati 020069 Signature: [Signature]  
 Time: 19/6/26



NARCOTIC PRESCRIPTION FORM  
(PATIENT COPY)

PHYSICIAN: DR. [Name]      PATIENT: [Name]

CLINIC: [Name]      ADDRESS: [Address]

DATE: [Date]

Drug Name	Dosage	Frequency	Route
[Drug Name]	[Dosage]	[Frequency]	[Route]
[Drug Name]	[Dosage]	[Frequency]	[Route]
[Drug Name]	[Dosage]	[Frequency]	[Route]
[Drug Name]	[Dosage]	[Frequency]	[Route]

Signature: [Signature]      Date: [Date]

NARCOTIC DISPENSING FORM  
APPENDIX A - FORM NO. 32  
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

Registration No. [Number]      Date [Date]

Name of the Patient [Name]

Date	Name of the Essential Narcotic Drug	Quantity	Signature of the Pharmacist	Remarks, if any
[Date]	[Drug Name]	[Quantity]	[Signature]	[Remarks]
[Date]	[Drug Name]	[Quantity]	[Signature]	[Remarks]
[Date]	[Drug Name]	[Quantity]	[Signature]	[Remarks]

Checked by Nurse [Signature]      Date [Date]

Pharmacy [Name]

26-0000207314



### NARCOTIC PRESCRIPTION FORM (MEDICAL RECORD)

Patient Name: Mrs. P. Shirisha	Age: 28y	Gender: F	
UHID No: 11NH-00010732	IP No: 26-00006602	Date: 19/6/26	
Diagnosis: Pain management with 3 days post op with 6000ml of blood			
PRESCRIPTION DETAILS (Tick only one of the following)			
S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/ML	100mcg	- 01
2.	Morphine Sulphate Inj. 15mg/ML		
3.	Remifentanyl Hydrochloride Inj. 2MG		
4.	Remifentanyl Hydrochloride inj. 1MG		
Doctor Name: Dr. Samir		Doctor Registration No: 67029	
Signature: [Signature]			

### NARCOTIC DISPENSING FORM APPENDIX 4 – FORM NO. 3E (Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: 26-00006602 Date: 19/6/26

Aadhaar No. of the Patient (Optional):

1.	Name: Mrs. P. Shirisha	Remarks		
2.	Complete postal address (with contact number, if any)	1-68145, East (numbers) region, Hyderabad, Hyderabad, India, 500012		
3.	Brief description of the illness			
4.	Whether registered with any other registered medical practitioner / recognized medical institution ( If yes, details of the recorded)	No		
5.	Details of essential Narcotic drug dispensed	inj fentanyl		
Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
19/6/26	inj fentanyl	01	[Signature]	
19/6/26				

Dispensed by (Name & ID No.): Sonia (015662) Signature: [Signature]

Received by (Name & ID No.): Alati (020067) Signature: [Signature]

Time: 19/6/26

NARCOTIC PRESCRIPTION FORM  
(MEDICAL RECORD)

Patient Name		Age		Gender	
DR No		Date		Time	
Diagnosis					
PRESCRIPTION DETAILS (tick only one of the following)					
S.No	Drug Name	Dosage	Remarks		
1	Pentamyl Citrate inj. 50mg/ml				
2	Lidocaine Sulphate inj. 1mg/ml				
3	Kemintal Hydrochloride inj. 1MG				
4	Kemintal Hydrochloride inj. 1MG				
Doctor Name		Doctor Registration No			
Signature					

NARCOTIC DISPENSING FORM  
APPENDIX 1 - FORM NO-3E  
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No. .... Date: .....

Address No. of the Patient (Optional) .....

1	Name	Remarks		
2	Complete postal address with contact number if any			
3	Brief description of the illness			
4	Whether registered with any other registered medical practitioner (yes, details of the registered medical institution (yes, details of the registered))			
5	Details of essential Narcotic drug dispensed			
Date	Name of the Essential Narcotic Drugs	Quantity	Signature of the patient's Parent/Attender	Remarks, if any

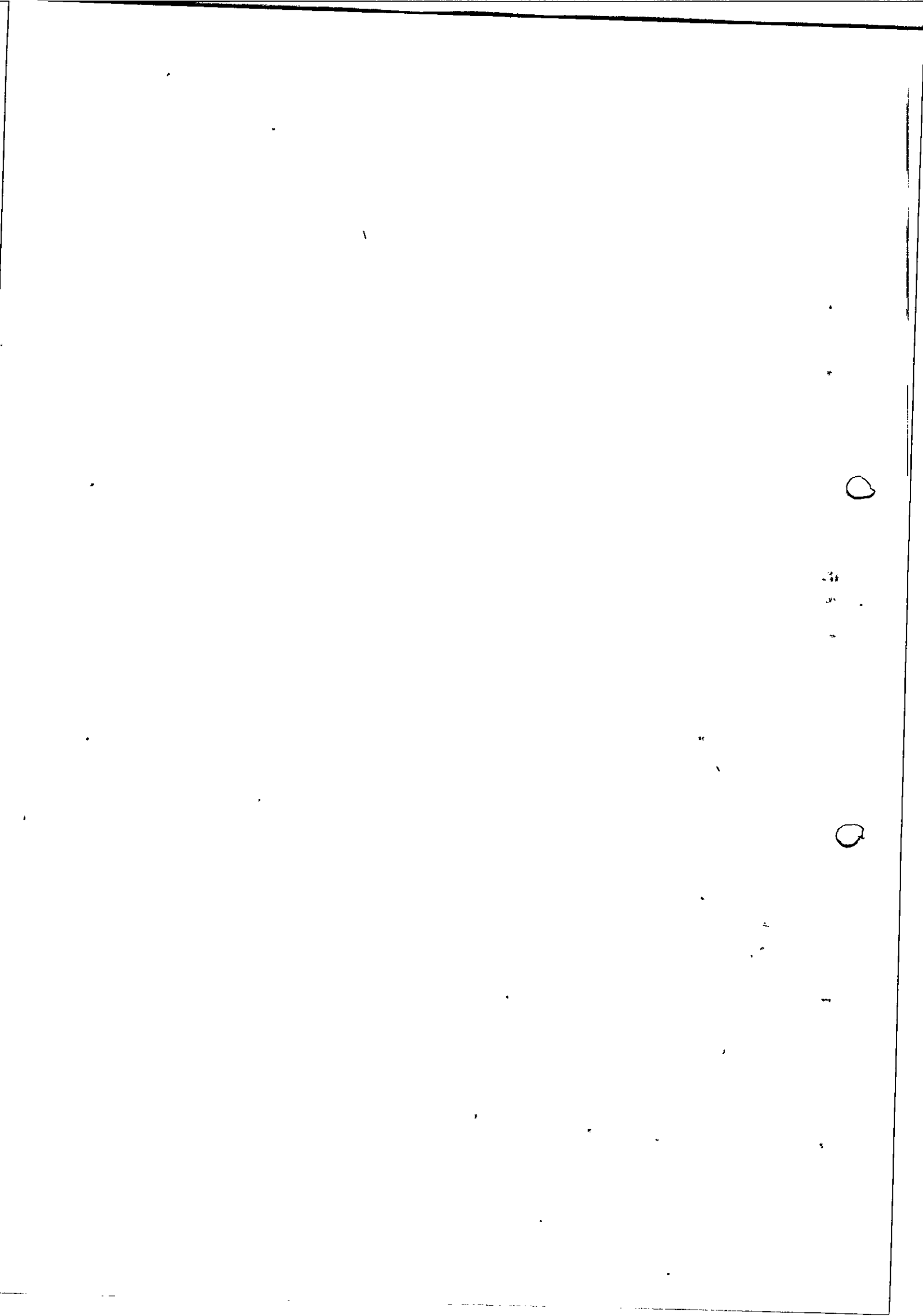
Signature

Signature

Dispensed by (Name & ID No)

Received by (Name & ID No)







## BILLING POLICY

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

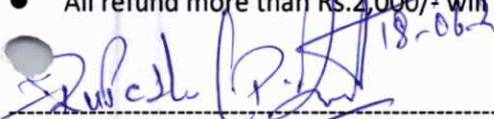
Patient attendant can collect for Interim/provisional bill of the patient from the billing section on daily basis. Interim Bill shall be based on the acknowledged services in HIS. Final Bill of the patient may vary from the Interim bill based on actual update taken on the day of discharge. It is requested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


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

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

### MODE OF PAYMENT & REFUNDS

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

  
Name & signature of Patient/Attendant

  
(Signature of Admission Desk executive)

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

## RAINBOW CHILDREN'S MEDICARE PRIVATE LIMITED

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

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

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

HNH-00010982  
Mrs P. SHIRISHA  
02-04-1998 28 Y 2 M 18 D (F)  
Dr. SWAPNA SAMUDRALA

306



# NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 20/6/26 Time: 11 AM

Origin: Indian Height: 5.4 Weight: 76 kg BMI:  ~ 26 kg/m<sup>2</sup>  
 ~ 28 kg/m<sup>2</sup>  
 ~ 30 kg/m<sup>2</sup>

Food Allergies: NO

Diagnosis: NVP

Type of Diet:  Liquid  Soft  Normal  Diabetic  
 Vegetarian  Non-Vegetarian  Vegan

Diet Advised:

Liquid Diet – ORS/ Coconut Water/ Butter Milk/ Barley Water/ Soups 3.145 kg (M)

Normal Diet – Rice, Rotis, Dal and Soft Cooked Vegetables and Curd

Soft Diet – Soft Rice, Dal and Vegetable Curries Soft Cooked, Curd

Diabetic Diet – Brown Rice/ Oats/ Dahlia/ Rotis, Dal and Vegetables and Curd (Avoid Roots/ Tubers)

Patient's / Attendant's  
Signature: [Signature]

Dietician's  
Signature: [Signature]

Name: Shirisha

Name: Sathwika G

Date & Time: 20/6/26; 11 AM

Date & Time: 20/6/26; 11 AM



HNH-00010982 IP26-00006607

Mrs P. SHIRISHA  
02-04-1998 28 Y 2 M 18 D (F)  
Dr. SWAPNA SAMUDRALA

306



# CROSS CONSULTATION FORM

Doctor Name : Dr. Swapna Date : 20/6/26 Time : 12 PM

Diagnosis : NVD

Hospital : RCH - HMNR

**Type of Referral :**

- Emergency
- Urgent
- Non Urgent

Referred for :  Opinion  Co-Management  Transfer of care

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

Signature: \_\_\_\_\_

**Findings and Recommendations :**

Lactation care plan

- well formed breast & nipple's
- colostom seen
- Baby in NICU
- Advice expressed breast milk every 2-3 hour
- primi

**Consultant :**

Name : Sathwika G Signature : [Signature] Date & Time : 20/6/26; 12pm