

Dr. S. Srinath / Dr. Rajan Kumar

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: 3/6/26 UHID / IP No.: NEW SI No. 1558
 Name of Patient: MRS. Vijaya Rani Age: 43 yrs Gender: F
 Father's / Husband's Name: MV. Navasimha Srinivasa Occupation: _____
 Address: Chickadpally Phone: 9032688306 Email: 9640212766
 Procedure / Plan: Abdominal Hysterectomy + LAVH EDD/Dos: _____
 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 →	13,500/- per Day	
Private Room →	2,50 K (2 Days)	
Super Deluxe Room	(PVT) 17,500/- per Day	
Suite Room		↳ Explained to Mangan
Package includes	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
Package starts from the (Date of admission)	Length of Stay for :	Length of Stay for :
	Pharmacy up to	Pharmacy up to <u>K. Manga</u>
	Investigations up to	Investigations up to <u>PT Sister</u>
Others		

Anesthetologist Charges: Covered Not Covered Epidural / Entonox: Covered Not Covered
 Initial Minimum Deposit: 50,000/- Advance

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

DECLARATION
M. Navasimha Srinivasa 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] Signatory Relationship: Husband Signature of the financial Counselor: [Signature]

HNH-00015784 IP26-00006491
 Mrs D VIJAYA RANI
 01-01-1983 43 Y (F)
 Dr. RAJANI KUMARI



SURGERY DETAILS

Date : 4/6/26

Patient Name: Mrs. Vijaya Rani Date of Birth: 1-01-1983 Age: 43yrs

Gender: female Ward: OT-2 UHID No.: HNH-00015784
IP26-00006491

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

Name of the Surgery : Lap. Hysterectomy + Bil salpingectomy

Time in : 12:00 PM Time Out : 4:00 PM

	<u>NAME</u>	<u>AMOUNT</u>
1. Surgeon	<u>Dr. Rajani Kumari, Dr. Varish</u>	
2. Anaesthetist	<u>Dr. Samir / Dr. Durg Bhowani</u>	
3. Assistant Surgeon	<u>Dr. Sri. S. Mathi</u>	
4. OT Technician	<u>Sr. pallavi, Sr. Saraswati</u>	
5. Circulating Nurse	<u>Dr. Sudipta</u>	
6. Assistant Nurse	<u>Sr. padmaja, Sr. Bikanth, Sr. Archana</u>	

Mrs D VIJAYA RANI (43 Y / F)

UTERS

HN26009329UTERS

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

26-0000204201 26-0000204200/201

Signature of the Surgeon: V. Kishu Signature of Circulating Nurse: A

Order No: 26-0000204200 Order by: Sushree 4/6/26 @ 4:21 PM

HNH-00015784 IP26-00006491
 Mrs D VIJAYA RANI
 01-01-1983 43 Y (F)
 Dr. RAJANI KUMARI



CONSUMABLES OF OT

Technician : S. Pallavi Date : 4/6/26 Time :

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube 7.0 cuffed		01	Major Pack	1		Inj Vit.K		
LMA			Sutures 2316	1		Cord Clamp		
ECG leads : A/P/N		105	Stratific 407	1		Suction Catheter		
HME filter : A/P/N		03	skin staples	01		Feeding Tube		
Syringes : 10 cc		04				Vaccum Suction Set		
05 cc		04	Gloves S.G 6 1/2, 7	5	1	Surgical Gloves		
02 cc		04	Endo. 6 1/2, 7	2	1	Gauze Pack		
01 cc			S.G-P.F-7.0	05		Syringe 1ml / 2ml		
Cautery plate : A/P/N		01	Surgical blade 11	2	1	Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL		03	Cautery pencil			NETTON 10F		02
NS : 10ml / 100ml / 500ml / 1000ml	01	10	Koochies XXL	1		20K JELLY		04
O ₂ mask (A)		01	Ointments			TRANSOFT		01
PCM		01	Suction Catheter			DRIP		
Fentanyl		01	Cap, Mask	10	10			
Morphine		01	Gauze Pack 7.5x7.5	6	4			
Ketamine			Mop Pack	2	2			
Propofol		03	Steristrip					
Rocuronium		03	Underpad	2				
Glycopyrolate		01	Draw sheet Corrugated drainage	1				
Myopyrolate			Abgel					
Ondansetron		01	Foleys catheter 14	1				
Pencan 25g/ Spinal Needle 22			Urobag	17	17			
Bupivacaine 0.25%		01	Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics Sugammadex		01	Bandage T.V.R.P set	1				
PMoline		01	Tegaderm					
Suppositories nasal air way 28		01	Ioban (Leggings big)	1				
Anamol : 80mg / 250mg / 170 mg			Double Stent					
Supridol : 100mg			Vaccum Suction set	01	01			
Justin : 12.5 mg / 25mg / 100mg		01	Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution	2				
Atoral 200mg 28			Microshield	2				
Ryles tube 14		01	Cotton Balls	1	1			
Gauze 7.5		01	Latex Gloves	20				
Vaccum Suction		01	Ramdione Scrub					
Oxygen mask (A)		01	Saral			Jox patch		01

Surgeon _____ Anaesthesiologist _____ Nurse _____ OT Technician _____

Order No. : 26-0000204239/288/237 Ordered by : S. Archana



ELECTRONIC MEDICINE PRESCRIPTION

MRN : HNH-00015784 Name : Mrs D VIJAYA RANI
 Age / Sex : 43 Y / Female Doctor : RAJANI KUMARI
 Adm/Reg Date/Time : 04/06/2026 06:33 Payor : SELFPAY
 Order Date : 04/06/2026 18:17 Ordernumber : 26-0000204238
 Visit ID : IP26-00006491 Ward/Bed No : 4F -OT / PPO-419
 Patient Address : Chikkadpally, Hyderabad, Telangana, INDIA, 500020

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	ADULT DIAPERS-XXL		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
2	HIGH PRESSUR EXTENTION 200 CM PRYMAX		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
3	NS 1000 ML CLOSED EUROFLEX	NORMALSALINE 1000ML CLOSED	1 Nos	External / Once Daily	1 Days		10 Nos	Dispensed
4	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
5	NELTON CATHETER-10 POLYMED		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
6	VACCUME SUCTION SET	VACCUME SUCTION SET	1 Nos	/ Once Daily	2 Days		2 Nos	Dispensed
7	COTTON BALLS 2GM 5 NOS	COTTON BALLS 2G- 5 NOS	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
8	MCT-ROF 100MG 10ML		1 Nos	Injection / Once Daily	1 Days		3 Nos	Dispensed
9	Encore Microptic gloves-8.5		1 Nos	/ Once Daily	1 Days		2 Nos	Dispensed
10	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		5 Nos	Dispensed
11	DSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
12	POVINANZ SOLUTION 10% 100 ML		1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
13	SURGICAL BLADE 11	SURGICAL BLADE 11	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
14	PROXIMATE PLUS MD 3500 STAPLER(PMW35)	PROXIMATE PLUS MD 3500 STAPLERPMW35	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
15	RL 500 ML CLOSED SYSTEM	RINGER LACTATE 500ML CLOSED	1 Bottle	/ Once Daily	3 Days		3 Bottle	Dispensed
16	RELIPARA(PARACETAMOL) 100MG 100ML BOTTLE		1 Nos	Injection / Once Daily	1 Days		1 Nos	Dispensed
17	FOLEYS CATHETER 14-URO CATH		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
18	NASOPHARYNGEAL TUBES 28	NASOPHARYNGEAL TUBE28	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
19	PREGELLED SURGICAL PLATES(ADULT)	PREGELLED PLATED ADULT	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
20	MOPS 30X30 8PLY 5S X-RAY	MOPS 30X308 PLYDATT	1 Nos	/ Once Daily	2 Days		2 Nos	Dispensed
21	UROBAG (ADULT) - URODYNE		1 Nos	External / 10 AM	1 Days		2 Nos	Dispensed
22	VICRYL 1-0 VP 2346	VICRYL 1-0 VP 2346	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
23	JUSTIN SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
24	OxygenMask With Tubing - Adult ROMSONS-FC		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
25	IRRIGATTO(T,U,R SET)	IRRIGATTO(T,U,R SET)	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
26	THEMIPYRRNOM 0.2MG INJ		1 Nos	Injection / 10 AM	1 Days		1 Nos	Dispensed
27	ONDOKIND INJ 4 MG 2 ML	ONDANSETRON 4MG 2ML INJ	1 Nos	/ Once Daily	1 Days		1 Vial	Dispensed
28	E.C.G ELECTRODES (ADULT)	ELECTRODES ADULT	1 Nos	External / Once Daily	1 Days		5 Nos	Dispensed
29	DSYRINGE 5ML (NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
30	SGLOVE # 7.0(SURGICARE)	SURGICAL GLOVES 7.0	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
31	STRATAFIX SPIRAL PDO (SXP02B407)	STRATAFIXSPIRALPDO (SXP02B407)	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed

RAJANI KUMARI

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

Note

* This prescription is valid only for specified duration.

* Do not refill medicines.



ELECTRONIC MEDICINE PRESCRIPTION

MRN : HNH-00015784 Name : Mrs D VIJAYA RANI
Age / Sex : 43 Y / Female Doctor : RAJANI KUMARI
Adm/Reg Date/Time : 04/06/2026 06:33 Payor : SELFPAY
Order Date : 04/06/2026 18:17 Ordernumber : 26-0000204237
Visit ID : IP26-00006491 Ward/Bed No : 4F -OT / PPO-419
Patient Address : Chikkadpally, Hyderabad, Telangana, INDIA, 500020

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	CORRUGATED DRAINAGE SHEET 250*25 MM-D	CORRUGATED DRAINAGE SHEET 250*25 MM-D	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
2	SURGEON CAP(FEMALE)	FEMALE CAP	1 Cap	/ Once Daily	10 Days		10 Cap	Dispensed
3	THEMICAINE 30GM JELLY		1 On Application	/ Once Daily	1 Days		1 Nos	Dispensed
4	GAUZE 7.5X7.5 12 PLY (5 NOS)	GAUZE 7.5X7.5 12 PLY 5 NOS	1 Nos	External / Once Daily	1 Days		12 Nos	Dispensed
5	MAJOR PACK (PROTECTCARE)		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
6	ENCORE MICROPTIC GLOVES-7 PF		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
7	LOX-LIDOCAINE-5PER PATCH 2S		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
8	H.M.E FILTER (ADULT)-1641-POLYMED		1 Nos	External / 10 AM	1 Days		3 Nos	Dispensed
9	LEGGINGS DISPOSABLE (PROTECTCARE) BIG		1 Nos	/ 10 AM	1 Days		1 Nos	Dispensed
10	BACTOPREP SOLUTIONS 100 ML	CHLORHEXIDINE GLUCONATE2% &ALCOHOL80% 500	1 mL	/ Once Daily	2 Days		2 Nos	Dispensed
11	BUPICAINE INJ VIAL 0.25% 20ML		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
12	ET TUBE 7.0 CUFFED RUSCH		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
13	NITRILE EXAMINATION GLOVES P F- LARGE		1 Nos	/ Once Daily	20 Days		20 Nos	Dispensed
14	ROCUNIM INJ 50 MG 5 ML		1 Nos	/ Once Daily	3 Days		3 Vial	Dispensed
15	FACE MASK 3 LAYER - ELASTIC	FACE MASK 3 LAYER	1 Nos	/ Once Daily	10 Days		10 Nos	Dispensed
16	NS 100ML ACCULIFE - EH		1 mL	External / 10 AM	1 Days		1 mL	Dispensed
17	SUGMADEX 2ML INJ		1 Ampule	Injection / Once Daily	1 Days		1 Ampule	Dispensed
18	UNDERPADS 60X90 BUTTERFLY		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
19	RYLES TUBE 14 POLYMED		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed

RAJANI KUMARI

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Note

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* Do not refill medicines.

Name	Mrs D VIJAYA RANI	UHID	HNH-00015784
Father/Guardian	Mr D NARASIMHA SWAMY	Age/Gender	43 Y / Female
Address	Chikkadpally, Hyderabad, Telangana, INDIA, 500020		
IP No	IP26-00006491	Admission Date	04-06-2026
Ref Doctor	SELF		
Discharge Date	07.06.2026		

DISCHARGE SUMMARY

Consultant:

Dr. RAJANI KUMARI
MD (OBGYN)

Diagnosis: P2L2 WITH PREVIOUS LOWER SEGMENT CAESAREAN SECTION WITH K/C/O HYPOTHYROIDISM WITH ABNORMAL UTERINE BLEEDING- LEIOMYOMA

TOTAL LAPROSCOPIC HYSTERECTOMY WITH BILATERAL SALPINGECTOMY DONE ON 04.06.2026

History: She presented with complain of heavy menstrual bleeding since 6 months and pain abdomen since 2-3 months. Scan done on 24.04.2026 showed Bulky Uterus (143*94*128 mm) anteverted, ET - 5.1 mm, E/o large well defined hypoechoic lesion measuring 13.5*9.3*14cms noted in left lateral wall of uterus abutting and displacing the endometrium towards right s/o Large intramural fibroid. On color doppler internal vascularity noted with in the lesion , with Bilateral ovaries normal in size and echotexture . Patient admitted for

Name	Mrs D VIJAYA RANI	UHID	HNH-00015784
IP No	IP26-00006491	Admission Date	04-06-2026

Total Laproscopic Hysterectomy with Bilateral Salpingectomy.

Menstrual History:-

LMP- 25.05.2026

Previous cycles: Regular cycles

Obstetric History: P2L2, 2 previous LSCS, LCB -2013

Medical History: Hypothyroidism since 2013 and on T.Thyronorm 125 mcg.

Surgical History: LSCS in 2011 and 2013

Allergies: Nil

Family History: Nil

Investigations: Enclosed.

Blood group : " A " Positive

Surgery Notes:

Operation performed:

TOTAL LAPROSCOPIC HYSTERECTOMY WITH BILATERAL SALPINGECTOMY DONE ON 04.06.2026

Indication: AUB-L

Operative findings:

1. Uterus about 24 weeks in size with large 14x13x12cm fundal fibroid on left side extending into Left broad ligament
2. Cervix normal
3. Bilateral fallopian tube normal
4. Bilateral ovaries normal

Name	Mrs D VIJAYA RANI	UHID	HNH-00015784
IP No	IP26-00006491	Admission Date	04-06-2026

5. Bladder adherant due to previous LSCS

Procedure:

1. Pneumoperitoneum created.
2. Total Laparoscopic hysterectomy with bilateral salpingectomy done.
3. Bilateral ovaries preserved.
4. Specimen cut and removed.
5. Vault sutured with Vicryl no. 1-0.
6. Corrugated Drain Sheet left in pelvis through the vault
7. Haemostasis secured.
8. Wash given.
9. Wound closed in layers- sheath closed with Vicryl no1-0 and skin closed with clips.
10. Post operative period was uneventful.

Post-Operative Notes: She was closely monitored in the postoperative period. Her vital signs remained stable. She was encouraged to ambulate. On first post operative day Foleys removed and she voided spontaneously. She was shifted to room. On second post operative day CRD removed. 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. T. Ceftum 500mg (Cefuroxime axetil) twice daily (9am-9pm) till 11.06.2026 after food.
2. T. Pantop 40mg (Pantaprazole) once daily at (8am) till 11.06.2026 before food.

Name	Mrs D VIJAYA RANI	UHID	HNH-00015784
IP No	IP26-00006491	Admission Date	04-06-2026

3. Tab Hifenac P (Aceclofenac 100 mg+Paracetamol 325mg) thrice daily (8am-3pm- 10pm) till 11.06.2026 after food.
4. Tab Zofer (Ondansetron) 8mg Twice daily (8am-8pm) before food till 11.06.2026
5. T. Zincovit once daily at 2 pm for 1 month.
6. Soft diet for 2 days (till 05.06.2026) and normal diet from 06.05.2026.
7. Continue T.Thyronorm 100mcg once daily (7am)
8. Collect HPE report.

Review consultation with Dr. RAJANI KUMARI, and SURI SRIMATHI after 1 week on 11.06.2026 in Gynec OPD with HPE reports at rainbow Children's Hospital **(Review consultation will be charged)**.

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


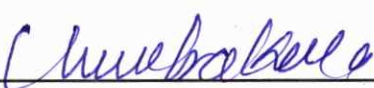

Patient/ Attender

In case of emergency like bleeding, fever kindly contact 9154865045 at Rainbow Children's Hospital just dial one toll free number - 18002122. You can also take appointments at any time by going online to our website **www.rainbowhospitals.in**


Registrar/Resident/C.M.O

Consultant:
Dr. RAJANI KUMARI

PATIENT TRANSFER FORM

Patient Name & UHID No. : HNH-00015784 IP26-00006491 Mrs D VIJAYA RANI 01-01-1983 43 Y (F) Dr. RAJANI KUMARI 		Date & Time of Admission 6/6/20	Date & Time of Transfer Order 6/6/20
		Transfer Ordered by Dr. Veena	Reason for Transfer obs
From Unit pre post	To Unit 209	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 30	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	Rb	LB	
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring 		Name of Person Ordered Transfer	
Patient & Clinical Records Received by : 			
Date & Time of Patient Received :			

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

- Unavailable Bed
 Nurse not Available
 Available Bed not ready



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 : IP26-00006491 Admit Date : 04-Jun-2026 Admit Time : 06:33 AM UHID : HNH-00015784

Patient Details :

Patient Name	: Mrs D VIJAYA RANI	Age	: 43 Y
Guardian	: Mr D NARASIMHA SWAMY	DOB	: 01-01-1983
Gender	: Female	Religion	:
Occupation	:	Martial Status	:
Address (H)	: Chikkadpally Hyderabad Telangana INDIA 500020	Phone No	: 9032688306
		E-mail	: NO@GMAIL.COM

Admission Details :

Bed Type : TWIN SHARING Bed No : PPO-419 Ward Name : 4F -OT
Room No : PPO-419 Admission Type : First Visit

Contact Details :

Name : Mr D NARASIMHA SWAMY Relationship : Husband
Contact Address : Chikkadpally Hyderabad Telangana INDIA 500020 Phone No : 9032688306


Signature

Doctor Details :

Doctor Name : Dr. RAJANI KUMARI Specialisation : OBSTETRICS AND GYNECOLOGY
Referral Doctor : SELF Phone No :
Co-Consultant :

Payment Details :

Deposit Amount : 100000.00
Payment Mode : DC/CC Card Payor Name : SELFPAY

HNH-00015784 IP26-00006491
 Mrs D VIJAYA RANI (F)
 01-01-1983 43 Y
 Dr. RAJANI KUMARI



ACTIVITY RECORD FOR BILLING

Name: -----
 UHID No : ----- IP 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
4/6/26	12hr	MICU	OT	@ RA
4/6/26	4:10pm	OT	MICU	A Akhila
6/6/26	9pm	me past	209	CA
6/6/26	4:50pm	ward.	209 304	@ madh

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
4/6/26	CBP.	9293 ✓	①
5/6/26	CBP.	9393 ✓	Akwis
6/6/26		HN26009371	
			cross checked
			by swathe
			6/6/26@
			3:30pm

amha *Re*
7/6/20

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
4/6/26	Cardiac monitor	4:10PM	3:30PM		
4/6/26	Infusion pump	4:10PM	3:30PM		Albi
4/6/26	oxygen	4:10PM	6PM		
			stop 4/6/26		

cross checked
by serialtm
6/6/26 @
3:30PM

cross checked by R
7/6/20

~~2042/6~~
~~Albi~~

PROCEEDURE

Date	Proceeedure	Quantity	Order No.	Signature
4/6/26	IV placement —	①	204058 ✓	Mauri
4/6/26	DAC — (IP)	①	26-0000 ✓ 204061 ✓	Mauri
4/6/26	catheterization	①	204217 ✓	Akaly
				cross checked
				by sunit
				6/6/26 @
				3:30pm

ANY OTHER INFORMATION

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Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
-------------	--------------	-------------------	--------------------



I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 4/6/2024 Time of Admission : 11:30

Allergies: NKDA Not know any drug allergies

PRESENTING COMPLAINTS :

pain abdomen. 2-3 month.
 Heavy menstrual bleeding = 6 month.

USG (24/4/2024) - Backup at 2 large intramural fibroids in left lateral wall (13.5 x 9.3 x 14.0cm) abnormally and displacing the endometrium towards right
 ET ~ 5mm
 Both ovaries @ normal size (cystic)

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : 2010	Parity : 2 L50
Previous Periods : Regular 5/30 days	Mode of Delivery :
LMP : 25/5/2026	Last Child Birth : 2013
Contraception :	Tubectomy

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
<p>Hypothyroidism - 2013 (7 tabs Thyronorm 125mcg OD) = 1/5/day</p>	<p>CS 2011 CS 2013</p>



FAMILY HISTORY: <p style="text-align: center;">Nil -</p>	MEDICATION HISTORY: <p style="text-align: center;">T. thyronom 125mcg OD</p>
--	--

INITIAL ASSESSMENT :

Date <u>4/6/2022</u> Ht. _____ Wt. <u>60kg</u> BMI _____ B.P. _____ Pallor _____ CVR <u>NR</u> Respiratory System <u>BARE</u> Thyroid <u>NR</u>	Breasts <p style="text-align: center;">(N)</p> Abdominal Examination <p style="text-align: center;">Soft</p>	Local/Speculum Examination <p style="text-align: center;">Not done</p> Bimanual Pelvic Examination <p style="text-align: center;">Not done</p>
--	---	---

PROVISIONAL DIAGNOSIS : P₂L₂ c/o previous LSCs c Hypothyroid c Fibroids

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT
BGT A ⊕ w HbU } HbSA } NR UORE } fuc } vORE } CBP	NBM Pains preop Days as charted Informed consent Inform Anesthetist Check for Blood Availability Shift to OT on call.

Name of the Doctor : Dr Rajani Kumari Signature of Doctor _____
 Date & Time : 4/6/2022

HNH-00015784
 Mrs D VIJAYA RANI
 01-01-1983 43 Y
 Dr. RAJANI KUMARI

IP26-00006491

(F)



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		<u>ds/B Dr. Veena</u>
<u>4/6/26</u> 4pm	<u>POD-0 / S/P TLH + BS</u>	
	Pt is stable, Noct/o o/e GC fair, Afebrile BP - 113/70 mmHg PR - 78 bpm SpO ₂ - 100% on 4L O ₂ P/A - soft soft, NT HE - NAD U/O - 200ml, clear urine	Adv - NBM today - vital monitoring - I/O charting - Drugs as charted - Pethoxin from c/m. - IV Abx (Trij-Magnex & Bij-Methoxy) - Inform SAS
<u>4/6/2026</u> 8:00pm	gls/by. o/e GC fair Afebrile Vitals - stable PA - soft, NT Dressing: dry & clean HE: NAB	Dr. Naveena. Adv - NBM - drugs as charted - Urine I/O charting - w/f PV bleeding - Mon Monitor Vitals - Inform SAS
	U/O: 500ml : 4pm. clear.	
		 Dr. Naveena.

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/6/2026 12:00am	cls/bgy Dr. Naveena	
	OLE GC-fair	Ado
	Afebrile SpO ₂ -100% on RA	- NBM
	Vitals - stable	- iv f & drugs
	PA - soft, NT	as charted
	Dressing - dry & clean	- Urine I/O charting
	IIE: NAB	- w/f PV bleeding
	ULO: adequate	- Monitor Vitals
		- Inform SOS
	Dr. Naveena	
5/6/2026 6:30am	cls/bgy Dr. Naveena	
	OLE GC-fair	Ado
	Afebrile SpO ₂ -98% on RA	- NBM
	PR: 60bpm	- iv f & drugs as
	BP: 99/72 mmHg	charted
	Cus/RS: NAD	- Urine I/O charting
	PA: soft, NT	- w/f PV bleeding
	Dressing: dry & clean	- Monitor Vitals
	IIE: NAD	- Inform. SOS
	ULO: Adequate	
	Bowel sounds - absent	Dr. Naveena



(2)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/6/20 9:30am	<p>cls/B Dr. Veena <u>POD-1 P₂L₂ TLT + BS</u></p>	
	<p>Pt is stable, Noct <u>o/e GC-fair Affable</u> Vitals-stable P/A - Soft, mild tenderness (+) BS (+) L/E - NAD. U/O - 100ml/hr, clear.</p>	<p><u>Adv</u> - Oral sips - Vital monitoring - No charky - Drugs as charted - w/f bleeding plv - Inform SOS</p>
	<p>cls/B Dr. Manisha</p>	
5/6/2020 12:40pm		<p><u>Adv</u></p>
	<p>GC Fair Affable BP 120/70 PR 75/min P/A Soft BS sluggish L/E NAD</p>	<p>⊛ Allow water/Tea/coffee only ⊛ Send CBP. - Spirometry QID - Prepped up. - Ambulatory ⊛ chest physio.</p>
	<p><u>GRD insitu</u> U/O Adeq. SpO₂ 97% on RA</p>	<p>- Inform SOS - Drugs as charted</p>
	<p>UO cough (9 Atelectasis) <u>P/H Dr. Samir Sr → Adv.</u> Spirometry/chest physio → Still Present → Nebulization</p>	<p>Dr. Manisha</p>

HNH-00015784

IP26-00006491

Mrs D VIJAYA RANI

01-01-1983

43 Y

(F)

Dr. RAJANI KUMARI



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/6/26 7:45 PM	C/S/B Dr. Dna POD-1 (S/P TLH + BS)	
passing flatus	AC fair Afebrile SpO ₂ : 99% on RA BP: 103/65 mmHg PR: 72 bpm P/A soft BS (+)	Re - Water/tea/coffee allowed - Propped up position - Spirometry BID - Drugs as charted
	U/O - Adequate clear CRD insitu	- Ambulation - chest physiotherapy - Vital Monitoring - Inform s/c
5/6/26 6 AM	C/S/B Dr. Dna POD-2 (S/P TLH + BS)	
V/O - 200ml clear CRD insitu	AC fair Afebrile BP: 114/72 mmHg PR: 69/min SpO ₂ : 97% on RA P/A soft BS (+) H&E NBBS	Adv - Clear liquid - Propped up position - Spirometry BID - Drugs as charted - Ambulation - chest physiotherapy - Vital Monitoring - Inform s/c



3

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/06/2026 10:00am	cls/by	Dr. Naveena.
	<p>o/c GC-fair</p> <p>Alebnile SpO₂-96% on RA</p> <p>PR: 98bpm</p> <p>BP: 100/60mmHg</p> <p>CUSRS: NAD</p> <p>PA: soft, NT.</p> <p>Dressing: dry & clean</p> <p>ILE: NAD.</p> <p>ULO: adequate & clear.</p>	<p>Adv</p> <ul style="list-style-type: none"> - liquid diet - Adequate hydration - drugs as charted. - Spirometry QID. - drugs as charted. - Ambulation - Urine. I/O charted. - Propped up position - chest physiotherapy - Monitor Vitals - Inform SCS
	<p>Dr. Naveena</p>	
19/6/2026 1:00 pm	cls/by	Dr. Suci Srimati
<p>Kindly shift the patient to room.</p>	<p>o/c GC-fair</p> <p>Alebnile SpO₂-96% RA</p> <p>Vitals - stable.</p> <p>PA: soft, NT</p> <p>Dressing: dry & clean</p> <p>ILE: NAD</p> <p>CRD - removed - NAD</p> <p>ULO - adequate, clear.</p>	<p>Adv</p> <ul style="list-style-type: none"> - liquid diet - Adequate hydration. - drugs as charted - Remove Foley's. - Ambulation - Spirometry QID - Monitor Vitals - Inform SCS

Dr. Naveena

Noted by Madhavi

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/6/2022 7:30pm	Clots @ Mombaka	
	GC Fair Afebrile Vitals stable PIA Soft BS ⊕	Ad - Drugs as claud - Liquid Diet - Ambulation - Sprometry
UV FV Sa	1/2 NAD	- Inten srs Noted Divya 6/6/26 7:30pm M Bms
7/3	Clots @ Mombaka	
7:30AM	Poo 3	
	GC Fair Afebrile Vitals stable PIA Soft BS ⊕	Ad - Soft Diet - Adeq Hydrat - Drugs as claud - Sprometry
UV SV	1/2 NAD	- Ambulation - Inten srs N/B priyanka M Bms

HNH-00015784 IP26-00006491
 Mrs D VIJAYA RANI
 01-01-1983 43 Y (F)
 Dr. RAJANI KUMARI



GROSS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/13/26		cls/B Dr. Veena
11:00am		
	<u>POD-3. TCH+BS</u>	
	Pt is stable, Noct	APU
	ole GC fair	- Regular ^{Soft} diet
U ✓	Vitals-stable	- Adequate hydration
F ✓	P/A - Soft RT	- Spirometry
S ✓	UC - BUNAD	- Ambulation.
	Can be	- Inform SOS
	discharged	<i>[Signature]</i>



DRUG CHART

Date of Admission: 4/6/2020 Drug Allergies: NI 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 _____

REGULAR PRESCRIPTIONS

Weight. 60 Ward. HDR



Verified by Dr. Dhakshayani

DRUG : INJ MAGNEX FORTE				Date/Time	4/6	5/6	6/6	7/6												
Dose	Route	Frequency	Start Date	11 AM	11:30 AM	12 AM	12 AM	12 AM												
1-5g	IV	BD	4/6																	
Name & Signature of the Doctor Starting the Drugs:				<p><i>[Signature]</i></p> <p>11 AM 11:30 AM 12 AM 12 AM</p>																
Additional Instructions:				<p>Cefoperazone + Sulbactam (AID)</p>																
Daily Doctor's Endorsement by a Sign				<p><i>[Signature]</i></p>																

DRUG : INJ. PARACETAMOL				Date/Time	4/6															
Dose	Route	Frequency	Start Date	8 AM																
3gm	IV	QID	4/6																	
Name & Signature of the Doctor Starting the Drugs:				<p><i>[Signature]</i></p> <p>12 AM 12 AM</p>																
Additional Instructions:				<p>STOP @</p>																
Daily Doctor's Endorsement by a Sign				<p><i>[Signature]</i></p>																

DRUG : INJ. DICLOFENAC				Date/Time	4/6	5/6	6/6	7/6												
Dose	Route	Frequency	Start Date	9 AM	9 AM	9 AM	9 AM	9 AM												
75mg	IV	BD	4/6																	
Name & Signature of the Doctor Starting the Drugs:				<p><i>[Signature]</i></p> <p>9 AM 9 AM</p>																
Additional Instructions:				<p>STOP @</p>																
Daily Doctor's Endorsement by a Sign				<p><i>[Signature]</i></p>																

DRUG : INJ. METRONIDAZOLE				Date/Time	4/6	5/6	6/6	7/6												
Dose	Route	Frequency	Start Date	9 AM	9 AM	9 AM	9 AM	9 AM												
500mg	IV	TID.	4/6/26																	
Name & Signature of the Doctor Starting the Drugs:				<p><i>[Signature]</i></p> <p>9 AM 9 AM</p>																
Additional Instructions:				<p>STOP @</p>																
Daily Doctor's Endorsement by a Sign				<p><i>[Signature]</i></p>																

Verified by Dr. Dhakshayani



Sheet No:

REGULAR PRESCRIPTIONS

Weight ... 60 ... Ward ... 202 ...

Verified by
 Dr. Dhakshayani

Verified by
 Dr. Dhakshayani

Signature
 Name

Verified by
 Dr. Dhakshayani

DRUG: INS - PANTOPRAZOLE

Dose	Route	Frequency	Start Dt.	Date/Time
40mg	IV	QD	4/5/26	5/6 6/6 7/6

Name & Signature of the Doctor Starting the Drugs: *[Signature]*

Additional Instructions:

Daily Doctor's Endorsement by a Sign: *[Signature]*

DRUG: INS - ONDANSETRON

Dose	Route	Frequency	Start Dt.	Date/Time
8mg	IV	TID	4/5/26	5/6 6/6 7/6

Name & Signature of the Doctor Starting the Drugs: *[Signature]*

Additional Instructions:

Daily Doctor's Endorsement by a Sign: *[Signature]*

DRUG: T - LETHYROXINE

Dose	Route	Frequency	Start Dt.	Date/Time
125mcg	PO	OD	5/5/26	

Name & Signature of the Doctor Starting the Drugs: *[Signature]*

Additional Instructions: Before food.

Daily Doctor's Endorsement by a Sign: *[Signature]*

STOP *[Signature]*

DRUG: INS - PARACETAMOL

Dose	Route	Frequency	Start Dt.	Date/Time
1gm	IV	QID	4/6	4/6 5/6 6/6 7/6

Name & Signature of the Doctor Starting the Drugs: *[Signature]*

Additional Instructions:

Daily Doctor's Endorsement by a Sign: *[Signature]*



Sheet No:

REGULAR PRESCRIPTIONS

Weight ... 60 Ward ... 201

DRUG : T. THYRONORM				Date Time	5/6	6/6	7/6													
Dose	Route	Frequency	Start Dt.																	
100mg	PO	OD	5/6																	
Name & Signature of the Doctor Starting the Drugs: @ Dr. Naveena																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

verified by
Dr. Dhakshayani

Signature

VERIFIED BY: Name

Dr. Dhakshayani



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
4/6	11:45 AM	INJ PANTOPRAZOLE	40mg	IV	[Signature]	Arche
4/6	11:46 AM	INJ METOCLOPRAMIDE	10mg	IV	[Signature]	Arche
4/6	9:30 AM	BETADINE PESSARY	1 tab	PV	[Signature]	Arche
4/6	12:30 pm	INJ PARALAMOL	75mg	IV	[Signature]	Arche
4/6	12:40 pm	INJ MORPHINE SULPHATE	4.5MG	IV	[Signature]	Arche
4/6	3:45 pm	DICLOFENAC Suppository	100MG	PR	[Signature]	Arche
4/6		IP ANAALOL Suppository	100MG	PR	[Signature]	
4/6	2:45 pm	ONDANSETRON	4MG	IV	[Signature]	Arche

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

Verified by: Dr. Diakshayani

I.V. FLUIDS CHART

Weight. 60 Ward. 2DR



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
4/6	7:00am	RINGER LACTATE	IV	100 ml/hr	✓	A S	4/6	✓	
4/6	12:30pm	RINGER LACTATE	IV	500	✓	A A	4/6	✓	A A
4/6	1:20pm	RINGER LACTATE	IV	500	✓	A A	4/6	✓	A A
4/6	2:30 pm	RINGER LACTATE	IV	100	✓	A A	4/6	✓	✓ A
4/6	5pm	RINGER LACTATE	IV	100 ml/hr	✓	✓ ✓	4/6	✓	✓ ✓
4/6	11pm	DEXTROSE NORMAL SALINE	IV	100ml hr	✓	A A	5/6	✓	✓ ✓
5/6	4am	RINGER LACTATE	IV	100ml hr	✓	A A	5/6	✓	✓ ✓
5/6	10am	DEXTROSE NORMAL SALINE	IV	75ml/hr	✓	✓ ✓	5/6	✓	Li M
5/6	6pm	RC RINGER LACTATE	IV	75ml/hr	✓	Li M	5/6	✓	
6/6/26	2:30 Am	DEXTROSE NORMAL SALINE	IV	75ml/hr	✓	✓ ✓	6/6	✓	

Signature

VERIFIED BY : Name

HNH-00015784 IP26-00006491
 Mrs D VIJAYA RANI
 01-01-1983 43 Y (F)
 Dr. RAJANI KUMARI



(Handwritten signatures and initials)

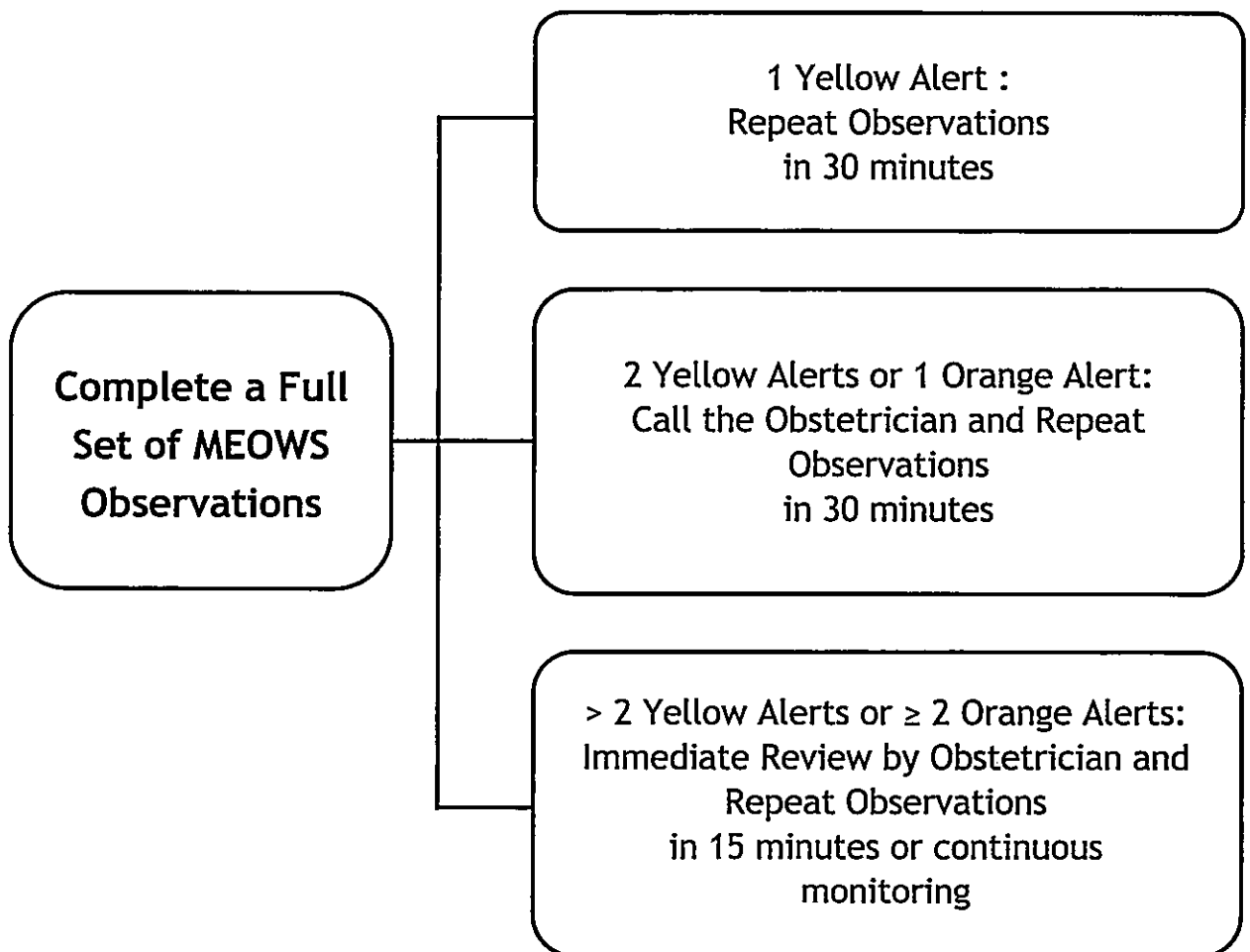
Rainbow[®]
 Children's
 Hospital
 It takes a lot to treat the little.

BirthRight[™]
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

RESULT SHEET

Date	4/6/28	5/6/26			
Time	7:53 AM				
Hb	12.7	12.0			
PCV	36.8	34.9			
RBC	4.60	4.36			
WBC	4.19	7.05			
N/L					
Platelets	151	122			
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					

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

HNH-00015784-
 Mrs D VIJAYA RANI
 01-01-1983 43 Y
 Dr. RAJANI KUMARI
 IP26-00006491 (F)



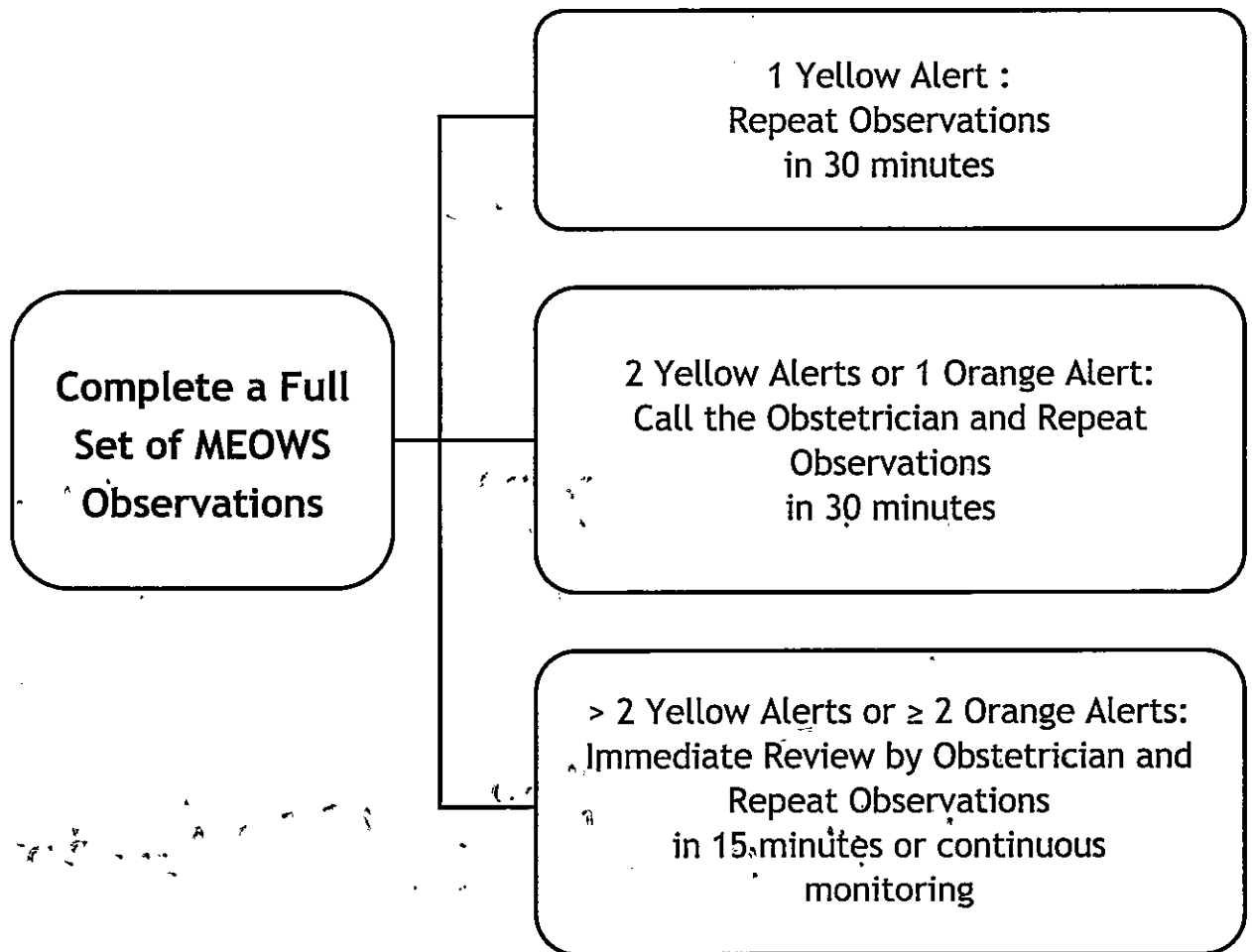
Early Warning Observation Score Chart - Obstetrics

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

		Date	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	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	20	20	20	20
	0 - 10																											
Saturations	94 - 100 %		100	100	100						100	100	100	98	98	99	99	99	99	99	99	99	99	99	99	99	99	
	< 94 %																											
Administered O ₂ (L/min.)											WIF	WIF																
Temp °C	40																											
	39																											
	38																											
	37																											
	36																											
	35																											
	< 35																											
Heart Rate	170																											
	160																											
	150																											
	140																											
	130																											
	120																											
	110																											
	100																											
	90																											
	80																											
	70		60	60	69						75	77	78	85	82	83	80	82	81	72	82	80	79	89	90			
	60																											
	50																											
40																												
Systolic Blood Pressure	190																											
	180																											
	170																											
	160																											
	150																											
	140																											
	130																											
	120																											
	110																											
	100		107	110	120						119	112	117	110	100	110	110	103	100	105	110	122	122	110	122	110		
	90																											
	80																											
	70																											
60																												
50																												
40																												
NEURO RESPONSE [✓]	Alert																											
	Voice																											
	Pain																											
	Unresponsive																											
URINE ml / 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	0	0	0	
TOTAL ORANGE SCORES			0	0	0						0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Nurse Initial																												

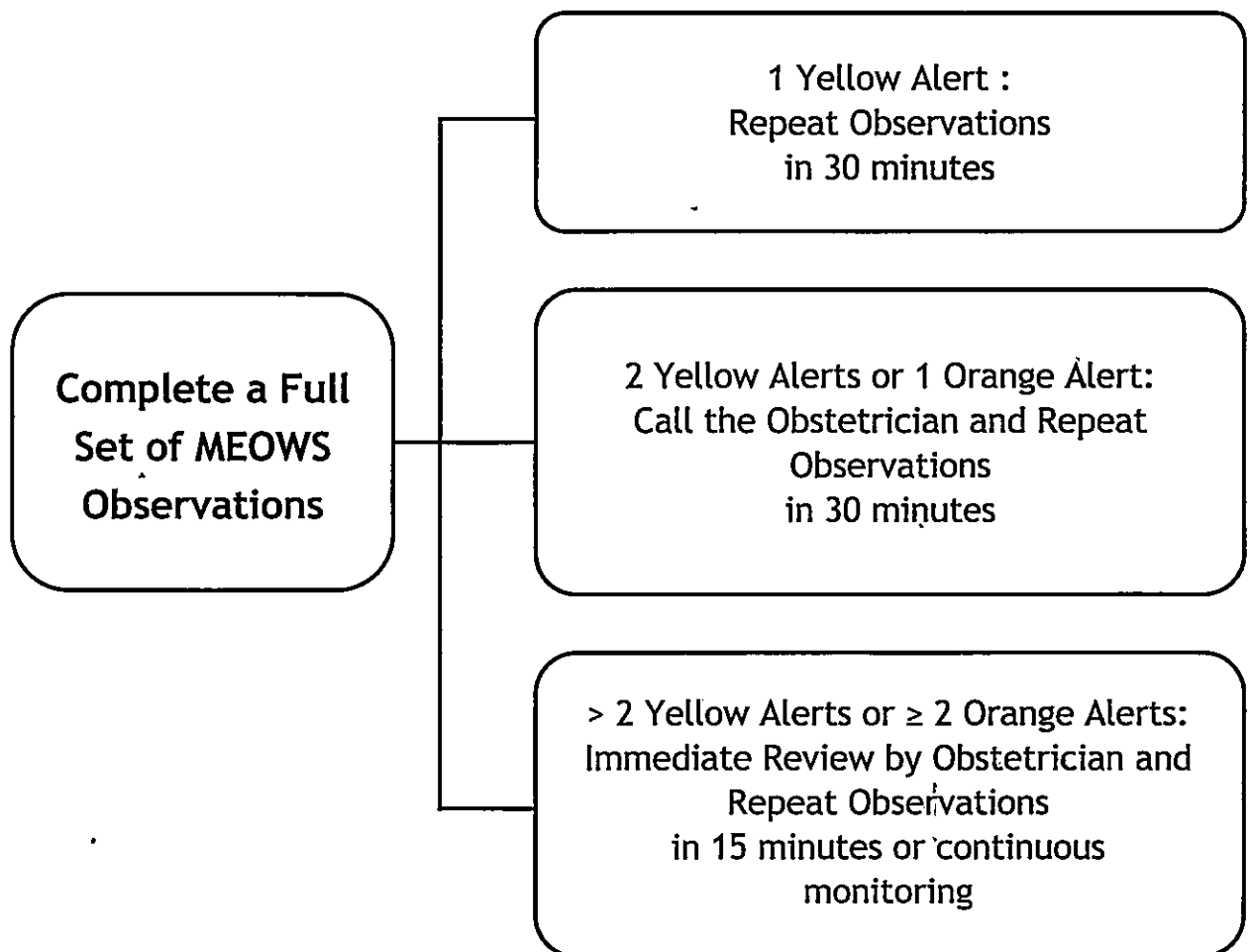
4/6/20

Obstetrics and Gynaecology Early Warning Signs



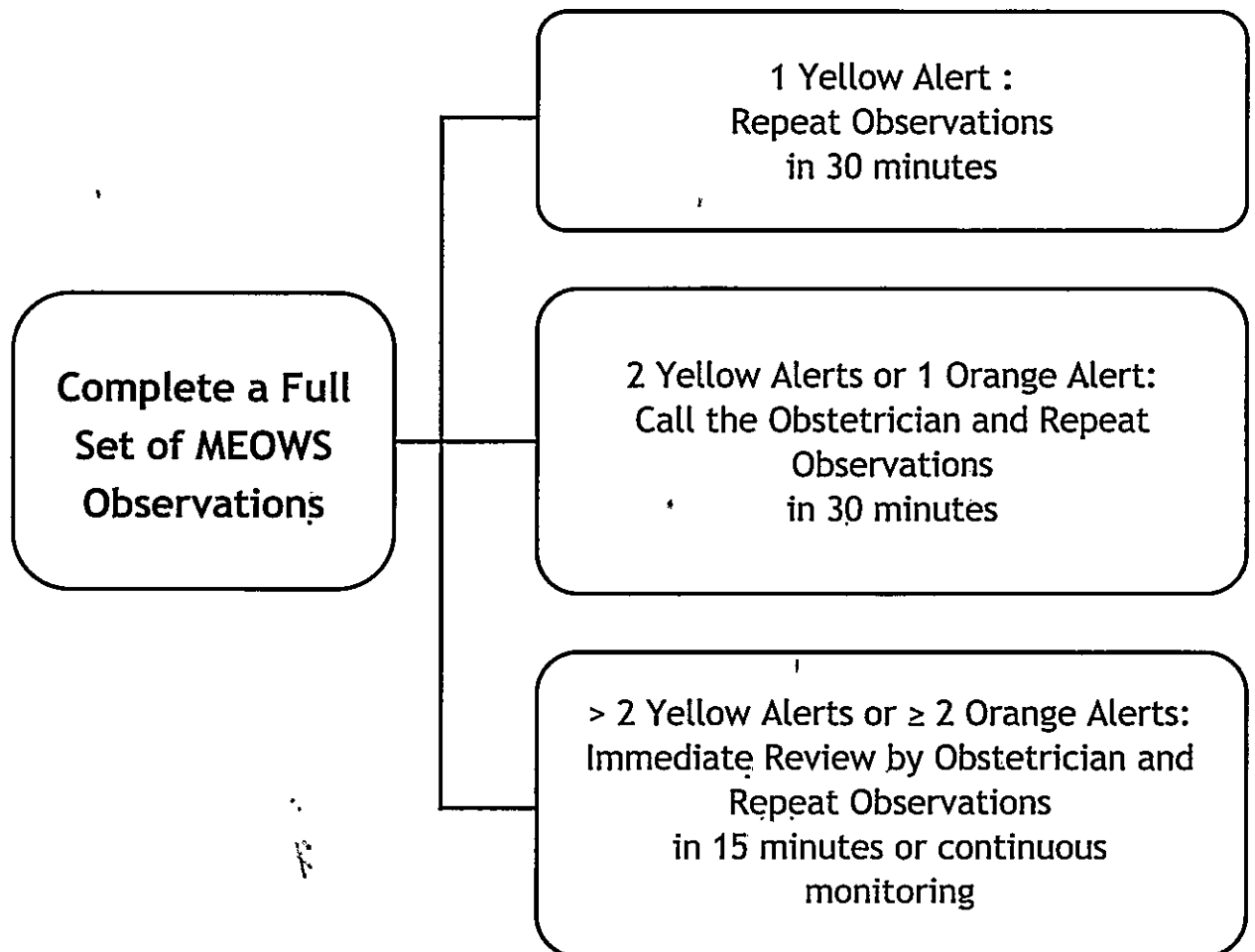
* The Modified Early Warning Score (MEOWS)

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)



FLUID CHART

Sheet No. : 1

- 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		
4/6/26	08:00 am	RL		100ml								
	09:00 am	RL		100ml								
	10:00 am	RL		100ml								
	11:00 am	RL		100ml								
	12:00 pm	RL		100ml								
	01:00 pm	RL		100ml								
Total Intake :			600ml			Total Output :					passed	
4/6	02:00 pm	RL		100ml								
	03:00 pm	RL		100ml								
	04:00 pm	RL		100ml								
	05:00 pm	RL		100ml								
	06:00 pm	RL		100ml								
	07:00 pm	RL		100ml								
Total Intake :			600ml			Total Output :					200ml	
4/6	08:00 pm	RL		100ml								
	09:00 pm	RL		100ml								
	10:00 pm	RL		100ml								
	11:00 pm	DNS		100ml								
	12:00 am	DNS		100ml								
	01:00 am	DNS		100ml								
Total Intake :			600ml			Total Output :					1100ml	
4/6	02:00 am	RL		100ml								
	03:00 am	RL		100ml								
	04:00 am	RL		100ml								
	05:00 am	RL		100ml								
	06:00 am	RL		100ml								
	07:00 am	RL		100ml								
Total Intake :			600ml			Total Output :						
Total 24 hrs. Intake			1800ml			Total 24 hrs. Output			2000ml			



FLUID CHART

Sheet No. : 2

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
5/6/20	08:00 am	RL		100ml							1	10:30 AM
	09:00 am	RL		100ml						0	}	
	10:00 am	DNS		100ml				500ml		1		
	11:00 am	DNS		100ml						1		
	12:00 pm	DNS		100ml						1		
	01:00 pm	ng		100ml						1		
Total Intake :						Total Output :						
5/6	02:00 pm	DNS	H ₂ O	75ml							1	2:40 PM Empty
	03:00 pm	DNS	CoP	75ml				200ml		0	}	
	04:00 pm	DNS		75ml						0		
	05:00 pm	DNS	H ₂ O	75ml						0		
	06:00 pm	RL		75ml				400ml		0		
	07:00 pm	RL		75ml						0		
Total Intake : taken						Total Output : passed						
5/6	08:00 pm	RL		75ml							1	6:40 PM Empty
	09:00 pm	RL	H ₂ O	75ml							1	
	10:00 pm	RL		75ml				37ml		1		
	11:00 pm	RL		75ml						1		
	12:00 am	RL	CoP	75ml						1		
	01:00 am	RL		75ml				200ml		1		
Total Intake :						Total Output :						
6/6	02:00 am	DNS		75ml							1	Empty
	03:00 am	DNS	H ₂ O	75ml							1	
	04:00 am	DNS		75ml						0		
	05:00 am	DNS		75ml						0		
	06:00 am	DNS		75ml				450ml		0		
	07:00 am	DNS		75ml						0		
Total Intake :						Total Output :						

Total 24 hrs. Intake 1800ml.

Total 24 hrs. Output 1950ml.

HNH-00015784

Mrs D VIJAYA RANI

01-01-1983 43 Y

Dr. RAJANI KUMARI

IP26-00006491

(F)



FLUID CHART

Sheet No. : 3

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
8/6	08:00 am	DNS	coffee	25ml								
	09:00 am	RL		25ml								
	10:00 am	RL		25ml								
	11:00 am	RL	H ₂ O	25ml								
	12:00 pm	RL		25ml								
	01:00 pm	RL	H ₂ O	25ml								

Total Intake :

Total Output :

6/6/26	02:00 pm	DNS	H ₂	75ml								
	03:00 pm											
	04:00 pm	DNS		75ml								
	05:00 pm											
	06:00 pm	DNS		75ml								
	07:00 pm											

Total Intake :

Total Output :

	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											

Total Intake :

Total Output :

	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											

Total Intake :

Total Output :

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

Total 24 hrs. Output	
-----------------------------	--

Patient Sticker



FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site Thrombophlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
7/6/26	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
	Total Intake : Taken						Total Output : U m					
7/6/26	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake : Taken						Total Output : U m						
7/6/26	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
7/6/26	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

HNH-00015784

IP26-00006491

Mrs D VIJAYA RANI

01-01-1983 43 Y

(F)

Dr. RAJANI KUMARI



NURSING CARE RECORD



Date: 4/6/26

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am	- Assess the Patient Condition	8am	- Assessed the pt condition	- patient stable	- vital signs	
	2pm	- plan for vital & record - plan for intake & output	2pm	- maintain vital - continued intake & output - maintain I/O chart			
Afternoon	2pm	- ASSESS the pt condition	2pm	- ASSESS the pt condition	PT IS stable	wound & vital	
	4pm	- monitor the vital & record - Administration of medication - PT IS on NBM - maintain I/O chart & H/VAT	4pm	- monitored the vital & record - Administered med - Cottons & Dressing - PT IS on NBM - maintain I/O chart & record			
Night	8pm	- Assess the pt condition	8pm	- Assessed the pt condition	Now pt is stable	Re-check the	
	8am	- monitor vital - maintain I/O chart	8am	- monitored vital - maintain			



NURSING CARE RECORD

Date: 5/6/26

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am	→ ASSES the pt condition → monitor the vitals & record	8Am	→ ASSESSED the pt condition → monitor the vitals & record	pt is stable	Monitor the vitals	Aklis CA
	2Pm	→ pt is NBM till tomorrow → Ambulation done → maintain I/O chart & record	2Pm	→ pt is NBM → maintained I/O chart & record → Administered ambulation			
Afternoon	2Pm	→ Assess the pt condition	2Pm	→ ASSESSED the pt condition	I/O chart maintained	Patient is stable	Si Sujatha
	10	→ plan for vitals		→ vital are checked & recorded			
	8Pm	→ plan for I/O chart		→ all medication given as per doctor's order			
Night	8Pm	→ ASSES the pt condition	8Pm	→ pt now liquid diet	How pt is stable	Re-check vitals	Mab Cay
	8A	→ monitor vitals → maintain I/O chart	8A	→ continue I/O fluids			



NURSING CARE RECORD

Date: 6/6/26

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am 10am 2pm	8am → ASSESS the pt condition → monitor the vitals & record → Administer medication 2pm → Maintain Pleural → Ptison provided	8am 10am 2pm	8am → Assessed the pt condition → monitored the vitals & recorded → Administered medication → maintained ple chest tube → Ptison void diet	Pt is stable	monitor vitals	<u>AKLIP</u>
Afternoon	2pm 7pm	2pm → Assess the patient condition → monitor the vitals & record → provide ple chest	2pm 7pm	2pm → Assess the patient condition → maintain vitals & record → maintain ple chest	patient is stable	vitals is normal	<u>CLAUDE</u>
Night	8pm 8pm	8pm → Assess the patient general condition → monitor vitals → Administer medication as per doctor's orders.	8pm 8pm	8pm → Assessed the patient general condition → monitored vitals → Administered medication as per doctor's orders.	Patient is stable	Rechecked vitals	<u>[Signature]</u>

Patient Sticker

NURSING CARE RECORD



Date: 7/6/26

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am 1 2pm	- Assess the pt condition - Monitor vitals - maintain I/O chart - Medication given as per drug chart					
Afternoon							
Night							

HNH-00015784
 Mrs D VIJAYA RANI
 01-01-1983 43 Y (F)
 Dr. RAJANI KUMARI

IP26-00006491



CHECKLIST FOR THROMBOPHLEBITIS

4/16/26 116

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

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IP26-00006491

Mrs D VIJAYA RANI

01-01-1983 43 Y (F)

Dr. RAJANI KUMARI



Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	2/6	2/6/26	2/6/2	Fall Risk Grading		
		Score	8 AM	12	11	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				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20	20	20	20	High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0						
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0						
Total Morse Fall Scale Score:			20	20	20			
Signature			<i>Red</i>	<i>Q</i>	<i>(M)</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

Patient Sticker

HNH-00015784 IP26-00006491
 Mrs D VIJAYA RANI
 01-01-1983 43 Y (F)
 Dr. RAJANI KUMARI



Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	5/6/21	5/6/21	8/6/26	Fall Risk Grading		
		Score	2PM	20PM	MB	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			15	Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0	0	0				
Ambulatory Aid	Furniture	30		0		High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0						
IV / Heparin Lock or Saline	Yes	20	20	20	20	Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0	0	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	35			
		Signature	<i>[Signature]</i>	<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
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HNH-00015784 IP26-00006491
 Mrs D VIJAYA RANI
 01-01-1983 43 Y (F)
 Dr. RAJANI KUMARI



Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	6/6/26				Fall Risk Grading		
		Score							
History of Falling (immediately or w/in 3 months)	Yes	25				Risk Level	Morse Fall Score (MFS)	Action	
	No	0							
Secondary Diagnosis (more than one diagnosis)	Yes	15				Low Risk	0 - 24	Standard Fall Precaution	
	No	0							
Ambulatory Aid	Furniture	30				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention	
	Crutches, Cane(S), Walker	15							
	None /Bed Rest /Nurse Assist	0							
IV / Heparin Lock or Saline	Yes	20				High Risk	≥ 51	Implement High Risk 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:									
		Signature							

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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Mrs D VIJAYA RANI
01-01-1983 43 Y
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(F)



BRADEN 'Q' SCALE

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

					Date :	2/16/22	2/16/22	2/16/22	2/16/22
					Time :	8:45 AM	12:00 PM	4:00 PM	6:00 PM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4	
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	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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28	28	28	28
Docu. No. : RCH /FRM / CLINICAL / 119					Evaluator's Name	AD	AD	AD	AD

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

HNH-00015784

IP26-00006491

Mrs D VIJAYA RANI

01-01-1983 43 Y

(F)

Dr. RAJANI KUMARI



BRADEN 'Q' SCALE



					Date :	5/6	5/6	6/6	6/6
					Time :	2PM	NI	mb	
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		4	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4	4	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4	4	4	4
FRICITION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings 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	25	28	28
					Evaluator's Name	J	(Raj)		

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

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

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

HNH-00015784
 Mrs D VIJAYA RAM
 01-01-1983 43 Y
 Dr. RAJANI KUMARI

IP26-00006491

(F)



PAIN ASSESSMENT TOOLS PAIN ASSESSMENT FORM



Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
4/6/28	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	AB
4/6/28	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	AB
4/6/28	2pm	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	AB
4/6	2pm	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	AB
4/6	10pm	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	AB
5/6	5am	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	AB
5/6/26	12pm	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	AB
5/6	5pm	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	Li
5/6	10pm	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	AB

Re-assessment Frequency:

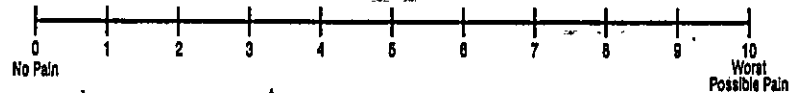
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 - a) At least every 2 hours for the first 24 hours
 - b) Then every 4 hours.
 - c) Prior to pain-relieving intervention.
 - d) Within 30 – 60 minutes after pain relief 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 0	Pain / Agitation	
	-2	-1		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



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

HNH-00015784
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IP26-00006491 (F)



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
6/6/20	3pm	2/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	[Signature]
6/6/20	10pm	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	[Signature]
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<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		

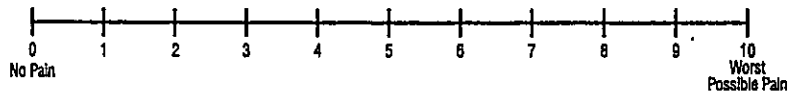
- Re-assessment Frequency:**
1. Every eight hours for all hospitalized patients.
 2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 - a) At least every 2 hours for the first 24 hours
 - b) Then every 4 hours.
 - c) Prior to pain pain-relieving intervention.
 - d) Within 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 of 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



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: TLH	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known If Yes Specify:						
	Surgery / Procedure:	Post OP Day:						
BACKGROUND	Date	4/6/26	4/6/26	4/6/26	5/6/26	5/6/26	5/6/26	
	Shift	8AM	8AM	N	2PM	2PM	N	
ASSESSMENT	Medical Condition (Any special condition to be noted):							
	Diet:	NBM	NBM	NBM	NBM	LIQUID	LIQUID	
RECOMMENDATIONS	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		
	Ventilation (RA, NP, NIV, VENTI):	RA						
	Tubes/Drains/Catheter:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	Vital Signs:	Temp:	98.6	98.1	97	98.2	98.8	98.1
		Res:	20	20bmt	20	20bmt	20	20
		SpO ₂ :	99	99.1	97	99.1	98.1	97
		Pulse:	82	87bmt	87	88bmt	78	76
		BP:	110/73	110/72	110/70	107/70	100/68	100/60
		LOC:	CO					
	Fall Risk Score:							
Pain Score:								
Skin Integrity	GOOD	GOOD	GOOD	GOOD		GOOD		
Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
Physiotherapy:								
Others Specify:	<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			
Special Diet:	NBM	NBM		NBM	LIQUID			
Critical Lab Test / Values:								
Other Special Orders / Medications:	<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			
PU Prophylaxis:	<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			
DVT Prophylaxis:	<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			
ADL (Dependent / Non Dependent):	DEP		DEP		NA	NA		
Post Operative Procedure Special Orders:			NR	NA	NA	NR		
Handed Over By Name :	Alia	AKWIS	MOU	AKWIS	SIGAL	MOU		
Signature / ID :	Alia	AKWIS	MOU	AKWIS	SIGAL	MOU		
Date:	4/6/26	4/6/26	5/6/26	5/6/26	5/6/26	5/6/26		
Time:	2PM	8PM	2PM	2PM	8PM	8PM		
Taken Over By Name :	AKWIS	MOU	AKWIS	SIGAL	MOU	AKWIS		
Signature / ID :	AKWIS	MOU	AKWIS	SIGAL	MOU	AKWIS		
Date:	4/6/26	5/6/26	5/6/26	5/6/26	5/6/26	6/6/26		
Time:	2PM	8PM	8AM	2PM	8PM	8AM		

HNH-00015784
 Mrs D VIJAYA RANI
 01-01-1983 43 Y
 Dr. RAJANI KUMARI

IP26-00006491

(F)



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <u>TLH</u>	Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:						
	Surgery / Procedure:	Post OP Day:						
BACKGROUND	Date	<u>6/6/26</u>	<u>6/6</u>					
	Shift	<u>11B</u>	<u>12B</u>					
	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>					
	Diet:	<u>1200</u>	<u>1200</u>					
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	<u>NA</u>	<u>NA</u>					
	Tubes/Drains/Catheter:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	<u>97.8</u>	<u>97.8</u>				
		Res:	<u>20bmt</u>	<u>20</u>				
		SpO ₂ :	<u>99%</u>	<u>99%</u>				
		Pulse:	<u>82bmt</u>	<u>86</u>				
		BP:	<u>100/70</u>	<u>118/77</u>				
		LOC:	<u>-</u>	<u>-</u>				
		Fall Risk Score:	<u>-</u>	<u>-</u>				
Pain Score:	<u>0/10</u>	<u>0/10</u>						
Skin Integrity	<u>good</u>	<u>good</u>						
Recommendations	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Physiotherapy:	<u>-</u>	<u>-</u>					
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Diet:	<u>1200</u>	<u>1200</u>					
	Critical Lab Test / Values:	<u>-</u>	<u>-</u>					
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
ADL (Dependent / Non Dependent):	<u>NA</u>	<u>NA</u>						
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>					
Handed Over By Name :		<u>AKULS</u>	<u>check</u>					
Signature / ID :		<u>[Signature]</u>	<u>[Signature]</u>					
Date:		<u>6/6/26</u>						
Time:		<u>8:30am</u>						
Taken Over By Name :		<u>Cher</u>						
Signature / ID :		<u>[Signature]</u>						
Date:		<u>6/6/26</u>						
Time:		<u>2pm</u>						

URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 4/6/26

Date of Removal: 6/6/26 at 3:30pm

Parameters	Date	Shift Time	<u>4/6</u> <u>8AM</u>	<u>4/6</u> <u>62</u>	<u>4/6</u> <u>NO</u>	<u>4/6</u> <u>MB</u>	<u>5/6</u> <u>2PM</u>	<u>5/6</u> <u>NOON</u>	<u>5/6</u> <u>B2</u>
Need for the Catheter			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Hand Hygiene			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Usage of Sterile Equipment			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Is the Collection bag below the level of bladder			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Check the Tube for Obstruction (Free of Kinking)			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Is Catheter dated as policy			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Collecting bag is been emptied regularly?			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Maintenance of closed system for the catheter			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Dressing clean and dry?			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Is the line removed as Policy?			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Performance of Perineal Care			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Onset of New Fever			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Asses for the leakage at the site of insertion			<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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Name of the Nurse			<u>AK</u>	<u>AKUP</u>	<u>monika</u>	<u>Arcis</u>	<u>Suatha</u>	<u>moni</u>	<u>anu dly</u>
Signature of the Nurse									

catheter removed 6/6/26 at 3:30pm

HNH-00015784 IP26-00006491
 Mrs D VIJAYA RANI
 01-01-1983 43 Y (F)
 Dr. RAJANI KUMARI



MEDICATION RECONCILIATION FORM

Drug Allergies: *nd* 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	<i>7. Thyronam</i>	<i>125mg</i>	<i>PO</i>	<i>OD</i>		<input checked="" 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: *[Signature]* *Dr. Dna.*

Date & Time: *4/6/26* *8:30 AM*

Nurse Name & Signature: *[Signature]* *Alex @ Alex*

Date & Time: *4/6/26 @* *8:30 AM*

OPERATION THEATER NOTES

HNH-00015784 IP26-00006491
Mrs D VIJAYA RANI
01-01-1983 43 Y (F)
Dr. RAJANI KUMARI

Patient's Name : Age : Gender :

UHID : ?No. : Weight :



Surgeon : DR VASISHT DR SURS SRINIVAS Asst. Surgeon :

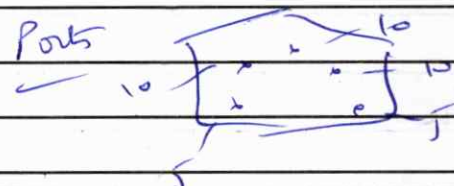
Anesthetist : DR SANKAR OT Nurse : Sis Padma / Sanket / Arda

Surgical Procedure : Lgs. Hysterectomy + BIL Salpingectomy

Indications for Surgery : FIBROID UTERUS.

Date : 4/6/20. Start Time : End Time :

PRE-OPERATIVE PREPARATION :



OPERATION NOTES:

Findng (1) uterus about 24 weeks in size & a large 14 x 13 x 12 cm fundal fibroid on (L) side extending into (L) broad ligament

- 1) U - (R)
- 2) BIL F - (R)
- 3) BIL ovaries - (R)
- 4) Bladder adherent due to previous LGS

Procedure

Lgs. Hysterectomy + BIL Salpingectomy was done

- Both ovaries are preserved

- ~~was~~ sp. cont of removed (specimen at 1.8kg)
- wound returned to no 1 to air Rapid vinyl.
- CRD kept in the policy through the vent
- Wash gown
- Hot water used
- wound closed in legs
- Start to no 1 to vinyl.
- skin to clip
- Anesth. period was inserted.

POST - OPERATIVE ORDERS :

R

- ① NBM
- ② IV fluids @ 100 ml/h - 1 GNS
1 GR
1 GNS
1 GR
- ③ 2mg MORPHINE 70275 1.5 gm IV BD
- ④ 2mg METROGOL 500mg IV TID
- ⑤ 2mg PANTOP 40mg IV QD
- ⑥ 2mg NEOMOL 1 gm IV TID
- ⑦ 2mg ropiv 8mg IV QD
- ⑧ vitals 2nd leg
- ⑨ Telfon 505
- ⑩ 7. ELTRONIN hem 5/6/10 25

Vasanth

Dr Vasanth

Consultant Surgeon's Name

Consultant Surgeon's Signature

Date : 4/6 Time : 3:30 pm

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

Patient Name : Mrs. VIJAYA RANI Age : 43y Gender : Male Female

UHID NO: HNH-00015784 Surgeon Name: Dr. SURI SRIMATHI / Dr. VASISHT

Anaesthesiologist : Dr. SAMIR

Operative procedure planned : TOTAL LAPAROSCOPIC HYSTERECTOMY

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

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

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

- Heart disease Hypertension Diabetes mellitus Renal failure
 Hepatic disorders Shock Multiple organ failure Polytrauma / Renal Tubular Acidosis
 Incapacitating Chronic Obstructive Pulmonary Disease

Others : Hypotension, Bleeding, Delayed Recovery, Need for transfusion

Comments : transfusion

- 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 Mrs. VIJAYA RANI the above mentioned operation / Diagnostic / Therapeutic procedures TOTAL LAPAROSCOPIC HYSTERECTOMY

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 anaesthesiologist 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 : D. Vijayarani

Name :

Relationship with Patient : D. VIJAYARANI
Self

Date & Time : 4/6/26 @ 8:30 AM

Witness :

Signature : [Signature]

Name :

Date & Time : 4/6/26 @ 8:30 AM

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. SK. Ayesha

Date & Time : 04/06/24, 7:50 AM

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE



Patient Name : Ms Vijaya Rani Gender: Male Female Age : 43y
 UHID No : LNM 00015784 Date : 4/6/2026

Instruction:

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

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

TOTAL LAPAROSCOPIC HYSTERECTOMY + BILATERAL SALPINGECTOMY
 upon
 (Name of the Patient) Ms Vijaya Rani

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.

Bleeding, Infection, Injury to Bowel, Bladder or Blood vessel,
Chances of Blood transfusion, Chances of Conversion to Laparotomy

My signature on this form indicates that

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

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

Consentee :

Signature : D. Vijaya Rani
 Name : Vijaya Rani
 Date & Time : 4/6/2026 8:35 AM

Patient Attendant :

Signature : [Signature]
 Name : Nastimha Suwandy
 Relationship with Patient : Husband
 Date & Time : 4/6/2026 : 8:35

Witness :

Signature : [Signature]
 Name : Nadlumister
 Date & Time : 4/6/26 @ 8:35 AM

Doctor (who is taking the consent) :

Signature : [Signature]
 Name : Dr. Dina
 Date & Time : 4/6/26 8:35 AM

Dnly mobile

92 461 60 961

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



Name: Mrs. Vijaya Rani Age: 43y Sex: F UHID: HN1-00015784

Date: 2/6/26 Time: 11 AM Proposed Operation: Abdominal hysterectomy/TLH

Diagnosis: fibroid uterus.

B.P / CRT: 110/70 mmHg H.R: 70bpm Weight: 60kgs. ASA Physical Status: 1 2 3 4 5

24/4

baic-5.7/1

SR-20

BT-1 30
CT-5'40"

Laboratory Data:
Fasting - Single
Glucose: PL-120 mg/dL Protein: 7.8
Urea: 22.4 mg/dL Alb: 4.5
Creat: 0.7 mg/dL Total Bil: 0.2 / 0.5
Na: 140 Dir. Bill:
K: 4.1 LDH:
Ca++: 10.3 mg/dL Alk phos: 57
Mg++:
Cl: 99 SGOT/SGPT: 10/13

HIV: X-Ray: (N) Study
HBS Ag: ECG: (N) Sinus rhythm
HCV: T2 Echo: T.k. in v1 & v3
Blood group: A+ve. Stress/Angio: EF-65% (N) VALV
T3 (Total) 174.05 ng/dL Other: NO LV RWMA.
T4 (Total) 15.62 µg/dL
TSH: 0.14 µIU/mL (was 36 µIU/mL - on 24/4)
on Thyronorm 75µg

Lipid Profile - (N)

Allergies: NKDA.

Medical History: CVS: No H/o chest pain/palpitations/syncope

RESP: No URTI/Bronchial asthma/P-TB. Diabetes: NOT a diabetic.

CNS: No H/o Seizures/TIA/CVA

Renal: No Renal Stones

Hepatic/GE: H/o Hypothyroidism Since 2013, Now Using Physical Activity:

Others: Tab-Thyronorm 125µg OD (since 15 days)

Past Anaesthetic History: P2L2, 2 P LSCS (2011, 2013) CAB, Uneventful, Tubectomised.

Physical Exam:

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

Lungs: RLC RAE (+) Clear.

Heart: S1S2 (+)

CNS: NAD

Pregnant: Yes No NA

Venous Access Site: accessible Spine Exam for regional: Midline, Spares palp

Anaesthetic Plan: MAC REGIONAL GA-ETT LMA

USG: - Uterus - Anteverted bulky in size 14.3x9.4x12.8 cm.

Peri-Operative Plan Explained to the Patient: Yes No

- large well defined hypoechoic lesion

CURRENT MEDICATIONS	DOSAGE
P. Thyronorm 125 mcg OD.	

Pre-Operative Instructions: measuring 13.5x9.3x14.0 cm

- DVT Prophylaxis: noted in left lateral wall of uterus. Water / ORS 2 Hours Others 6 Hours
- NIL ORAL: Explained.
- Informed Consent: Standard High Risk
- Post Operative Pain Management: Discussed with Patient
- Other Instructions:

- 2D Echo to be done.
- Endocrinologist opinion to be done
- Review PAC.
- TO TAKE THYRONORM 100MG
- TO Reserve 10 PRBC

Signature: Dr. Brunda Name: Dr. Brunda

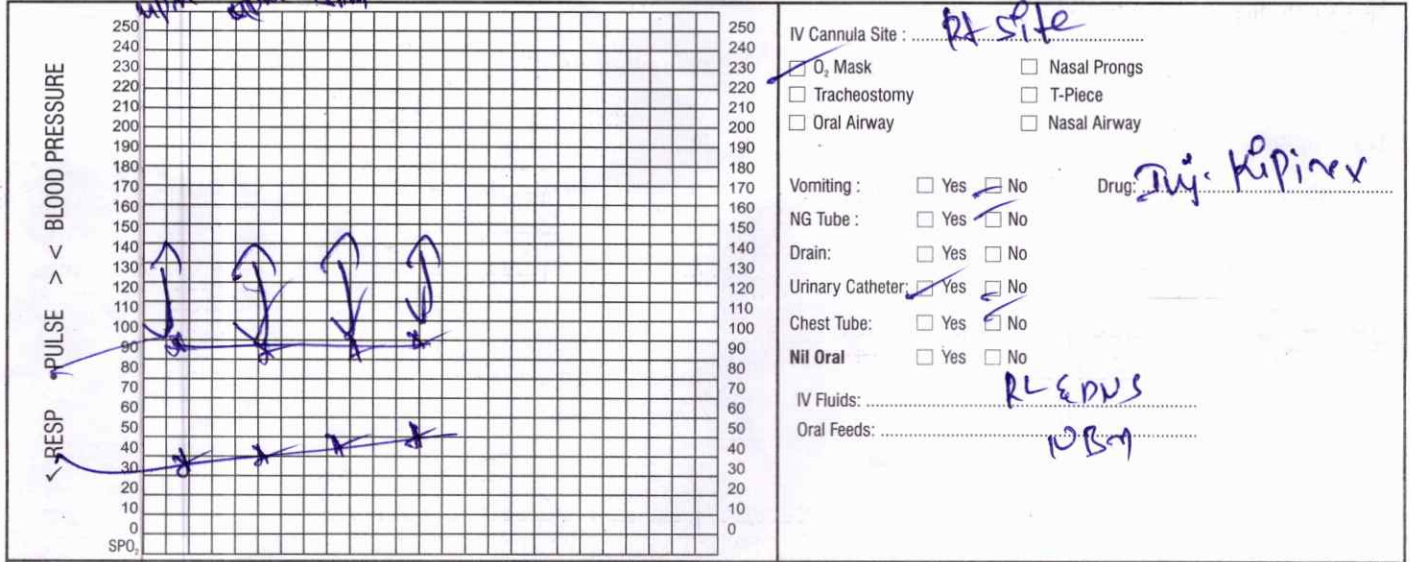
Docu. No.: RCH / FRM / CLINICAL / 044

HNH-00015784
 Mrs D VIJAYA RANI
 01-01-1983 43 Y
 Dr. RAJANI KUMARI
 IP26-00006491 (F)



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : S.S. Akhila Time Received : Time Discharged :



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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
u/b	u/m	0/10	NA	<u>[Signature]</u>
u/b	5pm	0/10	NA	<u>[Signature]</u>
u/b	6pm	0/10	NA	<u>[Signature]</u>


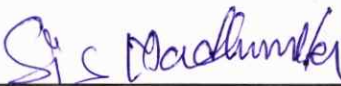

Pain Tool Used: N PASS FLACC Wong Baker NPS

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

Anaesthesiologist Name : Dr. S. Akhila
 Anaesthesiologist Signature: [Signature]
 Date & Time:
 PACU Nurse Name :
 PACU Nurse Signature:
 Date & Time:

Transferred to Unit by (PACU):
 Date & Time:

PATIENT TRANSFER FORM

Patient Name & UHID No.		Date & Time of Admission	Date & Time of Transfer Order
HNH-00015784 IP26-00006491 Mrs D VIJAYA RANI 01-01-1983 43 Y (F) Dr. RAJANI KUMARI 		4/6/26/20 6:33 AM	4/6/26/20 12 PM
		Transfer Ordered by	Reason for Transfer
		Dr DVA	TLH
From Unit	To Unit	Information to Attendant Yes <input type="checkbox"/> No <input type="checkbox"/>	
Micu	OT		
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
35	X0A -		
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.	Pl room - (1)		
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring		Name of Person Ordered Transfer	
		DR DVA	
Patient & Clinical Records Received by : 			
Date & Time of Patient Received :			

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

- Unavailable Bed
 Nurse not Available
 Available Bed not ready

SURGICAL SAFETY CHECKLIST

Surgeon : *Dr. Vassht*
 Asst. Surgeon : *Dr. Ganix*
 Anaesthetist : *Dr. Ganix*
 Scrub Nurse : *Sr. Padmaja*
Br. Jithanth
Sr. Archana

HNH-00015784 IP26-00006491
 Mrs D VIJAYA RANI 43 Y
 01-01-1983 (F)
 Dr. RAJANI KUMARI
 Pat UH
 Date : *4/6/16* IN-DATE Out-time :

Age : *43* Gender : *F*
 ne :



Before Induction of Anaesthesia >>

SIGN IN	Time: <i>12 PM</i>
Patient Has Confirmed	
Identity <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Site <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Procedure <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Consent <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Site Marked <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA	
Anaesthesia Safety Check Completed <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Pulse Oximeter on Patient & Functioning <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Does Patient have a:	
Known Allergy? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Difficult Airway / Aspiration Risk?	
Yes, & Equipment / Assistance Available <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Risk of > 500ml Blood Loss (7ml/kg In Children)?	
Yes, and Adequate Intravenous Access and Fluids Planned <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA	
Blood Units Reserved <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA	
Has Antibiotic Prophylaxis been given within the last 60 minutes? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Signature : <i>[Signature]</i>	
Name :	

Before Skin Incision >>

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

Before Patient Leaves Operating Room

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

PATIENT TRANSFER FORM

HNH-00015784 IP26-00006491
Mrs D VIJAYA RANI (F)
01-01-1983 43 Y
Dr. RAJANI KUMARI



Date & Time of Admission <i>4/14/26 @ 6:33 AM</i>		Date & Time of Transfer Order <i>4/14/26 @ 6:33 AM</i>
Treating Consultant Name <i>Dr. Roy and Kumar</i>	Transfer Ordered by <i>Dr.</i>	Reason for Transfer <i>Delivery</i>
From Unit <i>GS</i>	To Unit <i>ICU</i>	Information to Attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

Shifting Summary / Notes Written by Doctor : Yes No

Name & Signature of Person who is Transferring <i>Archan</i>	Name of Person Ordered Transfer <i>Dr. Samir</i>
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Patient & Clinical Records Received by : *Archan*

Date & Time of Patient Received : *4/16/26 @ 10:00 AM*

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

- Unavailable Bed Nurse not Available Available Bed not ready

26-000020406

NARCOTIC PRESCRIPTION FORM (PATIENT COPY)

Patient Name: <u>Mrs D Vijaya Rani</u>	Age: <u>43Y</u>	Gender: <u>Female</u>	
UHID No: <u>HNH-00015784</u>	IP No: <u>26-00006491</u>	Date: <u>4/6/26</u>	
Time: <u>7:40</u>			
Diagnosis: <u>Abdominal Hysterectomy LAVH</u>			
PRESCRIPTION DETAILS (Tick only one of the following)			
S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/ML	<u>100mcg</u>	<u>01 Amp</u>
2.	Morphine Sulphate Inj. 15mg/ML	<u>---</u>	<u>---</u>
3.	Remifentanyl Hydrochloride Inj. 2MG	<u>---</u>	<u>---</u>
4.	Remifentanyl Hydrochloride inj. 1MG	<u>---</u>	<u>---</u>
Doctor Name: <u>Dr. Amir</u>		Doctor Registration No: <u>67529</u>	
Signature: <u>[Signature]</u>			

NARCOTIC DISPENSING FORM APPENDIX 4 - FORM NO. 3E

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

IP Registration No: 26-00006491 Date: 4/6/26

Aadhaar No. of the Patient (Optional):

1.	Name: <u>Mrs D Vijaya Rani</u>	Remarks		
2.	Complete postal address (with contact number, if any)	<u>Chikkadpally Hyderabad</u>		
3.	Brief description of the illness	<u>Abdominal Hysterectomy LAVH</u>		
4.	Whether registered with any other registered medical practitioner / recognized medical institution (If yes, details of the recorded)	<u>NO</u>		
5.	Details of essential Narcotic drug dispensed	<u>INJ: Fentanyl</u>		
Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
<u>4/6</u>	<u>INJ: Fentanyl</u>	<u>01</u>	<u>[Signature]</u>	

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

Received by (Name & ID No.): M Arvind Kumar (021257) Signature: [Signature]

Time: 8:58

26-0000 204067

NARCOTIC PRESCRIPTION FORM (PATIENT COPY)

Patient Name: <u>MRS. D. VIJAYA RANI</u>	Age: <u>43 Y</u>	Gender: <u>F</u>	
UHID No: <u>HNH-00015784</u>	IP No: <u>TP26-00006491</u>	Date: <u>04/6/26</u> Time: <u>5:41 Am.</u>	
Diagnosis: <u>ABDOMINAL HYSTERECTOMY LAUH</u>			
PRESCRIPTION DETAILS (Tick only one of the following)			
S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/ML	-	-
2.	Morphine Sulphate Inj. 15mg/ML	<u>15 MG</u>	<u>ONE Amp</u>
3.	Remifentanyl Hydrochloride Inj. 2MG	-	-
4.	Remifentanyl Hydrochloride inj. 1MG	-	-
Doctor Name: <u>Dr. Amir</u>		Doctor Registration No: <u>67529</u>	
Signature: <u>[Signature]</u>			

NARCOTIC DISPENSING FORM APPENDIX 4 – FORM NO. 3E

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

IP Registration No: TP26-00006491 Date: 04/6/26

Aadhaar No. of the Patient (Optional):

1.	Name: <u>MRS. D. VIJAYA RANI</u>	Remarks		
2.	Complete postal address (with contact number, if any)	<u>CHIKKADPALLY H/D</u>		
3.	Brief description of the illness	<u>ABDOMINAL HYSTERECTOMY LAUH</u>		
4.	Whether registered with any other registered medical practitioner / recognized medical institution (If yes, details of the recorded)	<u>NO</u>		
5.	Details of essential Narcotic drug dispensed	<u>MORPHINE</u>		
Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
<u>04/6/26</u>	<u>MORPHINE</u>	<u>ONE Amp</u>	<u>[Signature]</u>	

Dispensed by (Name & ID No.): Sania (018448) Signature:

Received by (Name & ID No.): Sai Chandu 021153 Signature: [Signature]

Time: