

Dr. Romya



ESTIMATION SLIP

Date : 8/6/26 UHID / IP No. : HINH-00015841 SI No. 1585
 Name of Patient : Mrs. Nikhat Fatime Age : 24y Gender : F
 Father's / Husband's Name : Mr. Ibrahim Corporate / Occupation : _____
 Address : Talagadde Phone : 9618178822 Email : _____
 Procedure / Plan : TOP EDD/Dos : June 6
 MODE OF PAYMENT : SELF TPA : _____ GIPSA : _____ OTHER

TARIFF INFORMATION :

Particulars	Package Amounts (Rs.)	
	Normal Delivery	LSCS
Room Category		
Multi Shared Ward		
Shared Ward		
Twin Shared Ward →	<u>45k</u>	<u>55k</u>
Private Room	<u>58k</u>	<u>75k</u>
Super Deluxe Room		
Suite Room	<u>+ Pharmacy &</u>	<u>Investigation Enter</u>
Package includes (Package starts from the time of admission)	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee and Labour Ward Charges	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee Anesthetist's Fees and OT Charges
	Length of Stay for : <u>1 Day</u>	Length of Stay for : <u>2 Days</u>
	Pharmacy up to	Pharmacy up to
	Investigations up to	Investigations up to
Others		

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

Final Minimum Deposit : 40,000/- Paid

REMARKS :

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

DECLARATION

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

Signature of the Client

Signature Relationship

Signature of the financial Counselor

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HNH-00015841 IP26-00006541
 Mrs NIKHAT FATHIMA
 13-06-1996 29 Y 11 M 26 D (F)
 Dr. KADIYALA RAMYA THEJA



SURGERY DETAILS

Date : 9/6/26

Patient Name: Mrs. Nikhat Fathima Date of Birth: 13/06/1996 Age: 29y

Gender: Female Ward: LDR UHID No.: HPH-00015841

Date of Surgery: 9/6/26 OT-1 OT-2 OT-3 OT-4 OBG OT-1 OBG OT-2 LDR-1

Name of the Surgery : Termination of pregnancy (TOP)

Time in : 3AM

Time Out : 9AM

	<u>NAME</u>	<u>AMOUNT</u>
1. Surgeon	<u>Dr. Ramya Theja</u>	
2. Anaesthetist		
3. Assistant Surgeon		
4. OT Technician		
5. Circulating Nurse	<u>Sis. Akhila</u>	
6. Assistant Nurse	<u>Sis. Madhumita</u>	



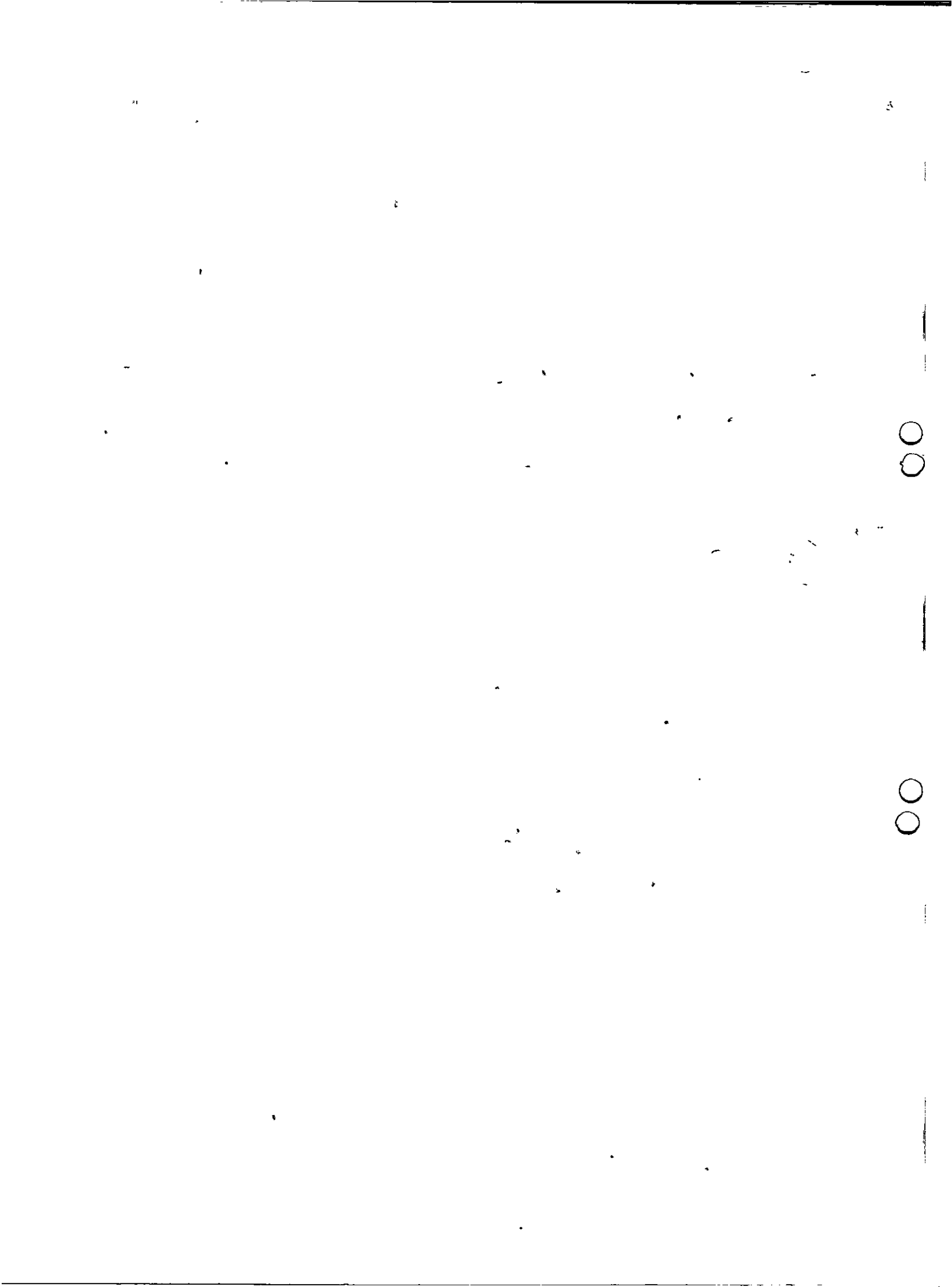
- Special Equipment:
- | | | | |
|--------------------------------------|---------------------------------------|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Laparoscopy | <input type="checkbox"/> Broncoscope | <input type="checkbox"/> Harmonic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

Signature of the Surgeon [Signature]

Signature of Circulating Nurse [Signature]

Order No: 26-0000205491

Order by: [Signature]



Name	Mrs NIKHAT FATHIMA	UHID	HNH-00015841
Father/Guardian	Mr IBRAHIM MOHAMMED	Age/Gender	29 Y 11 M 27 D/ Female
Address	13-5-431/A/5/1 TALLAGADDA, Karwan, Hyderabad, Telangana, INDIA, 500006		
IP No	IP26-00006541	Admission Date	08-06-2026
Ref Doctor	Self.		
Discharge Date	09.06.2026		

DISCHARGE SUMMARY

Consultant:

Dr. Kadiyala Ramya Theja
MBBS, DNB
TSMC/FMR/01458

Diagnosis: G2P1L1 WITH 20 WEEKS OF GESTATION WITH ANOMALOUS FETUS FOR MEDICAL TERMINATION OF PREGNANCY

MEDICAL TERMINATION OF PREGNANCY BY MERPC DONE ON 09.06.2026

History:

LMP: 19.01.2026
EDD: 26.10.2026

Obstetric formula: G2P1L1
Gestation at admission: 20 weeks

Name	Mrs NIKHAT FATHIMA	UHID	HNH-00015841
IP No	IP26-00006541	Admission Date	08-06-2026

Obstetric History:

G1 - 2022 - FTNVD, Male, B.wt.: 2.8kgs, Alive and Healthy

G2 - Present pregnancy, spontaneous conception.

Medical History: Nil.

Surgical History: Nil.

Allergies: Nil.

Family History: Mother - Hypertensive.

Antenatal Details:

Mrs NIKHAT FATHIMA was booked to Rainbow hospital at 19⁺⁵ weeks of gestation. Previous ANC's elsewhere. She had regular antenatal checkups and investigations as advised. NT scan - showed Increased NT - 4.3mm, nasal bone present. NIPT at 13+3 weeks - Low risk. Early TIFFA at weeks. Genetic counselling done. Amniocentesis done at weeks, chromosomal microarray report awaited. Repeat TIFFA at 19+5 weeks showed Spine - sacral spine (S3& S4) not visualised, sacral tip not ossified, CVS- Peri membranous Ventricular septal defect, left axis deviation, narrow aorta, Right kidney - Hydroureteronephrosis - UTD A2-3, Right ureter is grossly dilated and tortuous, Right renal cortex is thinned out and echogenic. Couple decided to go ahead with termination of pregnancy in view of multiple anomalies in fetus. She took tab Mifepristone 400mg on 06.06.2026. She was admitted at 20 weeks for MTP in view of anomalous fetus.

Investigations: Enclosed

Name	Mrs NIKHAT FATHIMA	UHID	HNH-00015841
IP No	IP26-00006541	Admission Date	08-06-2026

Blood Group: "O" Positive

Management:

On admission her vitals were stable. Routine blood investigations were sent and traced. Consent taken for medical termination of pregnancy. Antibiotic prophylaxis Inj Taxim 1 gm was given. MERPC done with 2 doses of PGE1. She was closely monitored. She expelled a still born male fetus at 03:30am of wt 320gm on 09.06.2026 with placenta and membranous in toto weighing 180gm. USG done on 09.06.2026 showed heterogenous echogenic areas noted in lower uterine cavity extending into cervical canal measuring 39x31x44mm- suggestive of organised blood clots. Gentle curettage done and clots were removed under USG guidance. Per speculum examination revealed ?genital warts on cervix ~0.5cm. Lactation suppression given. Couple declined fetal autopsy. Placenta sent for HPE as per hospital protocol. Baby disposal done as per hospital protocol. Her general condition was satisfactory and she was found to be fit for discharge. Medications were explained to the patient supplemented by written information.

Advice:

1. Tab Taxim O 200mg (Cefixime 200mg) twice daily after food (9am-9pm) till 13.06.2026
2. Tab Misoprostol 200 mcg thrice daily (6am-2pm-10pm) for 3 days till 11.06.2026
3. Tab Pantop 40mg twice daily before food (7am-7pm) till 13.06.2026.
4. Tab Dolo 650mg SOS (for pain).
5. Tab Zincovit once daily at 2pm after food for 1 month.

Name	Mrs NIKHAT FATHIMA	UHID	HNH-00015841
IP No	IP26-00006541	Admission Date	08-06-2026

6. Tab Livogen-Z once daily at 7am for 1 month.
7. RPOC scan on day 4 of next cycle
8. PAP smear after 4-6 weeks
9. Collect Placental HPE report

Report to the emergency in case of heavy bleeding, pain abdomen, fever, giddiness, foul smelling discharge.

Review with **Dr. KADIYALA RAMYA THEJA** on day 4 of next cycle with RPOC scan report at Rainbow Children's Hospital with prior appointment (**Review consultation will be charged**).

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, immunization and safe parenting, when and how to obtain emergency care etc also have been explained by doctorin 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

Name	Mrs NIKHAT FATHIMA	UHID	HNH-00015841
IP No	IP26-00006541	Admission Date	08-06-2026

website www.rainbowhospitals.in


Registrar/Resident/C.M.O



Consultant:

Dr. Kadiyala Ramya Theja
MBBS, DNB
TSMC/FMR/01458

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ADMISSION SHEET

Registration Details :



Admission No : IP26-00006541 Admit Date : 08-Jun-2026 Admit Time : 08:34 PM UHID : HNH-00015841

Patient Details :

Patient Name : Mrs NIKHAT FATHIMA Age : 29 Y 11 M 26 D
Guardian : Mr IBRAHIM MOHAMMED DOB : 13-06-1996
Gender : Female Religion :
Occupation : Martial Status :
Address (H) : 13-5-431/A/5/1 TALLAGADDA Karwan Phone No : 9618178827/ 7893209787
Hyderabad Telangana INDIA 500006 E-mail : mohdibrahim493@gmail.com

Admission Details :

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

Contact Details :

Name : Mr IBRAHIM MOHAMMED Relationship : Husband
Contact Address : Phone No : 9618178827

Signature

Doctor Details :

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

Payment Details :

Payment Mode : Cash Deposit Amount : 40000.00
Payor Name : SELFPAY

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ACTIVITY RECORD FOR BILLING

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Name: -----
 UHID No: ----- IP No: ----- Dept: -----
 Date of Admission: ----- Time: ----- Discharge: ----- Time: -----
 Room / Bed No: ----- Ward: ----- Suggested Billable bed type: -----

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 Mrs NIKHAT FATHIMA
 13-08-1996 29 Y 11 M 26 D (F)
 Dr. KADIYALA RAMYA THEJA



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

Cross Consultation Visit

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



I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 8/6/26 Time of Admission : 9pm

Allergies: Nil Not know any drug allergies

PRESENTING COMPLAINTS :

- Admitted for termination of pregnancy in view of fetal anomalies
 - NT : s/o ↑ NT (4.3mm), NB ⊕, NIPS : low risk @ VAS.
 - ~~any~~ DITTA @ Pericardis : s/o Sacral spine S3, S4 not visualised, VSD ⊕, left axis deviation, Rt kidney hydronephrosis.
 - Underwent Amniocentesis, genetic testing - reports awaited
 - decided for termination of pregnancy.
 - Took Mifepristone 400mg on 8/6/26.

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : 5yrs, 2 ^o wcm	Parity : G2P14.
Previous Periods : Regular.	Mode of Delivery :
LMP :	Last Child Birth : S: 2022: FNVVD, boy, 2.8kg, A&H
Contraception : POG: down	M: PP, spontaneous

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
Nil	Nil



<p>FAMILY HISTORY:</p> <p>mother: H/O</p>	<p>MEDICATION HISTORY:</p> <p>-</p>
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INITIAL ASSESSMENT :

Date <u>8/6/26</u> Ht. <u>153</u> Wt. <u>62kg</u> BMI <u>26.49</u> PR: <u>80/100</u> B.P. <u>113/70 mmHg</u> Pallor <u>(-)</u> CVR <u>++ (+)</u> Respiratory System <u>RAO (+)</u> Thyroid <u>(N)</u>	Breasts Abdominal Examination <p>N down relaxed</p>	Local/Speculum Examination Bimanual Pelvic Examination <p>PV: Gx Cong, post IF light Internal os closed</p>
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PROVISIONAL DIAGNOSIS : G2P14 / down / MTP for anomalous fetus

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT
<p>O Positive</p> <p>HIV HBsAg HCV } (N)</p> <p>CBS: 111</p>	<ul style="list-style-type: none"> - MTP by IPMSRc - soft diet/oral fluids = Monitor vitals - drugs as charted - w/ft subs used for - R/v see - w/ft expulsion - Consent for MTP.

Name of the Doctor: Dr Ramya - Theja Signature of Doctor: Ramya
 Date & Time: 8/6/26 @ 10pm



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/6/26 10:30pm	No complaints fc fast/afebrile vitals (N) PA: soft w/ ut down relaxed No. ca long, or if	None Dexamethasone
8/6/26 3:30 AM	she had spontaneous <u>boy</u> baby weighing 320 gm along with placenta & <u>180 gm.</u>	expulsion of a live born on 8/6/26 @ 3:20 AM. membranes in toto weighing
fetal autopsy ↓ to decide	0/5 pr cycle fc fast/afebrile vitals (N) R: 90/min BP: 112/60 mmHg RR: 28. PA: soft UWR A: bleeding (N)	Adv 1) Monitor vitals 2) w/ ut down bleed fr 3) drugs as charted 4) soft diet before 7 AM 5) Norm > 7 AM 6) RPOC scan today None Dexamethasone

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Mrs NIKHAT FATHIMA

13-08-1998 29 Y 11 M 26 D (F)

Dr. KADIYALA RAMYA THEJA



RESULT SHEET

Date					
Time					
Hb	11.0				
PCV					
RBC					
WBC					
N/L					
Platelets					
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Blood group = O+ve						
<div style="display: flex; align-items: center;"> <div style="margin-right: 10px;"> HIV HbsAg HCV </div> <div style="font-size: 2em;">}</div> <div style="margin-left: 10px;"> NR </div> </div>						

Culture and Sensitivities :

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Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :

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 Mrs NIKHAT FATHIMA
 13-06-1996 29 Y 11 M 26 D (F)
 Dr. KADIYALA RAMYA THEJA

Patient



MEDICATION RECONCILIATION FORM

Drug Allergies: Not known any Drug Allergies

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

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

Shifting From: NA Shifted to: NA

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						<input type="checkbox"/> C <input type="checkbox"/> DC
2						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : M. S. Mousha

Date & Time : 8/6/2020 @ 10 pm

Nurse Name & Signature: SKS

Date & Time : 8/6/20

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



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 Mrs NIKHAT FATHIMA
 13-06-1996 29 Y 11 M 26 D (F)
 Dr. KADIYALA RAMYA THEJA

Weight. 62kg Ward. UDK



e>					
ie	Nurse Sig.	Nurse Sig.	Nurse Sig.	Nurse Sig.	Nurse Sig.

DRUG :	Dose	Dose	Dose	Dose
	Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.
Route	Dose	Dose	Dose	Dose
	Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.
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	Dose	Dose	Dose	Dose
	Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.
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.

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
8/6/26	10:30pm	Tab MIDOPROPRAL	400mg	PV	Ranveer	Madhu
9/6/26	2:30pm	Tab MIDOPROPRAL	400mg	PO	Ranveer	Madhu
9/6/26	3:30am	Tab MIDOPROPRAL	400mg	P.R	Ranveer	Madhu
9/6/26	7:30am	Tab MIDOPROPRAL	400mg	PO	Ranveer	Madhu Akshita
9/6/26	3:30AM	Tab OXYCODONE	10U	IM	Ranveer	Madhu
9/6/26	10AM	Tab CASBERGRELIN	0.5mg x 2 tabs	PO	Ranveer	Aarti
9/6	11:10AM	INS TRANEXAMIC	1g	I.V	Ranveer	Aarti
9/6	11:15AM	INS ONDANSETRON	4mg	I.V	Ranveer	Aarti

VERIFIED BY: Name Signature

HNH-00015841 IP26-00006541
 Mrs NIKHAT FATHIMA
 13-08-1996 29 Y 11 M 26 D (F)
 Dr. KADIYALA RAMYA THEJA



OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 21/6/26

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: Top Doctor Notified on Admission: Yes No
 Name of the Doctor: Dr. Ramya Theja
 Time Notified:

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

Past Medical History	Past Surgical History	Previous Hospital Admission

<p>Gynecology Assessment: <input type="checkbox"/> Not Applicable</p> <p>Menstrual History: <u>Regular</u></p> <p>Onset of Menarche:</p> <p>Menstrual Cycle: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular</p> <p>Last Menstrual Period:</p>	<p>Gynecology Surgical History:</p> <p>Caesarean Section: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Cervical Cerclage: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Ectopic Pregnancy: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Myomectomy: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Others:</p>	<p>Gynecological History:</p> <p>Contraceptives: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Vaginal Discharge: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Post-Coital Bleeding: <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Infertility: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If Yes Type: <input type="checkbox"/> Primary <input type="checkbox"/> Secondary</p>
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Obstetric History: G 2 P 1 L 1 A

Previous LSCS:

Current Medication: None Yes, If Yes, Fill the reconciliation form

Family History: No Abnormalities Detected

Heart Disease Hypertension Diabetes Stroke Seizures Kidney disease

Liver disease Other

Vital Signs / Measurements: Temp: 97.8 HR: 84 RR: 20
 BP: 110/70 Weight: Height: BMI:

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



PHYSICAL ASSESSMENT

General Appearance: Healthy ill looking Anxious Agitated Others:

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

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

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

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING: No Abnormality Detected

- Overweight
- Poor Appetite > 3 Days
- Needs Therapeutic Diet.
- Under Weight
- Diabetes Mellitus
- Hyperemesis Gravidarum

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

Inform consultant for positive criteria

SOCIAL SCREENING:

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

Social History: Lives With family members

Orientation has been given regarding the following aspects:

- Call Bell in Reach : Yes No
- Waste Disposal Explained: Yes No
- Infusion Pump : Yes No
- Hand Hygiene Explained: Yes No
- Others

Above information given to Patient

Name of Person Orientation was given to: Mrs. Patil

Orientation not given Reason:

Nurse Signature: *[Signature]*

Nurse Name: Anu's

Date & Time: 8/6/26

HNH-00015841 IP26-00006541

Mrs NIKHAT FATHIMA

13-08-1996 29 Y 11 M 28 D (F)

Dr. KADIYALA RAMYA THEJA



Early Warning Observation Score Chart - Obstetrics

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

8/6/26

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

NA

10

2

6

20

10

90%

90%

85

86

115

116

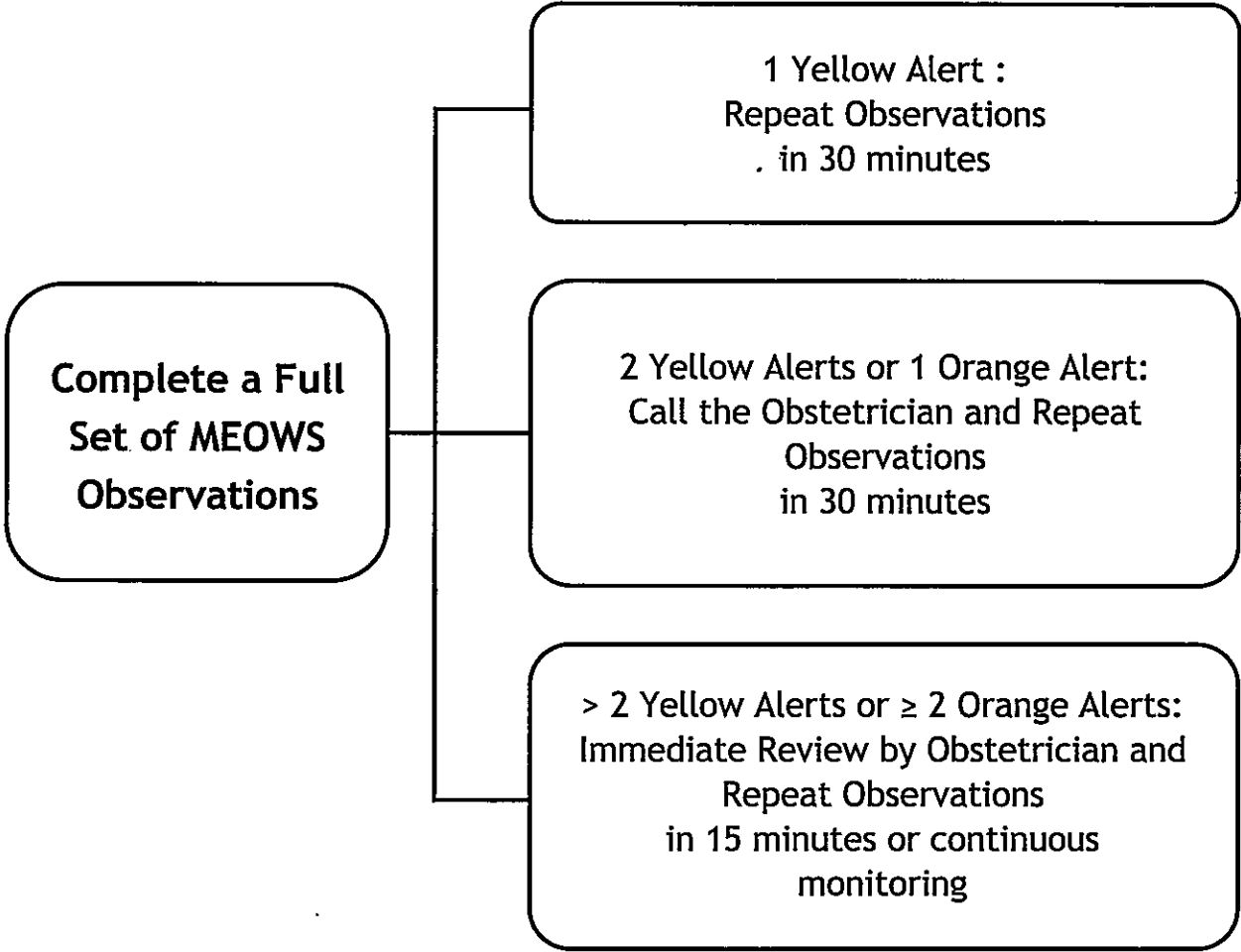
80

82

000

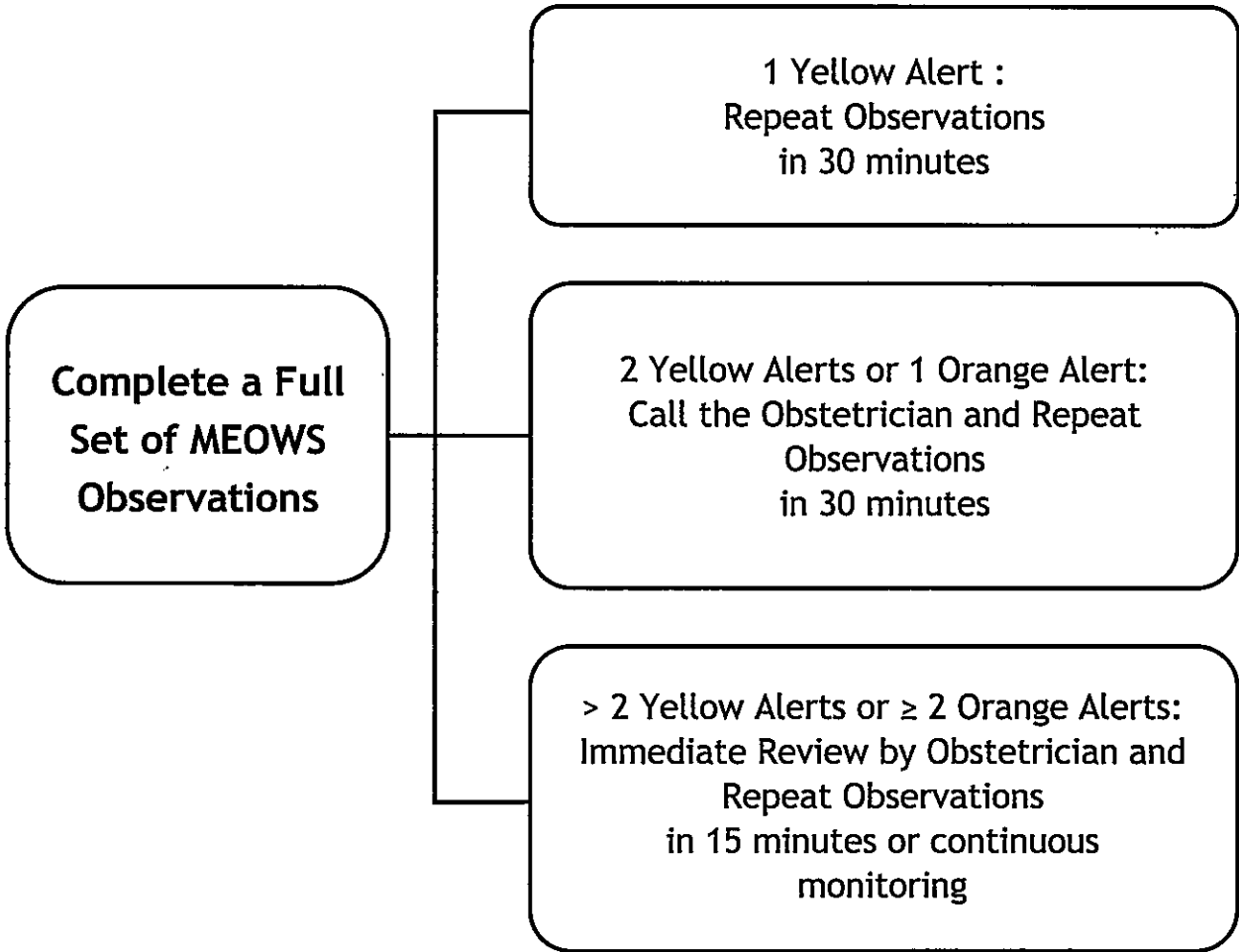
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**Obstetrics and Gynaecology
Early Warning Signs**



* The Modified Early Warning Score (MEOWS)

**Obstetrics and Gynaecology
Early Warning Signs**



* The Modified Early Warning Score (MEOWS)

HNH-00015841 IP26-00006541
 Mrs NIKHAT FATHIMA
 13-06-1996 29 Y 11 M 26 D (F)
 Dr. KADIYALA RAMYA THEJA



FLUID CHART

Sheet No. :

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

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

Total 24 hrs. Intake

Total 24 hrs. Output

HNH-00015841 IP26-00006541

Mrs NIKHAT FATHIMA
13-08-1996 29 Y 11 M 28 D (F)
Dr. KADIYALA RAMYA THEJA



FLUID CHART

Sheet No. : 0

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
a/06	08:00 am												
	09:00 am		N										
	10:00 am		B										
	11:00 am		M										
	12:00 pm		H ₂ O	✓									
	01:00 pm												
Total Intake : <i>240ml</i>						Total Output : <i>240ml</i>							
a/06	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



PAIN ASSESSMENT FORM

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

Re-assessment Frequency:

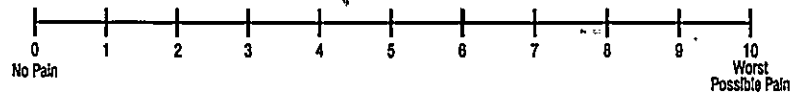
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 - a) At least every 2 hours for the first 24 hours
 - b) Then every 4 hours.
 - c) Prior to pain relieving intervention.
 - d) Within 30 - 60 minutes after pain relief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

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



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 Mrs NIKHAT FATHIMA
 13-08-1996 29 Y 11 M 26 D (F)
 Dr. KADIYALA RAMYA THEJA

BRADEN 'Q' SCALE



Date: 16/06/20
 Time: 27:04

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

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

TOTAL SCORE	28	28		
Evaluator's Name	@			

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

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Mrs NIKHAT FATHIMA

13-08-1996 29 Y 11 M 26 D (F)

Dr. KADIYALA RAMYA THEJA



Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	8/6/26	9/6/26	Fall Risk Grading		
		Score	80	81	Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25			Low Risk	0 - 24	Standard Fall Precaution
	No	0					
Secondary Diagnosis (more than one diagnosis)	Yes	15			Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0	0	0			
Ambulatory Aid	Furniture	30			High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Crutches, Cane(S), Walker	15					
	None /Bed Rest /Nurse Assist	0					
IV / Heparin Lock or Saline	Yes	20	20	20	Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0					
GAIT / Transferring	Impaired	20			High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10					
	Normal /On Bed Rest /Immobile	0					
Mental Status	Forgets limitations	15			High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0					
Total Morse Fall Scale Score:			20	20			
		Signature	<i>[Signature]</i>	<i>[Signature]</i>			

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

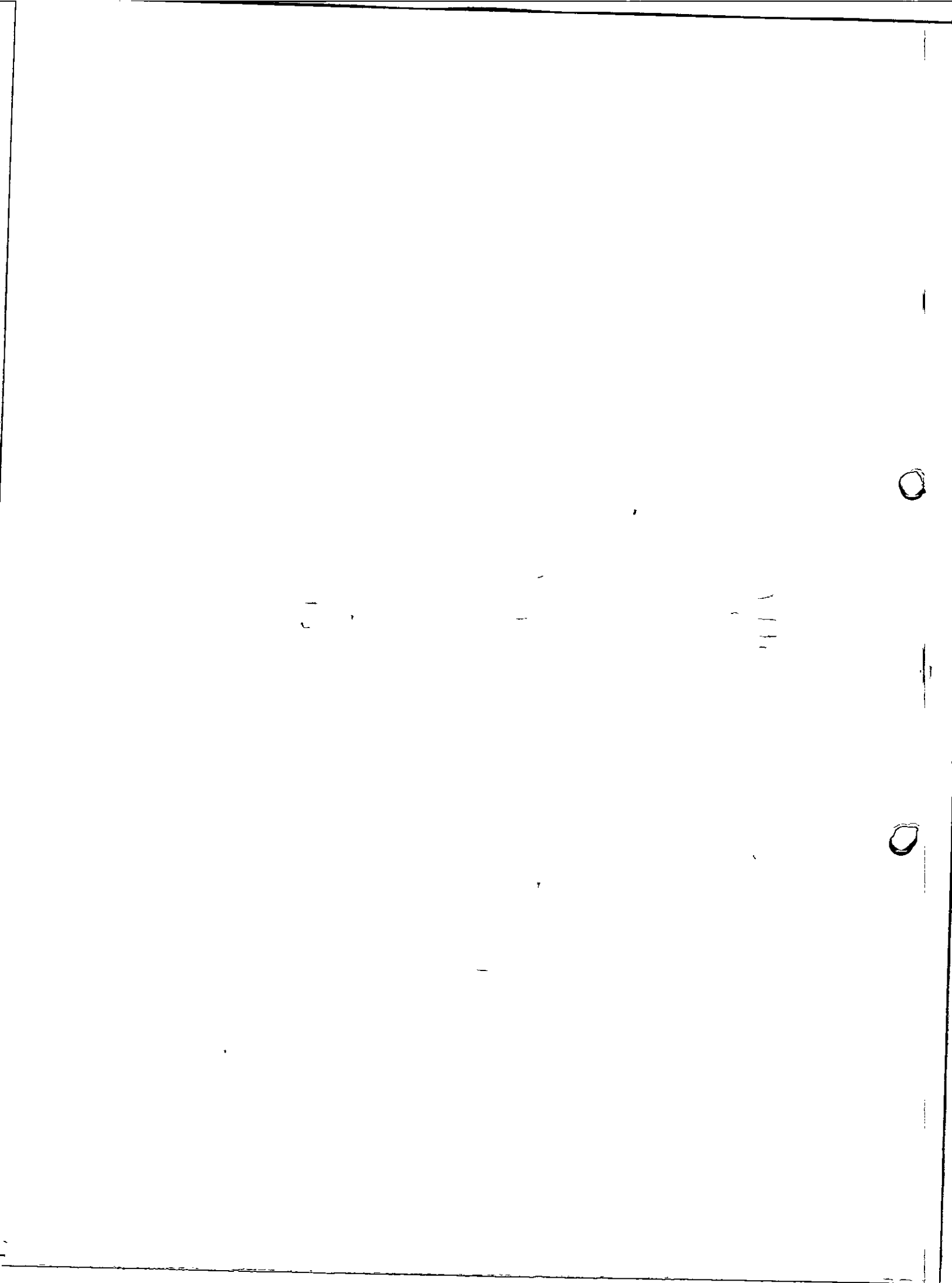
- Ensure patients use their prescribed eye glasses if any, in the hospital
- Use chairs with arm rests
- Use safety straps on stretchers and wheelchairs while transporting patients

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 NIKHAT FATHIMA
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NURSING CARE RECORD



Date: 8/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night	8PM	<p>8PM -> Assessed the pt condition</p> <p>-> monitor the vitals</p> <p>-> administration of medication</p> <p>-> maintain stock chart</p> <p>Enrolled</p>	8AM	<p>8AM -> Assessed the pt condition</p> <p>-> monitored the vitals</p> <p>-> administered medication</p> <p>-> maintained stock chart</p> <p>Enrolled</p>	pt is stable	maintain 2/2 chest Enrolled	AKW/g ①

HNH-00015841 IP26-00006541
 Mrs NIKHAT FATHIMA 29 Y 11 M 26 D (F)
 13-06-1996
 Dr. KADIYALA RAMYA THEJA



NURSING CARE RECORD



Date: 21/6/20

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am 2pm	<ul style="list-style-type: none"> → Assess the patient's condition → plan for vital → plan for medication → plan for attached 	8am 2pm	<ul style="list-style-type: none"> → Assessed the pt condition → Maintain vital → medication given → maintain fluid 	<ul style="list-style-type: none"> → patient stable 	<ul style="list-style-type: none"> → vital → normal 	
Afternoon							
Night							



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: LDR Date of Admission: 8/6/26

SITUATION	Diagnosis: <u>Cuticle 20 wles for top</u>		Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:				
	BACKGROUND	Area	<u>8/6/26</u>	<u>9/6/26</u>			
Shift Time		<u>11</u>	<u>12</u>				
ASSESSMENT	Medical Condition (Any special condition to be noted):	<u>N/A</u>	<u>-</u>				
	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
RECOMMENDATIONS	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	<u>97.8 F</u>	<u>98.6 F</u>			
		Res:	<u>55bmt</u>	<u>60bmt</u>			
		SpO ₂ :	<u>99.5</u>	<u>99.1</u>			
		Pulse:	<u>150bmt</u>	<u>118</u>			
		BP:	<u>-</u>	<u>-</u>			
	Fall Risk Score:	<u>-</u>	<u>-</u>				
Pain Score:	<u>-</u>	<u>-</u>					
Other Special Orders / Medications:	Safety Needs:	<u>Yes</u>	<u>-</u>				
	Physiotherapy	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Others Specify:	<u>-</u>	<u>-</u>				
	Special Diet:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Post Operative Procedure Special Orders:		<u>N/A</u>	<u>-</u>				
Handed Over By Name :		<u>AKKILS</u>	<u>KASHI</u>				
Signature :		<u>[Signature]</u>	<u>[Signature]</u>				
Date:		<u>8/6/26</u>	<u>8/6/26</u>				
Time:		<u>9AM</u>	<u>11:15</u>				
Taken Over By Name :		<u>KASHI</u>	<u>[Signature]</u>				
Signature :		<u>[Signature]</u>	<u>[Signature]</u>				
Date:		<u>8/6/26</u>	<u>8/6/26</u>				
Time:		<u>12:30</u>	<u>1:00</u>				

Patient Sticker



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

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

RMP - FORM I
(See Regulation 3)



Dr RAMYA THEJA KADIYALA, DNB OBGYN

(Name and qualifications of the Registered Medical Practitioner in block letters)

RAINBOW BIRTHRIGHT, HIMAYATHNAGAR, HYDERABAD.

(Full address of the Registered Medical Practitioner in block letters)

Dr MANISHA MAURYA, MS OBGYN

(Name and qualifications of the Registered Medical Practitioner in block letters)

RAINBOW BIRTHRIGHT, HIMAYATHNAGAR, HYDERABAD

(Full address of the Registered Medical Practitioner) hereby certify that * I/We/am/are of opinion, formed in good faith, that it is necessary to terminate the pregnancy of

Mrs NIKHAT FATHIMA

(Full name of pregnant woman in block letters) resident of 73-5-93/A/5/1, Pallapadde, Karwan

(Full address of woman in block letters)

Hyderabad, 500006

for the reasons given below**.

* I/We hereby give intimation that *I/We terminated the pregnancy of the woman referred to above who bears the serial No. in the Admission Register of the Hospital /approved place.

1126-00006541

1111-00015841

Ramyas

Signature of Registered Medical Practitioner

Manisha

Signatures of Registered Medical Practitioner

Place: Rainbow Children's Hospital & Birthright

Date: 8/6/26

*Strike out whichever is not applicable.

** of the reasons specified items (i) to (v) write the one which is appropriate:-

- (i) In order to save the life of the pregnant woman.
- (ii) In order to prevent grave injury to the physical or mental health of the pregnant woman.
- (iii) In view of the substantial risk that if the child was born it would suffer from such physical or mental abnormalities as to be seriously handicapped.
- (iv) As the pregnancy is alleged by pregnant woman to have been caused by rape.
- (v) As the pregnancy has occurred as a result of failure of any contraceptive device or methods used by married woman or her husband for the purpose of limiting the number of children.

Note:-

Account may be taken of the pregnant woman's actual or reasonably foreseeable environment in determining whether the Continuance of a pregnancy would involve a grave injury to her physical or mental health.

Ramyas

Signature of the Registered Medical Practitioner

Manisha

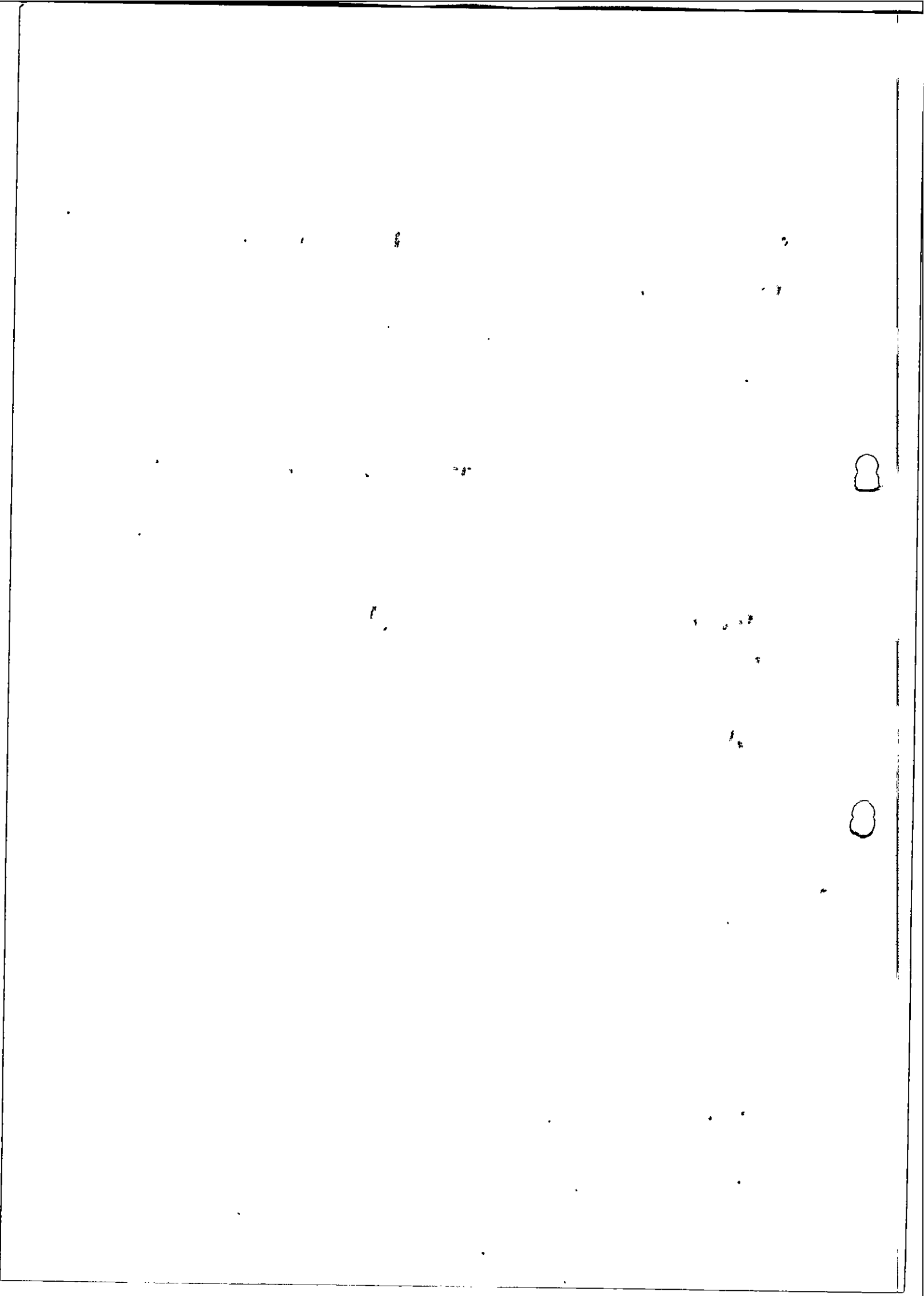
Signatures of the Registered Medical Practitioner

Place:

Hyderabad

Date:

8/6/26.



CONSENT FORM FOR MEDICAL TERMINATION OF PREGNANCY



Patient Name : Mrs Nikhat Fathima Age : 29y
 UHID No : FNT-00015841 Date : 8/6/2026

I, the undersigned, Mrs./Miss : Nikhat Fathima W/o, D/o, C/o : Mr Ibrahim Mohammed
 aged 29 years and residing at 13-5-42/A/5/1 Pellapadde Karwan, Hyderabad, 500006 request to terminate my pregnancy.

Reason for Undergoing Medical Term of Pregnancy : (Tick whichever applicable)

- The continuance of the pregnancy would involve a risk to my life due to serious medical disease.
- In order to prevent injury to my physical or mental health.
- The continuance of the pregnancy has a substantial risk of the newborn being born with serious physical / mental handicap.
- This pregnancy has resulted from me being raped.
- This pregnancy has occurred as a result of failure of contraceptive techniques -Intrauterine Device/ Oral Pills/ Condoms/ Coitus Interruptus/ periodic abstinence/ tubectomy/ vasectomy.
- In order to prevent a risk of injury to my physical or mental health by reason of my actual/ reasonably foreseeable environment.

I have been explained in the language known and understood by me about all the options available, counseled about the procedure, its risks, and costs & care to be taken after the procedure. Thus, I give my full valid consent as an act of my own free will to undergo the above-mentioned procedure to terminate my pregnancy.

I have been explained also the risks, benefits and alternatives of the procedure.

The future consequence of infertility has been explained to me in view of the voluntary termination of pregnancy and I am willing to accept the risk.

I also indemnify the Doctor and Rainbow Hospitals& its staff of any liability arising because of undergoing the above-mentioned procedure.

Name of the Doctor performing the procedure : Dr Ranysa Thomas

Patient :
 Signature : *Nikhat*
 Name : Mrs Nikhat Fathima
 Date & Time : 8/6/26 @ 10pm

Patient Attendant / Guardian :
 Signature : *Ibrahim Mohammed*
 Name : Ibrahim Mohammed
 Relationship with Patient : Husband
 Date & Time : 8/6/26 @ 10pm

Doctor (who is taking the consent) :
 Signature : *Ranysa*
 Name : DRANYSA THOMAS
 Date & Time : 8/6/26 @ 10pm

Witness :
 Signature : *Ranysa*
 Name : DRANYSA THOMAS
 Date & Time : 8/6/26 @ 10pm

*Guardian consent & signature needed in case of patient being less than 18 years or mentally unstable.

8

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HNH-00015841 IP26-00006541
Mrs NIKHAT FATHIMA
13-06-1996 29 Y 11 M 26 D (F)
Dr. KADIYALA RAMYA THEJA

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

25
of being the guiding light.
BirthRight. Shining Bright

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.

Name & signature of Patient/Attendant

(Signature of Admission Desk executive)

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

RAINBOW CHILDREN'S MEDICARE PRIVATE LIMITED

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

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

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

CIN: U85110 TG1998 PTC029914

email : info@rainbowhospitals.in

www.rainbowhospitals.in

OP Census Report

From Date : 08-06-2026

To Date : 08-06-2026

Date	Careprovider	New Visit	Followup Patients	Paid Patients	Total(Follow up+Paid Patients)
08/06/2026	Y.INDIRA RANI	1	0	1	1
	Total	18	28	131	159
	Grand Total	18	28	131	159

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It takes a lot to treat the little.

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

25
of being the guiding light
BirthRight Smiles, Shining Bright

UNDERTAKING FOR BALANCE DEPOSIT

To
The Management,
Rainbow Children's Hospital, Himayatnagar
Hyderabad-500029

Sub:- Undertaking Balance Deposit

I Mr./Mrs./Ms. Ibrahim Mohamud (Father/
 Mother/ Other Husband) of Master/ Baby/ Baby of
Mrs./ Ms. Nikhat Fathima was
bought to your hospital on 08-06-26 at 08:34 P.M
Admitted in 4F-07. Approximate charges deposit details
were explained by the Front office/ Billing executive on duty.
I have to pay the amount of 50 k as a caution deposit but for
now I'm depositing 40 k. The remaining amount
I'll deposit on _____ at _____.

Thanking You



Signature

Name:- Ibrahim

Ph. No.:- 961878827

