Dr. Ramya

Rainbow® Children's Hospital — It takes a lot to treat the little. | BirthRight™ BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

ESTIMATION SLIP

Date : 13/6/26 **UHID / IP No. :** HNK-0001232 9 **Sl No.** 1594

Name of Patient : Ms. Sashitale **Age:** 3 days **Gender:** F

Father's / Husband's Name : Mr. Vinod Reddy **Corporate / Occupation :**

Address : Champapet **Phone :** 9346319291 **Email :**

Procedure / Plan : ND / LSCS **EDD/Dos:** June-17

MODE OF PAYMENT : ☑ SELF ☐ TPA : _____ ☐ GIPSA : _____ OTHER

TARIFF INFORMATION :

Particulars	Package Amounts (Rs.) 2 day	3 days
Room Category	Normal Delivery	LSCS
Multi Shared Ward		
Shared Ward →	0.80.	1.00.
Twin Shared Ward →		
Private Room →		
Super Deluxe Room		
Suite Room		
Package includes (Package starts from the time of admission)	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee and Labour Ward Charges	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee Anesthetist's Fees and OT Charges
	Length of Stay for : 2 Days	Length of Stay for : 3 Days
	Pharmacy up to 9,000/-	Pharmacy up to 12,000/-
	Investigations up to 2,500/- (Lumps)	Investigations up to 3,000/-
Others	Well baby Care	ISL. (ISL Baby)

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

Initial Minimum Deposit : 80% Advance

REMARKS : Vaccination, Neonatal SBR, B/G

1. 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.
2. 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.
3. **Total baby charges are extra which include admission, pharmacy, vaccinations, investigations, disposables, consumables, equipments, speciality consultations, etc.**
4. 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
5. **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.**
6. 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.
7. 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
8. Tariffs are subject to revision
9. Kindly check your billing status on day to day basis at IP Billing Department.
10. Additional Charges on package are applicable for Non-working hours and Non-working days (sundays and public holidays)

DECLARATION

I S. Vinod Reddy. 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.

Vinod Reddy.	Husband	
Signature of the Client	Signatory Relationship	Signature of the financial Counselor

HNH-00012329 IP26-00006587
Mrs V SASHIKALA
20-12-1995 30 Y 5 M 26 D (F)
Dr. KADIYALA RAMYA THEJA

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SURGERY DETAILS

Date : 15/6/26

Patient Name: Mrs. Sashikala Date of Birth: 20-12-1995 Age: 30yrs

Gender: female Ward : OT-II UHID No.: HNH-00012329

Date of Surgery: 15/6/26 ☐ OT -1 ☑ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : EMERGENCY LOWER SEGMENT CAESAREAN SECTION + Epidural anaesthesia

Time in : 7:15pm Time Out : 8:45pm

	NAME	AMOUNT
1. Surgeon	Dr. Ramya Theja	
2. Anaesthetist	Dr. Samir	
3. Assistant Surgeon	Dr Swathi	
4. OT Technician	Br. Sai chandu	
5. Circulating Nurse	Sr. Karuna	
6. Assistant Nurse	Sr. Archana	

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

Signature of the Surgeon

Karuna.
Signature of Circulating Nurse

Order No: 26-000206935

Order by: Sandhya 16/6/26 @ 1:40Am
(or record saved)

Docu. No. : RCH /FRM / GENERAL / 114

HNH-00015997 IP26-00006592
Baby Of V SASHIKALA
15-06-2026 0 Y 0 M 0 D 5 H (F)
Dr. SPANDANA PASUPULETI

9 Em. LSCS

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CONSUMABLES OF OT

Circulating staff : Karuna Technician : Sai Chandu Date : 15/6/26 Time :

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			~~Major Pack~~ LSCS Drape		01	Inj Vit.K		01
LMA			Sutures 2346, 2364	01+1		Cord Clamp		01
ECG leads : (A) / P / N		03	4242, 4248	1+1		Suction Catheter		
HME filter : A / P / N			1326.	1		Feeding Tube		
Syringes : 10 cc		03				Vaccum Suction Set		
05 cc		05	Gloves S.G 6½ →	2		Surgical Gloves S.G 7, 6.5		10
02 cc		03	Encore 6½ →	1		Gauze Pack 75x75		01
01 cc		01				Syringe ~~1ml~~ / 2ml		01
Cautery plate : (A) / P / N		01	Surgical blade 22	01		Surgical Blade # 20		01
IV set		01	NG tube			Koochies (S)		
RL		03	Cautery pencil	01				
NS : 10ml / 100ml / 500ml / 1000ml			Koochies XX	01		26-0000206934/933		
PCM		01	Ointments					
Tranexa 1grm		02	Suction Catheter					
Fentanyl		(01)	Cap, Mask		10 of 10			
Morphine			Gauze Pack 7.5cm		01			
Ketamine		01	Mop Pack		02			
Propofol		02	Steristrip					
Rocuronium			Underpad	01	[illegible]			
Glycopyrolate			Draw sheet					
~~Myopyrolate~~ Metrogyl		01	Abgel		01			
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
~~Antibiotics~~ Lox with Adrenaline		01	Bandage					
O2 mask (A)		01	Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg		01	Vaccum Suction set	01				
Justin : 12.5 mg / 25mg / 100mg		01	Plastic Bed Sheet Apron	3				
Tab. Misoprost : 200mg		04	Betadine Solution		02			
oxytocine		01	Microshield		01			
Encore 7.0		01	Cotton Balls		01			
Methergine		01	Latex Gloves		10			
Carboprost		01	Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 26-0000206932/931/6937 Ordered by : Sandya 16/6/26 @ 1:15 Am

Doc. No. : RCH / FRM / GENERAL / 125

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Old MLA quarters road AP State Housing Board Himayatnagar ,
Hyderabad ,Telangana, INDIA ,500029.
040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	HNH-00012329	Name	Mrs V SASHIKALA
Age / Sex	: 30 Y 5 M 27 D / Female	Doctor	: KADIYALA RAMYA THEJA
Adm/Reg Date/Time	15/06/2026 07:06	Payor	SELFPAY
Order Date	16/06/2026 00:15	Ordernumber	26-0000206931
Visit ID	IP26-00006587	Ward/Bed No	4F -OT / PPO-417
Patient Address	Champapet, Hyderabad, Champapet, Hyderabad, Telangana, INDIA, 500079		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	OxygenMask With Tubing - Adult ROMSONS-FC		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
2	BIOXAMIC 500 MG INJ		1 Ampule	External / Once Daily	1 Days		2 Ampule	Dispensed
3	VICRYL 1-0 NW 2364	VICRYL 1-0 NW 2364	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
4	EVATOCIN (OXYTOCIN) INJ 5 IU 1 ML		1 Vial	External / Once Daily	1 Days		7 Vial	Dispensed
5	VICRYL 1-0 VP 2346	VICRYL 1-0 VP 2346	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
6	ADULT DIAPERS-XXL		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
7	BACTOPREP SOLUTIONS 100 ML	CHLORHEXIDINE GLUCONATE2% &ALCOHOL80% 500	1 mL	/ Once Daily	1 Days		1 Nos	Dispensed
8	SURGICAL BLADE 22	SURGICAL BLADE 22	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
9	Encore Microptic gloves-6.5		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
10	DSYRINGE 1ML (NIPRO)	SYRINGE 1ML	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
11	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
12	POVINANZ SOLUTION 10% 100 ML		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
13	JUSTIN SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
14	ENCORE MICROPTIC GLOVES-7 PF		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
15	PREGELLED SURGICAL PLATES(ADULT)	PREGELLED PLATED ADULT	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
16	ABGEL SURGI PAD (BIG) (GELSPON)	ABGEL	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
17	MISOPROST TAB 200MCG 4S		1 Tabs	External / Once Daily	1 Days		4 Tabs	Dispensed
18	SUPRIDOL SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
19	MOPS 30X30 8PLY 5S X-RAY	MOPS 30X308 PLYDATT	1 Nos	/ Once Daily	2 Days		2 Nos	Dispensed
20	VACCUME SUCTION SET	VACCUME SUCTION SET	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
21	COTTON BALLS 2 GM 5 NOS	COTTON BALLS 2G- 5 NOS	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
22	THEMICAINE ADR INJ 30 ML		1 Vial	External / Once Daily	1 Days		1 Vial	Dispensed
23	RL 500 ML CLOSED SYSTEM	RINGER LACTATE 500ML CLOSED	1 Bottle	/ Once Daily	3 Days		3 Bottle	Dispensed
24	CATGUT 1-0 4248		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
25	MONOCRYL 3-0 NW 1326	MONOCRYL 1326	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
26	GAUZE 7.5X7 5 12 PLY (5 NOS)	GAUZE 7.5X7.5 12 PLY 5 NOS	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
27	TRUGUT CHROMIC CATGUT SN4242	TRUGUT CHROMIC CATGUT SN4242	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
28	DISPOSABLE APRONS STERIL XL	DISPOSABLE APPRON STERILE XL	1 Nos	/ Once Daily	3 Days		3 Nos	Dispensed
29	MCT-ROF 100MG 10ML		1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
30	RELIPARA(PARACETAMOL) 1000MG 100ML BOTTLE		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
31	LSCS DRAPE PACK	LSCS DRAPE PACK	1 Nos	/ 10 AM	1 Days		1 Nos	Dispensed

KADIYALA RAMYA THEJA

Reg No : TSMC/FMR/01458

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

Note

*** This prescription is valid only for specified duration.**

*** Do not refill medicines.**

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040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	: HNH-00012329	**Name**	: Mrs V SASHIKALA
Age / Sex	: 30 Y 5 M 27 D / Female	**Doctor**	: KADIYALA RAMYA THEJA
Adm/Reg Date/Time	: 15/06/2026 07:06	**Payor**	: SELFPAY
Order Date	: 16/06/2026 00:15	**Ordernumber**	: 26-0000206932
Visit ID	: IP26-00006587	**Ward/Bed No**	: 4F -OT / PPO-417
Patient Address	: Champapet, Hyderabad, Champapet, Hyderabad, Telangana, INDIA, 500079		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	NITRILE EXAMINATION GLOVES P F- MEDIUM	NITRILE GLOVES M	1 Nos	External / Once Daily	1 Days		10 Nos	Dispensed
2	UNDERPADS 60X90 BUTTERFLY		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
3	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
4	BCV-INTRAFIX SAFESET		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
5	ACUGYL 500MG INJ		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
6	SURGEONS CAP	SURGEONS CAP	1 Cap	Oral / Once Daily	1 Days		10 Cap	Dispensed
7	DSYRINGE 5ML.(NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		5 Nos	Dispensed
8	FACE MASK 3 LAYER - ELASTIC	FACE MASK 3 LAYER	1 Nos	External / Once Daily	1 Days		10 Nos	Dispensed
9	DSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
10	E.C.G ELECTRODES (ADULT)	ELECTRODES ADULT	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed

KADIYALA RAMYA THEJA

Reg No : TSMC/FMR/01458

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040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	: HNH-00015997	**Name**	: Baby Of V SASHIKALA
Age / Sex	: 0 Y 0 M 0 D 11 H / Female	**Doctor**	: SPANDANA PASUPULETI
Admreg Date/Time	: 15/06/2026 20:12	**Payor**	: SELFPAY
Order Date	: 16/06/2026 00:32	**Ordernumber**	: 26-0000206933
Visit ID	: IP26-00006592	**Ward/Bed No**	: 4F -OT / CRDL-HNPDA-415-1
Patient Address	: Champapet, Hyderabad, Champapet, Hyderabad, Telangana, INDIA, 500079		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	CORD CLAMP ALPHAMEDICARE		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
2	EASYCLOT-K1 1MG INJ 0.5 ML		1 Nos	External / 1-2 TIMES A DAY	1 Days		1 Nos	Dispensed
3	SURGICAL BLADE 20	SURGICAL BLADE 20	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
4	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
5	DSYRINGE 1ML (NIPRO)	SYRINGE 1ML	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed

SPANDANA PASUPULETI

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Note

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*** Do not refill medicines.**

Printed Date/Time : 16/06/2026 06:48 Printed By : GEDDAM SANDHYA PRAMEELA RANI

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Name	Mrs V SASHIKALA	**UHID**	HNH-00012329
Father/Guardian	Mr VINOD REDDY	**Age/Gender**	30 Y 5 M 27 D/ Female
Address	Champapet, Hyderabad, Champapet, Hyderabad, Telangana, INDIA, 500079		
IP No	IP26-00006587	**Admission Date**	15-06-2026
Ref Doctor	Self.		
Discharge Date	18.06.2026		

DISCHARGE SUMMARY

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

Diagnosis: PRIMIGRAVIDA WITH 38^{+1} WEEKS PERIOD OF GESTATION WITH LATENT LABOUR (PREMATURE RUPTURE OF MEMBRANES) WITH ? INTRA HEPATIC CHOLESTATSIS OF PREGNANCY WITH HYPOTHYROIDISM.

EMERGENCY LOWER SEGMENT CAESAREAN SECTION DONE ON 16.06.2026

History:
LMP: 21.09.2025
EDD: 28.06.2026

Obstetric formula: Primigravida.
Gestation at admission: 38^{+1}

Name	Mrs V SASHIKALA	UHID	HNH-00012329
IP No	IP26-00006587	Admission Date	15-06-2026

weeks

Obstetric History:
G1 - Present pregnancy, Spontaneous conception.

Medical History: .K/C/O Hypothyroidism since 6 years and on T. Thyronorm 100mcg, H/O Pulmonary Kochs 6-7 years ago,received ATT.

Surgical History: Nil
Allergies: Nil
Family History: Father-Hypertensive.

Antenatal Details:

Mrs V SASHIKALA was booked to Rainbow hospital at 10^{+3} weeks of gestation. She had regular antenatal checkups and investigations as advised. NT scan was normal. FTS was low risk. TIFFA showed Posterior low lying Placenta,rest normal. Fetal monitoring was done by serial growth scans.At 36^{+4} weeks patient came with complaints of generalised itching since 2-3 weeks, LFT done at 35^{+2} weeks (26.05.2026) SGOT/SGPT - 106/207, Total Bile sides - not done and was started on T.Udiliv 300mg twice daily. On 05.06.2026 Total Bile Acids - 9, SGOT/SGPT - 70/143, On 12.06.2026 SGOT/SGPT - 32/70. Growth scan done on 04.06.2026 at 36^{+4} weeks showed Cephalic Presentation, AFI:20.4cm, Placenta-posterior and right lateral high 3.8cm away from OS with EFW: 3.017kg (58%), AC: 74% with normal Doppler. She was admitted at 38^{+1} weeks with Premature rupture of membranes in early labour.

Name	Mrs V SASHIKALA	**UHID**	HNH-00012329
IP No	IP26-00006587	**Admission Date**	15-06-2026

Investigations: Enclosed
Blood group: "B" Positive

Management:

Course in hospital and Delivery Details:

At admission on clinical examination the vitals were stable, uterus was mild acting, cervix was partially effaced and 1cm dilated, vetrex -3, pelvis adequate with Active PV Clear leak. Fetal well being was confirmed by an admission CTG which was found to be reactive. As per hospital protocol she was started on IV. Taxim in view of ruptured membranes. Informed consent obtained for induction of labour and vaginal birth. She was induced with 3 doses of oral PGE1.She was Patient opted for epidural analgesia at 2cm dilatation for pain relief. The same was sited by an anesthetist after informed consent. Further augmentation was done by oxytocin infusion. She was decided for emergency C- section in view of Non Progression of Labour and Occipito - posterior position , prepared with indwelling Foley's catheter and IV canula under aseptic conditions. Written informed consent for surgery taken. Preanesthetic check up done. Anesthetic premedication (IV Pantop and Perinorm) given. Patient shifted to theatre.

Surgery Notes:

Under Epidural anesthesia she was painted and draped as per hospital protocol. Abdomen opened in layers. The parietal and visceral peritoneum carefully opened after identifying the urachus. Bladder was reflected. A lower segment curvilinear incision given on the uterus. Baby delivered. Cord clamped

Name	Mrs V SASHIKALA	UHID	HNH-00012329
IP No	IP26-00006587	Admission Date	15-06-2026

and cut and cord blood collected for blood grouping and Rh typing. Baby handed over to pediatrician. Placenta delivered with controlled cord traction. Uterus closed in layers. Hemostasis secured. Instruments and swab count checked. Rectus sheath closed. Skin closed with subcuticular sutures. Wound dressing done. Vagina cleaned with Betadine solution after expelling clots. Misoprostol 400 mcg given per rectum as prophylaxis against Postpartum hemorrhage. Patient was shifted out of theatre to post operative recovery room.

*** LUS thinned out.**
*** Bladder drawn up.**
*** LOP position / deflexed head.**
*** Endometriotic spots on bilateral adnexa and posterior wall.**
*** Right sided broad Ligament hematoma: 1x2cm , 2x2cm- hematoma secured.**
*** Uterus atonicity noted medically managed.**

Delivery Details :
Date : 15.06.2026
Time of Delivery: 07:24pm
Type of Delivery: Emergency lower segment cesarean section
Indication : NPOL with ? obstructed labour with OP position
Anaesthesia : Spinal

Baby Details:
Date : 15.06.2026
Time : 07:24pm

Name	Mrs V SASHIKALA	UHID	HNH-00012329
IP No	IP26-00006587	Admission Date	15-06-2026

Sex : Female
Weight : 2.9kg
Apgar : 7,9
Gestational Age: 38^{+1} weeks
NICU Admission: No

Post-Operative Notes:

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

Advice:

1. Tab. Taxim O 200mg twice daily till 21.06.2026 (9am-9pm) after food.
2. Tab. Calpol 500mg (Paracetamol 500mg) (2tabs) thrice daily till 19.06.2026 (8am-2pm-10pm) after food.
3. Tab. Voveran 50 mg (Diclofenac 50mg) thrice daily till 19.06.2026 (9am-3pm-11pm) after food.
4. Tab. Pantop 40mg twice daily till 21.06.2026 (7am-7pm) before food.
5. Tab.Thyronorm 100 mcg once daily(6am) till further orders.
6. Tab. Livogen (Elemental Iron - 50mg, folic acid 1.5mg) once daily (7am) for three months before breakfast.

Name	Mrs V SASHIKALA	**UHID**	HNH-00012329
IP No	IP26-00006587	**Admission Date**	15-06-2026

7. Tab. Shelcal (Elemental Calcium 500 mg, Vitamin D3 250 IU) once daily (2pm) till breast feeding for after food.
8. Follow up with FT3,FT4,TSH reports after 4 weeks.
9. Nebasulf Powder for local application.

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

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

Review with **Dr. KADIYALA RAMYA THEJA,** after 1 week at Rainbow Children's Hospital with prior appointment **(Review consultation will be charged).**

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

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Name	Mrs V SASHIKALA	**UHID**	HNH-00012329
IP No	IP26-00006587	**Admission Date**	15-06-2026

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**

Nalleena

Registrar/Resident/C.M.O

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

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Childrens Hospital-Himayatnagar

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

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006587 **Admit Date** : 15-Jun-2026 **Admit Time** : 07:06 AM **UHID** : HNH-00012329

Patient Details :

Patient Name	: Mrs V SASHIKALA	**Age**	: 30 Y 5 M 26 D
Guardian	: Mr VINOD REDDY	**DOB**	: 20-12-1995
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: Champapet, Hyderabad Champapet Hyderabad Telangana INDIA 500079	**Phone No**	: 8125584745/ 9346319291
		E-mail	: sasikalaece051@gmail.com

Admission Details :

Bed Type : TWIN SHARING **Bed No** : PPO-417 **Ward Name** : 4F -OT

Room No : PPO-417 **Admission Type** : First Visit

Contact Details :

Name : Mr VINOD REDDY **Relationship** : W/O

Contact Address : **Phone No** : 8125584745

S. Vinod Reddy.

Signature

Doctor Details :

Doctor Name : Dr. KADIYALA RAMYA THEJA **Specialisation** : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self. **Phone No** :

Co-Consultant :

Payment Details :

Payment Mode : DC/CC Card **Deposit Amount** : 30000.00

Payor Name : SELFPAY

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00012329 IP26-00006587 Mrs V SASHIKALA 20-12-1995 30 Y 5 M 26 D (F) Dr. KADIYALA RAMYA THEJA	15/06/2026 @ 07:06 AM	16/06/2026 @ 10 AM
	Transfer Ordered by Dr. Naveena.	Reason for Transfer observation
From Unit pre & post	To Unit 315	Information to Attendant Yes ☐ No ☐
Number of Sheets in Clinical File 32	Number of Imaging Films NST - 5	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Anusha .b	Dr. Naveena

Patient & Clinical Records Received by : Supriya

Date & Time of Patient Received : 9:52AM @ 16/6/26

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

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ACTIVITY RECORD FOR BILLING

HNH-00012329 IP26-00006587
Name : Mrs V SASHIKALA
20-12-1995 30 Y 5 M 26 D (F)
Dr. KADIYALA RAMYA THEJA

UHID No. :

Consultant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
15/6/26	7pm	pre post	OT	Sujitha / Archana
15/6/26	9:pm	OT	pre-post-	Sujitha / Archana
16/6/26	10AM	pre & post	315	

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Tejasvi	17/6/26	7121	
2				by Surgery
3			done	
4	Cross Checked			
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
15/6	NST - (1)	7195	Anubha
15/6	NST - (2)	7196	
15/6	NST - (3)	7197	
15/6	NST - (4)	7217	
15/6	NST - 5	7218	
16/6/26	CBP	9885	
			Cross checked done by Author.
			Cross checked done by Supriyo

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
15/6	cardiac monitor	3.30pm	16/06/2024 8pm	206876	[illegible]
15/6	infusion pump	3.30pm			[illegible]
15/6	Epidural	3.30pm			[illegible]

Cross checked [illegible]

cross checked done by Supriya

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
15/6/26	IV placement	1	206874	[illegible]
15/6	catheterization	1	6878	[illegible]
15/6	PAC	1	6877	[illegible]
			Cross checked	
			done	[illegible]
16/6/26 (10:30am)	NHA	1	7120	[illegible]

ANY OTHER INFORMATION

....

....

....

....

....

....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00012329 IP26-00006587
Mrs V SASHIKALA
20-12-1995 30 Y 5 M 26 D (F)
Dr. KADIYALA RAMYA THEJA

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ET FOR OBSTETRICS

Presenting Complaints
c/o PV leak - last night

LMP: 21/09/2025 EDD: 28/6/2026
Corrected EDD: 28/6/2026 GA: 38w 1 day

Obstetric Formula: Primi
ML: 1 year, NCM

Menstrual History: Regular: ☑ Yes ☐ No

Obstetric Hostory:
1st: PP, Spontaneous Conception

Obstetric Examination

Fundal Height: Term

Ut. Activity: ☑ Relaxed ☐ Mild ☐ Mod ☐ Severe

Present Pregnancy Record:
NT - (N), FTS - low risk.
TIFFA - posterior low lying placenta

Liquor: ☑ Adequate ☐ Oligo ☐ Poly

PP: ☑ Cephalic ☐ Breech Others ____

Head Fifths Palpable: 4/5th

RISK FACTORS: Rest (N)

FHS: ☑ Normal ☐ Tachy ☐ Brady ☐ Absent

pt had generalised itching - 2-3wks
& started on T. Udiliv. 300mg BD.

Per Speculum Examination

Draining: ☑ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☑ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination

Cervix: ☑ Long ☐ Partially effaced ☐ Effaced

Os: Closed ____ Dilated 1cm

Height: 154 cm
Weight: 55.2 kg
Allergies: Nil
Breast: ☑ Normal ☐ Abnormal
General Examination:
Consciousness: c/c. Pallor: No
Icterus: No Edema: Nil
Temp: Afebrile PR: 86bpm
BP: 100/60mg. DTR: (N)
CVS: S1S2 (+) no murmur RS B/L NVBS (+)
Liver/Spleen: Urine Output: adequate

Membranes: ☑ Present ☐ Absent

Liquor: ☑ Clear ☐ Meconium ☐ Blood Stained

Presenting Part: ☑ Vertex ☐ Breech ☐ Others

Sutton: ☐ -3 ☑ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Pelvis: ☑ Adequate ☐ Doubtful

10.51

DIAGNOSIS

Primigravida with 38w1days POG with ~~[illegible]~~ in latent labour (PROM).
hypothyroidism / ? IHCP

HNH-00012329 IP26-00006587
Mrs V SASHIKALA
20-12-1995 30 Y 5 M 26 D (F)
Dr. KADIYALA RAMYA THEJA

Family History: Father – HTN.	Surgical History:
Medical History: hypothyroidism :- 6yrs on T. thyronorm 75mcg. Pulmonary Kochs 6-7yrs	Medication History: T. IRON T. CALCIUM.
Plan of Care: - Admission NST. - Parts preparation - T. Misoprostol 25mcg PO stat f/b T. Misoprostol PO 25mcg at 9am. - Informed Consent [Induction + VD]. - liquid diet - drugs as charted. - strict FHR monitoring - w/f POL - Monitor Vitals - Inform SOS	Investigations: BGT – B positive. CBP (26/5/2026) Hb – 10.7 TLC – 7910 plt – 2.49. PCV – . USG (4/6/2026) SLIUF 36w 4days Cephalic. placenta – post. & Rt. lateral. high. 3.8cm away from OS. AFI – 20.4cm. EFW – 3.017kg (58%) [AC – 74%] Doppler – (N).

Doctor Name: Dr. Naveena.
Signature: [signature]
Date & Time: 15/06/2026 @ 7:15am.

Consultant Name: Dr. Ramya.theja
Signature: [signature]
Date & Time: 15/6/2026 @ 8Am

Dr. RAMYA THEJA KADIYALA Reg. ...

HNH-00012329 IP26-00006587
Mrs V SASHIKALA
20-12-1995 30 Y 5 M 26 D (F)
Dr. KADIYALA RAMYA THEJA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/6/26 9:30am	c/s/B Dr. Veena.	
	Primi / 38+1 wks / Low lying placenta (previously) - / IHCP.	
1st dose miso @ 6:30am	- Ongoing IOL.	
	- Pt is stable, Nocto	Adv
	o/e GC-fair.	- Soft diet.
	Vitals-stable	- @ NST 3rd hourly
NST - Reactive	P/A - Ut n Term	- FHR 2nd hourly
	Cephalic, 4/5th palpable	- w/f progress.
	FHS (+), 2/10"/10'	- Vital monitoring
	2nd dose - P/o Misoprostol 25mcg given	- Inform SOS.
3rd dose	- P/o Misoprostol 25mcg given.	
15/6/26 1:45pm.	c/s/B Dr. Ramya	Noted by Anusha.
	Primi / 38+1 wks / ~~Oligohydramnios~~	
	Ongoing IOL.	~~Adv~~
NST - Reactive	Pt is stable, Nocto	- Liquid diet
	o/e GC-fair	- NS 3rd hourly
	Vitals stable	- FHR 2nd hourly.
	P/A - Ut n Term	- w/f progress
	Cephalic, 4/5th	- vital monitoring
	FHS (+) 3/30"/10'	- Inform SOS.
P/v - 2cm dilated, ~~1~~ 1/2 inch long		- Epidural analgesia
	Vx = -2 station	
	Dr. RAMYA THEJA KADIYALA Reg. No: 01458	Dr Ramya Theja

HNH-00012329 IP26-00006587
Mrs V SASHIKALA
20-12-1995 30 Y 5 M 26 D (F)
Dr. KADIYALA RAMYA THEJA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/6/2026. 5:45pm	c/s/B Dr. Ramya	
	Primi c 38+1wk ↓IOL.	
	GC fair, Afebrile	Adv
	vitals - Normal	- NBM
	P/A ut ≃ term.	- ~~FHR 2nd hourly~~
N/c: Reduced	cephalic	- Continuous FHR Monitoring
variability	FHS ⊕.	- Vital Monitoring
c/f	3c/20/10.	- w/f POL
early	stimulation P/v Cx 1/2 long MC MP	- Inform / SOS
	⊕ os - 3-4cm M ⊖	
	OP with deflexed head PR mx -2 caput ⊕	Urine blood ...
	Pt & attendant counselled regarding fetal position - occipito posterior position. Need for Em. LSCS. i/v/o NPOL	
	Bedside USG done, findings confirmed.	
	Explained to Mrs. Sashikala, her attendants in detail regarding need for emergency LSCS for maternal fetal indication, explained possibility of obstructed labour.	
	- family wishes to wait for a 30-60mins.	
	Ramya Dr RAMYA THEJA.K	

Dr. RAMYA THEJA KADIYALA Reg. No: 01458

HNH-00012329 IP26-00006587
Mrs V SASHIKALA
20-12-1995 30 Y 5 M 26 D (F)
Dr. KADIYALA RAMYA THEJA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/6/26. 7pm.	FHR good	
	PA: suprapubic flatterly (+) uterus acutely aphonic	- USG: LOP with deflexed head
	PV: same findings.	
	Consent given for LSCS. Pediatrician informed	
		Ramya Dr. RAMYA THEJA.K
15/6/26. 10pm	0-POD / 1HLP-	
		Adv
	No complaints	1) NBM x 4-6 hrs
	GC fair/ afebrile	2) IV fluids as advised
baby well	PR: 86/min	3) Monitor vitals
	BP: 112/68 mmHg	4) drugs as charted
U/O: good clear	SpO2: 98%.	5) W/F excess bleed PV
	PA: soft, UWR	6) I/O charting
	PV: bleeding (N)	7) CBP @ 6AM on 16/6/26
		8) Inform SOP.
		Ramya Dr RAMYA THEJA.K

Dr. RAMYA THEJA KADIYALA Reg. No: 01458

Dr. RAMYA THEJA KADIYALA Reg. No: 01458

HNH-00012329 IP26-00006587
Mrs V SASHIKALA
20-12-1995 30 Y 5 M 26 D (F)
Dr. KADIYALA RAMYA THEJA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/6/26 2AM	O-POD	
	No complaints	
	GC fair/afebrile	
	vitals (N)	
U/O: good	PA: soft, UWR	
	BS (+).	Ramya
	PV: bleeding (N)	Dr RAMYA THEJA
16/6/26. 7AM.	O-POD	Adv
	No complaints	
	GC fair/afebrile	1) soft diet/oral fluids
baby well	PR: 89/min	2) drugs as charted
	BP: 100/61 mmHg	3) IV fluids as charted
	SpO2: 98%.	4) Monitor vitals
U/O normal/hr	PA: soft, UWR	5) W/F excess bleed PV
F: x	BS (+)	6) S/o charting
S: x	PV: bleeding (N)	7) Remove foley's @ 2pm
		8) Can shift to room
CBP: 9.7 / 12000 / 1.88.		
	Ramya	Dr RAMYA THEJA
Pt can be shifted to Room		NB - Supriya 16/6/26 10AM

Dr. RAMYA THEJA KADIYALA Reg. No: 91458

HNH-00012329 IP26-00006587
Mrs V SASHIKALA
20-12-1995 30 Y 5 M 27 D (F)
Dr. KADIYALA RAMYA THEJA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/6/2026 2:00pm	c/s/by	Dr. Naveena
	O/E: GC-fair	Adv.
	Afebrile	✓ Soft diet
	~~Soft~~ SpO_2 - 94% on RA.	✓ Adequate hydration
F - Y	Vitals - stable;	✓ drugs as charted.
S - Y	PA: ut. retracted.	- Ambulation
	well, Soft, NT	- Foley's removal @ 2pm
	Dressing: dry & clean	- Monitor Vitals
	U/F PV bleeding WNL.	- W/F PV bleeding
	U/O adequate & clear.	- Inform SOS
	Baby: MS	
		Dr. Naveena.
		N/B - Supriya 2:17pm @ 16/6/26

Docu. No. : RCH /FRM / CLINICAL / 088 (P.T.O)

HNH-00012329 IP26-00006587
Mrs V SASHIKALA
20-12-1995 30 Y 5 M 27 D (F)
Dr. KADIYALA RAMYA THEJA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/6/26 7:30PM	c/s/B Dr. Veena	
	POD-1 / Em.LSCS / P1L1	
Baby @ MS	Pt is stable, No c/o	
UV FV SV.	O/E GC-fair, Vitals-stable -Afebile Pallor (-)	Adv - Regular diet - Adequate hydration
B/L Breasts Soft, NS (+)	P/A - Ut well retracted BS (+) C/E - BWNL	- Drugs as charted - Ambulation - Vital monitoring - Inform SOS
17/6/26 7:45AM	c/s/B Dr. Veena	Noted by Dr. Veena 8pm
	POD-2 / Em.LSCS / P1L1	
UV FV SV Baby @ MS	Pt is stable, No c/o O/E GC-fair., Afebile Vitals - stable. P/A - Ut well retracted BS (+) C/E - BWNL	Adv - Regular diet - Adequate hydration - Drugs as charted - Vital monitoring - Ambulation - Inform SOS - ASD today.
		N.B. maheshwari

HNH-00012329
Mrs V SASHIKALA
20-12-1995 30 Y 5 M 27 D (F)
Dr. KADIYALA RAMYA THEJA
IP26-00006587

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/6/2026 10:00am	c/s/by Dr. Naveena	
	o/E GC- fair Afebrile. V- ✓ Vitals- stable F- ✓ PA: ut retracted S- ✓ So/f, NT Dressing: dry & clean. UE: PV bleeding WNL.	Adv. ✓ Regular diet ✓ Adequate hydration. ✓ Drugs as charted. ✓ W/F PV bleeding. ✓ Ambulation ✓ Monitor Vitals ✓ Inform SOS. ✓ close dressing.
	Baby: MS. Patient can be discharged	Dr. Naveena.
		N/B- Supriya 10:49 AM @ 17/6/26

1NH-00012329 IP26-00006587
Mrs V SASHIKALA
20-12-1995 30 Y 5 M 27 D (F)
Dr. KADIYALA RAMYA THEJA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00012329 IP26-00006587
Mrs V SASHIKALA
20-12-1995 30 Y 5 M 27 D (F)
Dr. KADIYALA RAMYA THEJA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00012329 IP26-00006587
Mrs V SASHIKALA
20-12-1995 30 Y 5 M 27 D (F)
Dr. KADIYALA RAMYA THEJA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00012329 IP26-00006587
Mrs V SASHIKALA
20-12-1995 30 Y 5 M 27 D (F)
Dr. KADIYALA RAMYA THEJA

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NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 16/6/26 Time: 11 Am

Origin: Indian Height: 154Cms Weight: 55.2kg BMI: ☑ ~ 26 kg/m² ☐ ~ 28 kg/m² ☐ ~ 30 kg/m²

Food Allergies: NO

Diagnosis: LSCS

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

Diet Advised:

Liquid Diet – ORS/ Coconut Water / Butter Milk / Barley Water / Soups

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	Dietician's
Signature: S. Vinod reddy.	Signature:
Name: Sashikala	Name: Sathwika.S
Date & Time: 16/6/26 ; 11 Am	Date & Time: 16/6/26 ; 11 Am

DIETARY NOTES

Date	Time	Notes	Sign

HNH-00012329
Mrs V SASHIKALA
IP26-00006587
20-12-1995
30 Y 5 M 27 D
(F)
Dr. KADIYALA RAMYA THEJA

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CROSS CONSULTATION FORM

Doctor Name : Dr. Ramya Date : 16/6/26 Time : 11:30 Am

Diagnosis : LSCS

Hospital : RCH - HNIVR

Referred for : ☐ Opinion ☑ Co-Management ☐ Transfer of care

Type of Referral :
☐ Emergency
☐ Urgent
☐ Non Urgent

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
- Colostrum seen
- primi
- Demand feeding do not more than 2½ hours as per early hunger cues.
- stimulate baby continously while feeding
- make baby to suck 15 - 20 mints on each side as demonstrated in lying down/ cross cradle.

Consultant :

Name : Sathwika Signature : Date & Time : 16/6/26 ; 11:30Am

Doc. No. : RCH / FRM / CLINICAL / 049

HNH-00012329 IP26-00006587
Mrs V SASHIKALA
20-12-1995 30 Y 5 M 26 D (F)
Dr. KADIYALA RAMYA THEJA

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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	1 TAB	PO	OD	14/6	☐ C ☑ DC
2	T. CALCIUM	1 TAB	PO	OD	14/6	☐ C ☑ DC
3	T. UDILIV	300mg	PO	BD	14/6	☐ C ☑ DC
4	T. THYRONORM	100mg	PO	OD	14/6	☑ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Naveena

Date & Time : 15/6/2026 @ 7:30 am.

Nurse Name & Signature: Soujanya

Date & Time : 15/6/2026 7:30am

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

HNH-00012329 IP26-00006587
Mrs V SASHIKALA
20-12-1995 30 Y 5 M 26 D (F)
Dr. KADIYALA RAMYA THEJA

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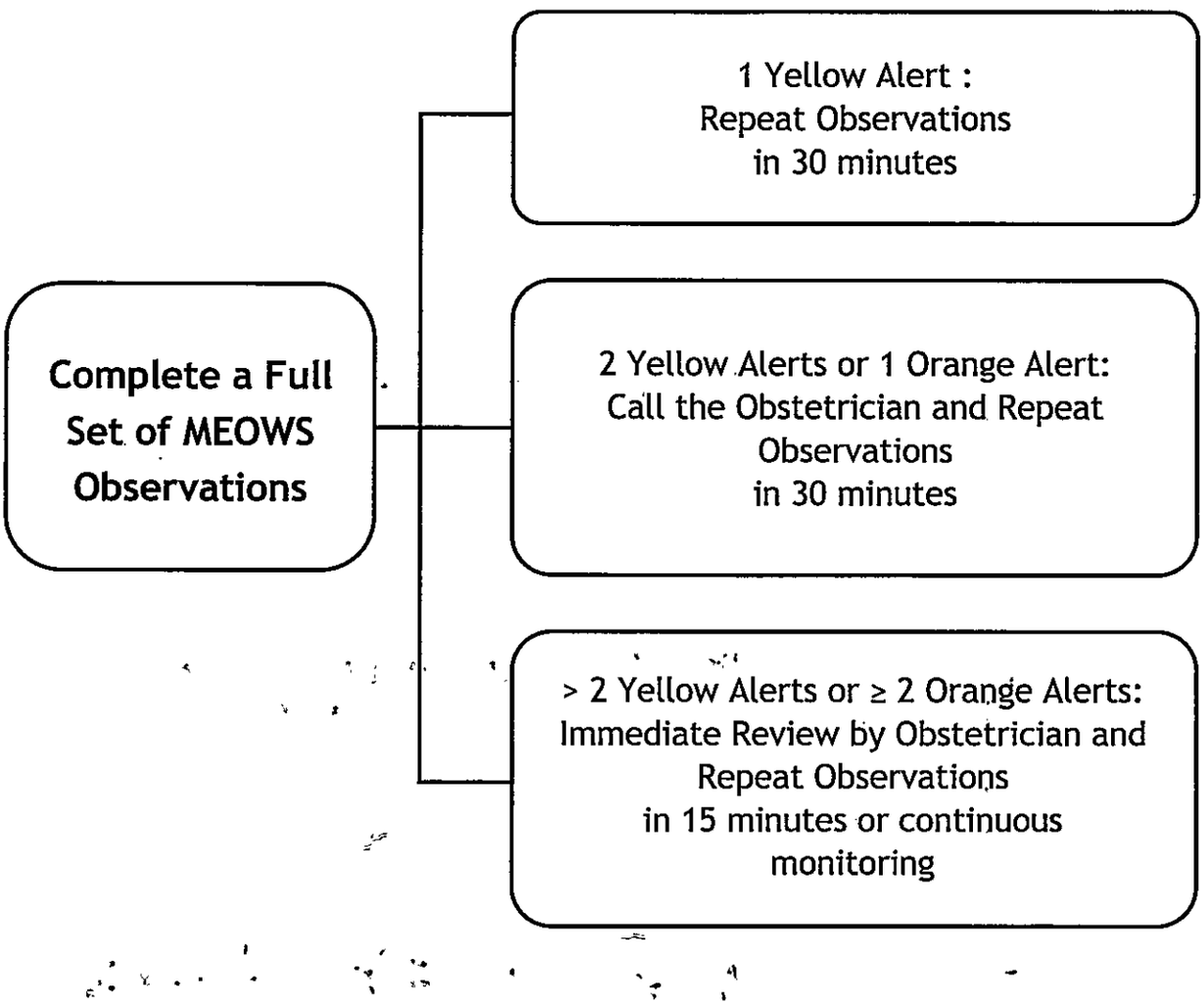
Early Warning Observation Score Chart - Obstetrics

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

15/6/26	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	20		20	20	20		20		20			20		20	20	20	20	20	20	20	20	20	20	
	0 - 10																								
Saturations	94 - 100 %			99	98	99		100		99			99		100	100	95	95	97	98	98	96	97	98	
	< 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	86		76	81	83		83		96			90		86	76	86	87	86	97	86	85	95	86	
	60																								
	50																								
	40																								
Systolic Blood Pressue ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110			124	108	117		115		106			106		110	120	100	115	106	106	110	110	100	110	
	100	100		90	90	90																			
	90																								
	80																								
	70																								
	60																								
	50																								
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70	77		66	71	74		60		76			60		70	80	70	60	70	70	60	70	60	60	
	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		0		0	0	0		0		0			0		0	0	0	0	0	0	0	0	0	0	
TOTAL ORANGE SCORES		0		0	0	0		0		0			0		0	0	0	0	0	0	0	0	0	0	
Nurse Initial																									

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score **(MEOWS)**

HNH-00012329 IP26-00006587
Mrs V SASHIKALA
20-12-1995 30 Y 5 M 27 D (F)
Dr. KADIYALA RAMYA THEJA

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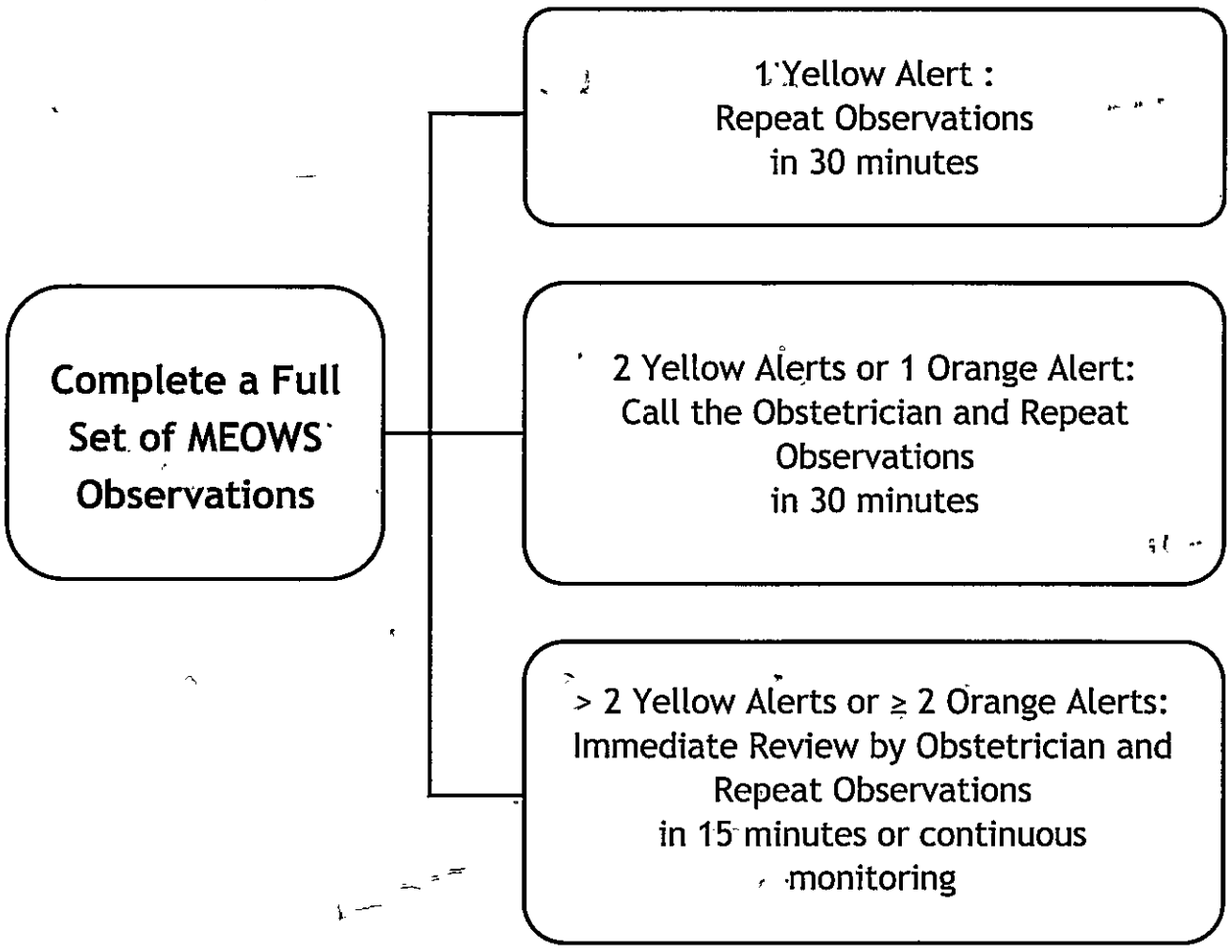
Early Warning Observation Score Chart - Obstetrics

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

16/6/26	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	20	20			20					20					20 b/m				20 b/m				20 b/m	
	0 - 10																								
Saturations	94 - 100 %	99%	100			99%					99%					99%				99%				99%	
	< 94 %																								
Administered O_2 (L/min.)																									
Temp°c	40																								
	39																								
	38																								
	37																								
	36					97.6°F					98.6°F					98.2°F					97.8°F				98.4°F	
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90	90	81			86					88					80 b/m				80 b/m				82 b/m	
	80																								
	70																								
	60																								
	50																								
	40																								
Systolic Blood Pressue ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120	114	109			101					113					115				110				103	
	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70	69	71			65					69					70				68				69	
	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		2	2			2					2					0				0				0	
TOTAL ORANGE SCORES		0	0			0					0					0				0				0	
Nurse Initial																									

Obstetrics and Gynaecology Early Warning Signs



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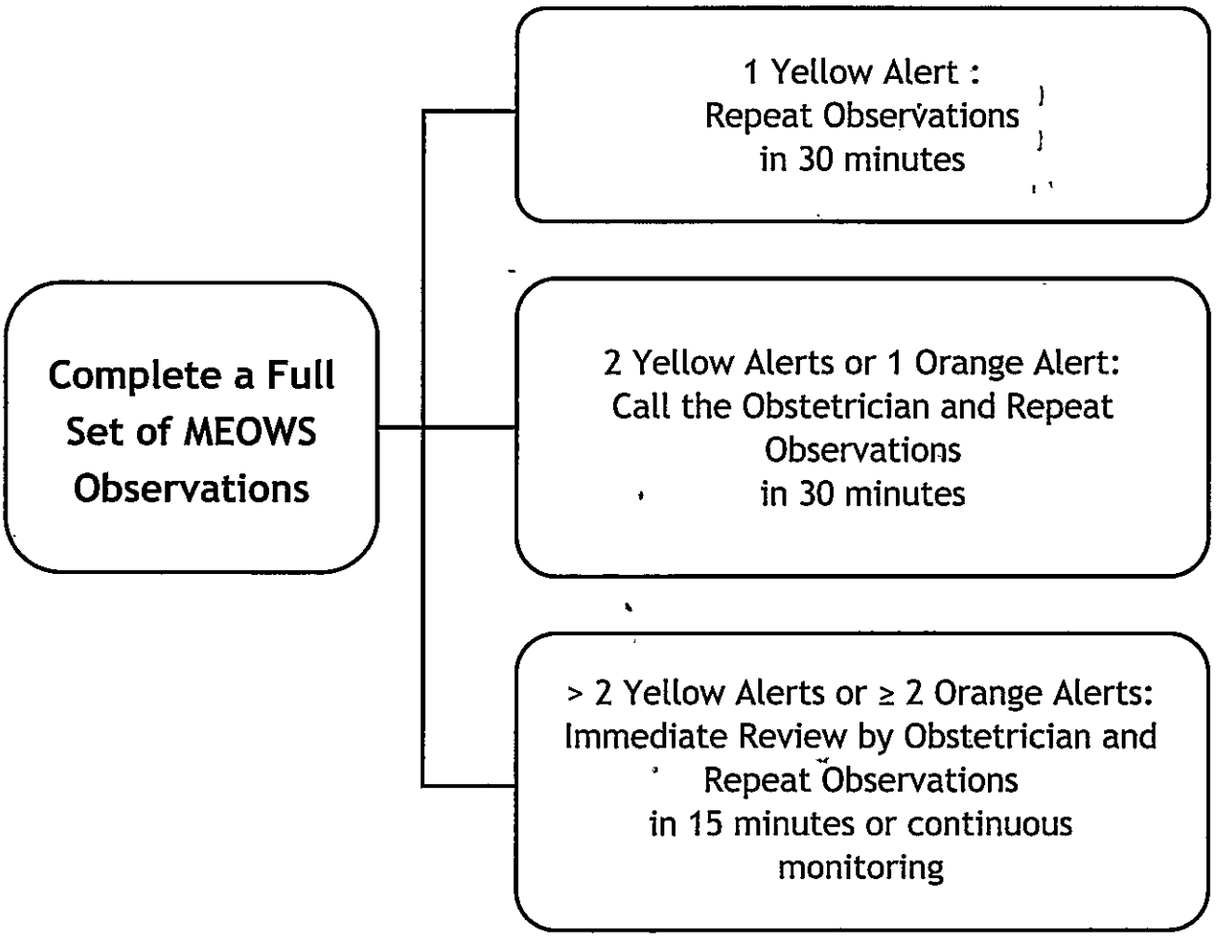
CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

17/6/26

		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			20					18																	
	0 - 10																									
Saturations	94 - 100 %			99					99.1																	
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37			97.9°F					97.4°F																	
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80			85					86																	
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130				100				101																	
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50				78				(71)																	
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70				68				69																	
	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				0				0																		
TOTAL ORANGE SCORES				0				0																		
Nurse Initial				S				S																		

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score **(MEOWS)**

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FLUID CHART

Sheet No. : 1

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

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
15/6	08:00 am	RL		FF								
	09:00 am	DL	H2O									
	10:00 am	DL	H2O									
	11:00 am	RL	H2O				NA			✓	0	CA
	12:00 pm	RL	H2O									
	01:00 pm	RL	H2O									
Total Intake : Jalu						Total Output : Pursed						
15/6	02:00 pm	RL		100ml								
	03:00 pm	RL		100ml								
	04:00 pm	RL		100ml								
	05:00 pm	RL		100ml			NA					
	06:00 pm	RL		100ml								
	07:00 pm	RL										
Total Intake :						Total Output :						
15/6	08:00 pm	RL		100ml								
	09:00 pm	RL	N	100ml						600ml	0	Empty
	10:00 pm	RL		100ml								
	11:00 pm	RL	B	100ml			NA				0	CA
	12:00 am	RL		100ml								
	01:00 am	RL	M	100ml						600ml	0	Empty
Total Intake :						Total Output :						
16/6	02:00 am	RL	H2O	100ml								
	03:00 am	RL	100ml	100ml								
	04:00 am	RL		100ml								
	05:00 am	RL	H2O	100ml			NA				0	CA
	06:00 am	RL		100ml								
	07:00 am	RL		100ml						300ml	0	Empty
Total Intake :						Total Output :						

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
16/6/26	08:00 am	RL	Tablet PCM	100 ml								
	09:00 am	RL		100ml								
	10:00 am	RL		100ml								
	11:00 am			100ml						300ml		
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
16/6/26	02:00 pm									600ml		Foley's
	03:00 pm											
	04:00 pm		Biscuit									
	05:00 pm											
	06:00 pm		ORS									
	07:00 pm											
Total Intake : Fallen						Total Output : U - M - O						
16/6/26	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm		Rice									
	12:00 am											
	01:00 am		H2O									
Total Intake :						Total Output :						
17/6/26	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						

Total 24 hrs. Intake		Total 24 hrs. Output	

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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						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
17/6/26	08:00 am	1	Jelly								1	
	09:00 am	0	Khichdi							✓		
	10:00 am				NA						0	
	11:00 am	1										
	12:00 pm									✓	1	
	01:00 pm											
Total Intake :								**Total Output :** U-2 M-0				
	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

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FLUID CHART

Sheet No. : .....

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

Intake						Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			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	

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PAIN ASSESSMENT FORM

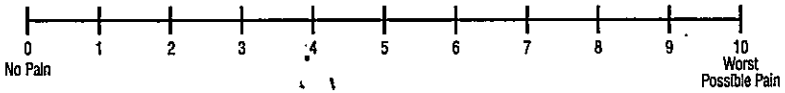
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
15/6/26	9AM	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
15/6/26	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
16/6/26	12AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
16/6/26	4AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
16/6/26	6AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
16/6/26	8AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
16/6/26	10AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
16/6/26	2PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
17/6/26	8AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
17/6/26	10AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	

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

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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, SaO_2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO_2 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO_2 less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

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BRADEN 'Q' SCALE

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					Date : 15/6/26	15/6	16/6/26	16/6/26
					Time : 2AM	2PM	6AM	6PM
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
				TOTAL SCORE	28	28	28	28
				Evaluator's Name				

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

Risk Score	Category	Action	Support Surfaces (**Please Note:** Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• 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	• 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	• 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	• Use same protocol as for **"High Risk"** Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

HNH-00012329 IP26-00006567
Mrs V SASHIKALA
20-12-1995 30 Y 5 M 27 D (F)
Dr. KADIYALA RAMYA THEJA

BRADEN 'Q' SCALE

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					Date : 16/6	17/6/26		
					Time : N	M		
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4		
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4		
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4		
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4		
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4		
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4		
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.	3	4		
				TOTAL SCORE	27	28		
				Evaluator's Name				

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

Risk Score	Category	Action	Support Surfaces (**Please Note:** Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
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Less than 9	Severe Risk	• Use same protocol as for **"High Risk"** Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

HNH-00012329 IP26-00006587
Mrs V SASHIKALA
20-12-1995 30 Y 5 M 26 D (F)
Dr. KADIYALA RAMYA THEJA

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	15/6/2024	15/6	16/6
		Score			
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			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0	0	0	0
IV / Heparin Lock or Saline	Yes	20	20	20	20
	No	0	0	0	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	20	20
		Signature			

Fall Risk Grading		
Risk Level	**Morse Fall Score (MFS)**	**Action**
Low Risk	0 - 24	Standard Fall Precaution
Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
High Risk	≥ 51	Implement High Risk Fall Prevention Intervention

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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Mrs V SASHIKALA
20-12-1995 30 Y 5 M 27 D (F)
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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Score	Date / Time	16/6/26	16/6/26	
				MT	N1	
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				
	Crutches, Cane(S), Walker	15				
	None /Bed Rest /Nurse Assist	0				
IV / Heparin Lock or Saline	Yes	20				
	No	0	0	0		
GAIT / Transferring	Impaired	20	20	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	20		
		Signature				

Fall Risk Grading		
Risk Level	**Morse Fall Score (MFS)**	**Action**
Low Risk	0 - 24	Standard Fall Precaution
Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
High Risk	≥ 51	Implement High Risk Fall Prevention Intervention

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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- ☐ Use chairs with arm rests
- ☐ Use safety straps on stretchers and wheelchairs while transporting patients

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

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

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

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

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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 15/6/26			DAY-2 16/6/26			DAY-3 17/6/26			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	—	✓	NA	NA	NA	NA	NA			
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	✓	✓	NA	NA	NA	NA	NA			
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	—	✓	NA	NA	NA	NA	NA			
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	—	✓	NA	NA	NA	NA	NA			
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	—	✓	NA	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 : .....

Signature of Ward In Charge :

Signature : ..... Name : .....

Patient Sticker

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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 : ..... Name : .....

Signature of Ward In Charge :

Signature : ..... Name : .....

HNH-00012329 IP26-00006587
Mrs V SASHIKALA
20-12-1995 30 Y 5 M 26 D (F)
Dr. KADIYALA RAMYA THEJA

NURSING CARE RECORD

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Date: 15/6/2026

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	→ Assess the pt condition → Check the Vital's → I/O chart Maintain → plan for NST → plan for Medication	8am 2pm	→ Assessed pt condition → Checked Vital's & done → Maintained I/O chart → 3rd hrly NST → given Medication as per doctor's order	pt is stable	Vital's is Normal	Anu
Afternoon							
Night	8pm to 8AM	→ Assess the patient condition → plan for vital → plan for I/O chart	8pm to 8AM	→ Assessed the patient condition → maintain vitals & Record → maintain I/O chart	patient is stable	vitals is normal	Cau

HNH-00004230 IP26-00006586
Mrs SABIHA SHAIK
10-05-1988 38 Y 1 M 6 D (F)
Dr. PADMAJA YELISETTY

Patient

NURSING CARE RECORD

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Date: 16/6/26

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 to 2PM	→ To assess the pt. condition → To check the vitals & record → To administer the medication as per. drug chart → I/O chart maintain	8AM to 2PM	→ To assessed the pt. condition → To checked the vitals & recorded → To administered the medication as per drug chart → I/O chart maintained at 2pm	→ Patient is stable now → Foley's removal at 2pm	→ Re-checked the vitals → I/O	Supriya
Afternoon							
Night	8pm 8AM	→ Assess the pt condition. → monitor the vitals. → Maintain I/o chart. → plan dressing tomorrow morning.	8pm 8AM	→ Assessed the pt condition. → monitored the vitals. → maintained I/o chart. → plained dressing tommorrow morning.	→ pt is stable now	→ Reassessed the vitals.	

HNH-00012329 IP26-00006587
Mrs V SASHIKALA
20-12-1995 30 Y 5 M 27 D (F)
Dr. KADIYALA RAMYA THEJA

NURSING CARE RECORD

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Date: 17/6/26

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
- ☐ Ensure Safety
- ☑ Improve Activity Tolerance
- ☐ 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	8pm to 2pm	→ To administer the pt. condition → To check the vitals & record → To administer the medication as per drug chart → I/O chart maintain	8AM to 2pm	→ To assessed the pt condition → To checked the vitals & recorded → To administered the medication as per drug chart → I/O chart maintained	→ Patient is stable → Dressing to be done today	→ Re-checked the vitals → I/O	Supriya
Afternoon	2pm to 8pm	→ Assess the pt condition → To check the vitals record. → To administer the medication at	2pm to 8pm	→ Assess the pt condition. → check the vitals → To administer the medication	pt is a stable	Re-check the vitals. I/O	Madhu
Night							

Patient Sticker

NURSING CARE RECORD

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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							

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NURSING SHIFT HAND OVER FORM - WARD

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

SITUATION

Diagnosis: J20

Any Infection: ☐ Yes ☐ No ☐ Not Known
If Yes Specify: .....

BACKGROUND

Area / Shift Time	15/6/2026 M6	15/6 N1	16/6/26 M6	16/6/26 M5	16/6/26 N1	17/6/26 M6
Medical Condition (Any special condition to be noted):	–	Cll.	–	–	–	–

ASSESSMENT

Allergy:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☑ No
Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Vital Signs: Temp:	98.1°F	98.4°F	98.1°F	98.2°F	98.1°F	98.1°F
Res:	20	20	20b/m	20b/m	20b/m	20 b/m
SpO_2:	98%	98	99%	99%	99%	99%
Pulse:	73	73	86b/m	85b/m	85 b/m	86b/m
BP:	111/76	110/70	112/71	120/70	120/71	116/71
Fall Risk Score:	–	–	–	–	–	–
Pain Score:	–	–	"0"	"0"	"0"	"0"

Recommendations

Safety Needs:	Yes	Yes	Yes	Yes	Yes	Yes
Physiotherapy	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
Others Specify:	–	–	–	–	–	–
Special Diet:	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☑ No	☑ Yes ☐ No
Other Special Orders / Medications:	–	–	–	–	–	–
Post Operative Procedure Special Orders:	–	–	–	–	–	–
Handed Over By Name :	Anusha	Claude	Supriya	Swetha	mahi	Supriya
Signature :						
Date:	15/6/26	15/6/26	16/6/26	16/6/26	17/6/26	17/6/26
Time:	2pm	8pm	2pm	8pm	8am	2pm
Taken Over By Name :	Claude	Supriya	Swetha	mahi	Supriya	Maddy
Signature :						
Date:	15/6/26	16/6/26	16/6/26	16/6/26	17/6/26	17/6/26
Time:	8pm	8pm	8pm	8pm	8AM	8pm

HNH-00012329 IP26-00006587
Mrs V SASHIKALA
20-12-1995 30 Y 5 M 27 D (F)
Dr. KADIYALA RAMYA THEJA

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NURSING SHIFT HAND OVER FORM - WARD

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

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area / Shift Time	17/6 M2					
	Medical Condition (Any special condition to be noted):	—					
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.3°					
	Res:	20bpm					
	SpO_2:	100					
	Pulse:	89					
	BP:	110/64					
	Fall Risk Score:	—					
	Pain Score:	—					
Recommendations	Safety Needs:	—					
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	—					
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	NA					
Post Operative Procedure Special Orders:		—					
Handed Over By Name :		Madhu					
Signature :							
Date:		17/6					
Time:		8pm					
Taken Over By Name :							
Signature :							
Date:							
Time:							

HNH-00012329
Mrs V SASHIKALA
20-12-1995 30 Y 5 M 26 D (F)
Dr. KADIYALA RAMYA THEJA
IP26-00006587

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DRUG CHART

Date of Admission: 17/6/26 Drug Allergies: NIL ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

GENERAL - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.

DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).

- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line *I* through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES - Nurses must follow strictly the FIVE RIGHTS before administration of medication.

1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time

- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

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

HNH-00012329 IP26-00006587
Mrs V SASHIKALA
20-12-1995 30 Y 5 M 26 D (F)
Dr. KADIYALA RAMYA THEJA

REGULAR PRESCRIPTIONS

Weight. 65kg Ward. .....

Dose	Route	Frequency	Start Date	Date / Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : Inj. CEFOTAXIM

Dose	Route	Frequency	Start Date	Date / Time
1gm	IV	TID	15/6/26 7PM	16/6 8.16.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

x 48hrs

4pm

STOP 17/6/26

Daily Doctor's Endorsement by a Sign

DRUG : PARACETAMOL

Dose	Route	Frequency	Start Date	Date / Time
1gm	P/O	TID	15/6	15/6 8pm OT

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

STOP

Daily Doctor's Endorsement by a Sign

DRUG : TRAMADOL

Dose	Route	Frequency	Start Date	Date / Time
100mg	P/O	TID	16/6	16/6 12PM 17/6

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

4pm

STOP

Daily Doctor's Endorsement by a Sign

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight 80 kg Ward ....

DRUG : DICLOFENAC

Dose	Route	Frequency	Start Dt.
50mg	P/O	TID	16/6

Name & Signature of the Doctor Starting the Drugs: DNAMIN

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	16/6	17/6
7AM		
3pm		
11pm		

DRUG : Inj. METRONIDAZOLE

Dose	Route	Frequency	Start Dt.
500mg	IV	TID	15/6/26

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions: x 24hrs b/b oral

Daily Doctor's Endorsement by a Sign

Date / Time	16/6
6AM	
2pm	
10pm	

STOP 16/6/26

DRUG : Inj TRANEXAMIC ACID

Dose	Route	Frequency	Start Dt.
1gm	IV	TID	16/6/26

Name & Signature of the Doctor Starting the Drugs: x 24hrs

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	16/6
6AM	
2pm	
10pm	

STOP 16/6/26

DRUG : Tab PANTOPRAZOLE

Dose	Route	Frequency	Start Dt.
40mg	PO	BD	16/6/26

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	16/6	17/6
6AM		
6pm		

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Verified by Dr. Dhakshayani

Sheet No: .....

REGULAR PRESCRIPTIONS

Weight 55kg Ward .....

DRUG : PARACETAMOL

Dose	Route	Frequency	Start Dt.
1g.	PO	TID	16/6

Name & Signature of the Doctor Starting the Drugs: Dr. Jha

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time	16/6	17/6
6AM		
2PM		
10PM		

DRUG : T. METRONIDAZOLE

Dose	Route	Frequency	Start Dt.
400mg	PO	TID.	16/6/26

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time	16/6	17/6
10PM		

DRUG : T. CEFEXIME

Dose	Route	Frequency	Start Dt.
200mg	P/o	BD	17/6/26

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions: At 7pm

Daily Doctor's Endorsement by a Sign

Date ▸ Time	17/6
10 AM	
10PM	

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time

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

Verified by Dr. Dhakshayani

HNH-00012329 IP26-0000658?
Mrs V SASHIKALA
20-12-1995 30 Y 5 M 26 D (F)
Dr. KADIYALA RAMYA THEJA

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STAT / ONCE ONLY DRUGS

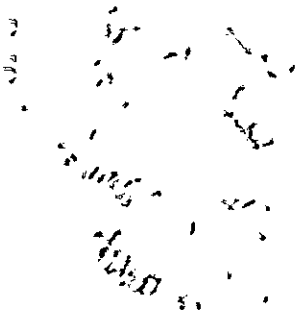
Weight: 55 kgs

Name: .....

Sheet No: .....

DATE	TIME	MEDICATION	DOSAGE & OTHER INSTRUCTIONS	ROUTE	SIGNATURE		
					Doctor	Nurse-1	Nurse-2
15/6	735 pm	CARBOPROST	250mcg	IM			
15/6	845 pm	DICLOFENAC	100mg	PR			
15/6	845 pm	TRAMADOL	100 mg	PR			
15/6	730 pm	TRANEXAMIC ACID	1gm	IV			
15/6	9:30 pm	Inj. METRONIDAZOLE	500mg	IV			

Verified by Dr. Dhakshayani



HNH-00012329
Mrs V SASHIKALA
20-12-1995 30 Y 5 M 26 D (F)
Dr. KADIYALA RAMYA THEJA

Weight. 55 kg Ward. ....

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

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

Signature ....

VERIFIED BY : Name ....

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
15/6	6:30am	T. MISOPROSTOL	25mcg	PO	[signature]	Chedu / Arati
15/6	7AM	INJ. CEFOTAXIME	1 GM	IV	[signature]	Chedu / Arati
15/6	~~9:00am~~ 9:30AM	T. MISOPROSTOL	25mcg	PO	[signature]	[signature]
15/6	12:45 pm	Tab MISOPROSTOL	25mcg	P/O	[signature]	[signature]
15/6/26	3PM	Inj. BUSCOPAN	1amp	IV	Ramo	Madhu
15/6/26	3.10PM	Inj. DROTIN	1amp	IV	Ramo	Madhu
15/6/26	7 pm	Inj PANTOPRAZOLE	40mg	IV	Ramo	Sujala / mouni
15/6/26	7 pm	Inj PERINORM	10mg	IV	Ramo	sujala / mouni
15/6	730pm	METHERGIN	0.2 mg	IV	[signature]	[signature] / Saraswathi
15/6	7PM	INJ. CEFOTAXIME	1g	IV	[signature]	[signature]

Verified by Dr. Dhakshayani

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20-12-1995 30 Y 5 M 26 D (F)
Dr. KADIYALA RAMYA THEJA

I.V. FLUIDS CHART

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

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
15/6	7AM	RINGER LACTATE	IV	100ml/hr					
15/6	3.30PM	RINGER LACTATE + OXYTOCIN	IV	125ml/hr			15/6		
15/6	7.00 PM	RINGER LACTATE	IV	500			15/6		
15/6	7.30 PM	RINGER LACTATE + 40U OXYTOCIN	IV	100			16/6		
16/6/26	12AM	RINGER LACTATE	IV	100 ml/hr			16/6		
16/6/26	3AM	RINGER LACTATE	IV	100 ml/hr			16/6		
16/6/26	6AM	RINGER LACTATE	IV	100 ml/hr			16/6		
		STOP 16/6/26							

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

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CAESAREAN SECTION OPERATIVE NOTES

Surgeon's Name:	Dr. Ramya Theja. K	Date of Delivery:	15/6/26
Assistant Surgeon:	Dr Swathi. H.V	Time of Delivery:	7:24 AM
Anaesthetist's Name:	Dr Ravi	Gender of Baby:	Female
Type of Anaesthesia:	Epidural	Weight of Baby:	2.9kg
Neonatologist:		AGPAR Score:	7, 9
Scrub Nurse:	Archana / Sandhya	NICU Admission:	☐ Yes ☑ No

Pre-Operative Diagnosis: Primi / 38+1 wks / ? IHCP / PROM

☐ Elective ☑ Emergency Indication: NPOL & ? Obstructed & OP position labour

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

Decision time: 5:42 pm Knief to rectus: 2min

CTG Description: Reactive

If there was a delay give the reasons: delay in consent

Surgical Procedure: Emg LSCS & GA

Post Operative Diagnosis: 0-POD

Peri-Operative Complications: N/L

Amount of Blood Loss: N 800ML Blood Transfused (in ML): Nil

Name and Number of Surgical Specimen sent for examination: None

Examination Findings when Appropriate:

Presentation: ☑ Cephalic ☐ Breech ☐ Other ..... Cervical Dilatation: 3-4cm cm

5th Palpable: ..... Fetal Position: OP | deflexed head

Station: ☐ -3 ☑ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2 Moulding: ☐ None ☐ + ☐ ++ ☐ +++

Caput: ☐ + ☐ ++ ☐ +++ Meconium: ☐ None ☐ + ☐ ++ ☐ +++

Bladder Catheterized : ☑ Yes ☐ No Urine: ☐ Clear ☑ Blood Stained (pre-surgery)

Skin Incision: ☑ Pfannensteil ☐ Transverse ☐ Midline ☐ Other .....

Uterine Incision: ☑ Lower Segment ☐ Classical ☐ Inverted T ☐ J Incision

Previous Scar: ☐ Intact ☐ Thinnedout ☐ Ruptured ☑ No Scar

Incision Through Placenta: ☐ Yes ☑ No

Delivery of head: ☑ Manual ☐ Forceps

Liquor: ☐ Clear ☐ Meconium: ☐ I ☐ II ☐ III ☐ Blood ☐ Offensive ☑ Not Offensive

Delivery of Placenta: ☐ Manual ☑ CCT ..... ☑ Complete ☐ Incomplete ☐ Piecemeal

Cord Appearance: N ..... Cord around the neck ☐ Yes ☑ No

Appearance of placenta: N ..... Cavity explored ☑ Yes ☐ No

Uterus, tubes and ovaries: ☑ Normal ☐ Not Normal Sterilization: ☐ Yes ☑ No

Uterine Closure: ☐ One Layer ☑ Two Layers ..... vicryl No1 ..... Suture

Peritoneal Closure: ☐ Pelvic ☑ Abdominal ☐ None ..... catgut 2-0 ..... Suture

Sheath Closure: ..... vicryl No1 ..... Suture

Fat Closure: ☑ Yes ☐ No ..... catgut 2-0 ..... Suture

Skin Closure: ☐ Subcuticular ☑ Mattress ..... monocryl 3-0 ..... Suture

Vagineal Evacuated ☑ Yes ☐ No

Drain: ☐ Yes ☑ No ☐ Remove in ..... days ☐ Await instructions

Ctheter ☑ Yes ☐ No ☐ Remove in 24hr ~~days~~ ☐ Await instructions

Swap & Instruments count correct? ☑ Yes ☐ No ☐ Post-op Antibiotics ☑ Yes ☐ No

Intra-Operative Antibiotics Cover: ☑ Yes ☐ No ☐ Thromboprophylaxis ☐ Yes ☑ No

Post-Operative Notes:

* CVS thinned out
* bladder drawn up.
* LOP position | deflexed head
* endometriotic spots on bilateral adnexa | posterior wall
* Right adnexa - broad ligament hematoma: 1x2 cm, 2x2cm - hemostasis secured
* uterus atonic - medically managed

Doctor Name: Dr Ramya Thyagu Doctor Signature: Ramya

Date & Time: 15/6/26 @ 9:30pm

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20-12-1995 30 Y 5 M 26 D (F)
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OBSTETRICS / GYNECOLOGY
NURSING INITIAL ASSESSMENT FORM

Date of Admission: 15/6/2026

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: .....

.....

.....

Doctor Notified on Admission: ☑ Yes ☐ No

Name of the Doctor: Dr. Naveena.

Time Notified: .....

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

Past Medical History	Past Surgical History	Previous Hospital Admission

Gynecology Assessment: ☐ Not Applicable

Menstrual History: .....

.....

Onset of Menarche: Regular

Menstrual Cycle: ☐ Regular ☐ Irregular

Last Menstrual Period: 21/9/2025

Gynecology Surgical History:

Caesarean Section: ☐ No ☐ Yes

Cervical Cerclage: ☐ No ☐ Yes

Ectopic Pregnancy: ☐ No ☐ Yes

Myomectomy: ☐ No ☐ Yes

Others: _____

Gynecological History:

Contraceptives: ☐ No ☐ Yes

Vaginal Discharge: ☐ No ☐ Yes

Post-Coital Bleeding: ☐ No ☐ Yes

Infertility: ☐ No ☐ Yes

If Yes Type: ☐ Primary ☐ 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: 98.1°F HR: 96 RR: 20

BP: 114/76 Weight: 55.2kgs Height: 154 BMI: .....

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

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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 ..... Pt .....

Name of Person Orientation was given to: ..... V. Sashikala. .....

Orientation not given Reason: .....

Nurse Signature: ..... Anuladevi .....

Nurse Name: ..... AV .....

Date & Time: ..... 15/6/2020 .....

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OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 15/6/2026 Time of Arrival: ..... Time Seen by Nurse: .....

1) **Level of Consciousness:** ☐ Conscious ☐ Semi-Conscious ☐ UnConscious

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

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

3) **Vital Signs:** Temperature: 98.1 F Pulse: 76 RR: 20 SpO_2: 98% BP: 116/76 Weight: .....

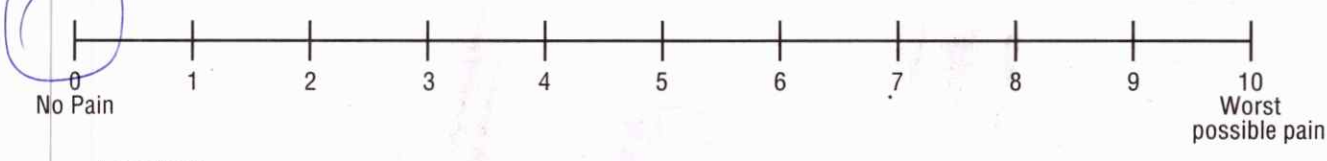
4) **Gestational Criteria:**

Gravida:	G 1	P 0	L 0	A 0

LMP: ..... EDD: ..... Gestational Age: .....

Uterine Contraction	☐ Yes	☑ No	☐ NA	Onset	Time	Frequency:
Membrane Rupture	☐ Yes	☑ No	☐ NA	Onset	Time	Fluid Color:
Vaginal bleeding	☐ Yes	☑ No	☐ NA	Onset	Time	Amount:
Pre Eclampsia Symptoms	☐ Yes	☑ No	☐ NA	If Yes specify: Headache / Visual Symptoms / Pain Abdomen / Vomiting		
Good fetal Movement	☑ Yes	☐ No	☐ NA	If No specify:		

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



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

.....

6) **Past History:**

a) Surgeries: .....

b) Medical: .....

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7) **Allergy:** ☐ Yes ☐ No, If Yes : .....

8) **Current Medications:** ☐ Prenatal Vitamin ☐ None ☐ Others: .....

9) **Prenatal Medical History:**

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

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

OTAS	Level 1 (Resuscitative)	Level 2 (Emergent)	Level 3 (Urgent)	Level 4 (Less Urgent)	Level 5 (Non Urgent)
Level 1 (Resuscitative)	Immediate	≤ 15 **minutes**	≤ 30 **minutes**	≤ 60 **minutes**	≤ 120 **minutes (2 Hours)**
Re-Assessment	Continuous Nursing Care	**Every 15 Minutes**	**Every 15 Minutes**	**Every 30 Minutes**	**Every 60 Minutes**
Labour / Fluid	Imminent Birth	Suspected Pre-term Labour / PPROM < 37 Weeks	Signs of Active Labour > 37 weeks	Signs of Early Labour/ SROM > 37 weeks	Discomforts of Pregnancy
Bleeding	Active Vaginal bleeding with/ without abdominal pain	Bleeding associated with cramping (<spotting) <37 weeks	Bleeding associated with cramping (>spotting) >37 weeks	Spotting	
Hypertension	Seizure activity	Hypertension > 160/110 and / or headache, visual disturbance, RUQ pain	Mild hypertension >140/90 with/without associated signs and symptoms		
Fetal Assessment	Abnormal FHR tracing Non-Fetal Movement	Atypical FHR tracing, abnormal dopplers Diseased fetal movement			
Others	• Acute onsite severe abdominal pain • Altered level of consciousness • Cord prolapse • Severe respiratory distress • Suspected sepsis	• Major trauma • Shortness of breath • Unplanned and unattended birth	• Abdominal/back pain greater than expected in pregnancy • Flank pain / hematuria • Nausea /vomiting and /or diarrhea with suspected dehydration	• Ongoing assessment from out patient clinic (for hypertension, blood work) • Minor trauma (minor MVC/fall) • Nausea/Vomiting and /or diarrhea • Signs of infection (ie dysuria ,cough, fever, chills)	• Anything that does not seem to pose threat to mother or fetus • Cervical ripening • Out patient placenta previa protocols • Pre-booked visits (ie Rh and progesterone injections, NST • Assessment for version • Rashes

Time seen by Doctor: 7:30AM

Nurse Name : Anjali Nurse Signature: A

Date: 15/6/2026 Time: 8AM

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BREAST FEEDING HANDOVER AND ASSESSMENT FORM

1. Breastfeeding initiated?
   - ☑ a. Yes
   - ☐ b. No

2. If No, Reason .....

3. Nipple condition:
   - ☐ a. Nipple well formed
   - ☐ b. Flat nipple
   - ☐ c. Inverted nipple
   - ☐ d. Short nipple

4. Milk flow:
   - ☐ a. Good
   - ☑ b. Drops of colostrums
   - ☐ c. Dry

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

Feeding Positions:
Cross Cradle

Feeding Positions:
Football / Clutch

6. Was the position explained:
   - ☐ a. Yes
   - ☐ b. No

7. For Caesarian mothers:
   - ☐ a. Mother is required sit and feed from the 4th feed
   - ☐ b. Please explain football hold

8. NICU admission:
   - ☐ a. Mother needs to stimulate her breast for 2 min every 2 hours

9. Additional notes: .....

Continuity of Care: Date: .....

=> Assess the patient condition
=> maintain Blochart
=> maintain Vital & Record
=> 2nd hourly EBF given

Handover given by ..... Handover taken by Chandra Kala

Signature ..... Signature

Date & Time: ..... Date & Time: 15/6/26

Patient Sticker

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URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 15/6/26 Date of Removal: 16/6/2026 2:14 pm

Parameters / Date / Shift Time	15/6 N1	16/6					
Need for the Catheter	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hand Hygiene	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Usage of Sterile Equipment	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the Collection bag below the level of bladder	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Check the Tube for Obstruction (Free of Kinking)	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Catheter dated as policy	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Collecting bag is been emptied regularly?	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Maintenance of closed system for the catheter	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing clean and dry?	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the line removed as Policy?	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Performance of Perineal Care	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Onset of New Fever	☐ Yes ☑ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Asses for the leakage at the site of insertion	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Nurse	Chanda	[signature]					
Signature of the Nurse	[signature]	[signature]					

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Ramya theja
Asst. Surgeon : Dr. Sowathi
Anaesthetist : Dr. Samy
Scrub Nurse : Sandya / Archana

HNH-00012329 IP26-00006587
Mrs V SASHIKALA
20-12-1995 30 Y 5 M 26 D (F)
Dr. KADIYALA RAMYA THEJA

Patient Nam ..... Gender : F
UHID No. : Gm: 1565
Date : ..... In-time : 7:15pm Out-time : 8:45pm

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 7:05pm

Patient Has Confirmed
- Identity ☑ Yes ☐ No
- Site ☑ Yes ☐ No
- Procedure ☑ Yes ☐ No
- Consent ☑ Yes ☐ No

Site Marked ☐ Yes ☐ No ☑ NA

Anaesthesia Safety Check Completed ☑ Yes ☐ No

Pulse Oximeter on Patient & Functioning ☑ Yes ☐ No

Does Patient have a:
- Known Allergy? ☐ Yes ☑ No

Difficult Airway / Aspiration Risk?
- Yes, & Equipment / Assistance Available ☑ Yes ☐ No

Risk of > 500ml Blood Loss (7ml/kg In Children)?
- Yes, and Adequate Intravenous Access and Fluids Planned ☑ Yes ☐ No ☐ NA
- Blood Units Reserved ☐ Yes ☑ No ☐ NA

Has Antibiotic Prophylaxis been given within the last 60 minutes? ☑ Yes ☐ No ☐ NA

Signature : .....
Name : Dr. RAMYA THEJA

Before Skin Incision ➤➤

TIME OUT Time: 7:10pm

Confirm all team members have introduced themselves by Name and Role ☑ Yes ☐ No

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm
- Correct Patient (Check ID Band) ☑ Yes ☐ No
- Correct Site ☑ Yes ☐ No
- Correct Procedure ☑ Yes ☐ No

Anticipated Critical Events

Surgeon Reviews:
- What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? Bleeding <2cm ☑ Yes ☐ No ☐ NA

Anaesthesia Team Reviews:
- Are There Any Patient-specific Concerns? ☑ Yes ☐ No ☐ NA

Nursing Team Reviews:
- Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☑ Yes ☐ No ☐ NA
- **Is Essential Imaging Displayed?** ☑ Yes ☐ No ☐ NA
- Power Supply, Earthing, Power Backup and functioning of equipment checked. ☐ Yes ☑ No

Signature : .....
Name : Archana

Before Patient Leaves Operating Room

SIGN OUT Time: 8:45pm

Nurse Verbally Confirms with the Team:
- The Name of the Procedure Recorded ☑ Yes ☐ No
- That Instrument, Sponge and Needle Counts are Correct (or Not Applicable) ☑ Yes ☐ No ☐ NA
- The Specimen is Labelled (including patient name) ☐ Yes ☐ No ☑ NA
- Whether there are any Equipment Problems to be addressed ☐ Yes ☑ No ☐ NA

To Surgeon, Anaesthetist and Nurse:
- What are the key concerns for recovery and management of this patient? ☐ Yes ☑ No

Signature : .....
Name : DR. RAMYA THEJA

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PATIENT TRANSFER FORM

HNH-00012329 IP26-00006587
Mrs V SASHIKALA
20-12-1995 30 Y 5 M 26 D (F)
Dr. KADIYALA RAMYA THEJA

	Date & Time of Admission	Date & Time of Transfer Order
	15/6/26 @ 7:00pm	15/6/26 @ 8:30pm
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
	Dr. Samir	Observation
From Unit	**To Unit**	**Information to Attendant**
OT	Pre-post	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
—	—	Yes ☒ No ☑
		If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	RL	01
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sandhya 15/6/26 @ 8:45 pm	Dr. Samir

Patient & Clinical Records Received by : Chandrakala

Date & Time of Patient Received : 15/6/26 @ 9pm

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

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PATIENT TRANSFER FORM

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00012329 IP26-00006587 Mrs V SASHIKALA 20-12-1995 30 Y 5 M 26 D (F) Dr. KADIYALA RAMYA THEJA	15/6/26 at	15/6/26 at 7 30pm
	Transfer Ordered by	Reason for Transfer
	Dr DUO.	Em LSCS
From Unit	To Unit	Information to Attendant
LDR	O.T	Yes ☑ No ☐
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	RL	10
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
sujatha	

Patient & Clinical Records Received by : Archana

Date & Time of Patient Received : 15/6/26 at 8 30pm

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

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Patient Name : Mrs V. Sashikala. Gender: ☐ Male ☑ Female Age : 30 yr.

UHID No : HNH-0001 2329 Date : 15/06/2026

Instruction:

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

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

EMERGENCY LOWER SEGMENT CESAREAN SECTION.

upon

Mrs V. Sashikala. (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: Dr Ramya Thota

Consentee :

Signature : V. Sashikala

Name : V. Sashikala.

Date & Time : 15/6/26 @ 6:30 pm

Witness :

Signature :

Name : Dr Ramya Thota

Date & Time : 15/6/26 @ 6:30pm

Patient Attendant :

Signature : S. Vinod Reddy.

Name : S. Vinod Reddy.

Relationship with Patient: Husband.

Date & Time : 15/6/26 @ 6:30pm

Doctor (who is taking the consent) :

Signature :

Name : Dr. Dua

Date & Time : 15/6/2026 @ 6:30pm

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : Mrs. V. Sashikala ..... Age : ..... Gender : Male ☐ Female ☑

UHID NO: ..... Surgeon Name: Dr. Ramya Teja .....

Anaesthesiologist : Dr. Sanil Nayak .....

Operative procedure planned : LSCS. .....

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 arid 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 Aacidosis

☐ Incapacitating Cronic Obstructive Pulmonary Disease

☑ Others : Bleeding / Need for transfusions .....

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 .....

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 : V. Sashikala

Name : V. Sashikala.

Relationship with Patient: .....

Date & Time : .....

Witness :

Signature : S. Vinod Reddy

Name : S. Vinod Reddy.

Date & Time : .....

Doctor (who is taking the consent) :

Signature : .....

Name : .....

Date & Time : 15/6 6 pm

26-0000 20688

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NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name:	MRS. V. JAYALAKSHMI		Age: 30	Gender:	f
UHID No:	MH 0001329	IP No: IP26000065 87	Date: 15/6/26	Time:	5.07 pm
Diagnosis:	LSCS				

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	100mcg	ONE Amp
2.	Morphine Sulphate Inj. 15mg/Ml	-	-
3.	Remifentanil Hydrochloride Inj. 2MG	-	-
4.	Remifentanil Hydrochloride inj. 1MG	-	-

Doctor Name: DIVAKAR Doctor Registration No: 67929

Signature:

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

IP Registration No: IP26 0000 6587 **Date:** 15/6/26

Aadhaar No. of the Patient (Optional): .....

1.	**Name :** MRS. V JAYALAKSHMI.	**Remarks**
2.	Complete postal address (with contact number, if any)	CHAMPET, HYD
3.	Brief description of the illness	LSCS
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	NO
5.	Details of essential Narcotic drug dispensed	FENTANYL

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
15/6/26	FENTANYL	ONE AMP		

Dispensed by (Name & ID No.): Sonia (01846) Signature: Sonia

Received by (Name & ID No.): SAI CHANDU 02153 Signature:

Time: .....

26-ou

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NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name: Mrs. Shoshirala			Age: 30Y	Gender: Female	
UHID No: HNCH-000123399	IP No: 26-00006558		Date: 15/6/26	Time:	
Diagnosis: primigravida with 38 weeks POG with low lying placenta. LOR.					

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	100MCG	
2.	Morphine Sulphate Inj. 15mg/Ml		
3.	Remifentanil Hydrochloride Inj. 2MG		
4.	Remifentanil Hydrochloride inj. 1MG		

Doctor Name: Dr. Amir   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: 26-00006557 **Date:** ....

Aadhaar No. of the Patient (Optional): ....

	Name :	Remarks
2.	Complete postal address (with contact number, if any)	chompopet Hyderabad chompopet
3.	Brief description of the illness	-No.
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	
5.	Details of essential Narcotic drug dispensed	

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
15/6	fentanyl	100mcg	[signature]	

Dispensed by (Name & ID No.): Sonia (018442) Signature: Sonia

Received by (Name & ID No.): Mounika (604575) Signature: [signature]

Time: ....

26-[illegible]

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NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name: Mrs. Shashikala		Age: 30Y	Gender: Female
UHID No: [illegible]	IP No: 26-00006587	Date: 15/6/26	Time:
Diagnosis: primigravida with 35 weeks POG with [illegible] LDP.			

PRESCRIPTION DETAILS (Tick only one of the following)

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

Doctor Name: Dr. Amir   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: 26-00006587   **Date:** ....

Aadhaar No. of the Patient (Optional): ....

		Remarks
1.	**Name :**	
2.	Complete postal address (with contact number, if any)	[illegible] Hyderabad [illegible]
3.	Brief description of the illness	[illegible]
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	
5.	Details of essential Narcotic drug dispensed	

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
11/6	fentanyl	one ampl	[signature]	

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

Received by (Name & ID No.): Mounika (60452) Signature: [signature]

Time: ....

NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name		Age	Gender
UHID No	IP No	Date	Time
Diagnosis			

PRESCRIPTION DETAILS (Rx only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml		
2.	Morphine Sulphate Inj. 15mg/Ml		
3.	Ropivacaine Hydrochloride Inj. 2Mg		
4.	Ropivacaine Hydrochloride Inj. 1Mg		

Doctor Name:

Signature

Doctor Registration No

NARCOTIC DISPENSING FORM
APPENDIX 4 – FORM NO. 32E
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: Date:

Address No of the Patient (Optional)

1.	Name :	
2.	Complete postal address (with contact number, if any)	
3.	Brief description of the illness	
4.	Whether registered with any other Registered medical practitioner/ recognized medical institution (If yes, details of the records)	
5.	Details of essential Narcotic drug dispensed	

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attendee	Remarks, if any

Dispensed by (Name & ID No.)

Received by (Name & ID No.)

Signature

Signature

Time

CONSENT FOR SPECIAL PROCEDURES

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Patient Name : MM. V. SASHIKALA Gender: ☐ Male ☒ Female

UHID No : HNH-12329 Department : LABOUR WARD Date : 15/6/26

I MM. V. SASHIKALA S/D/W/O MR. VINOD REDDY

Here by give consent for procedure of : - EPIDURAL LABOUR ANALGESIA -

For my patient, Named : - SELF -

The doctors have clearly explained to me that the procedure has following possible complications:

HEADACHE, HYPOTENSION, BRADYCARDIA, PATCHY EPIDURAL, EPIDURAL FAILURE, NEED FOR RESITE

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :

ENTONOX / IV ANALGESICS

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. SAMIR INAYATH

Patient Attendant :

Signature : S. Vinod Reddy.

Name : S. Vinod Reddy.

Relationship with Patient: Husband

Date & Time :

Witness :

Signature : V. Sashikala

Name :

Date & Time :

Doctor (who is taking the consent) :

Signature :

Name : Dr Samir INAYATH

Date & Time : 15/6 at 2.30pm.

ప్రత్యేక విధానాలకు సమ్మతి

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రోగి పేరు ..... లింగం ☐ పురుషుడు ☐ స్త్రీ

యు.హెచ్.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)

సంతకము .....

పేరు .....

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము .....

పేరు .....

సాక్షి

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తేదీ మరియు సమయము .....

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: MRS. V. SASHIKALA Age: 30 Sex: FEMALE UHID.No : HNH-12329

Date: 15/6 Time: 215pm. Proposed Operation: Epidural Labour Analgesia

Diagnosis: Primi @ TG.

B.P / CRT: ..... H.R: ..... Weight: 55.2 ASA Physical Status: ☐ 1 ☑ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

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

Allergies: NKDA

Medical History: CVS : -

RESP : NO SIGNIFICANT MEDICAL HISTORY Diabetes : -

CNS : -

Renal : REGULAR ANC1- DONE - GENERALISED TRAINING

Hepatic / GE : - Physical Activity: GOOD.

Others : HYPOTHYROID.

Past Anaesthetic History: DENTAL PROCEDURES.

Physical Exam: COHERENT / ALERT

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

Lungs : CLEAR CLINICALLY

Heart:

CNS:

Pregnant: ☑ Yes ☐ No ☐ NA | Venous Access Site: PERIPHERAL | Spine Exam for regional : MIDLINE

Anaesthetic Plan: ☐ MAC ☑ REGIONAL ☐ GA-ETT ☐ LMA

Peri-Operative Plan Explained to the Patient: ☑ Yes ☐ No

CURRENT MEDICATIONS	DOSAGE
THYRONORM	100MCG.
Fe/Ca/VDILIV	300MG.

Pre-Operative Instructions: on NPO.

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours; Others 6 Hours
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☑ Discussed with Patient
5. Other Instructions:
   - CBP to check

Signature: ..... Name: DR SAMIR INAYATH.

Docu. No. : RCH /FRM / CLINICAL / 044

HNH-00012329 IP26-00006587
Mrs V SASHIKALA
20-12-1995 30 Y 5 M 26 D (F)
Dr. KADIYALA RAMYA THEJA

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No — Fasting Status: ok, adq.

Physical Status: ☑ Patient Identified ☑ Consent Present ☑ Chart Reviewed

H.R: 94/m | B.P / CRT: 126/74 | SpO_2: 99% | R.R: 18 | Last Feed: > 6 hrs for solids

Pre-OP Diagnosis: primi c NPL | Operation: LSCS cat II | Date: 15/6

Surgeon: Dr RT | Anaesthesiologist: Dr Sanu | Technician: Sai Chandu

TIME	7:15	7:45	8:15	8:45
N_2O /AIR/O_2 LPM	FM @ 4 L/min →	→		
HALO /SO /SEVO				
FIO_2 / SaO_2	99	99	99	99
$ETCO_2$				
ECG	← SR →		← SR →	
Temperature				
Urine Output				

Drugs:
OXYTOCIN 3U + 40U infusion
METHERGIN 0.2mg iv
KETAMINE 50mg
PROPOFOL 50mg + 50mg
CARBOPROST 250mcg im — TRANEXAMIC ACID 1gm iv.

Fluids / Blood: RL; RL + 40U SYNTO → →

B.P chart (V Systolic, Λ Diastolic, X Mean, • Heart Rate): systolic ~120, heart rate ~100, diastolic ~60 from 7:15 to 8:45.
Tourniquet on Time / Tourniquet off Time / Throat Pack In / Throat Pack Out

Antibiotic: given
Suppository: DICLOFENAC 100mg, TRAMADOL 100mg
Blood Loss: ~100ml
NOTES

LAB Values: ABG / GRBS / Others — stable throughout. shifted out in stable condition

☑ Equipment Checked and Functional
☑ BP
☐ Cuff Site: (R) UL
☐ Art Site:
☑ EKG Lead 3 lead
☐ Temp Site
☐ FIO_2 Monitor
☐ Agent Monitor
☑ Pulse Oximeter
☑ Capnograph
☐ Ventilator
☐ Nerve Stimulator
Position: supine
☑ Pressure Points Checked

Eye Care:
☐ Oint
☐ Tape
☐ Padding
☑ Awake

Temp:
☐ HME ☐ Fluid Warmer
☐ Cling Film ☐ OH Warmer
☐ Hugger's ☐ Cotton Wool
☑ Other sheets

Times:
Anaes Start: 7:15
OP Start:
OP End:
Leave OR: 8:45 pm

Anaesthesia:
☐ GA
☑ Monitored Anaesthesia Care
☑ Regional

Line (Size & Location)
☐ CVP:
☐ ART:
☑ IV: 18G (L) UL
☐ IV:
☐ IV:

Induction
☐ IV ☐ Inhal
☐ Pre O_2 ☐ RSI
☐ Others

☐ Mask ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
ETT# .... at .... cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug:
☐ Awake ☐ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# .... Attempts: ....
Difficulty Why? ....

☐ Bilat = BS
☐ Semi-Closed Circle
☐ Closed Circle
☐ Other
facemask

Regional:
Extremity Specify:
☐ Spinal ☐ Epidural ☐ Caudal
Others: topup.
Position:
Site: 10ml of 2% lox c ADA
Needle Size: .... Depth: ....
Parasthesia ☐ Yes ☐ No
Catheter at skin .... cm
Drug Name & Conc:
Bolus:
Infusion:
Block Level: T6 - T8
Comments:
Transportation to ☑ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☑ NA
Name of the Doctor: Dr Sanu
Signature of the Doctor: [signature]

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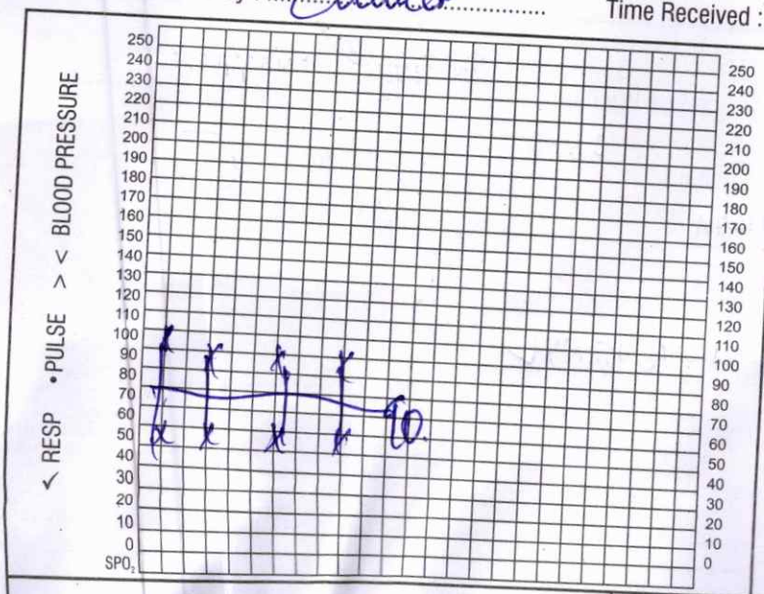
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Chandu Time Received : 9pm Time Discharged : .....



IV Cannula Site : Rt hand

☐ O_2 Mask ☐ Nasal Prongs
☐ Tracheostomy ☐ T-Piece
☐ Oral Airway ☐ Nasal Airway

Vomiting : ☐ Yes ☑ No
NG Tube : ☐ Yes ☑ No
Drain: ☐ Yes ☑ No
Urinary Catheter: ☑ Yes ☐ No
Chest Tube: ☐ Yes ☑ No
Nil Oral ☐ Yes ☑ No

Drug: .....

IV Fluids: RL @ 80ml
Oral Feeds: .....

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
15/6/26	9pm	0	warmed,	
15/6/26	10pm	0	warm	
15/6/26	11pm	0	warmed	
15/6/26	11-30	0	warm	

Pain Tool Used: ☐ N PASS ☐ FL Wong Baker ☐ NPS

Anaesthesiologist Name : Dr PHILIPA

Anaesthesiologist Signature: .....

Date & Time: .....

PACU Nurse Name : .....

PACU Nurse Signature: .....

Date & Time: 16/6/2026 @ 10Am

Reassessment Frequency:

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

Transferred to Unit by (PACU): 315

Date & Time: 16/6/2026

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: 15/6 Time: 245pm Procedure done by Dr. SAMIR INAYATH

CSE /Spinal /Epidural Position : SITTING Space : L3-4 Technique (LOR/LOS)

Depth: 3cm Catheter at Skin: 9cm Attempts : -01-

Parasthesia : Yes/No if yes details : —

Solution Composition : 0.1% BUPIVACAINE + 2MG FENTANYL

Any other issues :

a)

b)

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level Left Right	Maternal BP	Maternal Pulse	FHR	Comments
3pm		8mL		108/67	87	136	0.8% LOX EADR BOTH LUMEN
330pm	8mL		T_{10} - T_{10}				infusion started
5pm	— patient has moderate pain relief ←						
645 →	decision to operate.						

Delivery Details : Time : 7:24 APGAR: 6/8 SVD / Instrume LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected :

Patient Satisfaction : Good

Discharge /Shifting ordered by

Doctor Signature:

Doctor Name: Dr Akhil

Date and Time : 16/6/26 12:30pm

INFORMED CONSENT FOR VAGINAL BIRTH

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Patient Name : MRS. V. Sashikala. UHID No : HNH-0001232 9.

Gender: ☐ Male ☐ ~~Female~~ Date : 15/6/2026 Time : .....

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. Ramya Theja.

Consentee :

Signature : V. Sashikala

Name : V. Sashikala.

Date & Time : 15/6/2026 @ 7:00am

Patient Attendant :

Signature : S. Vinod Reddy.

Name : Vinod Reddy

Relationship with Patient: Husband

Date & Time : 15/6/2026 @ 7:00am

Witness :

Signature : .....

Name : Chandrakala

Date & Time : 15/6/26 at 7am

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. Naveena.

Date & Time : 15/6/2026 @ 7:00am.

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INDUCTION OF LABOR CONSENT

Name: MRS. V. Sashikala. Age: 30YRS Gender: Male ☐ Female ☑

UHID.No : HNH-0001 2329 Date: 15/06/2026.

You are scheduled for an induction of labor on 15/06/2026 (date) at 38w 1day. (weeks of gestation).

The reason for your induction is PV leak. (SRM).

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: V. Sashikala

Name: MRS. V. Sashikala.

Date & Time: 15/6/2026 @ 7:00am

Patient Attendant:

Signature: Vinod Reddy.

Name: Vinod Reddy.

Relationship with Patient: Husband

Date & Time: 15/6/2026 @ 7:00am.

Doctor:

Signature:

Name: Dr. Naveena.

Date & Time: 15/06/2026 @ 6:40am

Witness

Signature:

Name:

Date & Time:

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

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Mrs V SASHIKALA**	**Age :**	**30 Y 5 M 26 D**
IP No:	**IP26-00006587**	**Sex:**	**Female**
Consultant:	**Dr. KADIYALA RAMYA THEJA**	**Ward/Bed No:**	**4F -OT/PPO-417**

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned also consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science and that no guarantee have been made to me as the results of my evaluation and I or treatment.

I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal items and valuables.

"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process as per evidence based guidelines".

Note:
1 We do not allow use of medication brought from outside by the patient.
2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.
(Receivers Signature: S.Vinod Reddy)

3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.
4 Financial and billing counseling has been done to me.

S.Vinod Reddy.
Signature of Patient/Relative:

Name: S.Vinod Reddy.
Relationship: Husband.
Date: 15/06/2026. Time: 07.06 AM.
Witness Name: Surendra Naidu
Witness Signature:

Patient Address:
Champapet, Hyderabad Champapet
Hyderabad Telangana INDIA 500079

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BILLING POLICY

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

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

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

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

MODE OF PAYMENT & REFUNDS

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

S. Vinod Reddy.

Name & signature of Patient/Attendant

Sumandu Mourek

(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

CIN: U85110 TG1998 PTC029914 email : info@rainbowhospitals.in **www.rainbowhospitals.in**

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UNDERTAKING FOR BALANCE DEPOSIT

To

The Management,

Rainbow Children's Hospital, Himayatnagar

Hyderabad-500029

Sub:- **Undertaking Balance Deposit**

I Mr./Mrs./Ms. VINOD REDDY (Father/ Mother/ Other _____) of Master/ Baby/ Baby of/ Mrs./ Ms. V SASHIKALA was bought to your hospital on 15/06/26 at 07.06AM. Admitted in _____. Approximate charges deposit details were explained by the Front office/ Billing executive on duty. I have to pay the amount of 50K as a caution deposit but for now I'm depositing 30K. The remaining amount I'll deposit on 10.00AM. at _____.

Thanking You

S.Vinod Reddy.
Signature

Name:- S.Vinod Reddy.

Ph. No.:- 9346319291.