103
216
Fc

Name	Mrs HEENA JAIN	UHID	HNH-00011326
Father/Guardian	Mr VAIBHAV JAIN	Age/Gender	28 Y 8 M 31 D/ Female
Address	3-6-465 to 467, flat no 604,legend siddi apt sreat 5, himayathnagar,hyd, Himayathnagar, Hyderabad, Telangana, INDIA, 500029		
IP No	IP26-00006503	Admission Date	04-06-2026
Ref Doctor	Self.		
Discharge Date	06.06.2026		

DISCHARGE SUMMARY

Consultant:
Dr. SWATHI H V
MBBS/MS
TSMC/FMR/15501

Diagnosis: PRIMI AT 39 WEEKS FOR INDUCTION OF LABOUR

ASSISTED VAGINAL DELIVERY(OUTLET FORCEPS) DONE ON 05.06.2026

History:
LMP:07.09.2025
EDD:11.06.2026

Obstetric formula: Primigravida
Gestation at admission: 39 weeks

Obstetric History:
G1 - Present pregnancy Spontaneous conception.

Medical History : Nil

Family History : Nil

Name	Mrs HEENA JAIN	UHID	HNH-00011326
IP No	IP26-00006503	Admission Date	04-06-2026

Surgical History: Nil

Allergies : Nil

Antenatal Details:
Mrs HEENA JAIN was booked to Rainbow hospital at 5^{+6} weeks of gestation. She had regular antenatal checkups and investigations as advised. NT scan normal. FTS- Low risk. TIFFA-normal. OGTT-normal. Fetal monitoring done by serial growth scans. Scan done on 23.05.2026 showed single live fetus with cephalic presentation, Placenta posterior and left lateral high,AFI-14.3cm,EFW-3.005kg(42%),AC- 8% with normal dopplers. She was admitted at 39 weeks for induction of labour.

Investigations: Enclosed
Blood group: "B Positive"

Management: Course in hospital and Delivery Details:
At admission on clinical examination the vitals were stable, uterus was relaxed, cervix was 1 finger dilated. Fetal well being was confirmed by an admission CTG which was found to be reactive. Informed consent taken for Induction of labour. Labour induced with 4 doses of PGE1. Artificial rupture of membranes done at 4cm dilatation revealing clear liqour. As per hospital protocol she was started on IV. Taxim in view of ruptured membranes. Partographic monitoring of labour was done. She progressed to full dilatation at 12 pm. Passive descent of fetal head was allowed post full dilatation. She was put into position for vaginal birth at 12:30pm. Parts painted with betadine solution and draped to ensure full asepsis. She was encouraged to bear down. At crowning of head episiotomy was given under local anesthesia (10 ml of 2 % xylocaine solution). Baby was delivered by assisted vaginal delivery with outlet forceps in view of poor maternal bearing down efforts and fetal distress, Cord clamped and cut and baby handed over to pediatrician. Cord blood collected for blood grouping and Rh typing. Placenta and membranes delivered completely with controlled

Name	Mrs HEENA JAIN	UHID	HNH-00011326
IP No	IP26-00006503	Admission Date	04-06-2026

cord traction. Prophylactic syntocinon given. Episiotomy inspected. Right lateral vaginal mucosal tear noted and sutured in layers. Adequate hemostasis achieved. Episiotomy sutured in layers. Instrument and swab count checked. 600 mcg of misoprostol given per rectally as prophylaxis against post partum hemorrhage. Vagina cleaned with betadine solution. Botroclot soaked vaginal pack kept in-situ.

Delivery Details:
Date : 05.06.2026
Time of Delivery: 12:59 PM
Type of Labour : Induced
Type of Delivery: Assisted vaginal delivery (outlet forceps)
Analgesia : None
Indication : Poor maternal efforts and Fetal distress

Baby Details:
Date : 05.06.2026
Time : 12:59 PM
Sex : Female
Weight : 3.32Kg
Apgar :6,7
Gestational Age: 39weeks
NICU Admission: Yes

Post-Partum Notes: She was closely monitored for post partum hemorrhage. Vitals were stable; Vaginal pack removed after 4 hours.On postoperative day one Foley's catheter removed.Patient was encouraged for spontaneous voiding. patient ambulated and was shifted to room. Dietary advice given. Her postpartum period following that was uneventful. On first postpartum day episiotomy wound was healthy and intact. Her general condition was

Name	Mrs HEENA JAIN	UHID	HNH-00011326
IP No	IP26-00006503	Admission Date	04-06-2026

satisfactory and she was found to be fit for discharge. Wound care and medications were explained to patient supplemented by written information. She was given the postpartum book for further reference.

Advice:

1. Tab. Taxim - O 200mg (Cefixime 200mg) twice daily till 10.06.2026 (9am-9pm) after food.
2. Tab. Calpol 500mg (Paracetamol 500mg) (2tabs) thrice daily till 08.06.2026 (8am-2pm-10pm) after food.
3. Tab. Pantodac (Pantoprazole - 40mg) 1 tablet twice daily till 10.06.2026(7am-7pm) before food.
4. Tab. Voveran 50 mg (Diclofenac 50mg) thrice daily till 08.06.2026 (9am-3pm-11pm) after food.
5. Tab. Livogen (Elemental iron - 50mg, folic acid 1.5mg) once daily (7am) for three months before breakfast.
6. Tab. Shelcal (Elemental Calcium 500 mg, vitamin D3 250 IU) once daily (2pm) till breast feeding after food.
7. Metro-P ointment for local application twice daily .
8. Syp. Duphalac 15 ml (Lactulose 3.33gm/5ml) at bed time for one week
9. T.Chymoral forte thrice daily (8am-2pm-10pm) till 12.06.2026
10. Sitz bath thrice daily

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

* Suggest **PAP smear** and **HPV Vaccine** after **6 weeks**; Please discuss with

Name	Mrs HEENA JAIN	UHID	HNH-00011326
IP No	IP26-00006503	Admission Date	04-06-2026

your treating doctor regarding **HPV vaccination.**

Review with Dr. SWATHI H V, after **1week on 13.06.2026**on at Rainbow Children's Hospital with prior appointment **(Review consultation will be charged).**

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

Patient/ Attender

In case of emergency like bleeding, fever [please refer to postpartum book for further details - Chapter II page 6] kindly contact 9154865045 at Rainbow Himayatnagar or 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. SWATHI H V
MBBS/MS
TSMC/FMR/15501

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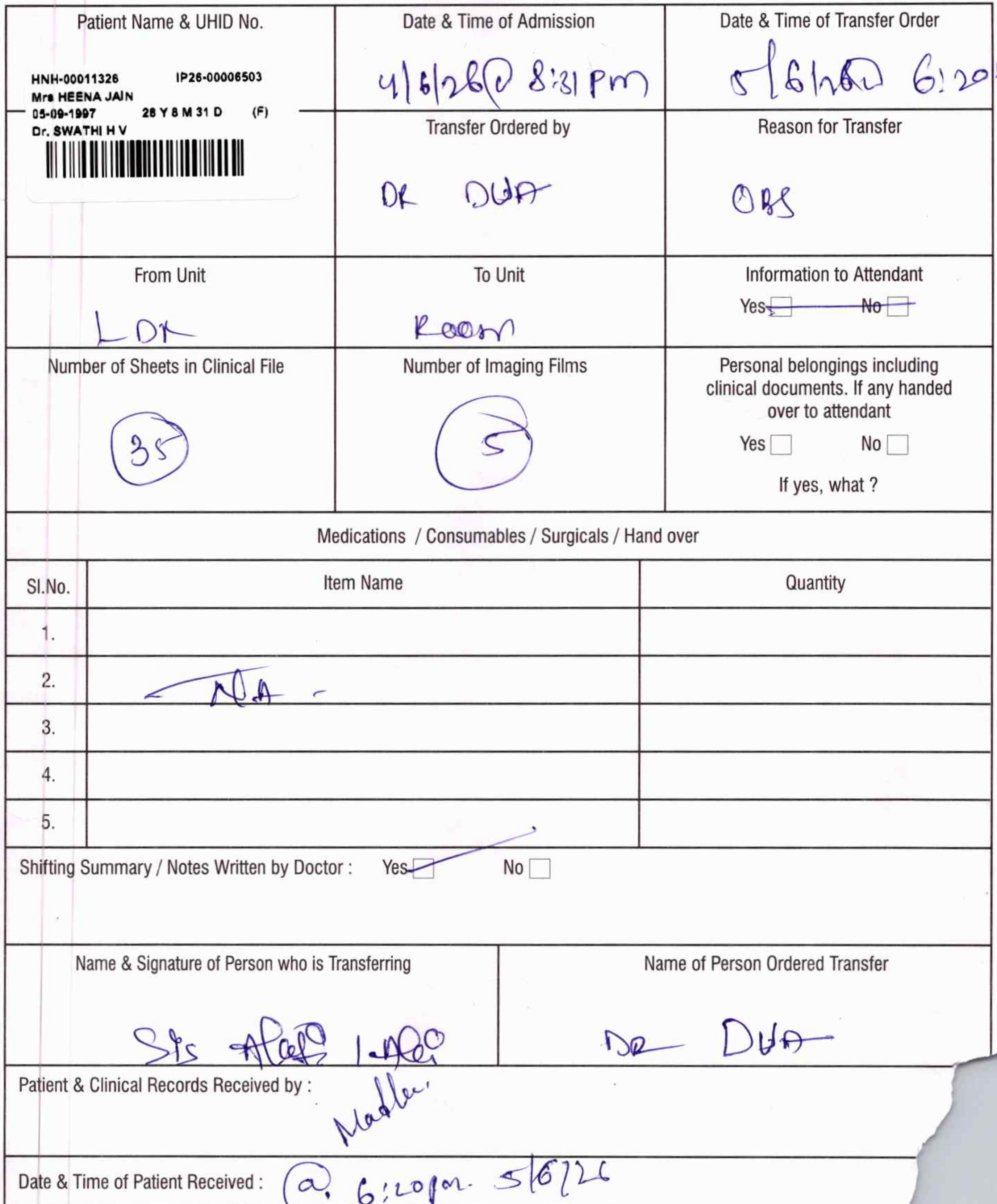
PATIENT TRANSFER FORM



Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00011326 IP26-00006503 Mrs HEENA JAIN 05-09-1997 28 Y 8 M 31 D (F) Dr. SWATHI H V	4/6/26 @ 8:31 PM	5/6/26 6:20 PM
	Transfer Ordered by	Reason for Transfer
	DR DUA	OBS
From Unit	To Unit	Information to Attendant
LDR	Room	Yes ☐ No ☐
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant
35	5	Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.	NA	
3.		
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
S/s [illegible]	DR DUA

Patient & Clinical Records Received by : Madhu

Date & Time of Patient Received : @ 6:20pm. 5/6/26

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

☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed

Docu. No. : RCH /FRM / CLINICAL / 102

Rainbow Children's Hospital | BirthRight by Rainbow

Rainbow Childrens Hospital-Himayatnagar

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

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006503 **Admit Date** : 04-Jun-2026 **Admit Time** : 08:31 PM **UHID** : HNH-00011326

Patient Details :

Patient Name	: Mrs HEENA JAIN	**Age**	: 28 Y 8 M 30 D
Guardian	: Mr VAIBHAV JAIN	**DOB**	: 05-09-1997
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 3-6-465 to 467, flat no 604,legend siddi apt sreat 5, himayathnagar,hyd Himayathnagar Hyderabad Telangana INDIA 500029	**Phone No**	: 9700409144/ 9521776976
		E-mail	: heenakjain06@gmail.com

Admission Details :

Bed Type	: TWIN SHARING	**Bed No**	: PDA-413	**Ward Name**	: 4F -OT
Room No	: PDA-413	**Admission Type**	: First Visit		

Contact Details :

Name	: Mr VAIBHAV JAIN	**Relationship**	: Husband
Contact Address	: 3-6-465 to 467, flat no 604,legend siddi apt sreat 5, himayathnagar,hyd Himayathnagar Hyderabad Telangana INDIA 500029	**Phone No**	: 9700409144

Signature

Doctor Details :

Doctor Name	: Dr. SWATHI H V	**Specialisation**	: OBSTETRICS AND GYNECOLOGY
Referral Doctor	: Self.	**Phone No**	:
Co-Consultant	:		

Payment Details :

Payment Mode	: DC/CC Card	**Deposit Amount**	: 10000.00
		Payor Name	: BAJAJ ALLIANZ GENERAL INSURANCE CO LTD.

HNH-00011326 IP26-00006503
Mrs HEENA JAIN
05-09-1997 28 Y 8 M 30 D (F)
Dr. SWATHI H V

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
5/6/26	6:20pm	LDR	Room	[signature]

Cross Consultation Visit

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

Docu. No. : RCH / FRM / GENERAL / 145

INVESTIGATIONS

Date	Investigations	Order No.	Sign
4/6/26	NST — ①	6752	Anchal
4/6/26	NST — ②	6753	Anchal
5/6/26	NST — ③	6754.	Anu
5/6/26.	NST — ④	6755	Anchal
5/6/26	NST — ⑤	6758	Chanda
		cross checked done	
		5/6/26	
5			

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
4/6/26	Iv placement	1	204282	Moni
5/6/26	catherization	1	204413	
			cross checked done	
			5/6/26.	
5/6/26	Iv Placement	1	04537	
6/6/26	NHA	1	204708	
		cross chd by		
			6/6/26 12pm	

ANY OTHER INFORMATION

Date :   Time :   Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00011326 IP26-00006503
Mrs HEENA JAIN
05-09-1997 28 Y 8 M 30 D (F)
Dr. SWATHI H V

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IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints
came for safe Confinement

LMP: 25/9/2025 EDD: 14/6/2026
Corrected EDD: 11/06/2025 GA: 39wks

Obstetric Formula: Primi
ML-1yr

Menstrual History: Regular: ☑ Yes ☐ No

Obstetric Hostory:
1st: PP; Spontaneous Conception.

Obstetric Examination

Fundal Height: term

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

Liquor: ☑ Adequate ☐ Oligo ☐ Poly

Present Pregnancy Record:
1st: NT-(N) FTS: lowrisk.
TIFF-(N), OGTT-(N)

PP: ☑ Cephalic ☐ Breech Others ____

Head Fifths Palpable: 4/5th

RISK FACTORS:

FHS: ☑ Normal ☐ Tachy ☐ Brady ☐ Absent

Per Speculum Examination not done.

Draining: ☐ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination

Cervix: ☐ Long ☐ Partially effaced ☑ Effaced

Height: 166 cm
Weight: 66 kg
Allergies: Nil.
Breast: ☑ Normal ☐ Abnormal
General Examination:
Consciousness: c/c Pallor: -ve
Icterus: no Edema: No
Temp: Afebrile PR: 82bpm
BP: 121/61mmHg DTR: (N)
CVS: S1S2+, nomurmur RS B/L NVBS (+)
Liver/Spleen (N) Urine Output: Adequate

Os: Closed ____ Dilated 1 Finger

Membranes: ☑ Present ☐ Absent

Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Presenting Part: ☑ Vertex ☐ Breech ☐ Others

Sutton: ☐ -3 ☑ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Pelvis: ☐ Adequate ☑ Doubtful

DIAGNOSIS
Primigravida with 39wks POG for Induction of labour.

HNH-00011326
Mrs HEENA JAIN IP26-00006503
05-09-1997 28 Y 8 M 30 D (F)
Dr. SWATHI H V

Family History: Nil	Surgical History: Nil
Medical History: Nil.	Medication History: T. IRON T. CALCIUM
Plan of Care: Admission NST Parts preparation IOL with T. Misoprostol 25mcg PV @ 10pm ↓ 25mcg @ 1am ↓ 25mcg @ 5am NST - 4 hrly strict FHR monitoring 2hrly w/f POL/PV leak/PV bleeding drugs as charted Monitor Vitals, Inform SOS	Investigations: BGT - 'B' positive CBP - 30/5/2026 Hb - 10.8 TLC - 9,058 PCV - 30.1% plt - 1.86 HIV, HbsAg, HCV, VDRL USG (23/5/2026) SLIUF 37w 2day Cephalic placenta - post. lt. lateral high AFI - 14.3cm EFW - 3,005gm (42% / AC - 8%) Dopplers - (N)

Doctor Name: Dr. Naveena.

Signature:

Date & Time: 04/06/2026 @ 8:30pm

Consultant Name: Dr. Swathi HV

Signature:

Date & Time:

HNH-00011326 IP26-00006503
Mrs HEENA JAIN
05-09-1997 28 Y 8 M 30 D (F)
Dr. SWATHI H V

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/6/2026 12:35am	c/s/by	Dr-Naveena
	O/E GC-fair	Adv
	Afebrile	- liquid diet
	Vitals - stable	- Adequate hydration
	PA: ut- term size	- Ambulation
	Irritable	- NST 4th hrly
	Cephalic	- strict FHR monitoring 2hrly
	FHR (+)	- w/f POL/PV leak/ PV bleeding
	NST-Reactive	- drugs as charted
1am	2nd dose - P/O Misoprostol 25mcg given	- Monitor Vitals, I/SOS
5/6/2026 5:30am	c/s/by	Dr. Naveena c/b/w Dr-Swathi
	O/E GC-fair	Adv
	Afebrile SpO2-100%	- liquid diet
	NST-Reactive PR: 75bpm	- Adequate hydration
	BP: 110/74mmHg	- NST-4th hrly
	PA: ut term size, 3-4c/30-40"/10'	- strict FHR monitoring 2hrly
	Cephalic, FHR (+)	- w/f POL/PV leak/
	PV: Cx 1 Finger loose	PV bleeding
	40% effaced	- drugs as charted
	Vx - 2 station	- Monitor Vitals
3rd dose	- T. Misoprostol P/O 25mcg given.	- Inform SOS

HNH-00011326 IP26-00006503
Mrs HEENA JAIN
05-09-1997 28 Y 8 M 31 D (F)
Dr. SWATHI H V

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/6/26 9:30am	c/s/B Dr. Neena	
	Primi / 39+1 wks / Ongoing IOL	
	Pt is stable, No c/o	
NST - Reactive	O/E GC - fair,	Adv
	BP - 110/70 mmHg	- Liquid diet
	PR - 86bpm	- Adequate hydration
	SpO_2 - 99% on RA	- NST - 3rd hourly
	P/A - Ut ~ Term	- FHR - 2nd hourly monitoring
	4/5th palpable.	- Drugs as charted
	3/25"-30"/10'	- Monitor vitals
	FHR (+)	- Inform SOS
9:30am	- T. Misoprostol 25mcg P/o given (4th dose)	[signature]
5/6/26. 10:45am	C/s/B Dr. Swathi H.V	
	Primi / 39+1 wks / Ongoing IOL	
	Pt is stable, No c/o	
	O/G GC - fair	Adv
	BP - 110/70 mmHg	- Liquid diet
	PR - 77 bpm	- Drugs as charted
	P/A - Ut ~ Term	- Vital monitoring
	3/5th palpable	- Plan for ARM and
	FHS (+), 4/30"/10'	further progress
	- P/V - 3-4 cm dilated,	- Option for Epidural analgesia
	well effaced,	given
	Vx = 'O' station	[signature]

HNH-00011326 IP26-00006503
Mrs HEENA JAIN
05-09-1997 28 Y 8 M 30 D (F)
Dr. SWATHI H V

(9)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/6/26 11:30am	ARM done – P/V – Cervix 8cm dilated, 1cm long cervix, 'O' station. Membranes (+)	→ ARM done – Clear leak noted
5/6/26 1:30pm	c/s/b Dr. Swathi H.V +	
	PND-0	
	Pt is stable, No c/o	Adv
	D' O/E GC-fair	– Soft diet
	BP- 120/86mmHg	– IV Abx for 24 hours
	PR- 68bpm	– Inj. Tranexa 1g after 6 hours.
	SpO_2 - 100% on RA	– Vital monitoring
	P/A- Ut well retracted	– I/O charting
	L/E – Vaginal pack in-situ (+)	– Vaginal pack to be removed after 6 hours
	No active bleeding P/V.	– Foley's removal after 6hrs.
		– Inform SOS

Docu. No. : RCH /FRM / CLINICAL / 088

HNH-00011326 IP26-00006503
Mrs HEENA JAIN
05-09-1997 28 Y 8 M 30 D (F)
Dr. SWATHI H V

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/6/26 6 PM	C/S/B Dr. Ramya PND-0: P1L1 (outlet forceps)	
	P° P0 GC fair Afebrile BP: 140/80 mmHg PR: 88/min H/L NAD U/O – 400ml Clear. P/A Uterus Retracted well P/V bleed WNL. vaginal pack removed Mild Vulval edema (+). Pt can be shifted to Room.	Adv - Regular diet - Drug as charted - Inj Tranexa 1g IV TID for 24h. - Adequate hydration. - Vital Monitoring w/f bleeding PV. Inform SOS - Ice pack over perineal area. - Foleys to be removed t/m 6AM.
5/6/26 9:30 PM	C/S/B Dr [illegible] PND-0 P1L1 (outlet forceps)	
	GC fair Afebrile Vitals – (N) U/O – Adequate Clear. H/L NAD P/A Uterus Retracted well. P/E – bleeding WNL.	Adv - Regular diet / Adequate hydration - Drugs as charted - Foleys removal t/m 6Am - Ice packs over perineal area - Vital monitoring - Inform SOS

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

HNH-00011326
Mrs HEENA JAIN
05-09-1997
Dr. SWATHI H V
IP26-00006503
28 Y 8 M 30 D (F)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/s/b Dr. Dna	
6/6/26		Adv
7:30 AM	PND-1 P,L4 (Outlet forceps)	- Regular diet
		- Adequate hydration
	Baby @ NICU	GC fair Afebrile	- Drugs as charted
	vitals - (N)	- Cold compresses
	Foleys Removed, Urine - Yet to void	P/A Ut ≈ Retracted well	over perineum
	P/V - NAB	- Vital Monitoring
		- w/f P/V bleed.
		Inform sos
	[signature]	
6/6/26		
11:30am	C/s/B Dr. Veena	
	PND-1 | P,L1 (Outlet forceps)	
Baby @ NICU	⊙ Pt is stable, Nocto	Adv
	O/E GC fair, Afebrile	- Regular diet
	Vitals - stable	- Drugs as charted
U ✓	Pallor (-)	- Adequate hydration
F ✓	P/A - Ut well retracted	- MgSO4 dressing over ~~vulvato~~ perineum
SX	Ep L/E - Mild swelling (+)	
	No active bleeding.	- Vital monitoring
Can be discharged		- w/f excessive bleeding P/V
		- Inform SOS
		[signature]

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00011326 IP26-00006503
Mrs HEENA JAIN
05-09-1997 28 Y 8 M 31 D (F)
Dr. SWATHI H V

PARTOGRAPH

LABOUR

Labour: ☐ Spont ☑ IOL-PGE 1 ☐ E2 ☐ Others

Indications for IOL-Accel: ☑ None ☐ Oxytocin

Memb. Repture Type: ☐ SROM ☐ PROM ☑ ARM

Presentation: ☑ Vertex ☐ Breech ☐ Others

INTRA PARTUM COMPLICATION

Maternal: ☑ None ☐ Pyrexia ☐ HTN ☐ Others

Liquor: ☑ Adequate ☐ Oligo ☐ Poly ☐ Clear

☐ Blood ☐ Meconium ☐ Cord: ....

Shoulder Dystocia: ☐ Yes ☑ No

DELIVERY DETAILS

Anesthesia: ☑ None ☐ Epidural

Non-epi: ☑ Local ☐ Spinal ☐ General

Del. Type: ☑ SVD ☐ Asst. Breech ☐ Twins

AVD: ☑ Outlet ☐ Low Forceps ☐ Ventouse

☐ Trails of Forceps

Indications: Poor maternal bearing down efforts

Application, Locking & Traction: Done. (N) ē Fetal distress

Duration of Instrumentation: 3 mins

No. of Pulls: 1 pull

Catherised : ☑ Yes ☐ No

Type: ☑ Fileys ☐ Plain

Perineum : ☐ Intact ☑ Episiotomy ☐ Tear

Suture Material Used: Rapid vicryl No. 1

STAGE III

Placenta: ☑ Normal ☐ Abnormal ☐ RP Clots

☑ CCT ☐ Retained ☐ MRP

PPH : ☐ Atomic ☐ Traumatic ☑ None

Lacerations: One lateral tear (Rt side) ~4 cm

Cervical: None

Perineal: Grade 2 - Episiotomy

Others: -

Prophylaxis: (Synocinon) Prostodin

Blood Loss: 300 ml

Blood Transfusion: None

Other Details (if any): -

Ractal Examination: - Intact & normal

Mops, needles counts are verified

DURATION OF LABOUR

1st Stage: 6½ hrs

2nd Stage: 1 hr

3rd Stage: 10 mins.

Duration of Active Pushing: 1 hr

No. of VE'S: 4

BABY DETAILS

Gender: FEMALE

Weight: 3.32 kg

APGAR: 6, 7.

Date and Time of Delivery: 5/6/26 @ 12:59 pm

LW Doctor: Dr. Swathi / Dr. Veena

LW Sister: S/N Chandrakala.

[signature]

Docu. No. : RCH /FRM / CLINICAL / 143

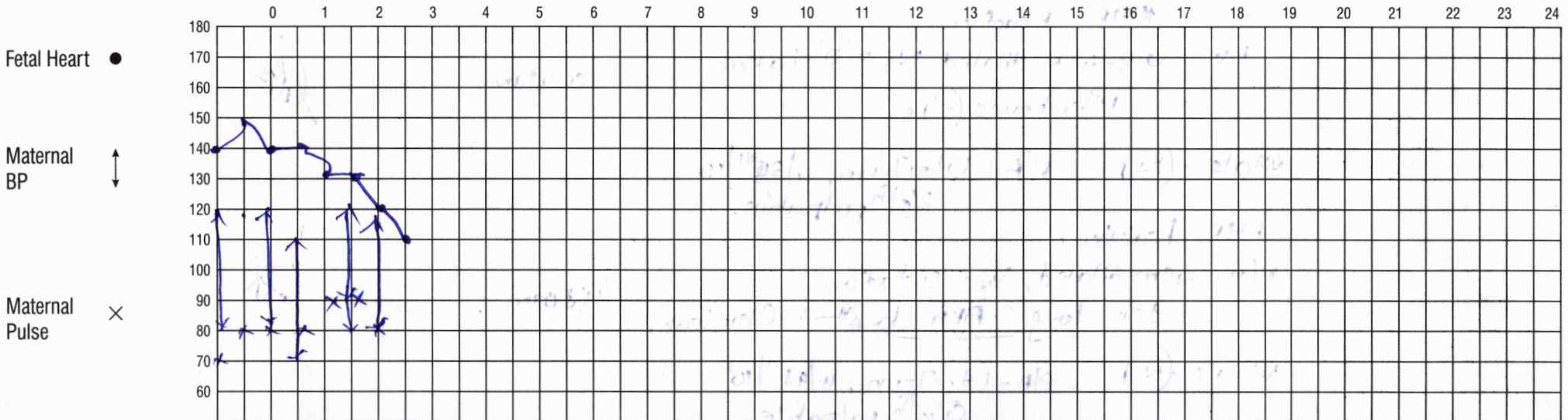
(P.T.O.)

Time	10:45	11:45am	12:45pm																						
Signature	[signature]	[signature]	[signature]																						
Fifths Palpable	3/5	0/5	0/5																						
Moulding / Caput	(–)	(–)	(–)																						
Amniotic Fluid	C	C	C																						
Position Cephalic / Breeth	C	C	C																						
Oxytocin	–	–	12dr/hr																						
Contractions in 10 mins (1–5)	4	4	4																						
Drugs and IV Fluids	Inj. Oxytocin 10U Infusion started.																								
Urinalysis — Test	–	–	–																						
Urinalysis — Amount	–	–	–																						

PARTOGRAPH

Name: Mrs. Heera Jain **Obstetrics Formula:** Primi **Blood Group Type:** "B positive"

Memb. Ruptured: **SROM** **PROM** **ARM** **Risk Factors:** Nil.



-3
-2
-1
±0
+1
+2

10:45 11:45 12:45

Record of Labor:

Maternal Condition: Vitals - (N), P/A - Ut ~ Term, 3/5th palpable, 4/30''/10'.

Fetal Condition: FHR - Reactive

Progress of Labor: P/V - 3-4cm dilated, Vx = '0' station

Management: Membranes (+).

Time: 10:45am Signature: [signature]

Maternal Condition: Vitals - (N), P/A - Ut ~ Term, 2/5th palpable. 4/35''/10'

Fetal Condition: FHR - Reactive.

Progress of Labor: P/V - 4cm dilated, Vx = '0' station

Management: 1cm long, ARM done → Clear leak.

Time: 11:30am Signature: [signature]

Maternal Condition: Vitals (N) P/A - Ut ~ Term, 0/5th palpable 4/45''/10'

Fetal Condition: FHR (+)

Progress of Labor: P/V - Fully effaced, fully dilated

Management: Vx = +1 station.

Time: 12pm Signature: [signature]

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

Time: .... Signature: ....

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

Time: .... Signature: ....

HNH-00011326 IP26-00006503
Mrs HEENA JAIN
05-09-1997 28 Y 8 M 30 D (F)
Dr. SWATHI H V

RESULT SHEET

Date	30/5/26.					
Time						
Hb	10.8					
PCV	30.1					
RBC	3.49					
WBC	9.58					
N/L						
Platelets	1.86					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
	Blood group 'B' positive					
HIV						
HBsAg } Neg.						
HCV						

Culture and Sensitivities : ....

....

....

....

Radiology : USG : ....

X-Ray : ....

ECHO : ....

CT : ....

MRI ....

Others (ECG, Contrast Studies etc.,) : ....

26

NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 6/6/26 Time: 10 am.

Origin: Indian Height: 166 cm Weight: 66 kg BMI: ☐ ~ 26 kg/m² ☐ ~ 28 kg/m² ☑ ~ 30 kg/m²

Food Allergies: F.A

Diagnosis: NVD

Type of Diet: ☐ Liquid ☐ Soft ☑ Normal ☐ Diabetic

☑ Vegetarian ☐ Non-Vegetarian ☐ Vegan

Diet Advised:

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

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

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

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

Patient's / Attendant's	Dietician's
Signature: Jain	Signature: Sobiya
Name: Vaibhav Jain	Name: Syeda Sobiya Zaheer
Date & Time: 6/6/26 ; 10:00 am	Date & Time: 6/6/26 ; 10:00 am

DIETARY NOTES

Date	Time	Notes	Sign

HNH-00011326 IP26-00006503
Mrs HEENA JAIN
05-09-1997 28 Y 8 M 30 D (F)
Dr. SWATHI H V

MEDICATION RECONCILIATION FORM

Drug Allergies: Nil ☑ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.
(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: .... Shifted to: ....

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T- IRON	1 TAB	PO	OD	4/6	☐ C ☑ DC
2	T- CALCIUM	1 TAB	PO	OD	4/6	☐ C ☑ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Naveena

Date & Time : 4/06/2026 @ 8:30pm.

Nurse Name & Signature: Chumbakala

Date & Time : 4/6/26

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

HNH-00011326 IP26-00006503
Mrs HEENA JAIN
05-09-1997 28 Y 8 M 30 D (F)
Dr. SWATHI H V

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DRUG CHART

Date of Admission: 4/6/26 Drug Allergies: .... ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

NURSES - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

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

HNH-00011326 IP26-00006503
Mrs HEENA JAIN
05-09-1997 28 Y 8 M 30 D (F)
Dr. SWATHI H V

REGULAR PRESCRIPTIONS Weight. 66 Ward. LDR

DRUG : INJ. CEFOTAXIME				Date/Time	5/6/26	6/6
Dose	Route	Frequency	Start Date			
1g	IV	BD	5/6/26	11AM		
Name & Signature of the Doctor Starting the Drugs:				17		
				11PM		
Additional Instructions: 1 dose → 6/6 Oral						
Daily Doctor's Endorsement by a Sign						

DRUG : T. PANTAPRAZOLE				Date/Time	5/6	6/6
Dose	Route	Frequency	Start Date			
40mg	P/O	BD	5/6/26	6AM	✓	
Name & Signature of the Doctor Starting the Drugs:						
Additional Instructions: Before food.				6PM		
Daily Doctor's Endorsement by a Sign						

DRUG : T. PARACETAMOL				Date/Time	5/6	6/6
Dose	Route	Frequency	Start Date			
1g	P/O	TID	5/6/26	6AM	✓	
Name & Signature of the Doctor Starting the Drugs:				2PM	✓	
Additional Instructions:				10PM		
Daily Doctor's Endorsement by a Sign						

DRUG : T. DICLOFENAC				Date/Time	5/6	6/6
Dose	Route	Frequency	Start Date			
50mg	P/O	TID	5/6/26	7AM	✗	
Name & Signature of the Doctor Starting the Drugs:				3PM		
Additional Instructions:				11PM		
Daily Doctor's Endorsement by a Sign						

Verified by Dr. Dhakshayani

HNH-00011326 IP26-00006503
Mrs HEENA JAIN
05-09-1997 28 Y 8 M 30 D (F)
Dr. SWATHI H V

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REGULAR PRESCRIPTIONS

Sheet No: .... Weight 66 Ward LOR

DRUG : SYP. DUPHALAC

Dose	Route	Frequency	Start Dt.
15ml	P/O	OD	5/6/26

Date/Time	5/6	6/6
10pm	[initials]	

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : OINT. METRONIDAZOLE-POVIDONE IODINE

Dose	Route	Frequency	Start Dt.
1g	L/A	BD	5/6/26

Date/Time	5/6	6/6
10Am	X	[initials]
10Pm	[initials]	

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

Additional Instructions: (Oint. Metro-P).

Daily Doctor's Endorsement by a Sign

Verified by Dr. Dhakshayani

DRUG : Inj TRANEXAMIC ACID

Dose	Route	Frequency	Start Dt.
1g	IV	TID	5/6/26

Date/Time	5/6	6/6
6Am	X	[initials]
2Pm	X	
10Pm	[initials]	

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

Additional Instructions: for 24 hours

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

VERIFIED BY : Name .... Signature

Patient Sticker

REGULAR PRESCRIPTIONS

Sheet No: .... Weight .... Ward ...LDR.......

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				

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 : Name .... Signature ....

HNH-00011326 IP26-00006503
Mrs HEENA JAIN
05-09-1997 28 Y 8 M 30 D (F)
Dr. SWATHI H V

Weight. 66 Ward. 104

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
4/6	10pm	T. MISOPROSTOL	25mcg	PV	[signature]	[signature]
5/6	1AM	T. MISOPROSTOL	25mcg	PO	[signature]	[signature]
5/6	5:30 AM	T. MISOPROSTOL	25mcg	PO	[signature]	[signature]
5/6	9:30 am	T. MISOPROSTOL	25mcg	PO	[signature]	[signature]
5/6/26	11.40AM	INJ. CEFOTAXIME	1g	IV (ATD)	[signature]	[signature]
5/6/26	11.50AM	INJ. DROTAVARINE	1amp	IM	[signature]	[signature]
5/6/26	11.59AM	INJ. BUSCOPAN	1amp	IM	[signature]	[signature]
5/6/26	1.pm	INJ. OXYTOCIN	10U	IM	[signature]	[signature]
5/6/26	1.pm	INJ. TRANEXAMIC ACID	1g	IV	[signature]	[signature]

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

Verified by Dr. Dhakshayani

Mrs HEENA JAIN
05-09-1997 28 Y 8 M 30 D (F)
Dr. SWATHI H V

I.V. FLUIDS CHART

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

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
5/6/26	5Am	RINGER LACTATE	IV	FF	[signature]	[signature] [signature]	5/6	[signature]	[signature] [signature]
5/6/26	8.30Am	RINGER LACTATE	IV	100ml/hr	[signature]	[signature] [signature]		[signature]	[signature] [signature]
5/6/26	12pm	RINGER. LACTATE + 10U OXYTOCIN	IV	100ml/hr	[signature]	[signature] [signature]		[signature]	[signature] [signature]
		STOP							

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

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Mrs HEENA JAIN
05-09-1997 28 Y 8 M 31 D (F)
Dr. SWATHI H V

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STAT / ONCE ONLY DRUGS

Weight: .... kgs

Name: ....

Sheet No: ....

DATE	TIME	MEDICATION	DOSAGE & OTHER INSTRUCTIONS	ROUTE	SIGNATURE		
					Doctor	Nurse-1	Nurse-2
5/6/26.	1pm	INJ. TRAMADOL	1amp.	IV	[signature]	[signature]	[signature]
5/6/26	1pm	DICLOFENAC SUPPOSITORY	1.	P/R	[signature]	[signature]	[signature]
5/6/26.	1pm	T. MISOPROSTOL	600mg	P/R	[signature]	[signature]	[signature]
5/6/26.	7pm	INJ. TRANEXAMIC ACID	1g	IV	[signature]	Not	given.

Verified by Dr. Dhakshayani

Docu. No. : RCH /FRM / CLINICAL / 136

HNH-00011326 IP26-00006503
Mrs HEENA JAIN
05-09-1997 28 Y 8 M 30 D (F)
Dr. SWATHI H V

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Early Warning Observation Score Chart - Obstetrics

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

4/6/26	Date																								
	Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																								
	21 - 30																								
	11 - 20														20			20				20			20
	0 - 10																								
Saturations	94 - 100 %														99			99%				99%			99%
	< 94 %																								
Administered O_2 (L/min.)																									
Temp°c	40																								
	39																								
	38																								
	37																	—							
	36														36							—			—
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80														80			89				90			84
	70																								
	60																								
	50																								
	40																								
↑ Systolic Blood Pressure	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120														117			122				119			116
	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
↓ Diastolic Blood Pressure	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70														69			72							
	60																					75			70
	50																								
	40																								
NEURO RESPONSE [✓]	Alert														—			—				—			—
	Voice																								
	Pain																								
	Unresponsive																								
URINE mls / hour	> 30														—			—				—			
	< 30																								
Proteinuria	Protein + +																								
	Protein > + +																								
Lochia	Normal														—			—							
	Heavy / Foul																								
Liquor	Clear / Pink														—			—							
	Green																								
TOTAL YELLOW SCORES																									
TOTAL ORANGE SCORES																									
Nurse Initial															[illegible]			[illegible]				[illegible]			[illegible]

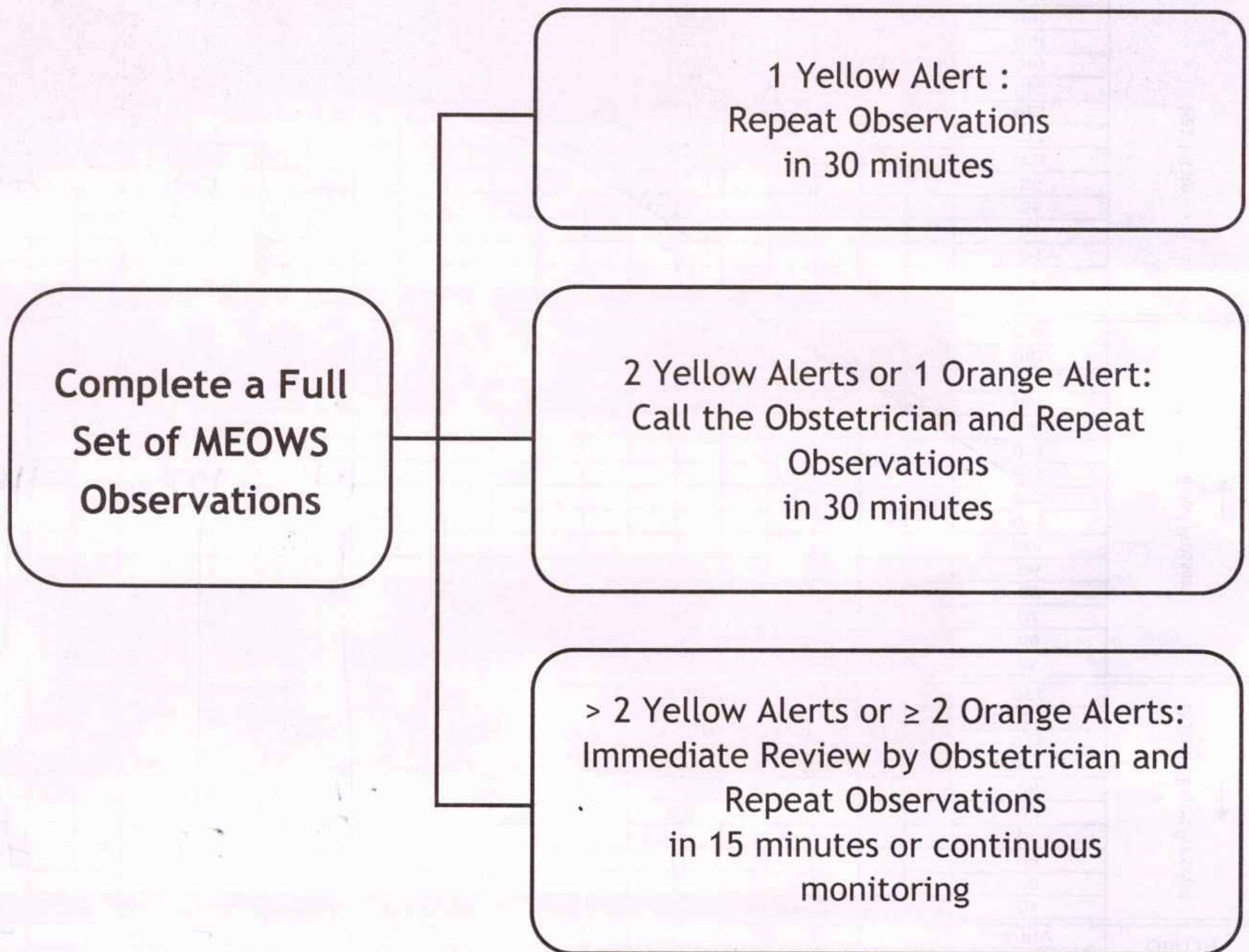
4/6/2026.

11pm → 148 bmt.

2AM → 152 bmt.

7AM → 148 bmt

Obstetrics and Gynaecology
Early Warning Signs



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

HNH-00011326 IP26-00006503
Mrs HEENA JAIN
05-09-1997 28 Y 8 M 30 D (F)
Dr. SWATHI H V

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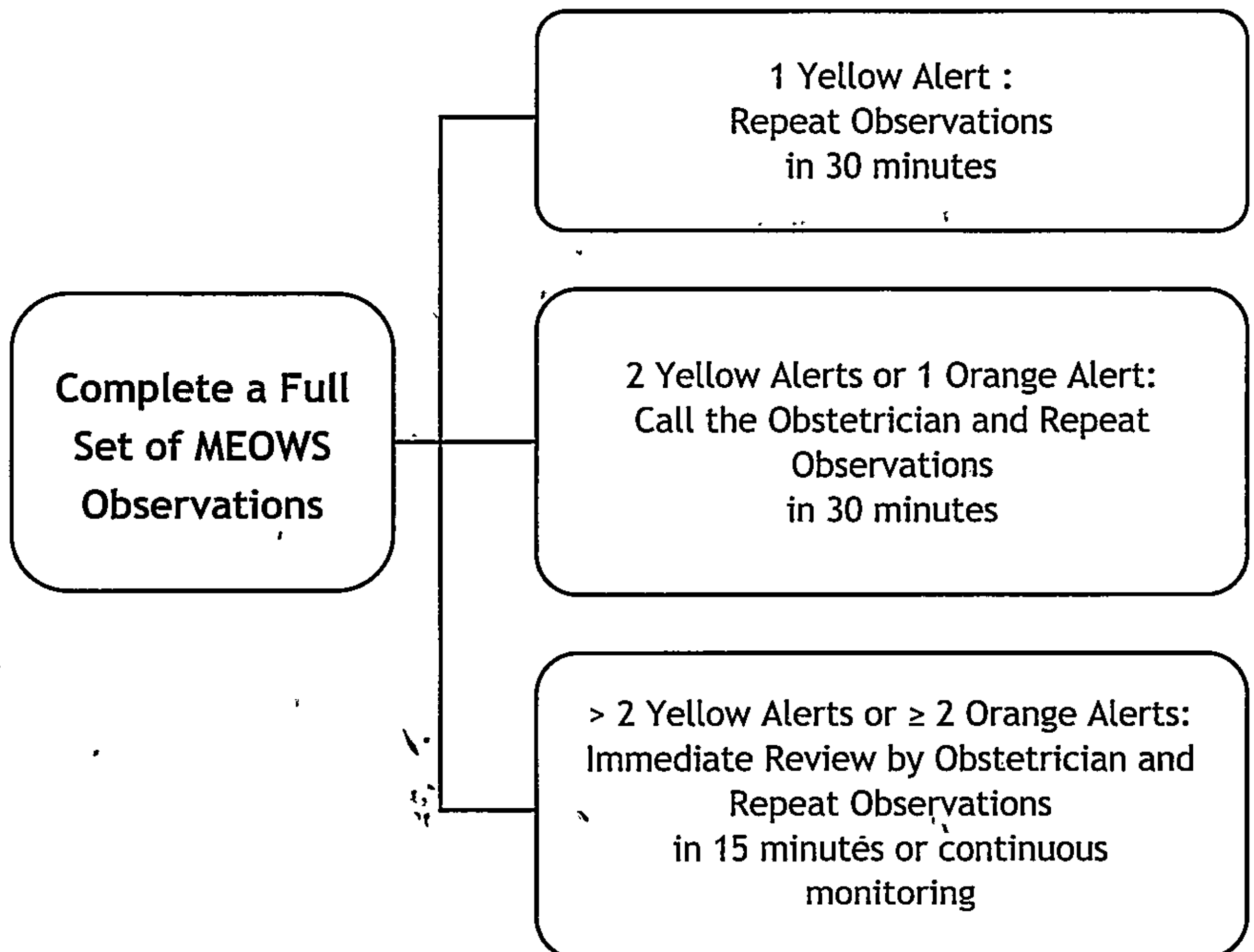
Early Warning Observation Score Chart - Obstetrics

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

Date: 5/6/26

Parameter	Range	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	
	0 - 10																								
Saturations	94 - 100 %	100		100	100	100	100	100		100			100%			100%				100%				100%	
	< 94 %																								
Administered O_2 (L/min.)																									
Temp°c	40																								
	39																								
	38																								
	37																								
	36	97								98°F			98°			98.5°F				98.5°F				98.6°F	
	35																								
	< 35																								
Heart Rate	170 – 90																								
	80 – 50	86		86	96	96	80	86		69			96			86 b/m				86 b/m				86 b/m	
	40																								
Systolic Blood Pressure ↑	190 – 150																								
	140 – 100	110		110	120	107	110	80		125						120				125				117	
	90 – 50																								
Diastolic Blood Pressure ↓	130 – 90																								
	80 – 50	76		70	77	60	70	70		78			67			70				70				80	
	40																								
NEURO RESPONSE [✓]	Alert									—			—			—				—				—	
	Voice																								
	Pain																								
	Unresponsive																								
URINE mls / hour	> 30	—								✓			—			—				—				—	
	< 30																								
Proteinuria	Protein + +																								
	Protein > + +																								
Lochia	Normal	—											—			—				—				—	
	Heavy / Foul																								
Liquor	Clear / Pink	—																							
	Green																								
TOTAL YELLOW SCORES		0		0	0	0	0	0		0			0			0				0				0	
TOTAL ORANGE SCORES		0		0	0	0	0	0		0			0			0				0				0	
Nurse Initial		[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]			[illegible]			[illegible]				[illegible]				[illegible]	

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

HNH-00011326 IP26-00006503
Mrs HEENA JAIN
05-09-1997 28 Y 8 M 30 D (F)
Dr. SWATHI H V

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FLUID CHART

Sheet No. : 1

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

Date	Time	Intake: Nature of Fluid	Route: Mouth	Route: I.V	Route: N.G	Output: NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombophlebitis Score	Sign. Nurse
	08:00 am	NP										
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
4/6/26	08:00 pm											
	09:00 pm	-	[illegible]									
	10:00 pm					NP				✓	0	Anitha
	11:00 pm											
	12:00 am		H2O							✓		
	01:00 am		-									
Total Intake : Taken						Total Output : Passed.						
5/6/26	02:00 am			-								
	03:00 am	-	H2O	-		NA						
	04:00 am	-		-						✓	0	Anitha
	05:00 am		H2O.	-								
	06:00 am	-		-						✓		
	07:00 am	-										
Total Intake : Taken						Total Output : passed						

Total 24 hrs. Intake		Total 24 hrs. Output	

Docu. No. : RCH /FRM / CLINICAL / 092

HNH-00011326 IP26-00006503
Mrs HEENA JAIN
05-09-1997 28 Y 8 M 30 D (F)
Dr. SWATHI H V

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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	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombophlebitis Score	Sign. Nurse
5/6/26	08:00 am	RL		FF						✓		
	09:00 am	RL		FF							0	
	10:00 am	RL	50ml	100ml		NA		0	0			[illegible]
	11:00 am	RL	H2O	100ml								
	12:00 pm	RL		100ml								
	01:00 pm	R	H2O									
Total Intake :		Taken						**Total Output :**		Passed		
5/6/26	02:00 pm		water			NA						
	03:00 pm		Dolly									
	04:00 pm		H2O				0					[illegible]
	05:00 pm		H2O									
	06:00 pm							0	0	400ml	0	Empty
	07:00 pm											
Total Intake :		Taken						**Total Output :**				
5/6	08:00 pm											
	09:00 pm		[illegible]									
	10:00 pm											
	11:00 pm	0	H2O		NA		0	NA		300ml	0	[illegible] Empty
	12:00 am											
	01:00 am											
Total Intake :								**Total Output :**				
6/6	02:00 am											
	03:00 am											
	04:00 am		H2O							350ml		Empty
	05:00 am	0			NA		0	NA			0	[illegible]
	06:00 am									300ml		Removed 6/6/26 @ 6:00 [illegible]
	07:00 am											
Total Intake :								**Total Output :**				

Total 24 hrs. Intake		Total 24 hrs. Output	

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CHECKLIST FOR THROMBOPHLEBITIS

W6 5/6/26

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

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

Signature of Shift In Charge :

Signature : [signature] Name : Mocile

Signature of Ward In Charge :

Signature : Kasthri Name : Kasthri

Docu. No. : RCH /FRM / CLINICAL / 137

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05-09-1997 28 Y 8 M 30 D (F)
Dr. SWATHI H V

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	4/6/26	5/6/26 mb	5/6 2pm
		Score			
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0			
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0		0	0
IV / Heparin Lock or Saline	Yes	20	20	20	20
	No	0			
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0			
Mental Status	Forgets limitations	15			
	Oriented to own ability	0		0	0
Total Morse Fall Scale Score:			20	20	20
		Signature	[signature]	[signature]	[signature]

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

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

☐ Ensure patients use their prescribed eye glasses if any, in the hospital

☐ Use chairs with arm rests

☐ Use safety straps on stretchers and wheelchairs while transporting patients

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

☐ Assist and/or supervise ambulation. Reinforce to always call for assistance

☐ Hourly safety check

☐ Assess patient after visitors, leave to ensure safety measures in place

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

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

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	5/6 10pm		
		Score			
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0			
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0			
IV / Heparin Lock or Saline	Yes	20	20		
	No	0			
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0			
Mental Status	Forgets limitations	15			
	Oriented to own ability	0			
Total Morse Fall Scale Score:			20		
		Signature	[signature]		

Fall Risk Grading

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

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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BRADEN 'Q' SCALE

				Date :	4/6	5/6	5/6	5/6
				Time :	8pm	m6	2pm	10pm
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
				TOTAL SCORE	28	28	28	28
				Evaluator's Name	[illegible]	[illegible]	[illegible]	[illegible]

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	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for **"At Risk"** Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for **"Moderate Risk"** Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for **"High Risk"** Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

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Mrs HEENA JAIN
05-09-1997 28 Y 8 M 30 D (F)
Dr. SWATHI H V

NURSING CARE RECORD

Date: 9/6/26

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		NA					
Afternoon							
Night	8pm to 8Am	→ Assess the pt condition → monitor vitals → monitor [illegible]	8pm to 8Am	→ Assessed the pt condition → monitored vitals → [illegible]	Now pt is stable	Re-check vitals	Mou[illegible]

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05-09-1997 28 Y 8 M 31 D (F)
Dr. SWATHI H V

NURSING CARE RECORD

Date: 5/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am to 2pm	=> Assess the patient condition => plan for vital => plan for flowchart	8Am to 2pm	=> Assessed the patient condition => maintain vital & Record => maintain flowchart	patient is stable	vital is normal	Claudy
Afternoon	8Am to 2pm	– Assess the Patient condition – plan for vital record – plan for flochart	8-Am to 2pm	– Assessed the Pt condition – Maintain vital & record – Maintain flochart	– Patient stable	– vital normal	[illegible]
Night	8pm to 8Am	=> Assess the pt condition => monitor vitals & record => maintain I/O chart => Administer medication as per drug chart	8pm to 8Am	=> Assessed the pt condition => monitored vitals & recorded => maintained I/O chart => Administered medication as per drug chart	=> pt is stable	=> vitals rechecked	[illegible]

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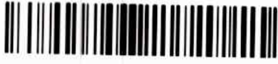
NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: DSL			Any Infection: ☐ Yes ☐ No ☑ Not Known If Yes Specify:			
	Surgery / Procedure:			Post OP Day:			
BACKGROUND	Date / Shift	4/6 N	5/6 MB	5/6 8pm	5/6 10pm		
	Medical Condition (Any special condition to be noted):	—		—	—		
	Diet:	—		Soft	Regular		
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	—		RA	—		
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	97	97	98.6	98.5°F		
	Res:	16	20	20	20b/m		
	SpO_2:	99	98	100%	100%		
	Pulse:	82	82	83	85b/m		
	BP:	110/70	110/70	114/73	120/70		
	LOC:	—	—	—	—		
	Fall Risk Score:	—	—	—	—		
	Pain Score:	—	—		—		
	Skin Integrity	good	—	Good	Good		
Recommendations	Safety Needs:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	—	—		—		
	Others Specify:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	—	—	Soft	—		
	Critical Lab Test / Values:	—	—	—	—		
	Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	Depen	—	NA	—		
Post Operative Procedure Special Orders:		NA	—		—		
Handed Over By Name :		Moni	[illegible]	Alai	Shwetha		
Signature / ID :		[signature]	[signature]	Alai	[signature]		
Date:		5/6/26	5/6/26	5/6/26	6/6/26		
Time:		8AM	8:30PM	[illegible]	8AM		
Taken Over By Name :		[illegible]	Alai	[signature]			
Signature / ID :		[signature]	Alai	[signature]			
Date:		5/6/26	5/6/26	5/6/26			
Time:		8PM	8:30pm	8pm			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OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 4/6/26 Time of Arrival: 8pm Time Seen by Nurse: 8:15pm

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

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

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

3) **Vital Signs:** Temperature: 97F Pulse: 82 RR: 22 SpO$_2$: 99 BP: 110/70 Weight: 66kg

4) **Gestational Criteria:**

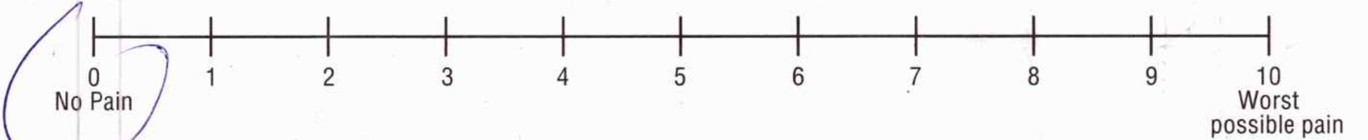
Gravida:	G	P	L	A

LMP: 25/9/25 EDD: 11/6/26 Gestational Age: 39 weeks

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

5) **Pain Screening:**

Numerical Pain Scale (NPS)



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

....

6) **Past History:**

a) Surgeries: ....
b) Medical: ....

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

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

9) **Prenatal Medical History:**

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

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

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

Time seen by Doctor: Dr. naveena

Nurse Name : Monika Nurse Signature: [illegible]

Date: [illegible] Time: [illegible]

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LABOUR AND DELIVERY NURSING ASSESSMENT

Date of Admission: 11/6/26

Baseline Information:

Admission From: ☐ ER ☐ OPD ☐ Admission Desk ☐ Others: specify ....

Primary Language: ☐ Telugu ☐ English ☐ Hindi ☐ Others

Do you require an interpreter? ☐ Yes ☐ No

Source of Information: ☐ Patient ☐ Family ☐ Others

Personal belonging if any: ☐ Jewelry ☐ Nose Ring ☐ Bangles ☐ Anklets ☐ Finger Ring ☐ Bracelets

handed over to ....

Allergies: ☒ Yes ☐ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: ....

If yes , identify ....

Chief Complaints: DOL

Doctor Notified on Admission: ☐ Yes ☐ No

Name of the Doctor: Dr Naveena

Time Notified: 8:30pm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
—	—	—

Blood Group: B+Ve LMP: 25/9/25 EDD: 11/6/26 Gestational age during admission: 38 weeks

Contractions: NO Vaginal Discharge: N-A

Obstetric History: G 1 P 1 L .... A .... Previous LSCS NA

Height: .... Weight: .... BMI: ....

Temp: 97 HR: 82 RR: .... BP: 110/70 SpO_2 94

High Risk Factors: (Please select by ticking (✓) the box as applicable)

☐ Hypothyroidism	☐ Rh Incompatibility	☐ Fertility Treatment
☐ Hyperthyroidism	☐ Previous LSCS	☐ Preterm Labour
☐ Hypertension	☐ Gestational Hypertension	☐ Others: (Specify)
☐ Diabetes	☐ Bad Obstetric History	
☐ Anemia	☐ Obesity (BMI)	
	☐ Twins / Multiple Pregnancy	

HNH-00011326 IP26-00006503
Mrs HEENA JAIN
05-09-1997 28 Y 8 M 30 D (F)
Dr. SWATHI H V

Family History: ...lities Detected

☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Stroke ☐ Seizures ☐ Kidney disease

☐ Liver disease ☐ Other ....

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

Fall Assessment: ☑ Yes ☐ No Score .... (complete the Morse Fall Risk Assessment Sheet)

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

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

☐ Mobility problem ☐ Walking Problem ☐ No Abnormality Detected

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

☐ Overweight ☐ Poor Appetite > 3 Days ☐ Needs Therapeutic Diet.

☐ Under Weight ☐ Diabetes Mellitus ☐ No Abnormality Detected

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

☑ Calm & Cooperative ☐ Restless ☐ Depressed ☐ Agitated ☐ Confused

☐ Others ....

Inform consultant for positive criteria

SOCIAL SCREENING:

1. Marital Status: ☐ Single ☑ Married ☐ Divorced ☐ Widow

2. Special Habits: **Smoker:** ☐ Yes ☑ No **Alcohol Abuse:** ☐ Yes ☑ No **Drug Abuse:** ☐ Yes ☑ No

Social History: Lives With .... family member ....

Orientation has been given regarding the following aspects:

Call Bell in Reach : ☑ Yes ☐ No Waste Disposal Explained: ☑ Yes ☐ No

Infusion Pump : ☑ Yes ☐ No Hand hygiene Explained: ☑ Yes ☐ No ☐ Others

Above information given to .... patient ....

Name of Person Orientation was given to: .... Heena ....

Orientation not given Reason: .... self ....

Nurse Signature: .... [signature] ....

Nurse Name: .... M. Monil ....

Date & Time: ....

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Your Right to a Safe Delivery

INFORMED CONSENT FOR VAGINAL BIRTH

Patient Name : MRS. HEENA JAIN UHID No : HNH - OOG 11326

Gender: ☐ Male ☑ Female Date : 04/06/2026 Time : ....

I hereby authorized the performance of the following procedure:

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

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

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

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

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

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

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

Name of the Doctor performing the procedure: Dr. SWATHI H.U

Consentee :

Signature : Heena Jain

Name : MRS. Heena Jain.

Date & Time : 4/6/2026 @ 9:45pm.

Patient Attendant :

Signature : [signature]

Name : Vaibhav Jain

Relationship with Patient: Husband.

Date & Time : 4/6/2026 @ 9:45pm.

Witness :

Signature : Anushop

Name : Anushop

Date & Time : 4/6/26 @ 9:45 pm

Doctor (who is taking the consent) :

Signature : [signature]

Name : Dr. Naveena.

Date & Time : 4/6/2026 @ 9:30pm.

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INDUCTION OF LABOR CONSENT

Name: MRS. HEENA JAIN Age: 28YRS Gender: Male ☐ Female ☑

UHID.No : HNH - 00611326 Date: 04/06/2026

You are scheduled for an induction of labor on 04/06/2026 (date) at ~~10pm~~ 39wks. (weeks of gestation).

The reason for your induction is Term Gestation.

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

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

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

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

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

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

Patient

Signature: Heena Jain

Name: MRS. Heena Jain.

Date & Time: 4/06/2026 @. 9:45pm

Patient Attendant:

Signature: [signature]

Name: Vaibhav Jain

Relationship with Patient: Husband.

Date & Time: 4/06/2026 @ 9:45pm

Doctor:

Signature: [signature]

Name: Dr. Naveena

Date & Time: 04/06/2026 @. 9:30pm

Witness

Signature: Anusha D

Name: Anusha D

Date & Time: 4/6/26 @ 9:45pm