

Mrs Pushpa Kumari
 Patient Sucker
 Dr. Suganya
 Dr. Vasud

TLH



CONSUMABLES OF OT

Circulating staff : Sr. Sangeeta Technician : Sr. Pallavi, Dr. Sachandru Date : 16/6/26 Time : 11:10 AM

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube 7.0 cuffed		01	Major Pack		01	Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : A / P / N		03				Suction Catheter		
HME filter : A / P / N		02	Stratix 407		01	Feeding Tube		
Syringes : 10 cc		04				Vacuum Suction Set		
05 cc		04	Gloves SG 65 . 7.0		02+1	Surgical Gloves		
02 cc		04	Encore 6.5.7.0		4+1	Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / P / N		01	Surgical blade 11		01	Surgical Blade # 20		
IV set		01	NG tube			Koochies (S)		
RL		04	Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml		01+2	Koochies		01			
Minispike [v] 100cm		01	Ointments Loz Jelly		01	10cc Syringe		03
Fentanyl		01	Suction Catheter		01	Distill water		01
Morphine		01	Cap, Mask		01			
Ketamine		01	Gauze Pack 7.5		01	Methylene blue 10%		01
Propofol		02	Mop Pack					
Rocuronium		03	Steristrip					
Glycopyrolate		01	Underpad					
Myopyrolate		01	Draw sheet					
Ondansetron		01	Abgel leggings big					
Pencan 25g/ Spinal Needle 22		01	Foleys catheter no-16					
Bupivacaine 0.25%		01	Urobag					
Bupivacaine 0.25%(Heavy)			Chest Drainage Catheter					
Antibiotics			Romodrain bag					
PMO line 200cm		01	Bandage					
Suppositories			Tegaderm					
Anamol : 80mg / 250mg / 170 mg			Ioban Turiset		01			
Supridol : 100mg		01	Double J Stent					
Justin : 12.5 mg / 25mg / 100mg		01	Vacuum Suction set		01			
Tab. Misoprost : 200mg		01	Plastic Bed Sheet Aprons		03			
PCM		01	Betadine Solution		02			
O2 mask [A]		01	Microshield		01			
Nasal airway 28		01	Cotton Balls		01			
Vacuum suction		01	Latex Gloves		02			
		01	Bardione Scrub					
			Sarat Proximate		01			

Surgeon _____ Anaesthesiologist _____ Nurse _____ OT Technician _____
 Order No. : 26-0000207006/7007 Ordered by : Sangeeta
 Doc. No. : RCH / FRM / GENERAL / 125



ELECTRONIC MEDICINE PRESCRIPTION

MRN : HNH-00015513 Name : Mrs THANUGUNDLA PUSHPA KUMARI
 Age / Sex : 53 Y 1 M 17 D / Female Doctor : SWAPNA SAMUDRALA
 Adm/Reg Date/Time : 16/06/2026 07:55 Payor : SELFPAY
 Order Date : 16/06/2026 13:40 Ordernumber : 26-0000207006
 Visit ID : IP26-00006594 Ward/Bed No : 4F -OT / PPO-418
 Patient Address : 306,aravind vihar apartment, aravind vihar colony, domalguda,hyd, Domalguda, Hyderabad, Telangana, INDIA, 500029

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	UNDERPADS 60X90 BUTTERFLY		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
2	IRRIGATOR(T.U.R SET)	IRRIGATOR(T.U.R SET)	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
3	ADULT DIAPERS-XXL		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
4	DSYRINGE 5ML.(NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
5	BACTOPREP SOLUTIONS 100 ML		1 mL	/ Once Daily	1 Days		1 Nos	Dispensed
6	FOLEYS CATHETER 16-URCCATH		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
7	MEBU-R INJ 10 ML - N CARE REMEDIES		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
8	BUPICAINE INJ VIAL 0.25% 20ML		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
9	DISPOSABLE APRONS STERILE XL	DISPOSABLE APRON STERILE XL	1 Nos	/ Once Daily	3 Days		3 Nos	Dispensed
10	MAJOR PACK (PROTECTCARE)		1 Nos	/ 10 AM	1 Days		1 Nos	Dispensed
11	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
12	UROBAG (ADULT)-URODYNE		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
13	ONDOKIND INJ 4 MG 2 ML		1 Nos	/ Once Daily	1 Days		1 Vial	Dispensed
14	MCT-ROF 100MG 10ML		1 Nos	/ Once Daily	1 Days		2 Nos	Dispensed
15	SGLOVE # 8.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
16	BUPICAINE HEAVY 80MG INJ 4ML		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
17	LEGGINGS DISPOSABLE (PROTECTCARE) BIG		1 Nos	/ 10 AM	1 Days		1 Nos	Dispensed
18	COTTON BALLS 2 GM 5 NOS		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
19	E.C.G ELECTRODES (ADULT)	ELECTRODES ADULT	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
20	DSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
21	D WATER 10ML AMPULE	DISTIL WATER:10ML	1 Bottle	External / Once Daily	1 Days		1 Bottle	Dispensed
22	THEMICAINE 30GM JELLY		1 On Application	/ Once Daily	1 Days		1 Nos	Dispensed
23	MINISPIKE-V	MINISPIKE-V	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
24	CAUTERY PENCIL(ADVANCE)		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
25	NS 1000 ML CLOSED EUROFLEX		1 Nos	IV Infusion / Once Daily	1 Days		2 Nos	Dispensed
26	ET TUBE 7.0 CUFFED RUSCH		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
27	SURGICAL BLADE 11	SURGICAL BLADE 11	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
28	NASOPHARYNGEAL TUBES 2#	NASOPHARYNGEAL TUBE 2#	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
29	OxygenMask With Tubing - Adult ROMSONS-FC		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
30	RELIPARA(PARACETAMOL) 1000MG 100ML BOTTLE		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
31	GAUZE 7.5X7.5 12 PLY (5 NOS)	GAUZE 7.5X7.5 12 PLY 5 NOS	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
32	VACCUME SUCTION SET		1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
33	MOPS 30X30 8PLY 5S X-RAY	MOPS 30X30 8PLY 5S X-RAY	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
34	Encore Microptic gloves-6.5		1 Nos	/ Once Daily	1 Days		4 Nos	Dispensed
35	JUSTIN SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
36	STRATAFIX SPIRAL PDO (SXP028407)	STRATAFIX SPIRAL PDO (SXP028407)	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
37	NS 500ML CLOSED BOTTLE		1 Bottle	External / Once Daily	1 Days		1 Bottle	Dispensed

SWAPNA SAMUDRALA

Reg No : 69924

* 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.

Name	Mrs THANUGUNDLA PUSHPA KUMARI	UHID	HNH-00015513
Father/Guardian	Mr A. LOURDU MAR REDDY	Age/Gender	53 Y 1 M 17 D/ Female
Address	306,aravind vihar apartment, aravind vihar colony, domalguda,hyd, Domalguda, Hyderabad, Telangana, INDIA, 500029		
IP No	IP26-00006594	Admission Date	16-06-2026
Ref Doctor	Self.		
Discharge Date	19.06.2026		

DISCHARGE SUMMARY

Consultant:

Dr. SWAPNA SAMUDRALA
MBBS, MS (OBG)
69924

Diagnosis: PERIMENOPAUSAL WOMEN WITH AUB-ADENOMYOSIS WITH CORRECTED ANAEMIA

TOTAL LAPAROSCOPIC HYSTERECTOMY + BILATERAL SALPINGO-OOPHERECTOMY + OMENTAL ADHESIOLYSIS DONE ON 16.06.2026

History: She came with complains of heavy menstrual bleeding on & off since 1 year associated with clots. USG done outside showed- Adenomyosis with ET=12.5mm, conservatively managed elsewhere - advised Hysterectomy in v/o failed medical management. H/o Severe anaemia (Hb-5g/dl) -2025, received IV

Name	Mrs THANUGUNDLA PUSHPA KUMARI	UHID	HNH-00015513
IP No	IP26-00006594	Admission Date	16-06-2026

FCM (4doses). Pap smear done on 22.05.2026 showed NILM. USG (20.05.2026) done showed Uterus RV, Adenomyosis, ET 8.21 MM, B/L Small Ovaries. Hysteroscopy + Endometrial biopsy was done on 29.05.2026 which showed Proliferative phase of endometrium. She was Admitted for Total Laproscopic Hysterectomy + Bilateral Salpingo-oophorectomy.

Menstrual History:-

LMP- 29.05.2026/ LLMP : 05.05.2026

Previous cycles: Regular, heavy flow with clots

Obstetric History: P2L2, 2 LSCS, LCB-2005 years, undergone sterilisation

Medical History: K/c/o Bronchial asthma (since childhood- on & off on medication)- last attack- 2022; K/C/O HTN since 2 months (on T. Telmisartan 40mg OD); K/C/O pre-DM since 2 months- on diet; H/O varicose veins since 2 years. H/O severe anemia, received parenteral iron,

Surgical History: 2 LSCS- 1998, 2005

Allergies: Nil

Family History: Mother-HTN+DM

Investigations: Enclosed.

Blood group: "O" Positive

Surgery Notes: TOTAL LAPAROSCOPIC HYSTERECTOMY + BILATERAL SALPINGO-OOPHERECTOMY + OMENTAL ADHESIOLYSIS .

Indication:

Endometrial hyperplasia + Adenomyosis

Name	Mrs THANUGUNDLA PUSHPA KUMARI	UHID	HNH-00015513
IP No	IP26-00006594	Admission Date	16-06-2026

Operative findings:

1. Dense omental adhesion to previous LSCS scar
2. No umbilical hernia seen.
3. Uterus- bulky.
4. Cervix - normal
5. Bilateral fallopian tubes -normal
6. Bilateral ovaries -normal
7. Bladder densely adherent due to previous LSCS scar on uterus
8. Rest of the viscera -normal.

Procedure:

- Omental adhesiolysis done
- No umbilical hernia seen
- Laproscopic hysterectomy + bilateral salpingo oophorectomy was done
- Vault sutured with no.2 -0 stratafix after removing specimen
- Wash given
- Hemostasis secured
- Wound closed in layers
- Skin closed with clips
- Postoperative period was uneventful.

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

Name	Mrs THANUGUNDLA PUSHPA KUMARI	UHID	HNH-00015513
IP No	IP26-00006594	Admission Date	16-06-2026

Advice:

1. Tab. Ceftum 500mg (Cefuraxime axetel 500 mg) twice daily till 20.06.2026 (9am - 9pm) after food.
2. Tab. Calpol 500mg (Paracetamol 500mg) (2tabs) thrice daily till 18.06.2026 (7am-3pm-10pm) after food.
3. Tab. Voveran 50 mg (Diclofenac 50mg) thrice daily till 18.06.2026 (10am-4pm-10pm) after food.
4. Tab. Pantodac 40 mg (Pantoprazole 40mg) once daily (7am) before food till
5. Tab. Zincovit once daily (2pm) for 1 month after food.
6. Continue Previous medications- Anti-hypertensives.
7. Injection Clexane 60 units once daily at 10 am subcutaneously till 25.06.2026.

Review with **Dr. SWAPNA SAMUDRALA**, after **10days** on **29.06.2026** for **clip removal** 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 Children's Hospital just dial one toll free number - 18002122. You can also take appointments at any time by going online to our

Name	Mrs THANUGUNDLA PUSHPA KUMARI	UHID	HNH-00015513
IP No	IP26-00006594	Admission Date	16-06-2026

website www.rainbowhospitals.in


Registrar/Resident/C.M.O

Consultant:

Dr. SWAPNA SAMUDRALA
MBBS, MS (OBG)
69924



**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 : IP26-00006594 Admit Date : 16-Jun-2026 Admit Time : 07:55 AM UHID : HNH-00015513

Patient Details :

Patient Name : Mrs THANUGUNDLA PUSHPA KUMARI Age : 53 Y 1 M 17 D
Guardian : Mr A. LOURDU MAR REDDY DOB : 30-04-1973
Gender : Female Religion :
Occupation : Martial Status :
Address (H) : 306,aravind vihar apartment, aravind vihar colony, domalguda,hyd Domalguda Hyderabad Telangana INDIA 500029 Phone No : 7569655303
E-mail : na@gmail.com

Admission Details :

Bed Type : TWIN SHARING Bed No : PPO-418 Ward Name : 4F -OT
Room No : PPO-418 Admission Type : First Visit

Contact Details :

Name : Mr A. LOURDU MAR REDDY Relationship : Husband
Contact Address : 306,aravind vihar apartment, aravind vihar colony, domalguda,hyd Domalguda Hyderabad Telangana INDIA 500029 Phone No : 7569655303


Signature


Doctor Details :

Doctor Name : Dr. SWAPNA SAMUDRALA Specialisation : OBSTETRICS AND GYNECOLOGY
Referral Doctor : Self. Phone No :
Co-Consultant :

Payment Details :

Payment Mode : Cash Deposit Amount : 199999.00
Payor Name : SELFPAY


PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00015513 IP26-00006594 Mrs THANUGUNDLA PUSHPA 30-04-1973 53 Y 1 M 17 D (F) Dr. SWAPNA SAMUDRALA 		Date & Time of Admission 16/06/2026 @ 7:55 AM	Date & Time of Transfer Order 17/06/2026 @ 12:55 PM
		Transfer Ordered by Dr Naveena	Reason for Transfer observation
From Unit pre/post	To Unit 302	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 32	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.	PC	500ml
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes No

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

Patient & Clinical Records Received by :

Supriya

Date & Time of Patient Received :

1 PM @ 17/6/26

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

- Unavailable Bed
 Nurse not Available
 Available Bed not ready

HNH-00015513 IP26-00006594
 Mrs THANUGUNDLA PUSHPA
 30-04-1973 53 Y 1 M 17 D (F)
 Dr. SWAPNA SAMUDRALA



T.H.



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
16/6/26	10:30 AM	Pre-post	OP	Anusha / Karan
16/6/26	PM	OT	Pre-post	Anusha
17/6/26	12:55 PM	pre-post	302	Anusha / S

Cross Consultation Visit

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
16/6/26	Dr placement	①	6999	①
16/6/26	PAC	①	212896	①
16/6/26	Catheterisation		6999	Aurka
17/6/26 (11Am)	NHA	①	207130	①
<p><i>Cross checked done by Supriya 10:00 18/6/26</i></p> <p><i>①</i></p>				

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : _____ Time : _____ Prepared By : _____

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



I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 16/6/26 Time of Admission : 8AM
 Allergies: Nil. Not know any drug allergies

PRESENTING COMPLAINTS :

- c/o HMB : 6 months, associated with passage of clots.
 - c/o lower abdominal pain on L side.
 - USG on 26/5/26: ut RU, adenomyosis, ET 8.2mm, 8pc small ovaries.
 - she underwent hysteroscopy + EB on 29/5/26:
 HPE: proliferation phase endometrium
 - CT abdomen on 6/6/26: mild hepatomegaly, umbilical hernia of 6x6mm with herniation of omentum fat.

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : 1996	Parity : P2L2
Previous Periods : Regular.	Mode of Delivery : 2 prev UC.
LMP : 03/5/26	Last Child Birth : 2005
Contraception : Tubectomy	

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
<p>k/c/o Asthma.</p> <p>k/c/o HMB : 3 months</p> <p>Pre diabetes on diet.</p> <p>Varicose veins.</p>	<p>UC - 1998 / 2005</p>



<p>Mother: HDM + DM.</p>	<p>MEDICATION HISTORY:</p> <p>Gas Relief 2/ony / 00 Gas 1KON.</p>
--------------------------	---

INITIAL ASSESSMENT :

<p>Date <u>16/6/26</u> Ht. <u>157 cm</u> Wt. <u>83.2kg</u> BMI <u>35.66</u> B.P. <u>130/80 mmHg</u> Pallor <u>(-)</u> CVR <u>HR 92 (+)</u> Respiratory System <u>RAE (+)</u> Thyroid <u>(-)</u></p>	<p>Breasts</p> <p style="text-align: center;"><i>sup</i></p> <p>Abdominal Examination</p> <p style="text-align: center;"><i>obese abdominal wall</i></p>	<p>Local/Speculum Examination</p> <p style="text-align: center;">+ Not done</p> <p>Bimanual Pelvic Examination</p> <p style="text-align: center;">not done</p>
--	--	---

PROVISIONAL DIAGNOSIS : P26 & 2154 & Perimenopausal AOB

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT
<ul style="list-style-type: none"> - Investigations noted - Recent CBP to be checked <p><i>FTLV xbs Ag / NR. v. 022</i></p>	<p>for TLH + BPO + Unilateral hernia repair</p> <ul style="list-style-type: none"> - NBM - Consent for surgery - Review PAC - Preparation of patient - CBP to be sent - preop medication - Monitor vitals - Reserve 2 units of PRBC

Name of the Doctor : Dr. Navya Thijun
 Date & Time : 16/6/26 @ 8AM.

Signature of Dr. Swapna Samudrala
 Consultant Obstetrician
 Reg. No: 69924

①

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/6/26	POD - 0 (S/P)	TLH + BSO + omental Adhesiolysis
1:10 pm	GC fair Afebrile	Adv
	BP: 109/76 mmHg	- NBM till further orders.
	PR: 82 bpm	- Drugs as charted
	P/A Soft	- IVF
	UE - NAB.	- I/O charting.
	U/O - 200ml clear.	- Monitor vitals.
	SPO ₂ 99% on RA	- w/f bleeding
		- Inform sos.
		<p>Dr. Swapna Samudrala Consultant Obstetrics and Gynecology Reg. No: 69924</p> <p><i>(Signature)</i></p>
16/6/26	cls/B Dr. Veena	
6:30 pm	POD - 0 / TLH + BSO	
	Pt is stable, No c/o	Adv
	GC fair Afebrile	- NBM till further orders
	BP - 106/73 mmHg	- Drugs as charted
	PR - 98 bpm	- IV fluids to continue
	SPO ₂ - 100% on RA	- Vital monitoring
	P/A - Soft, NF	- I/O charting.
	UE - NAB	- w/f bleeding Plu.
	U/O - 60ml/hr, clear urine	- Inform sos.



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>cls/B Dr. Veena</u>	
16/6/26		
10:30 AM	<p>POD-0 TLH + BSO</p>	
	<p>Pt is stable, Nocto</p>	<p>Adv</p>
	<p>ole GC-fair</p>	<p>- NBM till further orders</p>
	<p>vitals - stable</p>	<p>- NPO charting</p>
	<p>PIA - Soft, NT</p>	<p>- Vital monitoring</p>
	<p>BS (+)</p>	<p>- Drugs as charted</p>
	<p>L/C - NAD</p>	<p>- w/ bleeding plv.</p>
	<p>U/O - 60ml/hr, clear</p>	<p>- Inform SOS</p>
	<u>cls/B Dr. Veena</u>	
17/6/26		
2 AM	<p>POD-0 TLH + BSO</p>	
	<p>Pt is stable, Nocto</p>	<p>Adv</p>
	<p>ole GC-fair</p>	<p>- NBM till further orders</p>
	<p>vitals - stable</p>	<p>- NPO charting</p>
	<p>PIA - Soft, NT</p>	<p>- Vital monitoring</p>
	<p>BS (+)</p>	<p>- Drugs as charted</p>
	<p>L/C - NAD</p>	<p>- w/ bleeding plv</p>
	<p>U/O - 60ml/hr, clear</p>	<p>- Inform SOS</p>
	<u>cls/B Dr. Veena</u>	
17/6/26		
7 AM	<p>POD-0 TLH + BSO</p>	
	<p>No complaints.</p>	<p>Adv</p>
	<p>ole GC-fair - Afebrile</p>	<p>- Oral sips -> LIQ diet</p>
	<p>vitals - stable</p>	<p>- NPO charting w/ excessive bleeding plv</p>
	<p>PIA - Soft, NT, BS (+)</p>	<p>- vital monitoring</p>
	<p>L/C - NAD</p>	<p>- Drugs as charted</p>
	<p>U/O - 80ml/hr, clear</p>	<p>- Inform SOS</p>

HNH-00015513

IP26-00006594

Mrs THANUGUNDA PUSHPA

30-04-1973

33 Y 1 M 17 D

(F)

Dr. SWAPNA SAMUDRALA



2

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/06/2026 9:45am	cls by Dr. Naveena OLE GC - fair Alebnile. SpO ₂ - 100% RA	Add. - liquid diet
U-X	Vitals - stable	- Adequate hydration
F-X	PA: at Soft, NT	- Ambulation
S-X	BS (+)	- drugs as charted
	Dressings: dry & clean	- w/f PV bleeding
	LIE: NAD	- Encourage voiding
		- Monitor Vitals
		- Inform SCS
	Dr. Naveena	
17/06/2026 12:30pm	cls by Dr. Swapna OLE GC - fair Alebnile. SpO ₂ - 100% RA	Add. - liquid diet
U-V	Vitals - stable.	- Adequate hydration.
F-X	PA: soft, NT	- Ambulation
S-X	BS (+)	- drugs as charted.
	Dressings: dry & clean	- w/f PV bleeding
	LIE: NAD	- Monitor Vitals
	Kindly shift the patient to room	- Inform SCS. Noted by <u>Alvina</u>



...GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/6/26	<u>C/S/B Dr. Dua</u>	
7:30 PM	POD-1 (TLH+BSD)	
	No complaints	adv.
urine passed	GC fair, Afebrile	Liquid diet
flatus passed	BP: 117/69 mmHg	Drugs as charted
	PR: 76 bpm	Adequate hydration
	H/C NAB	Ambulation
	P/A soft	w/o P/V bleed.
	Non tender.	Monitor vitals
	UE NAB	Infom sos
	<u>Trishna</u>	Noted by Madhuri
18/6/26	<u>C/S/B Dr. Dua</u>	
8 AM	POD-2 (TLH+BSD)	adv
UL ✓ FL ✓ SL ✓	No complaints	Liquid diet. flb soft diet
	GC fair, Afebrile	Drugs as charted
	BP: 105/85 mmHg	Adequate hydration
	PR: 76 bpm	Ambulation.
	P/A soft	w/o P/V bleed
	Non tender	Monitor vitals
	UE NAB	Infom sos



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/6/26 11:10 AM	<u>Pos. 91</u>	
Urine ✓ Flatus ✓ Stools ✓	No camp / Voluntary Spk Diet O/E - Gic Jani Uterus ✓ Vitals - @ P/A - Spk MAS, As 1	Adv - Spk Diet → Regular Diet - Oral hypochlorine - Ambulation - Things as charted - monitor vitals - Oxygen 8cc.
<u>Can be discharged</u>		<p>Dr. Swapna Samudrala Consultant Obstetrics and Gynaecology Reg. No: 69924 (Ch. Swagmas)</p>
		<p>11:20 AM @ 18/6/26</p>

HNH-00015513 IP26-00006594
 Mrs THANUGUNDLA PUSHPA
 30-04-1973 53 Y 1 M 17 D (F)
 Dr. SWAPNA SAMUDRALA



302

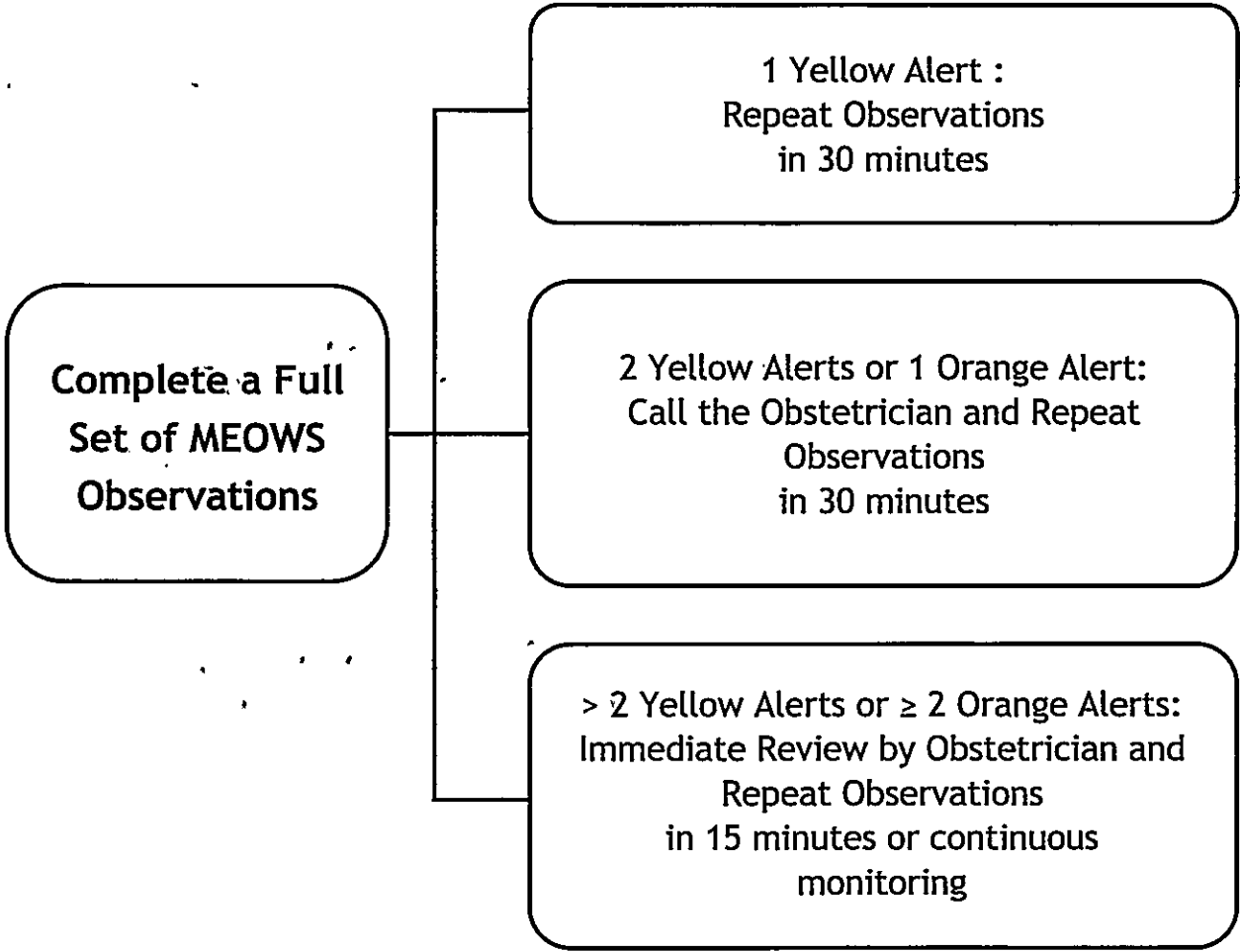
Rainbow
 Children's
 Hospital
 It takes a lot to treat the little.

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

RESULT SHEET

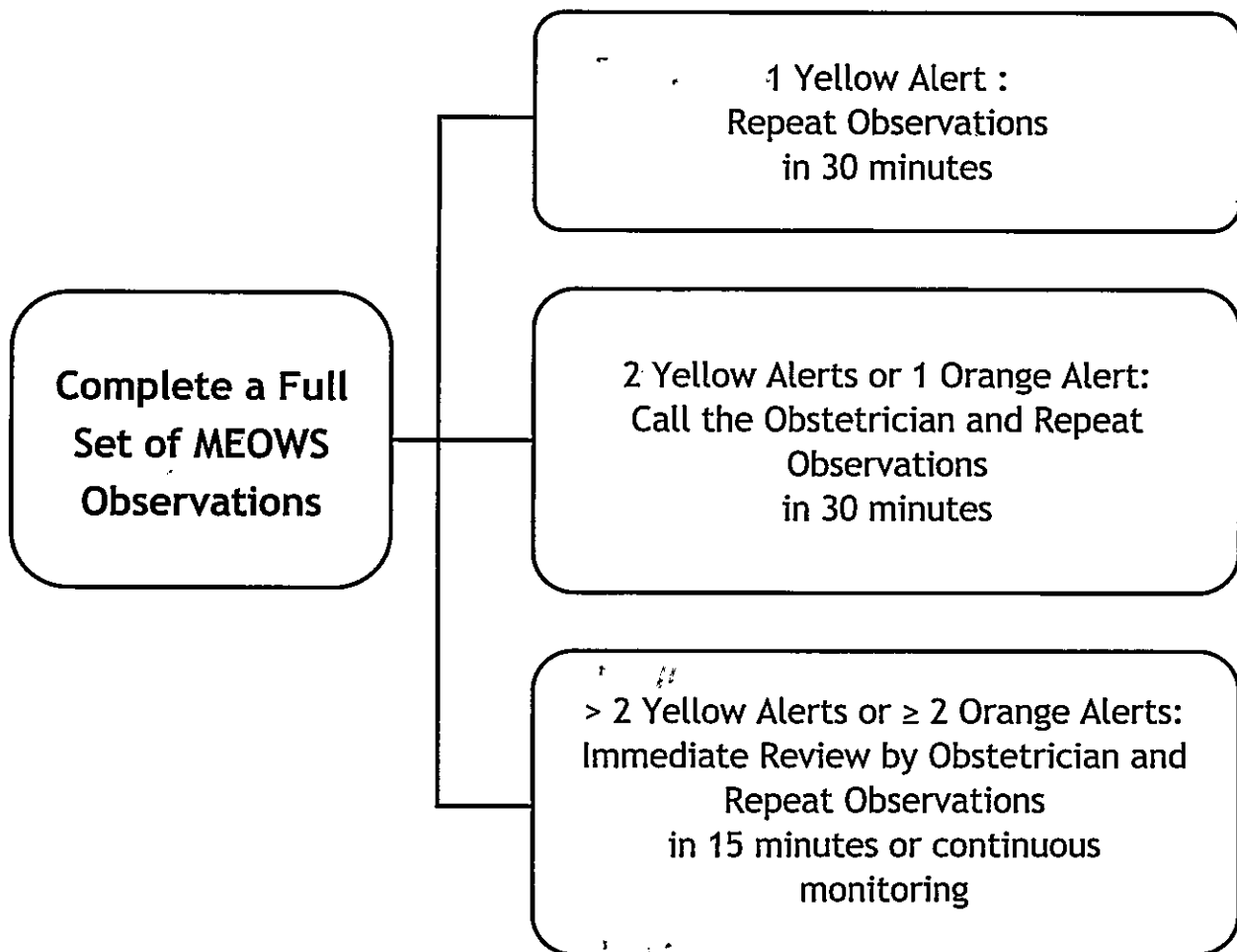
Date	16/6/2026			
Time	10:28 AM			
Hb	9.5			
PCV	29.0			
RBC	4.12			
WBC	6.77			
N/L				
Platelets	355			
CRP				
ESR				
PCT				
RBS				
Na				
K				
Cl				
Ca/Mg				
Phosphate				
Urea				
Creatinine				
ALP				
SGPT				
SGOT				
T.Bill/Conj				
T.Protein				
S.Albumin				
S.Globulin				
A/G Ratio				
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)

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

HNH-00015513 IP26-00006594
 Mrs THANUGUNDLA PUSHPA
 30-04-1973 53 Y 1 M 17 D (F)
 Dr. SWAPNA SAMUDRALA



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																											
		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																												
	0 - 10																												
Saturations	94 - 100 %																												
	< 94 %																												
Administered O ₂ (L/min.)																													
Temp ^o c	40																												
	39																												
	38																												
	37																												
	36																												
	35																												
	< 35																												
Heart Rate	170																												
	160																												
	150																												
	140																												
	130																												
	120																												
	110																												
	100																												
	90																												
	80																												
	70																												
	60																												
	50																												
	40																												
Systolic Blood Pressure ↑	190																												
	180																												
	170																												
	160																												
	150																												
	140																												
	130																												
	120																												
	110																												
	100																												
	90																												
	80																												
	70																												
	60																												
50																													
Diastolic Blood Pressure ↓	130																												
	120																												
	110																												
	100																												
	90																												
	80																												
	70																												
	60																												
	50																												
	40																												
	NEURO RESPONSE [✓]	Alert																											
		Voice																											
		Pain																											
		Unresponsive																											
URINE mls / hour	> 30																												
	< 30																												
Proteinuria	Protein ++																												
	Protein > ++																												
Lochia	Normal																												
	Heavy / Foul																												
Liquor	Clear / Pink																												
	Green																												
TOTAL YELLOW SCORES																													
TOTAL ORANGE SCORES																													
Nurse Initial																													

18/6/26

10

20

100%

97.6

89

22

(96)

85

✓

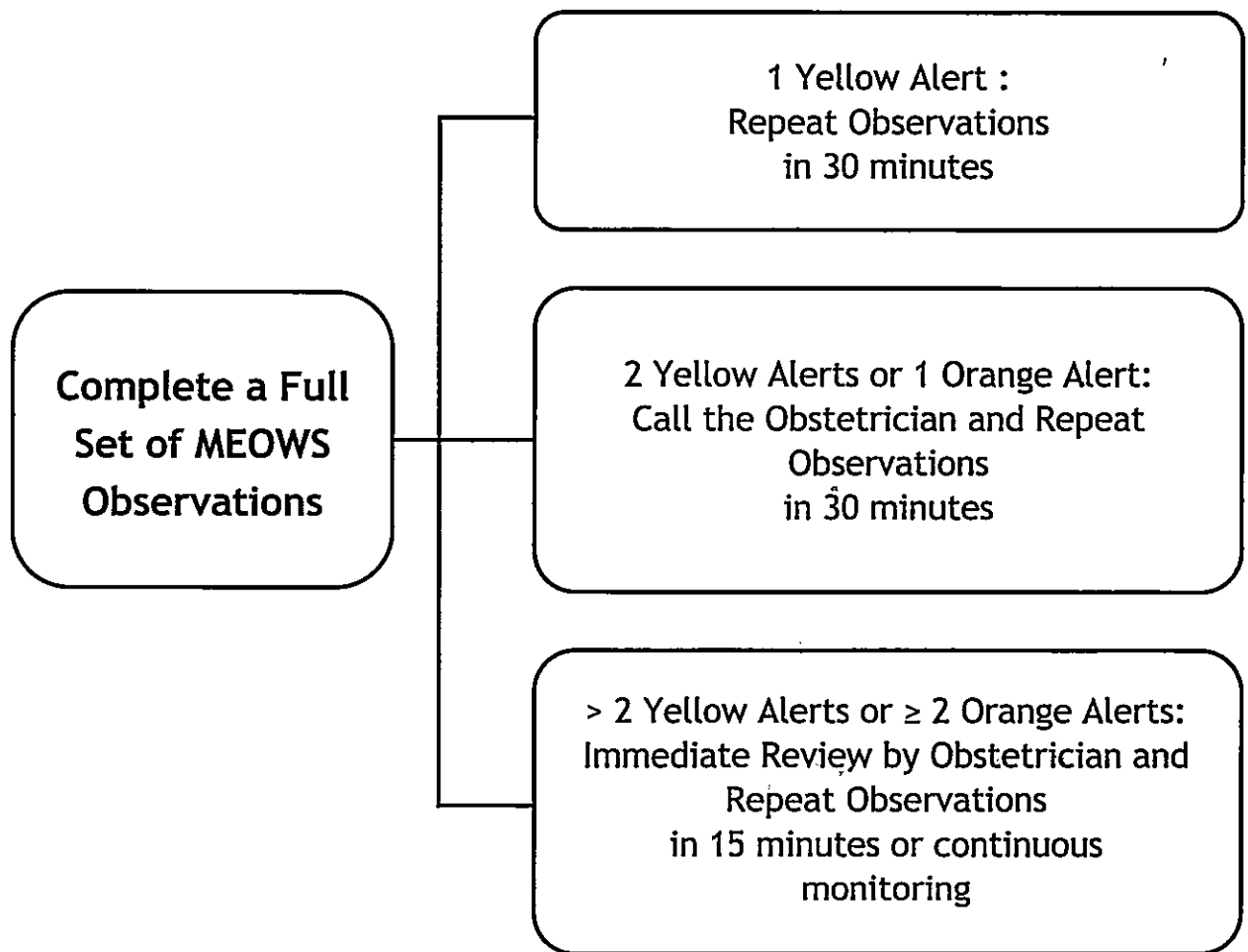
✓

✓

10

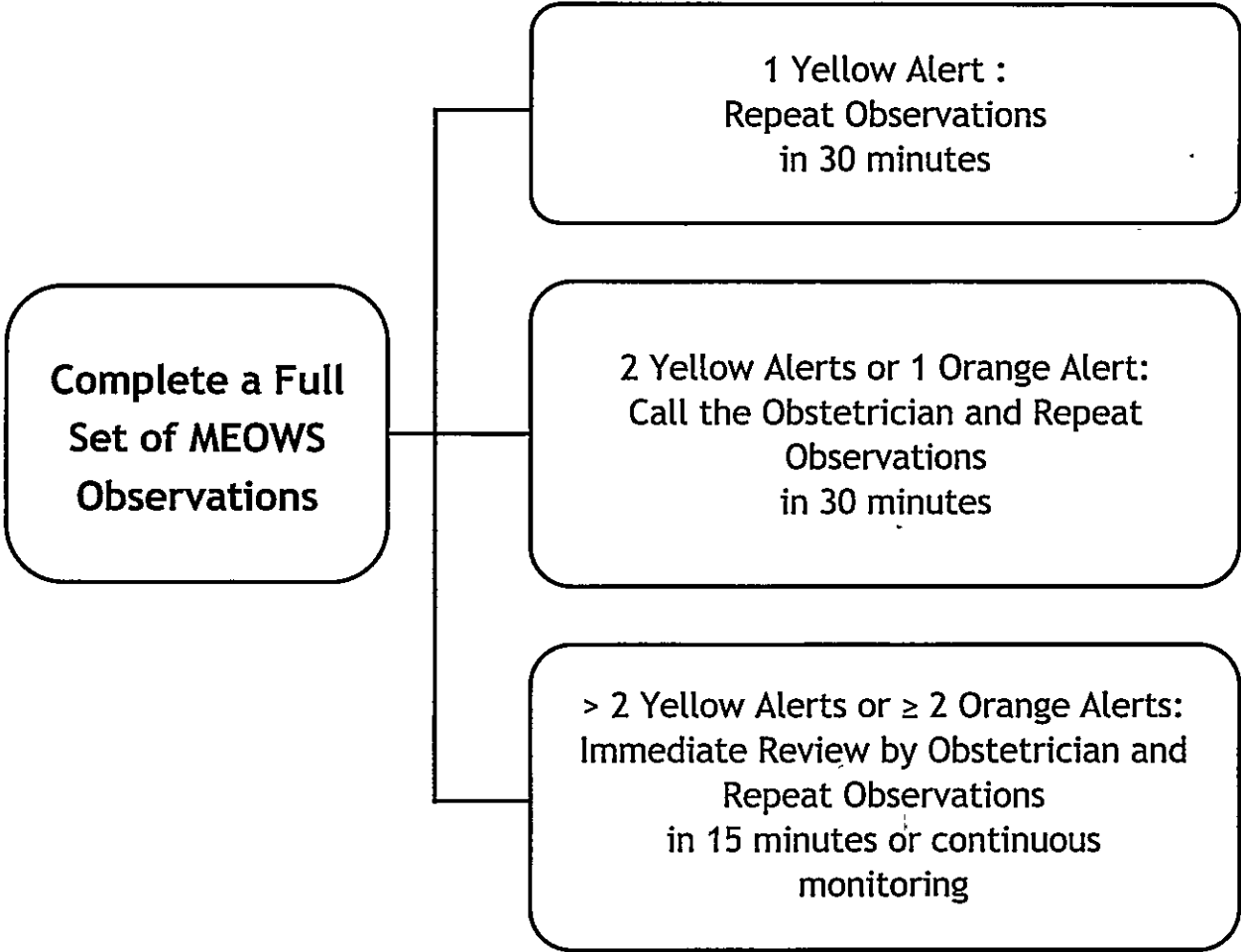
AS

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	Intake				Output					IV Site Thrombophlebitis Score	Sign. Nurse
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
16/6/20	09:00 am	RL		100ml								
	10:00 am	RL	14	100ml								
	11:00 am	RL	3	100ml								
	12:00 pm	RL	3	100ml								
	01:00 pm	RL	3	100ml								
Total Intake : taken 500ml				Total Output : passed 250ml								
	02:00 pm	RL	N	100ml								
16/6/20	03:00 pm	RL	B	100ml								
	04:00 pm	DNS	M	100ml								
	05:00 pm	DNS	N	100ml								
	06:00 pm	DNS	A	100ml						300ml		6/30
	07:00 pm	DNS	M	100ml						100ml		2ml
Total Intake : taken 600ml				Total Output : passed 300ml								
	08:00 pm	DNS	NBM	100ml								
16/6/20	09:00 pm	DNS	NBM	100ml								
	10:00 pm	DNS	NBM	100ml								
	11:00 pm	RL	NBM	100ml								
	12:00 am	RL	NBM	100ml								
	01:00 am	RL		100ml								
Total Intake : taken 600ml				Total Output : passed 200ml								
	02:00 am	RL	N	100ml								
17/6/20	03:00 am	RL	N	100ml								
	04:00 am	DNS	B	100ml								
	05:00 am	DNS	B	100ml								
	06:00 am	DNS	M	100ml								
	07:00 am	DNS		100ml								
Total Intake : taken 600ml				Total Output : passed 450ml								
Total 24 hrs. Intake		2,200ml				Total 24 hrs. Output		1,300ml				

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.

17/6/26		Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage			Urine
			Mouth	I.V	N.G							
17/6/26	08:00 am	RL	100								1	Anshu
	09:00 am	RL	100								1	
	10:00 am	RL	100							✓	0	
	11:00 am	RL	100ml								1	
	12:00 pm	RL	100ml								1	
	01:00 pm			100ml								
Total Intake :					Total Output :							
	02:00 pm	↑	100ml									
	03:00 pm	↓	100ml									
	04:00 pm	DNS	100ml									
	05:00 pm		100ml									
	06:00 pm		100ml									
	07:00 pm		100ml									
Total Intake :					Total Output :							
	08:00 pm	DNS	100ml									
	09:00 pm	RL	100ml									
	10:00 pm	RL	100ml									
	11:00 pm	RL	100ml									
	12:00 am	RL	100ml									
	01:00 am	RL	100ml									
Total Intake :					Total Output :							
	02:00 am	RL	100ml									
	03:00 am	RL	100ml									
	04:00 am	DNS	100ml									
	05:00 am	DNS	100ml									
	06:00 am	DNS	100ml									
	07:00 am	DNS	100ml									
Total Intake :					Total Output :							
Total 24 hrs. Intake												
Total 24 hrs. Output												

HNH-00015513 IP26-00006594
 Mrs THANUGUNDLA PUSHPA
 30-04-1973 53 Y 1 M 17 D (F)
 Dr. SWAPNA SAMUDRALA



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
18/6/26	08:00 am	↑	Idly								0	[Signature]	
	09:00 am										0		
	10:00 am	IVF											0
	11:00 am	Stop											0
	12:00 pm	↓											0
	01:00 pm												0
Total Intake :						Total Output : U-						M-	
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							

Patient Sticker



FLUID CHART

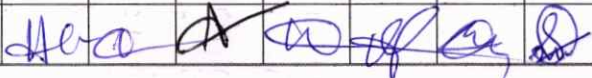
Sheet No. :

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake												Total 24 hrs. Output	



CHECKLIST FOR THROMBOPHLEBITIS

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

Signature of Ward In Charge :

Signature :  Name : Kustavi

Patient Sticker



CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :

Patient Sticker

CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :

Patient Sticker



CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :



Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	16/6	16/6/26	16/6/26	Fall Risk Grading		
		Score	16/6	16/6/26	16/6/26	Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25						
	No	0	0	0	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
Ambulatory Aid	Furniture	30				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0						
IV / Heparin Lock or Saline	Yes	20	20	20	20	Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0						
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0						
Total Morse Fall Scale Score:			20	20	20			
Signature			AN	AN	Anhe			

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

HNH-00015513 IP26-00006594
 Mrs THANUGUNDLA PUSHPA
 30-04-1973 53 Y 1 M 17 D (F)
 Dr. SWAPNA SAMUDRALA



Morse Fall Risk Assessment Form

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

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

HNH-00015513 IP26-00006594
 Mrs THANUGUNDLA PUSHPA
 30-04-1973 53 Y 1 M 17 D (F)
 Dr. SWAPNA SAMUDRALA



BRADEN 'Q' SCALE



Date : 16/6/2016
 Time : 16:00

	16/6	16/6	16/6	16/6
Mobility Does not make even slight changes in body or extremity position without assistance.	4	4	4	4
"Activity The degree of physical activity" 1. Bedfast : Confined to bed	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.	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.	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	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.	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.	4	4	4	4
TOTAL SCORE				
20 28 28 28				
Evaluator's Name				
S S S S				

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

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	<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-00015513 IP26-00008594
 Mrs THANUGUNDLA PUSHPA
 30-04-1973 53 Y 1 M 17 D (F)
 Dr. SWAPNA SAMUDRALA



BRADEN 'Q' SCALE



Date : 17/05/2018
 Time : 11:30 AM

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

TOTAL SCORE

25 28

Evaluator's Name

[Signature]

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

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	<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



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
16/6	9 AM	0/10	Lower	<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	Q
16/6	2 PM	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	Q
16/6	3 PM	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	Q
16/6/26	8 PM	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	Anlo
17/6	12 AM	0	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	L
17/6	4 AM	0	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	L
17/6	7 AM	0	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
17/6	9 AM	0	-	<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	Q
17/6	2 PM	0	-	<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	uf
18/6	8 AM	0	-	<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	Q

Re-assessment Frequency:

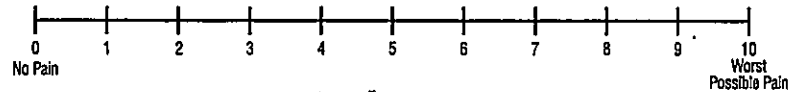
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 - a) At least every 2 hours for the first 24 hours
 - b) Then every 4 hours.
 - c) Prior to pain pain-relieving intervention.
 - d) Within 30 - 60 minutes after pain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

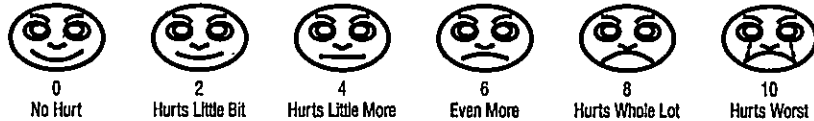
Numerical Pain Scale (Obstetric and Gynecology)



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





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
18/6/26	10AM	0/10	NA	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input checked="" type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	<i>[Signature]</i>
				<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		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Re-assessment Frequency:

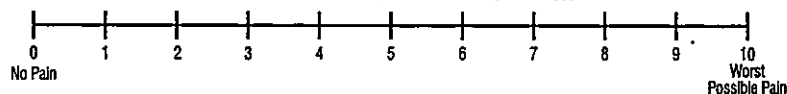
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



HNH-00015513 IP26-00006594
 Mrs THANUGUNDLA PUSHPA
 30-04-1973 53 Y 1 M 17 D (F)
 Dr. SWAPNA SAMUDRALA

NURSING CARE RECORD



Date: 16/6/20

- 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	- vitals stable	[Signature]
	2pm	- plan for vitals - plan for I/O chart	2pm	- Maintain vitals & record - Maintain I/O chart			
Afternoon	2pm	- Assess the pt condition	2pm	- Assessed the pt condition	- pt is stable	- vitals is normal	[Signature]
	8pm	- monitor the vitals & record - Administration of medication - maintain I/O chart - PHS NRM	8pm	- monitored the vitals & recorded - Administered medication as per doctor order - maintained I/O chart & recorded - PHS NRM			
Night	8pm	- plan for vitals	8pm	- vitals Normal	- stable	- Normal conscious coherent	[Signature]
	8am	- plan for I/O chart - plan for medication - plan for I/V fluids	8am	- I/O chart maintained - medication given as per chart - I/V fluids given as per chart			

HNH-00015513 IP26-00006594
 Mrs THANUGUNDLA PUSHPA
 30-04-1973 53 Y 1 M 17 D (F)
 Dr. SWAPNA SAMUDRALA



NURSING CARE RECORD



Date: 17/6/2026

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 pt condition → Check the vitals → I/O chart maintain → plan for medication	8am	→ Assessed pt condition → Checked vitals & heard → Maintained I/O chart → given Medication as per doctor's orders.	pt is stable	Vitals normal	Push A
	2pm		2pm				
Afternoon	2pm	→ Assess the pt condition → I/O chart maintain	2pm	→ Assess the pt condition → maintain I/O chart	pt is stable	Vitals is normal	Judee
	7:00	→ plan for medication on.	7:00	→ given medication as per doctor's orders			
Night	8pm	→ Assess the pt condition. → plan liquid diet today. → plan soft diet after rounds decided. → Maintain I/O chart.	8pm	→ Assessed the pt condition. → planed liquid today. → planned soft diet after rounds. decided. → maintained I/O chart.	pt is stable now	Reassessed the vitals	A
	8Am		8Am				

HNH-00015513 IP26-00006594
 Mrs THANUGUNDLA PUSHPA
 30-04-1973 53 Y 1 M 17 D (F)
 Dr. SWAPNA SAMUDRALA



NURSING CARE RECORD



Date: 18/6/26

- 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 10 2PM	<ul style="list-style-type: none"> → To assess the pt. condition → To check the vitals & record → To administer the medication as per drug chart → I/O chart maintain 	8AM 10 2PM	<ul style="list-style-type: none"> → To assessed the pt. condition → To checked the vitals & recorded → To administered the medication as per drug chart → I/O chart maintained 	<ul style="list-style-type: none"> → Patient is stable 	<ul style="list-style-type: none"> → Re-checked the vitals → I/O 	<p style="text-align: center;">Supriya</p>
Afternoon							
Night							

Patient Sticker

NURSING CARE RECORD

Date:

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

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



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: LDR Date of Admission: 16/6/26

SITUATION	Diagnosis:		Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known						
	<u>TCH</u>		If Yes Specify:						
BACKGROUND	Area	Shift Time	<u>16/6</u> <u>8 AM</u>	<u>16/6/26</u> <u>12</u>	<u>16/6/26</u> <u>N</u>	<u>17/6/26</u> <u>M6</u>	<u>17/6/26</u> <u>12</u>	<u>17/6/26</u> <u>N1</u>	
	Medical Condition (Any special condition to be noted):		-	-	<u>NA</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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	<u>98.1°</u>	<u>98.1°</u>	<u>98.1°</u>	<u>98.1°</u>	<u>98.3°</u>	<u>98.1°</u>	
		Res:	<u>20</u>	<u>20bmt</u>	<u>20</u>	<u>20</u>	<u>20</u>	<u>20bmt</u>	
		SpO ₂ :	<u>99%</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>	
		Pulse:	<u>76</u>	<u>76bmt</u>	<u>80</u>	<u>79</u>	<u>80</u>	<u>80</u>	
		BP:	<u>107/70</u>	<u>115/72</u>	<u>106/62</u>	<u>114/68</u>	<u>115/69</u>	<u>110/62</u>	
Fall Risk Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	-	-	-			
Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	-	-	-			
Recommendations	Safety Needs:	<u>yes</u>	<u>yes</u>	<u>yes</u>	-	-	<u>yes</u>		
	Physiotherapy	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>	-	-	-		
	Special Diet:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Other Special Orders / Medications:	-	-	-	-	-	-			
Post Operative Procedure Special Orders:	-	-	-	-	-	-			
Handed Over By Name :	<u>Anusha</u>	<u>Anusha</u>	<u>Anusha</u>	<u>Anusha</u>	<u>Maddie</u>	<u>Mahi</u>			
Signature :	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>			
Date:	<u>16/6/26</u>	<u>16/6/26</u>	<u>16/6/26</u>	<u>17/6/26</u>	<u>17/6</u>	<u>18/6/26</u>			
Time:	<u>2pm</u>	<u>8pm</u>	<u>8pm</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>			
Taken Over By Name :	<u>Anusha</u>	<u>Anusha</u>	<u>Anusha</u>	<u>Maddie</u>	<u>Mahi</u>	<u>Sushila</u>			
Signature :	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>			
Date:	<u>16/6/26</u>	<u>16/6/26</u>	<u>17/6/26</u>	<u>17/6</u>	<u>17/6/26</u>	<u>18/6/26</u>			
Time:	<u>2pm</u>	<u>8pm</u>	<u>8am</u>	<u>3pm</u>	<u>9pm</u>	<u>8AM</u>			

HNH-00015513 IP26-00006594
 Mrs THANUGUNDLA PUSHPA
 30-04-1973 53 Y 1 M 17 D (F)
 Dr. SWAPNA SAMUDRALA



IRISING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis: <i>TLH</i>	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:					
	BACKGROUND	Area: Shift Time: <i>18/6/26</i> <i>MG</i>					
ASSESSMENT	Medical Condition (Any special condition to be noted): <i>-</i>						
	Allergy:	<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 type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input 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 type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Vital Signs:	Temp: <i>97.6°F</i>					
		Res: <i>20b/m</i>					
		SpO ₂ : <i>99%</i>					
		Pulse: <i>86b/m</i>					
Recommendations	BP: <i>112/71</i>						
	Fall Risk Score: <i>-</i>						
	Pain Score: <i>"0"</i>						
	Safety Needs: <i>Yes</i>						
	Physiotherapy: <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 type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Others Specify: <i>-</i>							
Special Diet: <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 type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other Special Orders / Medications: <i>-</i>							
Post Operative Procedure Special Orders: <i>-</i>							
Handed Over By Name :	<i>Supriya</i>						
Signature :	<i>[Signature]</i>						
Date:	<i>18/6/26</i>						
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							



URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 16/6/2026 Date of Removal:

Parameters	Date	Shift Time	16/6/2026 Mb	16/6 E2	16/6 N				
Need for the Catheter			<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 type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hand Hygiene			<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 type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Usage of Sterile Equipment			<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 type="checkbox"/> Yes <input type="checkbox"/> No	<input 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 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
Check the Tube for Obstruction (Free of Kinking)			<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 type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is Catheter dated as policy			<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 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
Collecting bag is been emptied regularly?			<input type="checkbox"/> Yes <input checked="" 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 type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Maintenance of closed system for the catheter			<input type="checkbox"/> Yes <input checked="" 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 checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input 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 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
Is the line removed as Policy?			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" 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
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 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
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 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 type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asses for the leakage at the site of insertion			<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 type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of the Nurse			<u>Anjali</u>	<u>Mudaly</u>	<u>Anusha</u>				
Signature of the Nurse									

HNH-00015513 IP26-00006594
 Mrs THANUGUNDLA PUSHPA
 30-04-1973 53 Y 1 M 17 D (F)
 Dr. SWAPNA SAMUDRALA



DRUG CHART

Date of Admission: 16/6/21 Drug Allergies: NIL Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name Signature

HNH-00015513 IP26-00006594

Mrs THANUGUNDLA PUSHPA
30-04-1973 53 Y 1 M 17 D (F)
Dr. SWAPNA SAMUDRALA



Dr. Dhakshayani

Verified by

Dr. Dhakshayani

VERIFIED BY : Name

Sheet No:

REGULAR PRESCRIPTIONS

Weight 83.3kg Ward

DRUG : Inj ZONDANSETRON				Date Time	16/6	17/6	18/6													
Dose	Route	Frequency	Start Dt.																	
8mg	IV	BD	16/6	AM	X	AM	X													
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign				G ✓																
DRUG : Inj ENOXAPARIN				Date Time	17/6	18/6														
Dose	Route	Frequency	Start Dt.																	
60	S/C	OD	17/6	10AM	10AM															
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:				for 10 days																
Daily Doctor's Endorsement by a Sign				G ✓																
DRUG : DICLOFENAC SODIUM suppositories				Date Time	16/6	17/6	18/6													
Dose	Route	Frequency	Start Dt.																	
100mg	P/R	BD	16/6	AM	X	AM	X													
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign				G ✓																
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																				

(P.T.O.)

HNH-00015513 IP26-00006594
 Mrs THANUGUNDLA PUSHPA
 30-04-1973 53 Y 1 M 17 D (F)
 Dr. SWAPNA SAMUDRALA



Weight: 83.3kg Ward:

Date Time	Nurse Sig.	Dose	Nurse Sig.	Dose	Nurse Sig.	Dose	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.	

Date Time	Nurse Sig.	Dose	Nurse Sig.	Dose	Nurse Sig.	Dose	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
16/6/26	10:15AM	INJ PANTOPRAZOLE	40mg	IV	Panus	Archi
16/6/26	10:19AM	INJ PERINORM	10mg	IV	Panus	Archi
16/6/26	12:00pm	INJ-PARACETAMOL	1gm	W	@hij	Archi
16/6/26	12:30pm	INJ-ONDANSETRON	4mg	W	@hij	Archi
16/6/26	12:45pm	SUP-TRAMADOL	100mg	PR	@hij	Archi

VERIFIED BY: Name Signature

Dr. Dhakshayani
Verified by



I.V. FLUIDS CHART


Weight. 83.3kg 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
16/6/26	9 AM	RINGER LACTATE	IV	100 ml/hr	Ramesh	[Signature]	16/6	[Signature]	[Signature]
16/6/26	10:50 Am	RINGER LACTATE	IV	500ml hr	[Signature]	[Signature]	16/6	[Signature]	[Signature]
16/6/26	11:30 AM	RINGER LACTATE	IV	100ml hr	[Signature]	[Signature]	16/6	[Signature]	[Signature]
16/6/26	4:30 PM	DEXTROSE NORMAL SALINE	IV	100ml hr	[Signature]	[Signature]	16/6	[Signature]	[Signature]
16/6/26	10 PM	RINGER LACTATE	IV	100ml/hr	[Signature]	[Signature]	16/6	[Signature]	[Signature]
17/6/26	9 AM	DEXTROSE NORMAL SALINE	IV	100ml/hr	[Signature]	[Signature]	16/6	[Signature]	[Signature]
17/6/26	8 AM	RC RINGER LACTATE	IV	100ml/hr	[Signature]	[Signature]		[Signature]	[Signature]
17/6/26	2 PM	DNS	IV	100ml/hr		[Signature]		[Signature]	[Signature]
17/6/26	8:30 PM	RINGER LACTATE	IV	100ml/hr		[Signature]		[Signature]	[Signature]
18/6/26	4 AM	DEXTROSE NORMAL SALINE	IV	100ml/hr		[Signature]			

Signature
VERIFIED BY: Name

Stop Dame [Signature]

PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00015513 IP26-00006594 Mrs THANUGUNDLA PUSHPA 30-04-1973 53 Y 1 M 17 D (F) Dr. SWAPNA SAMUDRALA 		Date & Time of Admission 16/6/26 @ 07:55 AM	Date & Time of Transfer Order 16/6/26 @ 10:30 AM
Transfer Ordered by Dr. Naveena		Reason for Transfer TUE RSO	
From Unit Pre-post	To Unit OT	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 28	Number of Imaging Films 12	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.			
2.	Wool -		
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Sis Anshu		Name of Person Ordered Transfer Dr Naveena	
Patient & Clinical Records Received by : Kammy			
Date & Time of Patient Received : 16/6/26			

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

- Unavailable Bed Nurse not Available Available Bed not ready



HNH-00015513 IP26-00006594
 Mrs THANUGUNDLA PUSHPA
 30-04-1973 53 Y 1 M 17 D (F)
 Dr. SWAPNA SAMUDRALA

TER NOTES

Patient's Name : Age : Gender :
 UHID : I.P.NO. : Weight :

Surgeon : DR. SWAPNA DR VASISHT Asst. Surgeon :

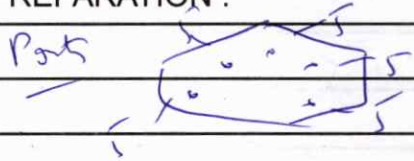
Anesthetist : DR. AKSHITA OT Nurse : Ss Padma/Santika

Surgical Procedure : Lyp. Hysterectomy + BSO + omentum adhesiolysis

Indications for Surgery : Endometrial Hyperplasia + Adenomyosis + Omentum adhesion

Date : 16/6/26. Start Time : 10:30am End Time : 1pm

PRE-OPERATIVE PREPARATION :



Findings (1) Dense omental adhesion to previous L5s

OPERATION NOTES: scan

- Ⓐ No umbilical Hernia seen
- Ⓑ uterus - Bulky
- Ⓒ L4 - Ⓐ
- Ⓓ BIL F-7 - Ⓐ
- Ⓔ BIL ovaries - Ⓐ
- Ⓕ Bladder densely adherent due to previous L5s
- Ⓖ Rest of viscera - Ⓐ

Procedure - Omentum adhesiolysis done
 - No umbilical Hernia seen

- Lyp. Hysterectomy + BSO was done

- vault sutured & no 2-0 staples
after removing sp

- wash given

- Haemostasis secured

- wound closed in layers - skin & clips

- Postop fluid was uneventful.

R

→ ① NBM

② 10 fluids @ 100 ml/hr - 1 G DNS

1 G RL

POST - OPERATIVE ORDERS :

1 G DNS

1 G RL

① Inj MAGNES FORTE 1.5 gm IV BD

② Inj PANTOP 40 mg IV OD

③ Inj NEOMOL 1 gm IV TID

④ Inj Zofen 8 mg IV BD

⑤ JUNAZ Suppository BD

⑥ Inj CLORANE 60 units SL q
10.30 AM on 17/6/2025

⑦ vitals & wound

⑧ inform SOB

Varshil

Varshil

Consultant Surgeon's Name

Consultant Surgeon's Signature

Date : 16/6/2026 Time :



MEDICATION RECONCILIATION FORM

Drug Allergies: NA Not known any Drug Allergies

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

Shifting From: NA Shifted to: NA

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Tab IRON	1 Tab	PO	OD		<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
2	Tab ALBUNA	4ony	PO	OD		<input type="checkbox"/> C <input checked="" 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: Dr. Swapna Thosani

Date & Time: 16/6/26 @ 8am

Nurse Name & Signature: Ausha

Date & Time: 16/6/26 @ 8am

HNH-00015513 IP26-00006594
 Mrs THANUGUNDLA PUSHPA
 30-04-1973 53 Y 1 M 17 D (F)
 Dr. SWAPNA SAMUDRALA



OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 16/6/23

Baseline Information:

Admission From: ER OPD Admission Desk Others, specify

Primary Language: Telugu English Hindi Others, specify

Do you require an interpreter? Yes No if Yes specify

Source of Information: Patient Family Others, specify

Allergies: Yes No Medications Blood Transfusion Food Other:

If yes, identify

Chief Complaints: THH Doctor Notified on Admission: Yes No
 Name of the Doctor: Dr. Kemya
 Time Notified:

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

Past Medical History	Past Surgical History	Previous Hospital Admission

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

Obstetric History: G P L A

Previous LSCS:

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

Family History: No Abnormalities Detected

Heart Disease Hypertension Diabetes Stroke Seizures Kidney disease
 Liver disease Other

Vital Signs / Measurements: Temp: 97.6 HR: 87 RR: 29
 BP: 125/73 Weight: Height: BMI:

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

PHYSICAL ASSESSMENT

General Appearance: Healthy ill looking Anxious Agitated Others:

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

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

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

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING: No Abnormality Detected

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

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

- Calm & Cooperative Restless Depressed Agitated Confused
- Others

Inform consultant for positive criteria

SOCIAL SCREENING:

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

Social History: Lives With *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: *Mrs*

Orientation not given Reason:

Nurse Signature: *[Signature]*

Nurse Name: *Anita*

Date & Time: *15/6/2024*

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Swapna
 Asst. Surgeon :
 Anaesthetist : Dr. Arkhila
 Scrub Nurse : Sr. Padmaja B. Srikanth
 Date : 16/6/25 In-time : 10:30 am Out-time : 1 pm

HNH-00015513 IP26-00006594
 Mrs. THANUGUNDLA PUSHPA
 30-04-1973 53 Y 1 M 17 D (F)
 Dr. SWAPNA SAMUDRALA



Before Induction of Anaesthesia >>

SIGN IN	Time: <u>10:30 AM</u>
Patient Has Confirmed	
Identity	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Site	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Procedure	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Consent	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Site Marked	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA
Anaesthesia Safety Check Completed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Pulse Oximeter on Patient & Functioning	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Does Patient have a:	
Known Allergy?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Difficult Airway / Aspiration Risk?	
Yes, & Equipment / Assistance Available	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Risk of > 500ml Blood Loss (7ml/kg In Children)?	
Yes, and Adequate Intravenous Access and Fluids Planned	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
Blood Units Reserved	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
Has Antibiotic Prophylaxis been given within the last 60 minutes?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Signature : <u>[Signature]</u>	
Name : <u>DR. ARKHILA K.</u>	

Before Skin Incision >>

TIME OUT	Time: <u>10:55 AM</u>
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 type="checkbox"/> No
Correct Procedure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anticipated Critical Events	
Surgeon Reviews:	
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss?	<u>Bleeding</u> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Anaesthesia Team Reviews:	
Are There Any Patient-specific Concerns?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
Nursing Team Reviews:	
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Is Essential Imaging Displayed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Signature : <u>[Signature]</u>	
Name : <u>Karuna @ 10:55 AM</u>	

Before Patient Leaves Operating Room

SIGN OUT	Time: <u>1 pm</u>
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 : <u>[Signature]</u>	
Name : <u>Dr. Swapna</u>	

PATIENT TRANSFER FORM

HNH-00015513 IP26-00006594

Mrs THANUGUNDLA PUSHPA
30-04-1973 53 Y 1 M 17 D (F)
Dr. SWAPNA SAMUDRALA



Date & Time of Admission 16/6/26 @ 7:55 Am		Date & Time of Transfer Order 16/6/26 @ 9pm
Treating Consultant Name Dr. Swapna Dr. Vasishth	Transfer Ordered by Dr. Akhila	Reason for Transfer Observation
From Unit 01	To Unit Pre Post	Information to Attendant Yes <input 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.	RL	1
2.		
3.		
4.		
5.		
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
Name & Signature of Person who is Transferring Keerthi		Name of Person Ordered Transfer Dr. Akhila
Patient & Clinical Records Received by : Anusha		
Date & Time of Patient Received : 16/6/26 @ 1 PM		

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

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

Patient Name : T. Pushpa Kumari Age : 53 y Gender : Male Female

UHID NO: LNH-00015513 Surgeon Name: Dr. Swapna I

Anaesthesiologist : Dr. Samir

Operative procedure planned : TLH+BSO+ Umbilical hernia repair

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 : laryngospasm, perioperative adverse cardiac events,

Comments : bleeding

- 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 T. Pushpa Kumari the above mentioned operation / Diagnostic / Therapeutic procedures Total Lap-Hysterectomy+BSO+umbilical hernia Repair

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.

HNH-00015513 IP26-00006594
Mrs THANUGUNDLA PUSHPA
30-04-1973 53 Y 1 M 17 D (F)
Dr. SWAPNA SAMUDRALA



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

SURGERY DETAILS

Date : 16/6/26
Patient Name: Mrs. Pushpa Date of Birth: 30-04-1973 Age: 53yrs
Gender: female Ward: OT-8 UHID No.: HNH-00015513
Date of Surgery: 16/6/26 OT-1 OT-2 OT-3 OT-4 OBG OT-1 OBG OT-2
Name of the Surgery: Lg. Hysterotomy + BSO + omentum adhesiolysis

Time in : 10:30 Am Time Out : 1pm

	NAME	AMOUNT
1. Surgeon	Dr. Swapna Dr. Vasist	
2. Anaesthetist	Dr. Akhila	
3. Assistant Surgeon		
4. OT Technician	Br. Sai, Pallavi. Sr	
5. Circulating Nurse	Sr. Lakshmi. Sr. Sangeetha	
Assistant Nurse	Sr. Padmya Br. Srikanth	



Vessel Suturey : 26-0000207008

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

Surgeon

Signature of Circulating Nurse

Order by: Sangeetha

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

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

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

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

- Pregnant : Yes No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

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

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

Patient Patient Attendant :

Signature :

Name : T. Prushpa Kumari

Relationship with Patient: Self

Date & Time : 16/06/2020 & 8:30 AM

Witness :

Signature :

Name : K. Prathyusha Reddy

Date & Time : 16/06/2020 & 8:30 AM

Doctor (who is taking the consent) :

Signature :

Name : DR. AKHILA - K.

Date & Time : 16/06/2020 8:30 AM

Handwritten initials

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



Name: Mrs. THIRUGUNDA PUSHPA KUMARI Age: 53y Sex: Female UHID.No: HN1100015513

Date: 12/6/26 Time: 1:03pm Proposed Operation: TLH + BSO + Umbilical Hernia Repa

Diagnosis: Perimenopausal -AUB

B.P / CRT: 137/84 H.R: 102/min Weight: 83.3kg ASA Physical Status: 1 2 3 4 5

(23/5/26) 9.3mg/dl

Hgb: 9.3mg/dl
PCV: 30.1
WBC: 8000
Plate: 3.84 lakh
PT: 14.2
PTT: 30.4
INR: 0.9

Glucose: 147mg/dl
Urea: 0.6mg/dl
Creat: 0.6mg/dl
Na: 139
K: 3.6
Ca++:
Mg++:
Cl: 101

Protein: 8.2
Alb: 4.3
Total Bill: 0.6
Dir. Bill: 0.1
LDH:
ALK phos: 98
Amylase:
SGOT/SGPT: 23/24

HIV: NR
HBS Ag: NR
HCV:
Blood group: O Positive
T3:
T4: 1.24ng/dl
TSH: 3.613uIU/ml

X-Ray: 1st Bv markings
ECG: NSR
2D Echo: EF 64% (N) study
Stress/Angio:
Other:

Allergies: NIL

Medical History: CVS: Denovo HTN (T. TELMA 40mg) Hysteroscopy + EB (Prophylactic ph)

RESP: H/o Asthma - Attack, last 4yr ago Diabetes: (Breath Holding: 20 sec) Cardiac: Moderate Dist

CNS: NAD

Renal:

Hepatic / GE: H/o Chronic - Anemia Physical Activity: METS > 4

Others: H/o Iron sucrose injections (2025) / altered LIPID PROFILE (14/1/26)

Past Anaesthetic History: Hysteroscopy + EB ↓, SMO (29/5/26) u/e (P26/22SCS/2CB: 200 Regular cycles)

Physical Exam:

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

Lungs: BAE(+), Clear

Heart: S1, S2 (+)

CNS: NAD

Peripheral (+)
Venous Access Site:

Midline

Pregnant: Yes No NA

Spine Exam for regional:

Anaesthetic Plan: MAC REGIONAL GA-ETT LMA

Peri-Operative Plan Explained to the Patient: Yes No

CURRENT MEDICATIONS	DOSAGE
T. Iron	OD
T. TELMESARTAN (: : 1 mnth)	40mg OD

Pre-Operative Instructions:

- DVT Prophylaxis:
- NIL ORAL $\left\{ \begin{array}{l} \text{Water / ORS 2 Hours} \\ \text{Others 6 Hours} \end{array} \right\}$ Explained
- Informed Consent: Standard High Risk
- Post Operative Pain Management: Discussed with Patient
- Other Instructions:

- Consent due
- Incentive spirometry everyday
- To hold anti-HTN on the day of sx
- 20 PRBC Reserve

Signature: [Signature] Name: Dr. Ayesha

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

HNH-00015513
 Mrs THANUGUNDLA PUSHPA
 30-04-1973 53 Y 1 M 17 D (F)
 Dr. SWAPNA SAMUDRALA

ANAESTHESIA CHART



Pre Induction Assessment: 10:30 AM

Change in Patient Condition: Yes No Fasting Status: Adequate

Physical Status: Patient Identified Consent Present Chart Reviewed

H.R.: 79/min B.P./CRT: 113/68 SpO₂: 100% R.R.: 14 Last Feed: >6 hrs

Pre-OP Diagnosis: Acromioclavicular AUB Operation: TLH+BCO+umbilical Date: 16/6/26

Surgeon: Dr. Vasisth Anaesthesiologist: Dr. Chitpa/Dr. Akherma/Dr. Sagar/Dr. Sachin/Dr. Praveen Technician: Saichandu/Praveen

TIME	10:30	11:00	11:30	12:00	12:30	1:00
N ₂ O(AIR) LPM	0.6					
HALO/ISO (SEVO) MAC						
Drugs:						
Inj. MIDAZOLAM	2mg					
Inj. PENTANYL	100mg					
Inj. PROPOFOL	40mg					
Inj. ROCURONIUM	40mg					
Inj. MORPHINE		6mg				
Inj. PARACETAMOL			1gm			
FiO ₂ (SaO ₂)	100	99	98	100	98	99
ETCO ₂	36	37	36	37	36	37
ECG	SR	SR	SR	SR	SR	SR
Temperature	36	36	36	36	36	36
Urine Output						
Fluids Blood	RL (1)					
B.P.						
V Systolic						
A Diastolic						
X Mean						
• Heart Rate						
Tourniquet on Time						
Tourniquet off Time						
Throat Pack In						
Throat Pack Out						

Antibiotic
 Suppository
 SUP-TRAMA
 BOL
 100mg
 Blood Loss
 ~30ml
 NOTES

LAB Values

ABG

GRBS

Others

Equipment Checked and Functional
 BP
 Cuff Site: RUL
 Art Site:
 EKG Lead
 Temp Site: skin
 FIO₂ Monitor
 Agent Monitor
 Pulse Oximeter
 Capnograph
 Ventilator
 Nerve Stimulator

Position: Lithotomy
 Pressure Points Checked

Eye Care:
 Quint
 Tape
 Padding
 Awake

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

Times:
 Anaes Start: 10:30AM
 OP Start: 10:30AM
 OP End: 1:00pm
 Leave OR: 1:00pm

Anaesthesia:
 GA
 Monitored Anaesthesia Care
 Regional

Line (Size & Location)
 CVP:
 ART:
 IV: RUL 18g
 IV: RUL 18g
 IV:

Induction
 IV Inhal
 Pre O₂ RSI
 Others

Mask SGA
 Airway Oral Nasal
 ETT# 7.0 at 18 cm
 Oral Nasal Cuff
 Tracheostomy Topical
 Drug: ROCURONIUM

Awake Direct Vision
 Video Laryngoscopy Stylette / Bougie
 Fiberoptic
 Blade# Mall Attempts: 1
 Difficulty Why?

Bilat = BS
 Semi-Closed Circle
 Closed Circle
 Other

Regional:
 Extremity Specify:
 Spinal Epidural Caudal
 Others:
 Position:
 Site:
 Needle Size: Depth:
 Parasthesia Yes No
 Catheter at skin: cm
 Drug Name & Conc:
 Bolus:
 Infusion:
 Block Level:
 Comments:
 Transportation to
 PACU ICU Other
 Relaxant Reversed Yes No NA
 Name of the Doctor: Dr. Anurag K
 Signature of the Doctor: Anurag K



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: Anuysa Time Received: 1pm Time Discharged:

250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 SPO ₂	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	IV Cannula Site: <u>left hand</u> <input type="checkbox"/> O ₂ Mask <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Oral Airway <input type="checkbox"/> Nasal Prongs <input type="checkbox"/> T-Piece <input type="checkbox"/> Nasal Airway
		Vomiting: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No NG Tube: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Drain: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Urinary Catheter: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Chest Tube: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Nil Oral: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No IV Fluids: <u>re NBM</u> Oral Feeds:

POST ANAESTHESIA SCORE (Modified Aldrete Score)	IN	MINUTES			OUT	SCORING INTERPRETATION
		30	60	90		
Able to move 4 extremities voluntary or on command = 2 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 0 ACTIVITY		1	2	2	2	A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0 RESPIRATION		2	2	2	2	
BP ± 20 of Pre Anaesthetic level = 2 BP ± 20-50 of Pre Anaesthetic level = 1 BP ± 50 of Pre Anaesthetic level = 0 CIRCULATION		2	2	2	2	
Fully awake = 2 Arousable on calling = 1 Not responding = 0 CONSCIOUSNESS		2	2	2	2	
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0 COLOR		2	2	2	2	
TOTAL		09	10	10	10	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
16/6	1pm	0	normal	[Signature]
16/6	2pm	0	normal	[Signature]
16/6	3pm	0	NA	[Signature]

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 :

Anaesthesiologist Signature:

Date & Time:

PACU Nurse Name :

PACU Nurse Signature:

Date & Time:

Transferred to Unit by (PACU):

Date & Time:

Dr. Swagha



ESTIMATION SLIP

Date : 5/6/26 UHID / IP No. : _____ SI No. 1571
 Name of Patient : Mrs. Pushpa Kumar Age: 53y Gender: F
 Father's / Husband's Name : _____ Corporate / Occupation : _____
 Address : _____ Phone : 8870116380 Email : _____
 Procedure / Plan : TLH+BSO+Umbilical Hernia EDD/Dos: _____
 MODE OF PAYMENT : SELF TPA : _____ GIPSA : _____ OTHER _____

TARIFF INFORMATION :

Particulars	Package Amounts (Rs.)	
	Normal Delivery	LSCS
Room Category		
Multi Shared Ward		
Red Ward <input checked="" type="checkbox"/>	<u>TLH+BSO+Umbilical Hernia Repair</u> <u>2.50k (2 Days)</u>	
Twin Shared Ward <input checked="" type="checkbox"/>	<u>Including Pharmacy & Investigations</u>	
Private Room		
Super Deluxe Room		
Suite Room		
Package includes (Package starts from the time of admission)	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee and Labour Ward Charges	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee Anesthetist's Fees and OT Charges
	Length of Stay for :	Length of Stay for :
	Pharmacy up to	Pharmacy up to
	Investigations up to	Investigations up to
Others	<u>80%</u>	

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

Initial Minimum Deposit : 80% Advance

MARKS :

- 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)

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

Signature of the Client: _____ Signatory Relationship: Son Signature of the financial Counselor: _____

1971

1971

1971

1971

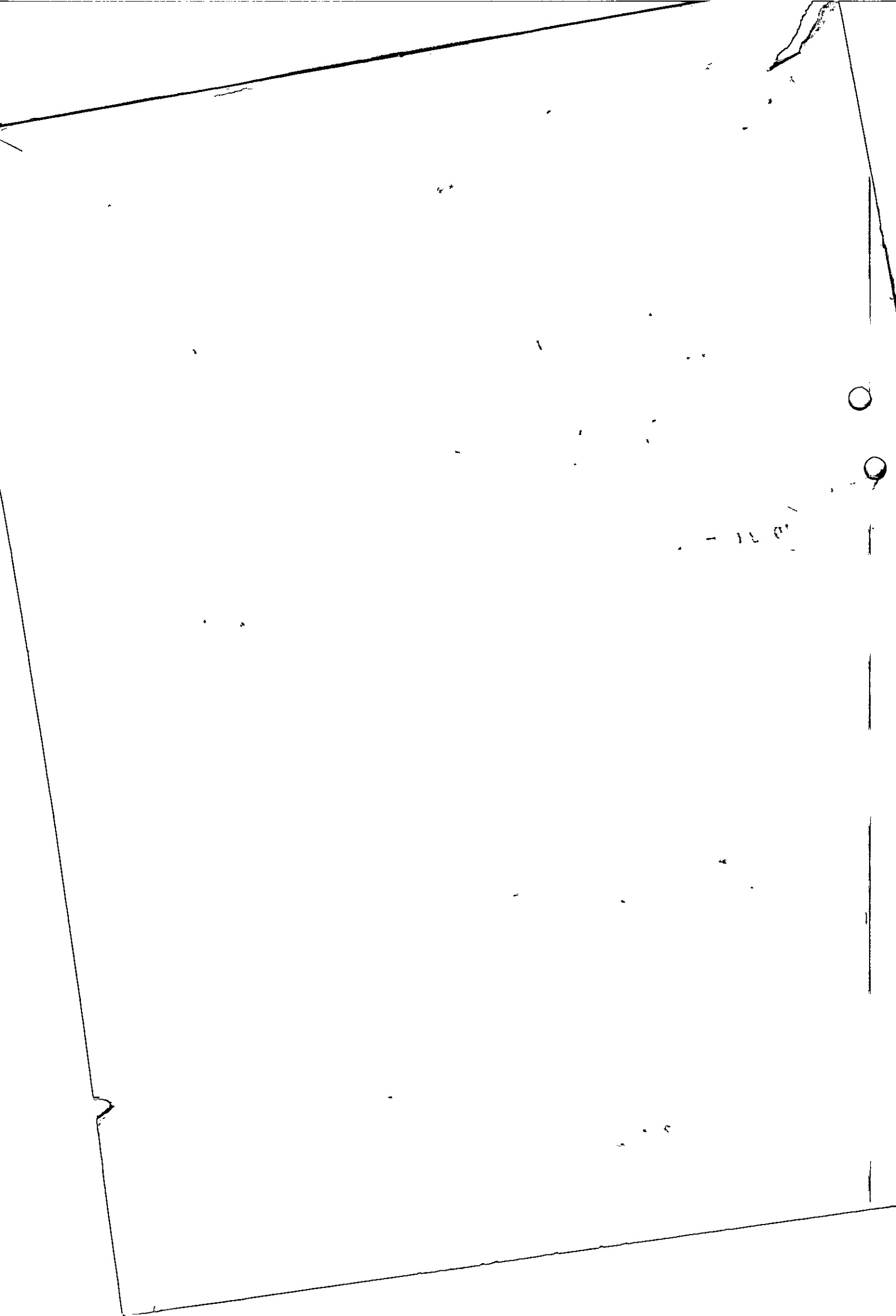
1971

1971

1971

1971

1971



INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE



Patient Name : Mrs. PUSHPA KUMARI Gender: Male Female Age : 53 yrs.
 UHID No : ANH-00015573 Date : 16/6/26 ANH-00015573

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 SALPINGO-OOPHORECTOMY
 upon PUSHPA KUMARI
 (Name of the Patient)

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

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

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

- hemorrhage, need for blood/blood product transfusion
- inadvertent injury to bowel/bladder/urter, conversion to laparotomy
- infection

My signature on this form indicates that

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

Name of the Doctor who is performing the Surgery / Procedure: Dr. SWAPNA SAMVARALA

Consentee :
 Signature : [Signature]
 Name : T. Pushpa Kumari
 Date & Time : 16/6/26

Patient Attendant :
 Signature : [Signature]
 Name : K. Prathvisha Reddy
 Relationship with Patient: Daughter in law
 Date & Time : 16/06/2026 @ 8:30AM

Witness :
 Signature :
 Name :
 Date & Time :

Doctor (who is taking the consent) :
 Signature : [Signature]
 Name : SWAPNA THORAN
 Date & Time : 16/6/26 @ 8AM

GENERAL CONSENT FOR TREATMENT

Patient Name: Mrs THANUGUNDLA PUSHPA KUMARI **Age :** 53 Y 1 M 17 D
IP No: IP26-00006594 **Sex:** Female
Consultant: Dr. SWAPNA SAMUDRALA **Ward/Bed No:** 4F -OT/PPO-418

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

Patient, be deemed advisable or necessary.

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

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

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

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

Note:

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

(Receivers Signature:.....*[Signature]*)

3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.

4 Financial and billing counseling has been done to me.

Signature of Patient/Relative:

Name: *A. Ritwile Reddy*

Relationship: *Son*

Date: *16/06/26*

Time: *8:00 AM*

Witness Name:

Witness Signature: *[Signature]*

Patient Address:

306,aravind vihar apartment, aravind vihar colony, domalguda,hyd Domalguda Hyderabad Telangana INDIA 500029

HNH-00015513 IP26-00006594
Mrs THANUGUNDLA PUSHPA
30-04-1973 53 Y 1 M 17 D (F)
Dr. SWAPNA SAMUDRALA



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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

25
years
of being the quality right
BirthRight. Making Right

BILLING POLICY

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

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

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

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

MODE OF PAYMENT & REFUNDS

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

A. Dilwale Reddy
Name & signature of Patient/Attendant

(Signature of Admission Desk executive)

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

RAINBOW CHILDREN'S MEDICARE PRIVATE LIMITED

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

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

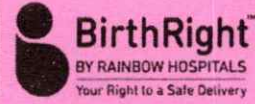
Branches : BANJARA HILLS - T: 2233 4455 | VIKRAMPURI - T: 4246 2200 | KONDAPUR - T: 4246 2400 | MADHAPUR
- T: 6464 2020 | KUKATPALLY - T: 4246 2300 | L B NAGAR - T: 7111 1333 | MARATHAHALLI, BENGALURU - T: +91 80
7111 2345 | BANNERGHATTA ROAD, BENGALURU - T: +91 80 2551 2345, HIMAYATNAGAR- T:- 40 48873000

CIN: U85110 TG1998 PTC029914

email : info@rainbowhospitals.in

www.rainbowhospitals.in

26-0000206950



NARCOTIC PRESCRIPTION FORM (PATIENT COPY)

Patient Name: Mrs. Thanugundla pushpa kumari Age: 53y Gender: Female
 UHID No: 11NA-00015573 IP No: IP26-00006594 Date: 16/6/26 Time: _____
 Diagnosis: TLH word - OT

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/ML	<u>100 mcg</u>	<u>1 Amp</u>
2.	Morphine Sulphate Inj. 15mg/ML	/	/
3.	Remifentanyl Hydrochloride Inj. 2MG	/	/
4.	Remifentanyl Hydrochloride inj. 1MG	/	/

Doctor Name: Dr. SAMIR Doctor Registration No: 67929
 Signature: [Signature]

NARCOTIC DISPENSING FORM APPENDIX 4 – FORM NO. 3E

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

IP Registration No: IP26-00006594 Date: 16/6/26
 Aadhaar No. of the Patient (Optional): _____

Name	Remarks
<u>Mrs. Thanugundla pushpa kumari</u>	
2. Complete postal address (with contact number, if any)	<u>306, arvind vihar apartment colony, domalguda, hyd telangana 500029</u>
3. Brief description of the illness	<u>TLH</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>Fentanyl</u>

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
<u>16/6/26</u>	<u>Fentanyl</u>	<u>1 amp</u>	<u>[Signature]</u>	

Dispensed by (Name & ID No.): Same (018142) Signature: Same
 Received by (Name & ID No.): Saraswathi (021006) Signature: [Signature]
 Time: _____

26-0000206930

NARCOTIC PRESCRIPTION FORM (MEDICAL RECORD)

Patient Name:	Ms. Manugundla Pushpa Kumari	Age:	53y	Gender:	Female
UHID No:	1114-0001-513	IP No:	00006594	Date:	16/1/20
Diagnosis:	7111				
PRESCRIPTION DETAILS (Tick only one of the following)					
S.No	Drug Name	Dosage	Remarks		
1.	Fentanyl Citrate Inj. 50mcg/MI	50 mcg	1 amp		
2.	Morphine Sulphate Inj. 15mg/MI				
3.	Remifentanil Hydrochloride Inj. 2MG				
4.	Remifentanil Hydrochloride inj. 1MG				
Doctor Name:		Dr. Samir			
Signature:		[Signature]			
		Doctor Registration No:		67929	

NARCOTIC DISPENSING FORM

APPENDIX 4 – FORM NO. 3E

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

IP Registration No: 1126-00006594 Date: 16/1/20

Aadhaar No. of the Patient (Optional):

1.	Name :	Ms. Manugundla Pushpa Kumari	Remarks	
2.	Complete postal address (with contact number, if any)		306,	
3.	Brief description of the illness		7111	
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)			
5.	Details of essential Narcotic drug dispensed			
Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
16/1/20	Fentanyl	1 amp	[Signature]	

Dispensed by (Name & ID No.): Same (010111) Signature: Same

Received by (Name & ID No.): Same (021006) Signature: [Signature]

Time:

26-0000206951



NARCOTIC PRESCRIPTION FORM (PATIENT COPY)

Patient Name: Mrs. Thanugundla pushpa kumari		Age: 534	Gender: Female
UHID No: HNH-0005513		IP No: 7P26-00006594	Date: 16/6/26
Diagnosis: T11		word-07	
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	15mg	1 Amp
3.	Remifentanyl Hydrochloride Inj. 2MG	1	1
4.	Remifentanyl Hydrochloride inj. 1MG		
Doctor Name: Dr. Samir		Doctor Registration No: 67729	
Signature: <i>[Handwritten Signature]</i>			

NARCOTIC DISPENSING FORM APPENDIX 4 – FORM NO. 3E

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

IP Registration No: 7P26 - 00006594 Date: 16/6/26

Aadhaar No. of the Patient (Optional):

1.	Name : Mrs. Thanugundla pushpa kumari	Remarks		
2.	Complete postal address (with contact number, if any)	306, Arvind Vihar apartment colony damalaguda hyd. 500029		
3.	Brief description of the illness	T11		
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	No		
5.	Details of essential Narcotic drug dispensed	Morphine		
Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
16/6/26	Morphine	1 amp	<i>[Handwritten Signature]</i>	

Dispensed by (Name & ID No.): Same (015001) Signature: Same

Received by (Name & ID No.): Saraswati (021006) Signature: *[Handwritten Signature]*

Time:

26-0000206951

NARCOTIC PRESCRIPTION FORM (MEDICAL RECORD)

Patient Name:	Mrs. Thanugundla Pushpa Kumari	Age:	53y	Gender:	F
UHID No:	11NH-0005513	IP No:	00006594	Date:	16/6/26
Diagnosis:					
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	1mg	1mg		
3.	Remifentanyl Hydrochloride Inj. 2MG				
4.	Remifentanyl Hydrochloride inj. 1MG	1	1		
Doctor Name:		Doctor Registration No: 67979			
Signature:					

NARCOTIC DISPENSING FORM

APPENDIX 4 – FORM NO. 3E

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

IP Registration No: 7126-00006594 Date: 16/6/26

Aadhaar No. of the Patient (Optional):

1.	Name :	Mrs. Thanugundla Pushpa Kumari	Remarks	
2.	Complete postal address (with contact number, if any)	306, Aravind Vihar apartment 1st floor, Kankarbagic, Lucknow-226029		
3.	Brief description of the illness			
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	No		
5.	Details of essential Narcotic drug dispensed			
Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
16/6/26	Morphine	1mg	[Signature]	

Dispensed by (Name & ID No.): [Signature] (015447) Signature: [Signature]

Received by (Name & ID No.): [Signature] (021006) Signature: [Signature]

Time:

HNH-00015513 IP26-00006594

Mrs THANUGUNDLA PUSHPA
30-04-1973 53 Y 1 M 17 D (F)
Dr. SWAPNA SAMUDRALA



NUTRITIONAL ASSESSMENT FOR GYNEC PATIENTS

Date: 17/6/26 Time: 11Am

Origin: Indian Height: 151cms Weight: 83.3kg BMI: 35.66 kg/m²

Food Allergies: NO

Diagnosis: POD - 0 / TLH + BSD

Medical History: K/O Asthma & HTN & pre diabetic on diet

Surgical History: NO

Vegetarian Non-Vegetarian Vegan

Diet Advised: clear liquid diet

Patient's / Attendant's

Signature: [Signature]

Name: puspa kamari

Date & Time: 17/6/26; 11Am

Dietician's

Signature: [Signature]

Name: sathwik . G

Date & Time: 17/6/26; 11Am

Dr. Swayam



ESTIMATION SLIP

Date : 5/6/26 UHID / IP No. : _____ SI No. 1571
 Name of Patient : Mrs. Poojita Kumar Age: 53yrs Gender: F
 Father's / Husband's Name : _____ Corporate / Occupation : _____
 Address : _____ Phone : 8870116380 Email : _____
 Procedure / Plan : TLM+BSo+Umbilical Hernia EDD/Dos: _____
 MODE OF PAYMENT : SELF TPA : _____ GIPSA : _____ OTHER

TARIFF INFORMATION :

Particulars	Package Amounts (Rs.)	
	Normal Delivery	LSCS
Multi Shared Ward	<u>TLM+BSo+Umbilical Hernia Repair</u>	
Red Ward <u>→</u>	<u>2.50k</u>	<u>(2 Days)</u>
Twin Shared Ward <u>→</u>	<u>Including Pharmacy & Investigation</u>	
Private Room		
Super Deluxe Room		
Suite Room		
Package includes (Package starts from the time of admission)	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee and Labour Ward Charges	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee Anesthetist's Fees and OT Charges
	Length of Stay for :	Length of Stay for :
	Pharmacy up to	Pharmacy up to
	Investigations up to	Investigations up to
Others	<u>80%</u>	

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

Initial Minimum Deposit : 80% Advance

MARKS :

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

DECLARATION

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

Signature of the Client: [Signature] Signatory Relationship: Son Signature of the financial Counselor: [Signature]

Very fine

1911

1911

1911

1911

1911

1911

1911

HNH-00015513 IP26-00006594
 Mrs THANUGUNDLA PUSHPA
 30-04-1973 53 Y 1 M 17 D (F)
 Dr. SWAPNA SAMUDRALA



SURGERY DETAILS

Date : 16/6/26
 Patient Name: Mrs. Pushpa Date of Birth: 30-04-1973 Age: 53yrs
 Gender: female Ward: OT-8 UHID No.: HNH-00015513
926-00006594
 Date of Surgery: 16/6/26 OT-1 OT-2 OT-3 OT-4 OBG OT-1 OBG OT-2
 Name of the Surgery: Lap. Hysterectomy + BSO + omentum adhesiolysis

Time in : 10:30 Am Time Out : 1pm

	NAME	AMOUNT
1. Surgeon	<u>Dr. Swapna Dr. Vasist</u>	
2. Anaesthetist	<u>Dr. Akhila</u>	
3. Assistant Surgeon		
4. OT Technician	<u>Br. Sai, Pallavi. Sr</u>	
5. Circulating Nurse	<u>Sr. Lakshma. Sr. Sangeetha</u>	
6. Assistant Nurse	<u>Sr. Padmya Br. Srikanth</u>	



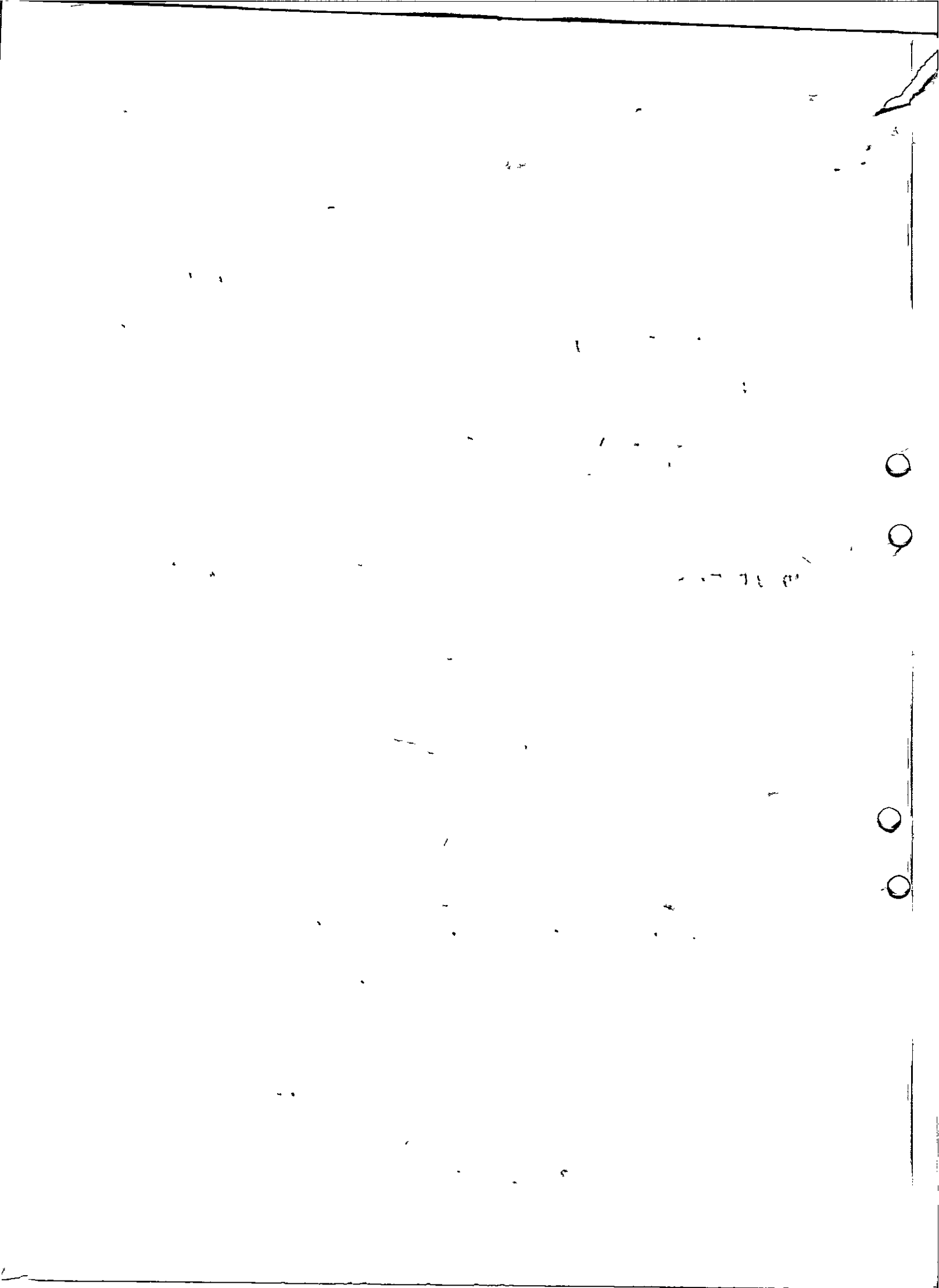
Vessel Serialy: 26-0000207082

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

Vasist
 Signature of the Surgeon

Lakshma
 Signature of Circulating Nurse

Order No: 26-000020709/20709 Order by: Sangeetha



Mrs. Pushpa Kumari
Patient Sacker
Dr. Suganya
Dr. Vasud

T L H



CONSUMABLES OF OT

Circulating staff: Sr. Sangeeta Technician: Sr. Pallavi, B. Sachardu Date: 16/6/26 Time: 11:10 AM

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube 7.0 cuffed		01	Major Pack		01	Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : A / P / N		03				Suction Catheter		
HME filter : A / P / N		02	Stratix 407		01	Feeding Tube		
Syringes : 10 cc		04				Vacuum Suction Set		
05 cc		04	Gloves S.G.65.7.0		02+1	Surgical Gloves		
02 cc		04	ENCORE 6.5.7.0		4+2	Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / P / N		01	Surgical blade 11		01	Surgical Blade # 20		
IV set		01	NG tube			Koochies (S)		
RL		01	Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml		01+2	Koochies		01			
Minispike [v] 100cm		01	Ointments Lox Jelly		01	10cc Syringe		03
Fentanyl		01	Suction Catheter			Distill water		01
Morphine		01	Cap, Mask					
Ketamine			Gauze Pack 75			Methylene blue Inj 10%		01
Propofol		02	Mop Pack					
Rocuronium		03	Steristrip					
Glycopyrolate		01	Underpad					
Myopyrolate		01	Draw sheet			NS 500ml		01
Ondansetron		01	Abgel leggings big					
Pencan 25g/ Spinal Needle 22		01	Foleys catheter no-16					
Bupivacaine 0.25%		01	Urobag					
Bupivacaine 0.25%(Heavy)			Chest Drainage Catheter					
Antibiotics			Romodrain bag					
PMO line 200cm		01	Bandage					
Suppositories			Tegaderm					
Anamol : 80mg / 250mg / 170 mg			Ioban Turiset		01			
Supridol : 100mg		01	Double J Stent					
Justin : 12.5 mg / 25mg / 100mg		01	Vacuum Suction set		01			
Tab. Misoprost : 200mg		01	Plastic Bed Sheet Aprons		03			
PCM		01	Betadine Solution		02			
O ₂ mask [A]		01	Microshield		01			
Nasal airway 28		01	Cotton Balls		01			
Vacuum Suction		01	Latex Gloves		02			
		01	Bamdione Scrub					
			Sarat Proximate		01			

Surgeon: _____ Anaesthesiologist: _____ Nurse: _____ OT Technician: _____

Order No.: 26-0000207006/7007

Ordered by: Sangeeta



ELECTRONIC MEDICINE PRESCRIPTION

MRN : HNH-00015513 Name : Mrs THANUGUNDLA PUSHPA KUMARI
Age / Sex : 53 Y 1 M 17 D / Female Doctor : SWAPNA SAMUDRALA
Adm/Reg Date/Time : 16/06/2026 07:55 Payor : SELFPAY
Order Date : 16/06/2026 13:40 Ordernumber : 26-0000207006
Visit ID : IP26-00006594 Ward/Bed No : 4F -OT / PPO-418
Patient Address : 306.aravind vihar apartment, aravind vihar colony, domalguda,hyd, Domalguda, Hyderabad, Telangana, INDIA, 500029

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	UNDERPADS 60X90 BUTTERFLY		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
2	IRRIGATO(T.U.R SET)	IRRIGATO(T.U.R SET)	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
3	ADULT DIAPERS-XXL		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
4	DSYRINGE 5ML (NPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
5	SACTOPREP SOLUTIONS 100 ML		1 mL	/ Once Daily	1 Days		1 Nos	Dispensed
6	FOLEYS CATHETER 16-UROCATH		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
7	MEBLU-N INJ 10 ML - N CARE REMEDIES		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
8	BUPICAINE INJ VIAL 0.25% 20ML		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
9	DISPOSABLE APRONS STERILE	DISPOSABLE APRON STERILE XL	1 Nos	/ Once Daily	3 Days		3 Nos	Dispensed
10	MAJOR PACK (PROTECTCARE)		1 Nos	/ 10 AM	1 Days		1 Nos	Dispensed
11	DSYRINGE 10ML (NPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
12	UROBAG (ADULT) -URODYME		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
13	ONDOKIND INJ 4 MG 2 ML		1 Nos	/ Once Daily	1 Days		1 Vial	Dispensed
14	MCT-ROF 100MG 10ML		1 Nos	/ Once Daily	1 Days		2 Nos	Dispensed
15	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
16	BUPICAIN HEAVY 80MG INJ 4ML		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
17	LEGGINGS DISPOSABLE (PROTECTCARE) BIG		1 Nos	/ 10 AM	1 Days		1 Nos	Dispensed
18	COTTON BALLS 2 GM 5 NOS		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
19	E.C.G ELECTRODES (ADULT)	ELECTRODES ADULT	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
20	DSYRINGS 2.5ML(NPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
21	D WATER 10 ML AMPULE	DMSTR, WATER10ML	1 Bottle	External / Once Daily	1 Days		1 Bottle	Dispensed
22	THEMICAINE 30GM JELLY		1 On Application	/ Once Daily	1 Days		1 Nos	Dispensed
23	MINISPIKE-V	MINISPIKE-V	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
24	CAUTERY PENCIL(ADVANCE)		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
25	NS 1000 ML CLOSED EUROFLEX		1 Nos	IV Infusion / Once Daily	1 Days		2 Nos	Dispensed
26	ET TUBE 7.0 CUFFED RUSCH		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
27	SURGICAL BLADE 11	SURGICAL BLADE 11	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
28	NASOPHARYNGEAL TUBES 2	NASOPHARYNGEAL TUBE28	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
29	OxygenMask With Tubing - Adult ROMSONS-FC		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
30	RELIPARA(PARACETAMOL) 1000MG 100ML BOTTLE		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
31	GAUZE 7.5X7.5 12 PLY (5 NOS)	GAUZE 7.5X7.5 12 PLY 5 NOS	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
32	VACCUME SUCTION SET		1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
33	MOPS 30X30 8PLY SS X-RAY	MOPS 30X306 PLYDATT	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
34	Encore Microptic gloves-6.5		1 Nos	/ Once Daily	1 Days		4 Nos	Dispensed
35	JUSTIN SUPPOSTORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
36	STRATAFIX SPIRAL POO (SKPD28407)	STRATAFIXSPIRALPOO (SKPD28407)	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
37	NS 500ML CLOSED BOTTLE		1 Bottle	External / Once Daily	1 Days		1 Bottle	Dispensed

SWAPNA SAMUDRALA

Reg No : 69924

* 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-00015513 Name : Mrs THANUGUNDLA PUSHPA KUMARI
 Age / Sex : 53 Y 1 M 17 D / Female Doctor : SWAPNA SAMUDRALA
 Adm/Reg Date/Time : 16/06/2026 07:55 Payor : SELFPAY
 Order Date : 16/06/2026 13:40 Ordernumber : 26-0000207007
 Visit ID : IP26-00006594 Ward/Bed No : 4F -OT / PPO-418
 Patient Address : 306,aravind vihar apartment, aravind vihar colony, domalguda,hyd, Domalguda, Hyderabad, Telangana, INDIA, 500029

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	BCV-INTRAFIX SAFESET		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
2	ROCUNIUM INJ 50 MG 5 ML		1 Nos	/ Once Daily	3 Days		3 Vial	Dispensed
3	H.M.E FILTER (ADULT) -1641-POLYMED		1 Nos	External / 10 AM	1 Days		2 Nos	Dispensed
4	SURGEON CAP(FEMALE) (PROTECTCARE)		1 Nos	External / Once Daily	1 Days		10 Nos	Dispensed
5	HIGH PRESSUR EXTENTION 200 CM PRYMAX		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
6	PROXIMATE PLUS MD 3500 STAPLER(PMW35)	PROXIMATE PLUS MD 3500 STAPLERPMW35	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
7	RL 500 ML CLOSED SYSTEM	RINGER LACTATE 500ML CLOSED	1 Bottle	/ Once Daily	4 Days		4 Bottle	Dispensed
8	THEMIPYRRNOM 0.2MG INJ		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
9	SGLOVE # 7.0(SURGICARE)	SURGICAL GLOVES 7.0	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
10	FACE MASK 3 LAYER - ELASTIC	FACE MASK 3 LAYER	1 Nos	External / Once Daily	1 Days		10 Nos	Dispensed
11	MYOPYROLATE-INJ-5ML		1 Nos	/ Once Daily	1 Days		1 Ampule	Dispensed
12	NITRILE EXAMINATION GLOVES P F- MEDIUM		1 Nos	External / Once Daily	1 Days		20 Nos	Dispensed
13	VEIN-O-LINE 100CM ROMSONS		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
14	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
15	ENCORE MICROPTIC GLOVES-7 PF		1 Nos	/ Once Daily	2 Days		2 Nos	Dispensed
16	SUPRIDOL SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
17	POVINANZ SOLUTION 10% 100 ML		1 Nos	/ Once Daily	1 Days		2 Nos	Dispensed

SWAPNA SAMUDRALA

Reg No : 69924

* 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.