

Dr. Niharika



ESTIMATION SLIP

Date : 23/5/26 UHID / IP No. : MNH-00012567 SI No. **1534**
 Name of Patient : Mrs. Rome Day De Age: 26yr Gender: F
 Father's / Husband's Name : Mr. Dibyendu Day Corporate / Occupation : _____
 Address : 1 Phone : 8918202358 Email : _____
 Procedure / Plan : Diagnostic Hysteroscopy EDD/Dos: May-26
 MODE OF PAYMENT : SELF TPA : _____ GIPSA : _____ OTHER

TARIFF INFORMATION :

Particulars	Package Amounts (Rs.)	
	Normal Delivery	LSCS
Room Category		
Multi Shared Ward		
Shared Ward	<u>75k (Day care)</u>	
Twin Shared Ward	<u>50k → Including Pharmacy</u>	
Private Room	<u>to 55k</u>	
Super Deluxe Room		
Suite Room	<u>+ pharmacy & Investigation extra</u>	
Package includes (Package starts from the time of admission)	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee and Labour Ward Charges	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee Anesthetist's Fees and OT Charges
	Length of Stay for :	Length of Stay for :
	Pharmacy up to	Pharmacy up to
	Investigations up to	Investigations up to
Others		

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

Initial Minimum Deposit : 80% Advance

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.

DHS Signature of the Client Husband Signatory Relationship [Signature] Signature of the financial Counselor

HNH-00012567
Mrs RIMA DAS
15-01-2000 26 Y 4 M 24 D (F)
Dr. MUNAGANURU NIHARIKA



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

SURGERY DETAILS

Date : 08/06/26

Patient Name: Mrs. Rima Das Date of Birth: 15-01-2000 Age: 26y88

Gender: Female Ward: OT UHID No: HNH-00012567

Date of Surgery: 8.6.26 OT-1 OT-2 OT-3 OT-4 OBG OT-1 OBG OT-2

Name of the Surgery : Diagnostic hysteroscopy

Time in : 10:30 Am Time Out : 10:50 Am

NAME

AMOUNT

- Surgeon : Dr. Niharika
- Anaesthetist : Dr. Veenitha
- Assistant Surgeon :
- OT Technician : Sr. Saichandru
- Circulating Nurse : Sr. Susheela, Sr. Nataslu
- Assistant Nurse : Sr. Archana



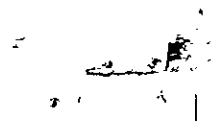
- Special Equipment: Laparoscopy Bronchoscope Harmonic Morcelator
 C-ARM Cystoscopy Versa Point Liver Cusa
 Neuro Cusa Others : hysteroscopy charges (26-0000205214)

Signature of the Surgeon: Niharika

Signature of Circulating Nurse: pooja

Order No: 26-0000205-229/2000

Order by: Archana 8.6.26 @ 11:22 Am



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HNH-00012567
Mrs RIMA DAS
15-01-2000

IP26-00006537

26 Y 4 M 24 D (F)

Dr. MUNAGANURU NIHARIKA



Diagnostic hysteroscopy.

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient S

CONSUMABLES OF OT

Circulating staff : Pathasha Technician : S. Chandu Date : 8/1/20 Time :

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube			Major Pack		✓	Inj Vit.K		
LMA		01	Sutures		✓	Cord Clamp		
ECG leads : A/P/N		03				Suction Catheter		
HME filter : A/P/N						Feeding Tube		
Syringes : 10 cc		04				Vaccum Suction Set		
05 cc		04	Gloves	6 1/2 S.G	4	Surgical Gloves		
02 cc		04	Encode	6 1/2	4	Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A/P/N			Surgical blade			Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL		02	Cautery pencil					
S : 10ml / 100ml / 500ml / 1000ml		02	Koochies					
		01	Ointments					
		01	Suction Catheter					
Fentanyl		01	Cap, Mask		40+10			
Morphine			Gauze Pack	7.5x7.5	2			
Ketamine			Mop Pack		4			
Propofol		03	Steristrip					
Rocuronium			Underpad					
Glycopyrolate			Draw sheet					
Myopyrolate			Abgel					
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
		01	Tegaderm					
Suppositories			loban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set					
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution		1			
		01	Microshield		12			
			Cotton Balls		4			
			Latex Gloves		10			
			Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician
 Order No. : 26-0000205219/218 Ordered by : Archana 8/1/20 @ 11:34 Am
 Doc. No. : RCH / FRM / GENERAL / 125



ELECTRONIC MEDICINE PRESCRIPTION

MRN : HNH-00012567 Name : Mrs RiMA DAS
Age / Sex : 26 Y 4 M 24 D / Female Doctor : MUNAGANURU NIHARIKA
Adm/Reg Date/Time : 08/06/2026 09:02 Payor : SELFPAY
Order Date : 08/06/2026 11:33 Ordernumber : 26-0000205219
Visit ID : IP26-00006537 Ward/Bed No : 4F -OT / PDA-414
Patient Address : Jangalpara, Hooghly, West Bengal, INDIA, 712701

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	RL 500 ML CLOSED SYSTEM	RINGER LACTATE 500ML CLOSED	1 Bottle	/ Once Daily	2 Days		2 Bottle	Dispensed
2	Encore Microptic gloves-6.5		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
3	DSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
4	POVINANZ SOLUTION 10% 100 ML		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
5	RELIPARA(PARACETAMOL) 1000MG 100ML BOTTLE		1 Nos	Injection / Once Daily	1 Days		1 Nos	Dispensed
6	BACTOPREP SOLUTIONS 100 ML	CHLORHEXIDINE GLUCONATE2% &ALCOHOL80% 500	1 mL	/ Once Daily	2 Days		2 Nos	Dispensed
7	MOPS 30X30 8PLY 5S X-RAY	MOPS 30X308 PLYDATT	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
8	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
9	COTTON BALLS 2 GM 5 NOS	COTTON BALLS 2G- 5 NOS	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
10	GAUZE 7.5X7.5 12 PLY (5 NOS)	GAUZE 7.5X7.5 12 PLY 5 NOS	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
11	OxygenMask With Tubing - Adult ROMSONS-FC		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
12	VACCUME SUCTION SET	VACCUME SUCTION SET	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
13	NS 1000 ML CLOSED EUROFLEX	NORMALSALINE 1000ML CLOSED	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
14	MEZOLAM INJ 5 MG 5 ML		1 Vial	Injection / Once Daily	1 Days		1 Vial	Dispensed
15	MCT-ROF 100MG 10ML		1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
16	IGEL NO 3.0	IGEL 3.0	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed

MUNAGANURU NIHARIKA

Reg No : APMC/FMR/74828

* This document is just for reference purpose only. Not to be considered as primary report.

Note

* This prescription is valid only for specified duration.

* Do not refill medicines.



ELECTRONIC MEDICINE PRESCRIPTION

MRN : HNH-00012567 Name : Mrs RIMA DAS
Age / Sex : 26 Y 4 M 24 D / Female Doctor : MUNAGANURU NIHARIKA
Adm/Reg Date/Time : 08/06/2026 09:02 Payor : SELFPAY
Order Date : 08/06/2026 11:33 Ordernumber : 26-0000205218
Visit ID : IP26-00006537 Ward/Bed No : 4F -OT / PDA-414
Patient Address : Jangalpara, Hooghly, West Bengal, INDIA, 712701

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	FACE MASK 3 LAYER - ELASTIC	FACE MASK 3 LAYER	1 Nos	/ Once Daily	10 Days		10 Nos	Dispensed
2	GENERAL SURGICAL KIT (MEDITAKE)	GENERAL SURGICAL KIT	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
3	DSYRINGE 5ML.(NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
4	SURGEON CAP(FEMALE)	FEMALE CAP	1 Cap	/ Once Daily	10 Days		10 Cap	Dispensed
5	E.C.G ELECTRODES (ADULT)	ELECTRODES ADULT	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
6	NITRILE EXAMINATION GLOVES P F- MEDIUM	NITRILE GLOVES M	1 Nos	/ Once Daily	10 Days		10 Nos	Dispensed
7	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed

MUNAGANURU NIHARIKA

Reg No : APMC/FMR/74828

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Note

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* Do not refill medicines.

Name	Mrs RIMA DAS	UHID	HNH-00012567
Father/Guardian	Mr DIBYENDU DAS	Age/Gender	26 Y 4 M 24 D/ Female
Address	Jangalpara, Hooghly, West Bengal, INDIA, 712701		
IP No	IP26-00006537	Admission Date	08-06-2026
Ref Doctor	Self.		
Discharge Date	08.06.2026		

DISCHARGE SUMMARY

Consultants :

Dr. Munaganuru Niharika
MBBS, MS, Mch
APMC/FMR/74828

**Diagnosis: PRIMARY INFERTILITY WITH Unicornuate uterus and Male factor
K/C/O HYPOTHYROIDISM**

DIAGNOSTIC HYSTEROSCOPY DONE ON 08.06.2026

History: She has been admitted for Diagnostic hysteroscopy. She is a case of Primary Infertility with Unicornuate uterus and male factor.
Menstrual History:- AOM: 13yrs
Irregular / 22-45 days cycles/3-4 days cycles/clots-/dysm-
LMP- 22.05.2026

Obstetric History: NIL

Medical History: Hypothyroidic since 2.3 years on Thyronorm 25mcg

Surgical History: Nil

Allergies: Nil

Family History: Husband-HTN-DM & Hypothyroidism

Investigations: Enclosed.

Blood group: "B" Positive

Surgery Notes:

Operation performed:

DIAGNOSTIC HYSTEROSCOPY UNDER GENERAL ANAESTHESIA

Name	Mrs RIMA DAS	UHID	HNH-00012567
IP No	IP26-00006537	Admission Date	08-06-2026

Indication: Primary infertility

Operative findings:

- Cervix normal.
- Canal narrow.
- Cavity - unicornate cavity small size
- Left ostia seen.
- Endometrium normal .
- Endometrial biopsy sent for HPE

Post-Operative Notes: She was closely monitored in the postoperative period. Her vital signs remained stable. She was encouraged to ambulate and void spontaneously. She was shifted to room. Her general condition was satisfactory and she was found to be fit for discharge. Medications were explained to the patient supplemented by written information.

Advice:

1. Tab. DOXT-SL100mg twice daily till 21.06.2026 (9am - 9pm) after food.
2. Tab. Calpol 500mg (Paracetamol 500mg) (2tabs) thrice daily till 10.06.2026 (7am-3pm-10pm) after food.
3. Tab. Metrogyl 400mg thrice daily till 14.06.2026 (10am-4pm-10pm) after food.
4. Tab. Pantodac 40 mg (Pantoprazole 40mg) once daily (7am) before food till 17.06.2026
5. Tab. Regesterone 10 mg twice daily till 14.06.2026
6. Collect HPE.

Review consultation with Dr. Munaganuru Niharika on **Day 2 of next cycle** in Gynec OPD with HPE report at Rainbow Children's Hospital (**Review consultation will be charged**).

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

Patient/ Attender

In case of emergency like bleeding, fever kindly contact 9154865045 at Rainbow Children's Hospital just dial one toll free number - 18002122.

You can also take appointments at any time by going online to our website **www.rainbowhospitals.in**

Name	Mrs RIMA DAS	UHID	HNH-00012567
IP No	IP26-00006537	Admission Date	08-06-2026


Registrar/Resident/C.M.O



Consultants :

Dr. Munaganuru Niharika
MBBS/MS/Mch
APMC/FMR/74828

ERROR LOG

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

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006537

Admit Date : 08-Jun-2026

Admit Time : 09:02 AM UHID : HNH-00012567

Patient Details :

Patient Name	: Mrs RIMA DAS	Age	: 26 Y 4 M 24 D
Guardian	: Mr DIBYENDU DAS	DOB	: 15-01-2000
Gender	: Female	Religion	:
Occupation	:	Martial Status	:
Address (H)	: Jangalpara Hooghly West Bengal INDIA 712701	Phone No	: 8918202358/ 7047832218
		E-mail	: na@gmail.com

Admission Details :

Bed Type	: TWIN SHARING	Bed No	: PDA-414	Ward Name	: 4F -OT
Room No	: PDA-414	Admission Type	: First Visit		

Contact Details :

Name	: Mr DIBYENDU DAS	Relationship	: W/O
Contact Address	: Jangalpara Hooghly West Bengal INDIA 712701	Phone No	: 8918202358


Signature

Doctor Details :

Doctor Name	: Dr. MUNAGANURU NIHARIKA	Specialisation	: INFERTILITY
Referral Doctor	: Self.	Phone No	:
Co-Consultant	:		

Payment Details :

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

ACTIVITY RECORD FOR BILLING

Name : HNH-00012587 IP26-00006537
Mrs RIMA DAS

UHID No. : 15-01-2000 28 Y 4 M 24 D (F)
Dr. MUNAGANURU NIHARIKA Consultant: _____ Dept : _____



Date of Admission: _____ Date of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
8/6	10:23 AM	pre - post	OT	Sujatha / Pija
8/6/28	11:00 AM	OT	pre - post	Pija / Abhi

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
8/6/20	Biopsy for Histopathology	9524	[Signature]
		cross checked done	
		8/6/20	[Signature]

HNH-00012567 IP26-00006537
Mrs RIMA DAS
15-01-2000 26 Y 4 M 24 D (F)
Dr. MUNAGANURU NIHARIKA



I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 8/6/2026 Time of Admission :

Allergies: Not know any drug allergies

PRESENTING COMPLAINTS :

Admitted for diagnostic hysteroscopy.
Case of Primary Infertility with Unicornate
uterus and male factor.

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : <u>13 yr.</u>	Parity : <u>-</u>
Previous Periods :	Mode of Delivery :
LMP : <u>22/5/2026</u>	Last Child Birth : <u>-</u>
Contraception :	

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
<u>hypothyroid - 2-3yr on.</u> <u>NI</u> <u>Thyronax 25mcg.</u>	<u>Nil</u>



MEDICATION HISTORY:

Husband - HTN
 DM.
 Hypothyroid

T. thyronin 25mcg OD

INITIAL ASSESSMENT:

Date <u>8/6/26</u>	Breasts	Local/Speculum Examination
Ht. _____ Wt. _____	<u>normal</u>	<u>Not done</u>
BMI <u>26.5</u>		
B.P. <u>110/80 mmHg</u>		
Pallor _____	Abdominal Examination	Bimanual Pelvic Examination
CVR <u>S1S2 (+)</u>	<u>soft</u>	<u>Not done.</u>
Respiratory System <u>B/LAE (+)</u>		
Thyroid <u>(N)</u>		

PROVISIONAL DIAGNOSIS:

Primary Infertility & Chronic Uterine and male factor
 KPCO Hypothyroid

INVESTIGATIONS ORDERED

PLAN OF MANAGEMENT

B+ve
 HIV }
 HbsAg } NR
 VDRL }

1/6/26
11.4/6.1/1.5

Diagnostic Hysteroscopy
 - NBM
 - Informed consent
 - Pains prepartal
 - Shift to OT on call

Name of the Doctor:

Dr. Niharika

Signature of Doctor

Date & Time:

8/6/26 9 AM.

HNH-00012587 IP26-00006537
 Mrs RIMA DAS 26 Y 4 M 24 D (F)
 15-01-2000
 Dr. MUNAGANURU NIHARIKA



OP

RESULT SHEET

Date	11/6/20				
Time					
Hb	11.4				
PCV					
RBC					
WBC	6.1				
N/L					
Platelets	1.5				
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

Date							
Time							
CUE - Alb							
CUE - Sugar							
CUE - Ketones							
CUE - PUS Cells							
CUE - RBC Cells							
CUE							
Stool Pus Cell							
OVA / Cyst							
Occult Blood							
blood group	B	positive					
HIV	}	JNR					
HCV							
VDRL							

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.) :



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BY RAINBOW HOSPITALS
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**Rainbow
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Hospital**
It takes a lot to treat the little.

HNH-00012587

Mrs RIMA DAS

15-01-2000

28 Y 4 M 24 D

(F)

Dr. MUNAGANURU NIHARIKA



IP26-00006537

ION THEATER NOTES

Patient's Name: Age : Gender :

UHID: I.P.No. : Weight :

Surgeon : D.M. Niharika Asst. Surgeon :

Anesthetist : OT Nurse :

Surgical Procedure :
Diagnostic Hysteroscopy

Indications for Surgery :
Binary infertility

Date : 08-06-26 Start Time : End Time :

PRE-OPERATIVE PREPARATION :
.....
.....
.....
.....

OPERATION NOTES:
Cervix - normal
Canal - narrow
Cavity - Unicornuate cavity, small size
Left ostia seen.
Endometrium - normal.
EB sending for HPE

[Signature]

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Niharika
 Asst. Surgeon : _____
 Anaesthetist : Dr. Sameer
 Scrub Nurse : Sr. Achane

Patient Name : Mrs RIMA DAI
 15-01-2000 26 Y 4 M 24 D (F)
 UHID No. : _____
 Date : _____



Gender : F



Before Induction of Anaesthesia >>

Before Skin Incision >>

Before Patient Leaves Operating Room

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

TIME OUT		Time: <u>10:30 AM</u>
Confirm all team members have introduced themselves by Name and Role <input type="checkbox"/> Yes <input type="checkbox"/> No		
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm		
Correct Patient (Check ID Band)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Correct Site	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Correct Procedure	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Anticipated Critical Events		
Surgeon Reviews:		
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Anaesthesia Team Reviews:		
Are There Any Patient-specific Concerns?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA	
Nursing Team Reviews:		
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Is Essential Imaging Displayed?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Signature : _____		
Name : _____		

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

HNH-00012567

IP26-00006537

Mrs RIMA DAS

15-01-2000

28 Y 4 M 24 D

(F)

Dr. MUNAGANURU NIHARIKA



MEDICATION RECONCILIATION FORM

Drug Allergies:

Not known any Drug Allergies

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

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

Shifting From:

Shifted to:

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Tab FOLIC ACID	5mg	PO	OD.		<input type="checkbox"/> C <input type="checkbox"/> DC
2	Cap EVION	400mg	PO	OD.		<input type="checkbox"/> C <input type="checkbox"/> DC
3	Syr 2h					<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Dna. [Signature]

Date & Time : 8/6/2026

Name & Signature : [Signature]

Time : 8/6/26 @ 10 AM

No. : RCH / FRM / GENERAL / 090

.011

34

1 6 1111

.10

11

111

10 111

11

1

11

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1 111

11 111

HNH-00012567 IP26-00006537
 Mrs RIMA DAS
 15-01-2000 28 Y 4 M 24 D (F)
 Dr. MUNAGANURU NIHARIKA



DRUG CHART

Date of Admission: 28/1/2020 Drug Allergies: Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name Signatu

HNH-00012567

IP26-00006537

Mrs RIMA DAS

26 Y 4 M 24 D (F)

15-01-2000

Dr. MUNAGANURU NIHARIKA



Early Warning Observation Score Chart - Obstetrics

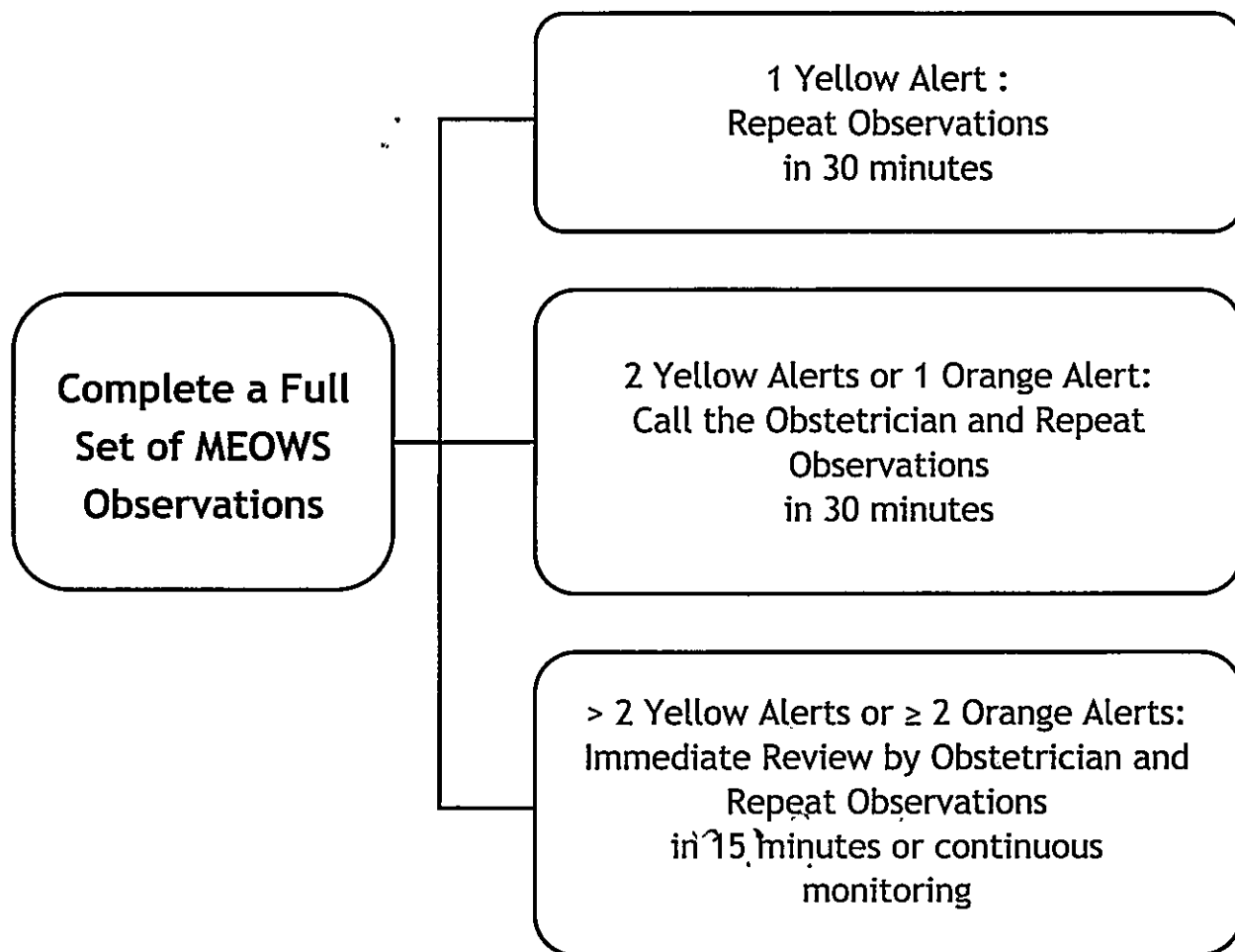
CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

8/6

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

Handwritten notes and signatures at the bottom of the chart, including '8/6', '8/6', and '2/6'.

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

HNH-00012567 IP26-00006537
 Mrs RIMA DAS
 15-01-2000 26 Y 4 M 24 D (F)
 Dr. MUNAGANURU NIHARIKA



FLUID CHART

Sheet No. :

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

Date		Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse		
				Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine				
8/6/26		08:00 am			100ml										
		09:00 am	RL	100ml	100ml					✓					
		10:00 am	RL	NBM	100ml							0	✗		
		11:00 am	RL	100ml	100ml										
		12:00 pm	RL	100ml	100ml										
		01:00 pm	RL	100ml	100ml										
Total Intake :				taken			Total Output :							passed	
8/6/26		02:00 pm													
		03:00 pm													
		04:00 pm													
		05:00 pm													
		06:00 pm													
		07:00 pm													
Total Intake :							Total Output :								
		08:00 pm													
		09:00 pm													
		10:00 pm													
		11:00 pm													
		12:00 am													
		01:00 am													
Total Intake :							Total Output :								
		02:00 am													
		03:00 am													
		04:00 am													
		05:00 am													
		06:00 am													
		07:00 am													
Total Intake :							Total Output :								
Total 24 hrs. Intake							Total 24 hrs. Output								

Patient Sticker



FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	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												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake													
Total 24 hrs. Output													

CHECKLIST FOR THROMBOPHLEBITIS

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

Signature of Ward In Charge :

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

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 cordpyrexia	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-00012567

IP26-00006537

Mrs RIMA DAS

15-01-2000

28 Y 4 M 24 D

(F)

Dr. MUNAGANURU NIHARIKA



BRADEN 'Q' SCALE



Date : 8/1/20
Time : 7/30

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

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

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

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



Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	Fall Risk Grading		
		Score	Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0			
Ambulatory Aid	Furniture	30	Low Risk	0 - 24	Standard Fall Precaution
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0			
IV / Heparin Lock or Saline	Yes	20	Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0			
GAIT / Transferring	Impaired	20			
	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:					
		Signature			

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

HNH-00012567
 Mrs RIMA DAS
 13-01-2000
 Dr. MUNAGANURU NIHARIKA (F)
 28 Y 4 M 24 D
 IP26-00006537

PAIN ASSESSMENT FORM

Date	Time	e (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
8/6/26	10AM	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	①	①
8/6/26	10AM	0/10	Abdom	<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	①	①
8/6/26	1PM	0/10	Abdom	<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	①	①
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Re-assessment Frequency:

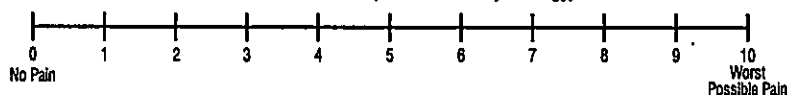
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs 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 of sobs, frequent complaints ¹
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



HNH-00012587 IP26-00006537
 Mrs RIMA DAS
 15-01-2000 26 Y 4 M 24 D (F)
 Dr. MUNAGANURU NIHARIKA



NURSING CARE RECORD



Date: 8/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM 2PM	→ ASSESS the PI condition → monitor the vitals & record → Administration of medication → maintain STO chart & record.	8AM 2PM	→ Assessed the pt condition → vital are checked & recorded → D/C chart maintained → all medication given	possible	maintain STO chart & record	AKL
Afternoon				D/C			
Night							

↳ Patient Sticker

NURSING CARE RECORD

Date:

Goals

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

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



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:	<p style="font-size: 1.2em; color: blue;">Diagnostic Hysteroscopy.</p>						Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:	
	BACKGROUND	Area	<p style="font-size: 1.2em; color: blue;">B16 mb</p>						
Shift Time									
ASSESSMENT	Medical Condition (Any special condition to be noted):	<p style="font-size: 1.2em; color: blue;">NA</p>							
	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
ASSESSMENT	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	<p style="font-size: 1.2em; color: blue;">99.4</p>						
		Res:	<p style="font-size: 1.2em; color: blue;">20b/min</p>						
		SpO ₂ :	<p style="font-size: 1.2em; color: blue;">94%</p>						
		Pulse:	<p style="font-size: 1.2em; color: blue;">84b/min</p>						
		BP:	<p style="font-size: 1.2em; color: blue;">110/70</p>						
	Fall Risk Score:	<p style="font-size: 1.2em; color: blue;">-</p>							
Pain Score:	<p style="font-size: 1.2em; color: blue;">0/10</p>								
Recommendations	Safety Needs:	<p style="font-size: 1.2em; color: blue;">NA</p>							
	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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Others Specify:	<p style="font-size: 1.2em; color: blue;">NA</p>							
	Special Diet:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Other Special Orders / Medications:	<p style="font-size: 1.2em; color: blue;">NA</p>							
Post Operative Procedure Special Orders:		<p style="font-size: 1.2em; color: blue;">NA</p>							
Handed Over By Name :		<p style="font-size: 1.2em; color: blue;">Sejitha</p>							
Signature :		<p style="font-size: 1.2em; color: blue;">[Signature]</p>							
Date:		<p style="font-size: 1.2em; color: blue;">8/6/26</p>							
Time:		<p style="font-size: 1.2em; color: blue;">2 PM</p>							
Taken Over By Name :		<p style="font-size: 1.2em; color: blue;">[Name]</p>							
Signature :		<p style="font-size: 1.2em; color: blue;">[Signature]</p>							
Date:		<p style="font-size: 1.2em; color: blue;">[Date]</p>							
Time:		<p style="font-size: 1.2em; color: blue;">[Time]</p>							

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

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

PATIENT TRANSFER FORM

HNH-00012587 IP26-00006537
Mr RIMA DAS
 15-01-2000 26 Y 4 M 24 D (F)
Dr. MUNAGANURU NIHARIKA


Date & Time of Admission <i>8/6/26 @</i>	Date & Time of Transfer Order <i>8/6/26 @ 11 am.</i>	
Treating Consultant Name	Transfer Ordered by <i>Dr.</i>	Reason for Transfer <i>observation</i>
From Unit <i>07</i>	To Unit <i>forepost</i>	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File <i>-</i>	Number of Imaging Films <i>-</i>	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	<i>Re</i>	<i>1</i>
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes No

Name & Signature of Person who is Transferring <i>Prof</i>	Name of Person Ordered Transfer
---	---------------------------------

Patient & Clinical Records Received by :
Ashish 8/6/26


Date & Time of Patient Received :
8/6/26

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

PATIENT TRANSFER FORM



Patient Name & UHID No. HNH-00012567 IP26-00006537 Mrs RIMA DAS 15-01-2000 28 Y 4 M 24 D (F) Dr. MUNAGANURU NIHARIKA 		Date & Time of Admission 8/6/26 @ 9:2AM	Date & Time of Transfer Order 8/6/26 @ 10:23 AM
		Transfer Ordered by DR. DUA	Reason for Transfer Hysteroscopy
From Unit Pre - post	To Unit OT	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 28	Number of Imaging Films —	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	RL - 500ml	①	
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Sis. Latha		Name of Person Ordered Transfer DR DUA	
Patient & Clinical Records Received by : pooya 8/6/26 @ 10:23 AM			
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

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE



Patient Name : Rima Das. Gender: Male Female Age : 26 yr.
 UHID No : HNH-00012567. Date : 8/6/2026.

Instruction:

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

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

DIAGNOSTIC HYSTEROSCOPY
 upon
Mrs Rima Das (Name of the Patient)

I have been advised of the benefits and reason of the procedure(s) as indicated by the clinical observations and / or diagnostics performed. I recognized that the practice of medicine is as much an art as a science and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcomes. My questions regarding the condition, the proposed surgery and the outcome have been answered to my satisfaction prior to signing this form by the surgeon.

I have been explained the risks of this surgery /procedure and also about the reasonable alternative and the relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment.

I have been explained that the following complications though rare are possible and will not hold Surgeon, Anesthesiologist or the hospital staff responsible for any untoward event thereof.

excessive bleeding, infection, injury to adjacent organs.
Need for blood & transfusion

My signature on this form indicates that

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

Name of the Doctor who is performing the Surgery / Procedure:

Consentee : Rima Das.
 Signature :
 Name : Rima Das.
 Date & Time : 8/6/26 9:30 am

Patient Attendant :
 Signature : [Signature]
 Name : Dibyendu
 Relationship with Patient: Husband
 Date & Time : 8/6/26 9:30 Am

Witness :
 Signature : [Signature]
 Name : Sushan
 Date & Time : 8/6/26 @ 9:30 Am

Doctor (who is taking the consent) :
 Signature : [Signature]
 Name : Dr Das
 Date & Time : 8/6/26 9:30 Am

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE



Patient Name : RIMA DAS Age : 26 Gender : Male Female

UHID NO: Surgeon Name: DR. NIHARIKA

Anaesthesiologist : DR. SHINY

Operative procedure planned : DIAGNOSTIC HYSTEROLOGY

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief without numbness can be achieved by infusing weak solutions of local anesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

Specific High Risk (s) : The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

- Heart disease Hypertension Diabetes mellitus Renal failure
- Hepatic disorders Shock Multiple organ failure Polytrauma / Renal Tubular Acidosis
- Incapacitating Chronic Obstructive Pulmonary Disease
- Others : HYPERTENSION, BRONCHOPATHY, LARYNGOPATHY

Comments :

- Doctor to document in medical record also if necessary (Cross-out if not applicable)

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient the above mentioned operation / Diagnostic / Therapeutic procedures DIAGNOSTIC HYSTEROLOGY

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

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

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

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

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

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

- Pregnant : Yes No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

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

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

Patient / Patient Attendant :

Signature : Rima Das.

Name : Rima Das.

Relationship with Patient: SELF

Date & Time : 23/5/26 11:40AM

Witness :

Signature : Dibyendu Das

Name : Dibyendu Das

Date & Time : 23/5/26 11:40AM

Doctor (who is taking the consent) :

Signature : K. SINGH

Name : DR. SHIN Y

Date & Time : 23/05/26 11:40AM

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



Name: RIMA DAS Age: 26 Sex: F UHID No: H.N.H. 00.012567

Date: 23/05/20 Time: 11:30 AM Proposed Operation: Diagnostic Hysteroscopy

Diagnosis: primary infertility with MP

B.P / CRT: 112/62 H.R: Weight: 64 kg ASA Physical Status: 1 2 3 4 5

Laboratory Data:

01/06

Hgb: <u>11.4</u>	Glucose:	Protein:	HIV:	X-Ray:
PCV:	Urea:	Alb:	HBS Ag: <u>NR</u>	ECG:
WBC: <u>6170</u>	Creat:	Total Bill:	HCV: <u>NR</u>	2D Echo:
Plate: <u>1.5</u>	Na:	Dir. Bill:	Blood group:	Stress/Anglo:
PT:	K:	LDH:	T3	Other:
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH <u>1.61</u>	<u>LMP = 22/05/20</u>
Cl-:	SGOT/SGPT:			

Allergies: _____

Medical History: CVS: - K/clo hypothyroidism since 2 yrs on medication

RESP: - Diabetes: -

CNS: -

Renal: -

Hepatic / GE: - Physical Activity: METS > 4

Others: _____

Past Anaesthetic History: oocyte Retrieval 1 month ago -> ↓ Sedation -> O/E

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: Adequate Mentohyoid Distance: (M) Neck: (M) Teeth: No loose teeth

Lungs: B/L A/E (+)

Heart: S/S (+)

CNS: conscious, oriented

Pregnant: Yes No NA Venous Access Site: Accessible Spine Exam for regional: Midline Spaces well felt

Anaesthetic Plan: MAC REGIONAL GA-ETT LMA

Peri-Operative Plan Explained to the Patient: Yes No

CURRENT MEDICATIONS	DOSAGE
<u>T. Thyronorm</u>	<u>25 mcg OD</u>

Pre-Operative Instructions:

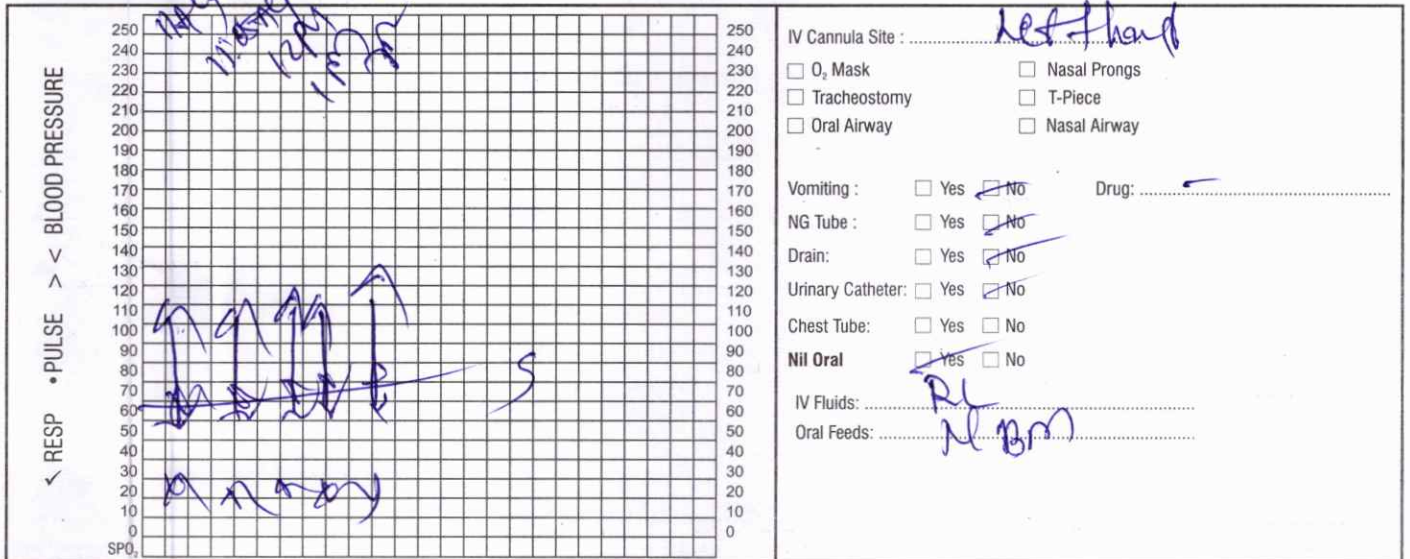
- DVT Prophylaxis:
 - Water / ORS 2 Hours
 - Others 6 Hours
- NIL ORAL Explained
- Informed Consent: Standard High Risk
- Post Operative Pain Management: Discussed with Patient
- Other Instructions: CBP

Signature: [Signature] Name: DR SHINNY



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: Alavi Time Received: 11:00 AM Time Discharged: 11:00 AM



POST ANAESTHESIA SCORE (Modified Aldrete Score)	IN	MINUTES			OUT	SCORING INTERPRETATION
		30	60	90		
Able to move 4 extremities voluntary or on command = 2 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 0	ACTIVITY	1	2	2	2	A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0	RESPIRATION	2	2	2	2	
BP ± 20 of Pre Anaesthetic level = 2 BP ± 20-50 of Pre Anaesthetic level = 1 BP ± 50 of Pre Anaesthetic level = 0	CIRCULATION	2	2	2	2	
Fully awake = 2 Arousable on calling = 1 Not responding = 0	CONSCIOUSNESS	2	2	2	2	
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0	COLOR	2	2	2	2	
TOTAL		9	10	10	10	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
8/6	11 AM	0/10	None	[Signature]
8/6	12 PM	0/10	None	[Signature]
8/6	1 PM	0/10	None	[Signature]
			D/C	

Pain Tool Used: N PASS FLACC Wong Baker NPS

Reassessment Frequency:

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

Anaesthesiologist Name: Alavi
 Anaesthesiologist Signature: [Signature]
 Date & Time: 8/6/20 11:00 AM
 PACU Nurse Name: Alavi
 PACU Nurse Signature: [Signature]
 Date & Time: 8/6/20 11:00 AM

Transferred to Unit by (PACU):
 Date & Time: 8/6/20

