

EOO-June

Privi

Dr. Meenu Ugale



ESTIMATION SLIP

Date : 01/03/2020 UHID / IP No. : _____ SI No. **1309**
 Name of Patient : Ruchi Lahoti Age: 28 Gender: F
 Father's / Husband's Name : Akshay Corporate / Occupation : _____
 Address : East Marolpur Phone : 9581187439 Email : _____
 Procedure / Plan : (Sec) NO / LSC EDD/Dos: _____
 MODE OF PAYMENT : SELF TPA : 2105CF GIPSA : _____ OTHER

TARIFF INFORMATION :

Particulars	Package Amounts (Rs.)	
	Normal Delivery	LSCS
Multi Shared Ward		
Shared Ward		
Twin Shared Ward		
Private Room	<u>90,000</u>	<u>1,00,000</u>
Super Deluxe Room	<u>1,00,000</u>	<u>1,10,000</u>
Suite Room	<u>Super-Nom Medical, IT to 2016</u>	
Package includes (Package starts from the time of admission)	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee and Labour Ward Charges	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee Anesthetist's Fees and OT Charges
	Length of Stay for : <u>5 days</u>	Length of Stay for : <u>3 days</u>
	Pharmacy up to <u>9000</u>	Pharmacy up to <u>12000</u>
	Investigations up to <u>2500</u>	Investigations up to <u>3000</u>
Others	<u>well baby care - 2T to 2016</u>	

Inclusion

well baby care - 2T to 2016

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

Initial Minimum Deposit : 20,000 advance

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

- ① Neonatology
- ② daily visit
- ③ Nursing fees
- ④ Blood group
- ⑤ Vaccin

DECLARATION

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

Signature of the Client

Signature Relationship

Signature of the financial Counselor

Handwritten notes at the top right corner.

- ② name
- ① play of mind
- ③ name of person
- ④ year of birth
- ⑤ address

Handwritten notes in the middle section, including a list of numbers: 2000, 1500, 1000, 500, 200, 100, 50, 20, 10, 5, 2, 1.

Handwritten notes at the bottom of the middle section, including the number 110000.

Handwritten notes at the bottom of the page, including the number 1212104 and other illegible text.

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HNH-00014208

IP26-00006531

Pati

Mrs RUCHI LAHOTI
08-08-1997 28 Y 10 M 1 D (F)
Dr. MEENA UGALE



INSUMABLES OF OT



Circulating staff _____ technician : S. Gaudy Date : _____ Time : _____

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube			Major Pack <u>1809 drey</u>	<u>01</u>		Inj Vit.K		<u>01</u>
LMA			Sutures <u>2346, 883</u>	<u>1</u>	<u>1</u>	Cord Clamp		<u>01</u>
ECG leads (A) P / N		<u>03</u>	<u>27-62</u>		<u>01</u>	Suction Catheter		
HME filter : A / P / N						Feeding Tube <u>5.0</u>		<u>01</u>
Syringes : 10 cc		<u>02</u>				Vaccum Suction Set		
05 cc		<u>02</u>	Gloves <u>S.G 6/2</u>		<u>02</u>	Surgical Gloves <u>S.G 6/2</u>		<u>02</u>
02 cc		<u>03</u>	<u>ENCORE 6/2</u>		<u>01</u>	Gauze Pack <u>7.5x7.5</u>		<u>02</u>
01 cc		<u>01</u>				Syringe 1ml / 2ml		<u>01</u>
Cautery plate (A) P / N		<u>01</u>	Surgical blade <u>22</u>		<u>01</u>	Surgical Blade # 20		<u>01</u>
IV set		<u>01</u>	NG tube			Koochies (S)		
RL		<u>02</u>	Cautery pencil		<u>01</u>	<u>26-0000205454</u>		
NS : 10ml / 100ml / 500ml / 1000ml			Koochies <u>XXL</u>		<u>01</u>			
<u>Put oxytocin</u>		<u>6</u>	Ointments					
<u>02 mask (A)</u>		<u>01</u>	Suction Catheter					
Fentanyl		<u>01</u>	Cap, Mask		<u>10</u>			
Morphine			Gauze Pack		<u>02</u>			
Ketamine			Mop Pack		<u>02</u>			
Propofol			Steristrip					
Rocuronium			Underpad		<u>02</u>			
Glycopyrolate			Draw sheet					
Myopyrolate			Abgel					
Ondansetron			Foleys catheter					
Pencan 25g / Spinal Needle 22			Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)		<u>01</u>	Romodrain bag					
Antibiotics			Bandage					
<u>Spinal needle 25</u>		<u>01</u>	Tegaderm					
Suppositories <u>Wistarone</u>			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg		<u>01</u>	Vaccum Suction set		<u>01</u>			
Justin : 12.5 mg / 25mg / 100mg		<u>01</u>	Plastic Bed Sheet <u>Amey</u>		<u>03</u>			
Tab. Misoprost : 200mg		<u>06</u>	Betadine Solution		<u>02</u>			
<u>Cante</u>		<u>01</u>	Microshield		<u>01</u>			
<u>6/2 Encore Glove</u>		<u>01</u>	Cotton Balls		<u>01</u>			
			Latex Gloves		<u>01</u>			
			Ramdione Scrub		<u>01</u>			
			Saral					

Surgeon _____ Anaesthesiologist _____ Nurse _____ OT Technician _____

Order No. : 26-0000205455/5456 Ordered by : Sangal



ELECTRONIC MEDICINE PRESCRIPTION

MRN : HNH-00014208 Name : Mrs RUCHI LAHOTI
 Age / Sex : 28 Y 10 M 1 D / Female Doctor : MEENA UGALE
 Adm/Reg Date/Time : 07/06/2026 21:47 Payor : ICICI ICICI LOMBARD GENERAL INSURANCE
 Order Date : 09/06/2026 01:34 Ordernumber : 26-0000205456
 Visit ID : IP26-00006531 Ward/Bed No : 4F -OT / PPO-417
 Patient Address : PRAGATHI RESIDENCY, East Maredpalli, Hyderabad, Telangana, INDIA, 500026

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	SURGICAL BLADE 22	SURGICAL BLADE 22	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
2	EVATOCIN (OXYTOCIN) INJ 5IU 1 ML		1 Nos	/ Once Daily	6 Days		6 Vial	Dispensed
3	BACTOPREP SOLUTIONS 100 ML	CHLORHEXIDINE GLUCONATE2% 8ALCOHOL80% 500	1 mL	/ Once Daily	1 Days		1 Nos	Dispensed
4	MOPS 30X30 8PLY 5S X-RAY	MOPS 30X308 PLYDATT	1 Nos	/ Once Daily	2 Days		2 Nos	Dispensed
5	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
6	OxygenMask With Tubing - Adult ROMSONS-FC		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
7	DSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		3 Nos	Partially Dispensed
8	VICRYL 2-0 NW 2762	VICRYL 2-0 NW 2762	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
9	VICRYL 1-0 VP 2346	VICRYL 1-0 VP 2346	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
10	PROLENE 1 NW 883	PROLENE 1 NW 883	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
11	JUSTIN SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
12	RL 500 ML CLOSED SYSTEM	RINGER LACTATE 500ML CLOSED	1 Bottle	/ Once Daily	2 Days		2 Bottle	Dispensed
13	PREGELLED SURGICAL PLATES(ADULT)	PREGELLED PLATED ADULT	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
14	LSCS DRAPE PACK (PROTECTCARE)		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
15	DISPOSABLE APRONS STERILE XL	DISPOSABLE APRON STERILE XL	1 Nos	/ Once Daily	3 Days		3 Nos	Dispensed
16	ADULT DIAPERS-XXL		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
17	VACCUME SUCTION SET	VACCUME SUCTION SET	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
18	CAUTERY PENCIL (ADVANCE)	CAUTERY PENCIL (ADVANCE)	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
19	MISOPROST TAB 200MCG 4S		1 Tabs	External / Once Daily	1 Days		6 Tabs	Dispensed
20	Encore Microptic gloves-6.5		1 Nos	/ Once Daily	1 Days		2 Nos	Dispensed
21	BUPICAIN HEAVY 80MG INJ 4ML	BUPIVACAINE 80MG INJ	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
22	DSYRINGE 1ML (NIPRO)	SYRINGE 1ML	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
23	COTTON BALLS 2 GM 5 NOS	COTTON BALLS 2G- 5 NOS	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed

MEENA UGALE

Reg No : 18967

* 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-00014208 Name : Mrs RUCHI LAHOTI
 Age / Sex : 28 Y 10 M 1 D / Female Doctor : MEENA UGALE
 Adm/Reg Date/Time : 07/06/2026 21:47 Payor : ICICI ICICI LOMBARD GENERAL INSURANCE
 Order Date : 09/06/2026 01:34 Ordernumber : 26-0000205455
 Visit ID : IP26-00006531 Ward/Bed No : 4F -OT / PPO-417
 Patient Address : PRAGATHI RESIDENCY, East Maredpalli, Hyderabad, Telangana, INDIA, 500026

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	UNDERPADS 60X90 BUTTERFLY		1 Nos	External / 10 AM	1 Days		2 Nos	Dispensed
2	SURGEON CAP(FEMALE) (PROTECTCARE)		1 Nos	/ Once Daily	1 Days		10 Nos	Dispensed
3	FACE MASK 3 LAYER - ELASTIC	FACE MASK 3 LAYER	1 Nos	/ Once Daily	10 Days		10 Nos	Dispensed
4	BCV-INTRAFIX SAFESET		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
5	SUPRIDOL SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
6	SPINAL NEEDLE 25 G WITACARE(120MM)	SPINAL NEEDLE 25G	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
7	GAUZE 7.5X7.5 12 PLY (5 NOS)	GAUZE 7.5X7.5 12 PLY 5 NOS	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
8	POVINANZ SOLUTION 10% 100 ML		1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
9	NITRILE EXAMINATION GLOVES P F- MEDIUM	NITRILE GLOVES M	1 Nos	/ Once Daily	20 Days		20 Nos	Dispensed
10	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
11	E.C.G ELECTRODES (ADULT)	ELECTRODES ADULT	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
12	DSYRINGE 5ML.(NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed

MEENA UGALE

Reg No : 18967

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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.
040-48873000, info@rainbowhospitals.in



ELECTRONIC MEDICINE PRESCRIPTION

MRN : HNH-00015883 Name : Baby Of RUCHI LAHOTI
 Age / Sex : 0 Y 0 M 0 D 4 H / Male Doctor : DILNAAZ FAROOQUI
 Adm/Reg Date/Time : 08/06/2026 22:31 Payor : SELFPAY
 Or Date : 09/06/2026 01:21 Ordernumber : 26-0000205454
 Visit ID : IP26-00006543 Ward/Bed No : 4F -OT / CRDL-HNPDA-415-1
 Patient Address : PRAGATHI RESIDENCY, East Maredpalli, Hyderabad, Telangana, INDIA, 500026

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
2	EASYCLOT-K1 1MG INJ 0.5 ML		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
3	CORD CLAMP-ALPHAMEDICARE		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
4	SURGICAL BLADE 20	SURGICAL BLADE 20	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
5	INFANT FEEDING TUBE-5	INFANT FEEDING TUBE 5	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
6	GAUZE 7.5X7.5 12 PLY (5 NOS)	GAUZE 7.5X7.5 12 PLY 5 NOS	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
7	DSYRINGE 1ML (NIPRO)	SYRINGE 1ML	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed

DILNAAZ FAROOQUI

Reg No : 56763

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Note

* This prescription is valid only for specified duration.

* Do not refill medicines.

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Name	Mrs RUCHI LAHOTI	UHID	HNH-00014208
Father/Guardian	Mr AKSHAY MUNDADA	Age/Gender	28 Y 10 M 1 D/ Female
Address	PRAGATHI RESIDENCY, East Maredpalli, Hyderabad, Telangana, INDIA, 500026		
IP No	IP26-00006531	Admission Date	07-06-2026
Ref Doctor	Self.		
Discharge Date	10.06.2026		

DISCHARGE SUMMARY

Consultant:
Dr. MEENA UGALE,
MBBS,MD
18967

Diagnosis: PRIMIGRAVIDA WITH 37⁺⁴ WEEKS WITH HYPOTHYROIDISM WITH OLIGOHYDRAMNIOS FOR INDUCTION OF LABOUR

EMERGENCY LOWER SEGMENT CAESERIAN SECTION DONE ON 08.06.2026.

History:

LMP: 15.09.2025
EDD: 24.06.2026

Obstetric formula: Primi
Gestation at admission: 37⁺⁴ weeks

Name	Mrs RUCHI LAHOTI	UHID	HNH-00014208
IP No	IP26-00006531	Admission Date	07-06-2026

Obstetric History:

G1 -Present pregnancy, Spontaneous conception.

Medical History: Hypothyroidism since 2022 on T.Thyronorm 125 mcg OD

Surgical History: Nil

Allergies: Nil

Family History: Nil

Antenatal Details:

Mrs RUCHI LAHOTI was booked to Rainbow hospital at 37⁺⁴ weeks of gestation. She had regular antenatal checkups and investigations as advised. NT scan was normal. FTS low risk. MTAS was normal. Fetal surveillance done by serial growth scans. Scan done on (07.06.2026) at 37⁺⁴ weeks showed single live intrauterine fetus with cephalic presentation, AFI:7cm EFW: 2.6kg,(11%) placenta: posterior upper segment ,dense calcifications and placental infarctions ,Doppler normal ,Single loop of nuchal cord around fetal neck,FGR .She was admitted at 37⁺⁴ weeks for induction of labour.

Investigations: Enclosed

Blood group: "O" Positive

Management:

Course in hospital and Delivery Details:

At admission on clinical examination the vitals were stable, uterus was mildly

Name	Mrs RUCHI LAHOTI	UHID	HHN-00014208
IP No	IP26-00006531	Admission Date	07-06-2026

acting, cervix was long and os 1 cm dilated. Fetal well being was confirmed by an admission CTG which was found to be reactive. She was induced with 2 doses of PGE2 gel. Artificial rupture of membranes was done at 2 cm dilatation revealing clear liquor. Antibiotic prophylaxis with Inj. Taxim 1 gm IV given in view of ruptured membranes. She was decided for emergency C-section in view of failed induction, prepared with indwelling Foley's catheter and IV canula under aseptic conditions. Written informed consent for surgery taken. Preanesthetic check up done. Anesthetic premedication (IV Pantop and Perinorm) given. Antibiotic prophylaxis with Inj. Taxim 1 gm IV given. Patient shifted to theatre.

Surgery Notes:

Under spinal anesthesia she was painted and draped as per hospital protocol. Abdomen opened in layers. The parietal and visceral peritoneum carefully opened after identifying the urachus. Bladder was reflected. A lower segment curvilinear incision given on the uterus. Baby delivered. Cord clamped and cut and cord blood collected for blood grouping and Rh typing. Baby handed over to pediatrician. Placenta delivered with controlled cord traction. Uterus closed in layers. Hemostasis secured. Instruments and swab count checked. Rectus sheath closed. Skin closed with subcuticular sutures. Wound dressing done. Vagina cleaned with Betadine solution after expelling clots. Misoprostol 400 mcg given per rectum as prophylaxis against Postpartum hemorrhage. Patient was shifted out of theatre to post operative recovery room.

***Liquor scanty.**

***Single loop of cord around neck .**

Name	Mrs RUCHI LAHOTI	UHID	HNH-00014208
IP No	IP26-00006531	Admission Date	07-06-2026

Delivery Details :

Date : 08.06.2026
Time of Delivery: 09:40pm
Type of Delivery: Emergency lower segment caesarean section
Indication : Failed induction
Anaesthesia : Spinal

Baby Details:

Date : 08.06.2026
Time : 09:40pm
Sex : Male
Weight : 2.82kg
Apgar : 7,8
Gestational Age: 37⁺⁴ weeks
NICU Admission: NO

Post-Operative Notes:

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

Name	Mrs RUCHI LAHOTI	UHID	HNH-00014208
IP No	IP26-00006531	Admission Date	07-06-2026

further reference.

Advice:

1. Tab. Taxim O 200mg twice daily till 15.06.2026 (9am-9pm) after food.
2. Tab. Calpol 500mg (Paracetamol 500mg) (2tabs) thrice daily till 13.06.2026 (8am-2pm-10pm) after food.
3. Tab. Voveran 50 mg (Diclofenac 50mg) thrice daily till 13.06.2026 (9am-3pm-11pm) after food.
4. Tab. Pantop 40mg twice daily till 15.06.2026 (7am-7pm) before food.
5. Tab. Livogen (Elemental Iron - 50mg, folic acid 1.5mg) once daily (7am) for three months before breakfast.
6. Tab. Shelcal (Elemental Calcium 500 mg, Vitamin D3 250 IU) once daily (2pm) till breast feeding for after food.
7. Nebasulf Powder for local application.
8. T.Thyronorm 125mcg once daily (7am) before food.
9. Review with FT3,FT4,TSH after 6 weeks.

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

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

Review with **Dr. MEENA UGALE** after **3 week** on **01.07.2026** at Rainbow Children's Hospital with prior appointment (**Review consultation will be**

Name	Mrs RUCHI LAHOTI	UHID	HNH-00014208
IP No	IP26-00006531	Admission Date	07-06-2026

charged).

For Women Who Have Had a Caesarean Section

Care of the wound:

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

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, headache [please refer to postpartum book for further details - Chapter II page 6] kindly contact 9154865045 at Rainbow Children's Hospital just dial one toll free number - 18002122.

You can also take appointments at any time by going online to our website **www.rainbowhospitals.in**

Name

Mrs RUCHI LAHOTI

UHID

HHN-00014208

IP No

IP26-00006531

Admission Date

07-06-2026


Registrar/Resident/C.M.O



Dr. MEENA UGALE
MBBS, MD
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Rainbow Childrens Hospital-Himayatnagar**Rainbow
Children's
Hospital**

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TEL NO :040-48873000

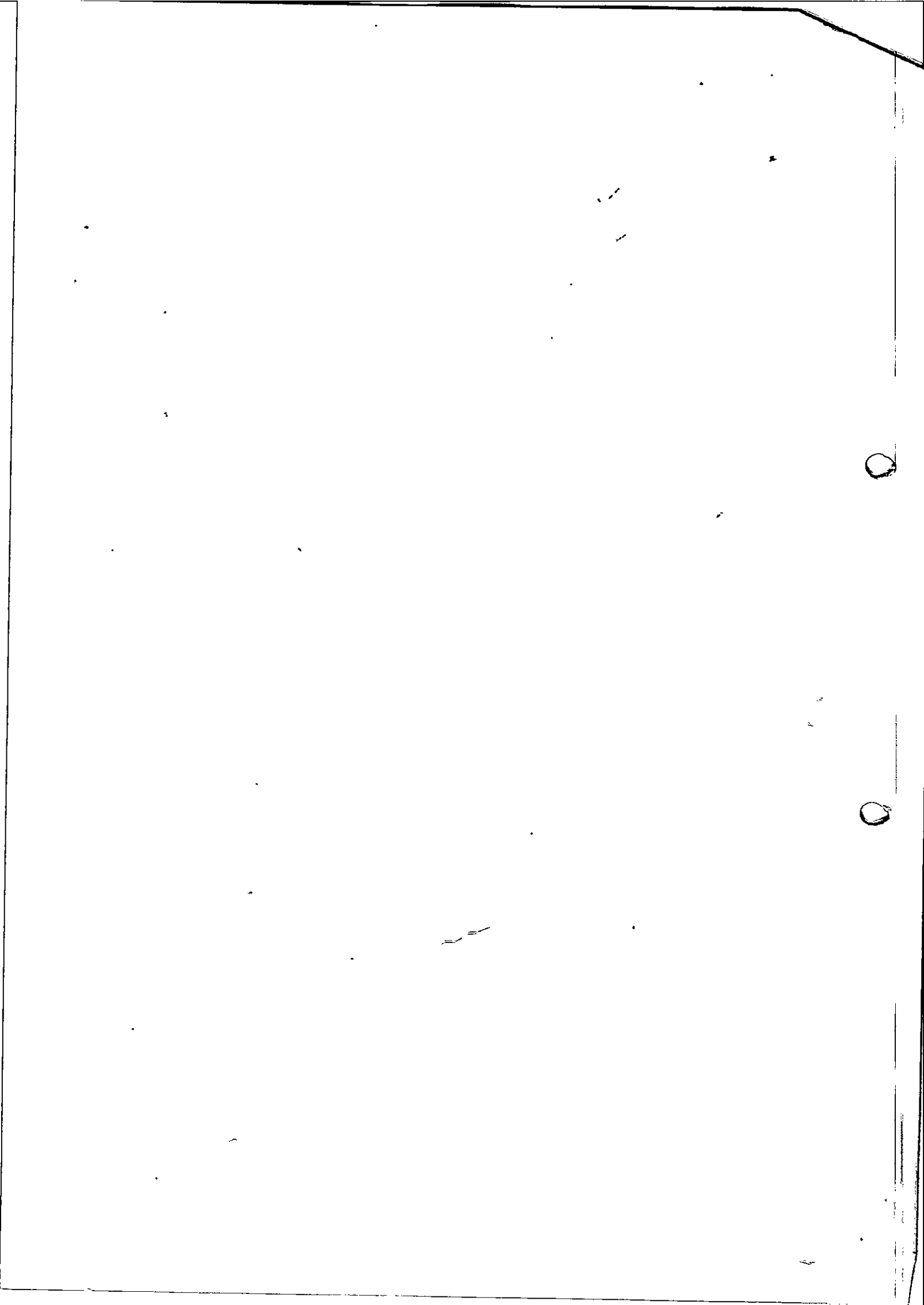
WEB : <https://rainbowhospitals.in>**ADMISSION SHEET****Registration Details :**

Admission No : IP26-00006531 Admit Date : 07-Jun-2026 Admit Time : 09:47 PM UHID : HNH-00014208

Patient Details :


Patient Name	: Mrs RUCHI LAHOTI	Age	: 28 Y 9 M 30 D
Guardian	: Mr AKSHAY MUNDADA	DOB	: 08-08-1997
Gender	: Female	Religion	:
Occupation	:	Marital Status	:
Address (H)	: PRAGATHI RESIDENCY East Maredpalli Hyderabad Telangana INDIA 500026	Phone No	: 9581185439/ 7799063752
		E-mail	: RUCHI.LAHOTI133@GMAIL.COM

Admission Details :Bed Type : TWIN SHARING Bed No : PPO-417 Ward Name : 4F -OT
Room No : PPO-417 Admission Type : First Visit**Contact Details :**Name : Mr AKSHAY MUNDADA Relationship : Husband
Contact Address : PRAGATHI RESIDENCY East Maredpalli
Hyderabad Telangana INDIA 500026 Phone No : 9581185439
Signature**Doctor Details :**Doctor Name : Dr. MEENA UGALE Specialisation : OBSTETRICS AND GYNECOLOGY
Referral Doctor : Self. Phone No :
Co-Consultant :**Payment Details :**Deposit Amount : 15000.00
Payment Mode : DC/CC Card Payor Name : ICICI ICICI LOMBARD GENERAL INSURANCE



PATIENT TRANSFER FORM



Patient Name & UHID No. HNH-00014208 IP26-00006531 Mrs RUCHI LAHOTI 08-08-1997 28 Y 9 M 30 D (F) Dr. MEENA UGALE 		Date & Time of Admission 2/6/26 @ 9:47 AM	Date & Time of Transfer Order 10/6/26 @ 9:40 AM
		Transfer Ordered by Dr. Ramya Thesga	Reason for Transfer observation
From Unit Pre & Post	To Unit Floor	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 35	Number of Imaging Films PST - 7	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	PL 500ml	1	
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Akshita		Name of Person Ordered Transfer Dr. Ramya Thesga	
Patient & Clinical Records Received by : Supriya M @ 9:40 AM			
Date & Time of Patient Received :			

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

- Unavailable Bed
 Nurse not Available
 Available Bed not ready

ACTIVITY RECORD FOR BILLING

Name: ----- HNH-00014208 IP26-00006531 -----
 Mrs RUCHI LAHOTI
 UHID No: ----- 08-08-1997 28 Y 9 M 30 D (F) -----
 Dr. MEENA UGALE
 Date of Admission: ----- Date of Discharge: ----- Time: -----
 Room / Bed No: ----- Ward: ----- Suggested Billable bed type: -----



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
8/6/26	9:15 PM	Pre post	OT	Akshita / Sangeeta
8/6/26	10:30 PM	OT	Pre post	Sangeeta / Akshita
10/6/26	9:40 AM	Pre & Post	OT	Akshita

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	Dr. S. Tejaswi	9/6/26	5549	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				



IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

for IOL

Obstetric Formula: Primi.

Obstetric History: Sp. conceptn

Booked @ 14 wks; NT - (N), Quadrant
 TIFPA (N), Oct - (N)

Present Pregnancy Record:

Growth (N)

LMP: 15/9/25

EDD:

Corrected EDD: 24/6/26

GA: 37⁺⁴

Menstrual History: Regular: Yes No

Obstetric Examination

Fundal Height: Ut ~ Term

Ut. Activity: Relaxed Mild Mod Severe

Liquor: Adequate Oligo Poly

PP: Cephalic Breech Others _____

Head Fifts Palpable: S/K

FHS: Normal Tachy Brady Absent

RISK FACTORS:

Low liquor

Per Speculum Examination - N/A

Draining: Present Absent Bleeding

Colour of Liquor: Clear Meconium Blood Stained

Vaginal Examination

Cervix: Long Partially effaced Effaced

Os: Closed _____ Dilated _____

Membranes: Present Absent

Liquor: Clear Meconium Blood Stained

Presenting Part: Vertex Breech Others

Sutton: -3 -2 -1 0 +1 +2

Pelvis: Adequate Doubtful

Height: cm

Weight: kg

Allergies: Nil

Breast: Normal Abnormal

General Examination:

Consciousness: (F) Pallor: (N)

Icterus: (N) Edema: (N)

Temp: (N) PR: 80/50

BP: 110/70 mmHg DTR: (F)

CVS: S1S2 (F) RS BLNVBS

Liver/Spleen: (N) Urine Output: (N)

DIAGNOSIS

Primi / 37⁺⁴ wks = low liquor (dehydration)
 & hypothyroidism



<p>Family History: Nil</p>	<p>Surgical History: Nil</p>
<p>Medical History: k/c/o Hypothyroidism -</p>	<p>Medication History: Ca T. Fe IT. Ca.</p>
<p>Plan of Care: <u>IOL</u> - Admission CTG - Prepare parts - NST 3rd hourly - FHR 2nd hourly - Send CBP - Dinoprostone gel @ 6am @ 1m.</p>	<p>Investigations: Blood Group - 'O' positive Hb - 10.2 g/dl. Plt - 4.5 L/cu. } 7/6/26 WBC - 13.8k HIV HbsAg } NR RPR } <u>USG (7/6/26) ~ 37th wks</u> SLF, Cephalic PI-PUS, AFI 27cm EFW @ ~ 2647g Dopplers - (N)</p>

Doctor Name: Dr. G. Meena
Signature: *[Signature]*
Date & Time: 7/6/26 @ 9pm
Date & Time: 8/6/26 @
Date & Time: 8/6/26 @

Consultant Name: Dr. Meena Ugale
Signature: *[Signature]*
Date & Time: 8/6/26 @
Date & Time: 8/6/26 @



1

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/6/26 6am	c/s/B Dr. Venar	
	Primi / 37 ⁺ 5 weeks / low liquor	
	Pt is stable, No clo	
	G/C GC-fair	Adv
	BP- 116/70mmHg	- Soft diet
	PR- 82 bpm	- NST 3 rd hourly
	SpO ₂ - 100% on RA	- FHR 2 nd hourly
	P/A - 10/10 Ut ~ Term	- Vital monitoring
	2/10" / 10'	- w/ff progress.
	FHS (+)	- Drugs as charted
	P/v - Cx 1 finger dilated	- Inform SOS
	2cm long, Vx = -3 station	
	Membranes (+)	
	Dinoprostone gel kept	
	c/s/B Dr. Dna	
	Primi ~ 37 ⁺ 5 week ~ oligohydramnios	
	No complaints	Adv
	G/C fair	- Soft diet
	BP: 115/65 mmHg	- NST - 3 rd hourly.
	PR: 82 bpm	- FHR 2 nd hourly
	SpO ₂ : ut ~ term	- vitals monitoring
	1c/10/10	- W/A POL
	FHS (+)	- Drugs as charted
	head / 5 palpable	- Inform SOS

NST - Reactive

[Signature]



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/6/26 7pm	C/O/B Dr Meena Ugale	
	No complaints FC post afebrile vitals (N) PA's ut line relaxed cephalic HR (+) IV: ca port 1/2 long cv: 2F ARM done clear (N) Vx - B.	Adv 1) epidural analg 2) IV fluids. 3) Oxytocin augmentation 4) HR mon 5) HR monitoring 6) Vaginal > 1 hr.
ANT: clear		
		Dr. RAMYA THEJA KADYALA Reg. No. 01458 Ramya
		Dr. RAMYA THEJA KADYALA
8/6/26 9pm	C/O/B Dr Meena Ugale	
	O/S PA: Janu findings IV: excessive show (N)	
	Counselled couple, her mother, mother-in-law regarding need for Em. use in view of failed induction.	Adv
		1) Consent for surgery 2) PAC
		3) Preop medications
	Dr. RAMYA THEJA KADYALA	4) Foley catheter



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/6/26 11pm	O-POD	Adv
baby well	No complaints GC fast/afebrile	1) No further orders
	PR: 86/mm	2) IV fluids as advised
	BP: 106/82 mmHg	3) drug as charted
	SpO2: 98%	4) WPC - exam blood R
U/O: clear	PA: soft, vwr	5) No chills
n 100ml	AV: bleeding (N)	6) Monitor vitals
		7) Deferr vac.
9/6/26 3 AM	O-POD	Adv
baby well	No complaints GC fast/afebrile	1) sips of water
	PR: 86/mm	
	BP: 120/80 mmHg	
	SpO2: 98%	
U/O: good	PA: ut - retracted well - soft	
	AV: steady (N)	
		Revised Dr. MEENA UGALE

Dr. RAMYA THEJA KADIVALA
 Reg. No. 51458

Dr. RAMYA THEJA KADIVALA
 Reg. No. 51458





3

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/6/26 9am	<p>O-POD</p> <p>No complaints GC fairly afebrile PR: 84/mm BP: 106/64 mmHg SpO₂: 98% PA: w/PR, UWR BP (+) N: blinding (N)</p>	<p>Adv</p> <ul style="list-style-type: none"> 1) liquid diet 2) soft diet 3) monitor vitals 4) w/PR even bleed PR 5) drugs as charted 6) SpO₂ charting 7) can shift to room <p>Dr. RAMYA THORAN Reg. No. 1458</p>
9/6/26 8:45pm	<p>C/S/B Dr. Dng</p> <p>POD 0</p> <p>No complaints GC fair Afebrile BP: 112/61 mmHg PR: 86/min SpO₂: 97% on RA P/A uterus retracted well. B/P (+) Enfan sor U/G NAB</p> <p>u/o - Adequate clear</p> <p>u/o - soft - emptied gut now</p>	<p>Adv</p> <ul style="list-style-type: none"> 1) Soft diet 2) Drugs as charted 3) Adequate hydration. 4) w/PR p/v bleed 5) Monitor vitals <p>NB - Supriya 8:43pm @ 9/6/26</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/6/26	C/S/B Dr. Meena	
8:30 PM	POD-1.	Adv
Baby & Mother	AC Fair vitals (N) P/A Ut Retracted well U/S NAB	- Soft diet - Drugs as charted - Adequate hydration - Foley's removal - Monitor vitals - Inform SES - Ambulation.
		
		N/B Supin
10/6/26	C/S/B Dr. Durg	
7:25 AM	POD-2.	Adv
Baby & Mother	AC Fair, Afebrile vitals (N) P/A Ut Retracted well U/S NAB	- Soft diet - Drugs as charted - Adequate hydration - Monitor vitals - w/f PV bleed - Ambulation - Inform SES
passed urine & flatus		
		N/B Supin @ 7:30 AM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	2 nd POD	
10/6/26	seen by Dr Meena Ugle	
10:30 AM	ac good	
	can be discharged	
	tomorrow	
		① galact granules c milk
		② lactare tabs
		oo — oo — oo
		x 15 days
		<u>meenabhi</u>
		noted by sr. Sandhya
		10/6/26
		10:30 a



CAESAREAN SECTION OPERATIVE NOTES

Surgeon's Name: <i>Dr Meena Ugal</i>	Date of Delivery: <i>8/6/26</i>
Assistant Surgeon: <i>Dr Ranuja Thigam</i>	Time of Delivery: <i>9:40 pm</i>
Anaesthetist's Name: <i>Dr. Suman Geethayali</i>	Gender of Baby: <i>Male</i>
Type of Anaesthesia: <i>Spinal</i>	Weight of Baby: <i>2.82kg</i>
Neonatologist: <i>Dr Dikane</i>	AGPAR Score: <i>2 8</i>
Scrub Nurse: <i>Sanyal</i>	NICU Admission: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Pre-Operative Diagnosis: *Primid 37+4 wtm / oligohydramnios / ~~PE~~*

Elective Emergency Indication: *failed induction*

Urgency

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

Decision time: *NA / 9pm* Knief to rectus: *2mm*

CTG Description: *baseline*

If there was a delay give the reasons: *No delay*

Surgical Procedure: *Emergency ces + sb*

Post Operative Diagnosis: *O-Pod*

Peri-Operative Complications: *NA*

Amount of Blood Loss: *~ 400ml* Blood Transfused (in ML): *None*

Name and Number of Surgical Specimen sent for examination:
None

Examination Findings when Appropriate: **NA**

Presentation: Cephalic Breech Other

Cervical Dilatation: cm

5th Palpable:

Fetal Position:

Station: -3 -2 -1 0 +1 +2

Moulding: None + ++ +++

Caput: + ++ +++

Meconium: None + ++ +++

Bladder Catheterized: Yes No

Urine: Clear Blood Stained

Skin Incision: Pfannenstiel Transverse Midline Other

Uterine Incision: Lower Segment Classical Inverted T J Incision

Previous Scar: Intact Thinnedout Ruptured No Scar

Incision Through Placenta: Yes No

* scanty liquor
1 loop of cord round neck

Delivery of head: Manual Forceps

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

Delivery of Placenta: Manual CCT Complete Incomplete Piecemeal

Cord Appearance: Cord around the neck Yes No

Appearance of placenta: Cavity explored Yes No

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

Uterine Closure: One Layer Two Layers Suture

Peritoneal Closure: Pelvic Abdominal None Suture

Sheath Closure: Suture

Fat Closure: Yes No Suture

Skin Closure: Subcuticular Mattress Suture

Vaginal Evacuated Yes No

Drain: Yes No Remove in days Await instructions

Catheter Yes No Remove in 4-6 hr days Await instructions

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

Intra-Operative Antibiotics Cover: Yes No Thromboprophylaxis Yes No

Post-Operative Notes: 1) NPO x 4-6 hr

2) IV fluids as advised

3) Monitor vitals

4) dress as changed

5) Wt exam sled IV

6) No charky

7) Inform ROS

Doctor Name: Dr. Ranjita Thapa

Doctor Signature: [Signature]

Date & Time: 9/6/26 @ 10:10 pm

[Signature]

HNH-00014208 IP26-00006531
 Mrs RUCHI LAHOTI
 08-08-1997 28 Y 9 M 30 D (F)
 Dr. MEENA UGALE



DRUG CHART

Date of Admission: 7/6/26 Drug Allergies: Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
 - Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
 - Discontinue a drug by drawing a line **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:																						

nature
verified by : Name

HNH-00014208 IP26-00006531
 Mrs RUCHI LAHOTI
 08-08-1997 28 Y 9 M 30 D (F)
 Dr. MEENA UGALE

REGULAR PRESCRIPTIONS

Weight: 82kg Ward: 502



Verified by
Dr. Dhakshayani

Verified by
Dr. Dhakshayani

Verified by
Dr. Dhakshayani

verified by
Dr. Dhakshayani

DRUG :				Date	Time
T. THYROXINE				8/6	9 AM
Dose	Route	Frequency	Start Date		
125mg	PO	OD	8/6/26		
Name & Signature of the Doctor Starting the Drugs:					
<i>[Signature]</i>					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : <u>eforaxem</u>				8/6	10 AM
Dose	Route	Frequency	Start Date		
18m	IV	BD	8/6/26		
Name & Signature of the Doctor Starting the Drugs:					
<i>[Signature]</i>					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : <u>Gal PANTOPRANUS</u>				8/6	8 AM
Dose	Route	Frequency	Start Date		
40mg	PO	BD	8/6/26		
Name & Signature of the Doctor Starting the Drugs:					
<i>[Signature]</i>					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : T. DICLOFENAC				9/6	11 AM
Dose	Route	Frequency	Start Date		
50mg	PO	TID	9/6/26		
Name & Signature of the Doctor Starting the Drugs:					
<i>[Signature]</i>					
Additional Instructions:					
AFTER FOOD					
Daily Doctor's Endorsement by a Sign					

HNH-00014208 IP26-00006531
 Mrs RUCHI LAHOTI
 08-08-1997 28 Y 9 M 30 D (F)
 Dr. MEENA UGALE



Verified by
 Dr. Dhakshayani

Verified by
 Dr. Dhakshayani

Verified by
 Dr. Dhakshayani

Sheet No:

REGULAR PRESCRIPTIONS

Weight 82kg Ward 202

DRUG : T-PARACETAMOL				Date Time	9/6	10/6															
Dose	Route	Frequency	Start Dt.	6 AM	10/6																
1gm	PO	TID	9/6																		
Name & Signature of the Doctor Starting the Drugs: 																					
Additional Instructions: AFTER FOOD																					
Daily Doctor's Endorsement by a Sign																					
DRUG : T TRAMADOL				Date Time	9/6	10/6															
Dose	Route	Frequency	Start Dt.	7 AM	10/6																
100mg	PO	TID	9/6																		
Name & Signature of the Doctor Starting the Drugs: 																					
Additional Instructions: AFTER FOOD																					
Daily Doctor's Endorsement by a Sign																					
DRUG : T. CEFIXIME				Date Time																	
Dose	Route	Frequency	Start Dt.	2 PM																	
200mg	PO	BD	10/6																		
Name & Signature of the Doctor Starting the Drugs: 																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					
DRUG : Cep lactase.				Date Time	10/6																
Dose	Route	Frequency	Start Dt.	10 AM	10/6																
2tab	PO	BD	10/6																		
Name & Signature of the Doctor Starting the Drugs: 																					
Additional Instructions: 10 PM																					
Daily Doctor's Endorsement by a Sign																					

HNH-00014208 IP26-00006531
 Mrs RUCHI LAHOTI
 08-08-1997 28 Y 9 M 30 D (F)
 Dr. MEENA UGALE

Weight. 82kg Ward.



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
8/6/26	6am	DINOPROSTONE NAGINAL GEL	0.5mg	PLV	[Signature]	Madhvi
8/6/26	12:30pm	DINOPROSTONE GEL	0.5mg	intra-cervical	[Signature]	Sujatha, Alati
8/6	7:30pm	INS CEFOTAXIME	1g (AST)	IV	[Signature]	Sujatha, Anvisha, Akshita
8/6	11pm	INS PARACETAMOL	1gm	IV	[Signature]	Madhvi
9/6	10:20pm	DICLOFENAC Suppository	100mg	PR	[Signature]	[Signature]
9/6	10:20pm	TRAMADOL Suppository	100mg	PR	[Signature]	[Signature]
9/6	9:35	4j. METHYLERGOMETRINE	0.2mg	IV	[Signature]	[Signature]
9/6	8:45AM	INS FURESEMIDE	5mg	IV	[Signature]	[Signature]

Signature
Name
VERIFIED BY : Name

Verified

Dr. Dhakshayani



I.V. FLUIDS CHART

Weight: 32kg Ward:

VERIFIED BY: Name Signature

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
8/6/20	7AM	RINGER LACTATE	IV	800 ml/hr	~	Si M	8/6	~	Si M
8/6	7:00 AM	INS OXYGEN 100 + 500 cc RINGER LACTATE	IV	6ml/hr ↓ 12ml/hr	~	Si M	8/6	~	Si M
9/6/20	12AM	RINGER LACTATE	IV	100 ml/hr	~	Si M	9/6	~	Si M
9/6	1AM	RINGER LACTATE	IV	100ml hr	~	Si M	9/6	~	Si M
9/6	5AM	RINGER LACTATE	IV	100ml hr	~	Si M	9/6	~	Si M
9/6	8AM	RINGER LACTATE	IV	100ml hr	~	Si M	9/6	~	Si M
9/6	1PM	RINGER LACTATE	IV	100ml hr	~	Si M	9/6	~	Si M

HNH-00014208 IP26-00006531
 Mrs RUCHI LAHOTI
 08-08-1997 28 Y 9 M 30 D (F)
 Dr. MEENA UGALE



MEDICATION RECONCILIATION FORM

Drug Allergies: Not known any Drug Allergies

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

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

Shifting From: NA Shifted to: NA

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	TAB. IRON	Tab	P/O	OD	7/6/26	<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
2	TAB. CALCIUM.	Tab	P/O	OD	7/6/26	<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
3	TAB. THYRONOR	125mcg	P/O	OD	8/7/26	<input checked="" 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. G. Veera

Date & Time : 8-7/6/26 @ 10 pm

Nurse Name & Signature : AKR/S

Date & Time : 7/6/26

HNH-00014208 IP26-00006531

Mrs RUCHI LAHOTI

08-08-1997 28 Y 9 M 30 D (F)

Dr. MEENA UGALE



315

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	(IP) 2/6/26				
Time	10:20 AM				
Hb	10.4				
PCV	30.3				
RBC	3.84				
WBC	13.89				
N/L	69.6/22.2				
Platelets	455				
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					

HNH-00014208 IP26-00006531
 Mrs RUCHI LAHOTI
 08-08-1997 28 Y 9 M 30 D (F)
 Dr. MEENA UGALE



Early Warning Observation Score Chart - Obstetrics

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

<div style="font-size: 2em; font-weight: bold; margin-left: 10px;">A16</div>		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 <small>(write rate in corresp. box)</small>	> 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																																																	
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	40																																																	
Systolic Blood Pressure	190																																																	
	180																																																	
	170																																																	
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	100																																																	
	90																																																	
	80																																																	
	50																																																	
Diastolic Blood Pressure	130																																																	
	120																																																	
	110																																																	
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	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																																																		

N/A

36

84

85

86

87

116

114

116

118

37

37

35

37

0

0

0

0

INT: oxytocin

.8/6/26 @ 7:00pm

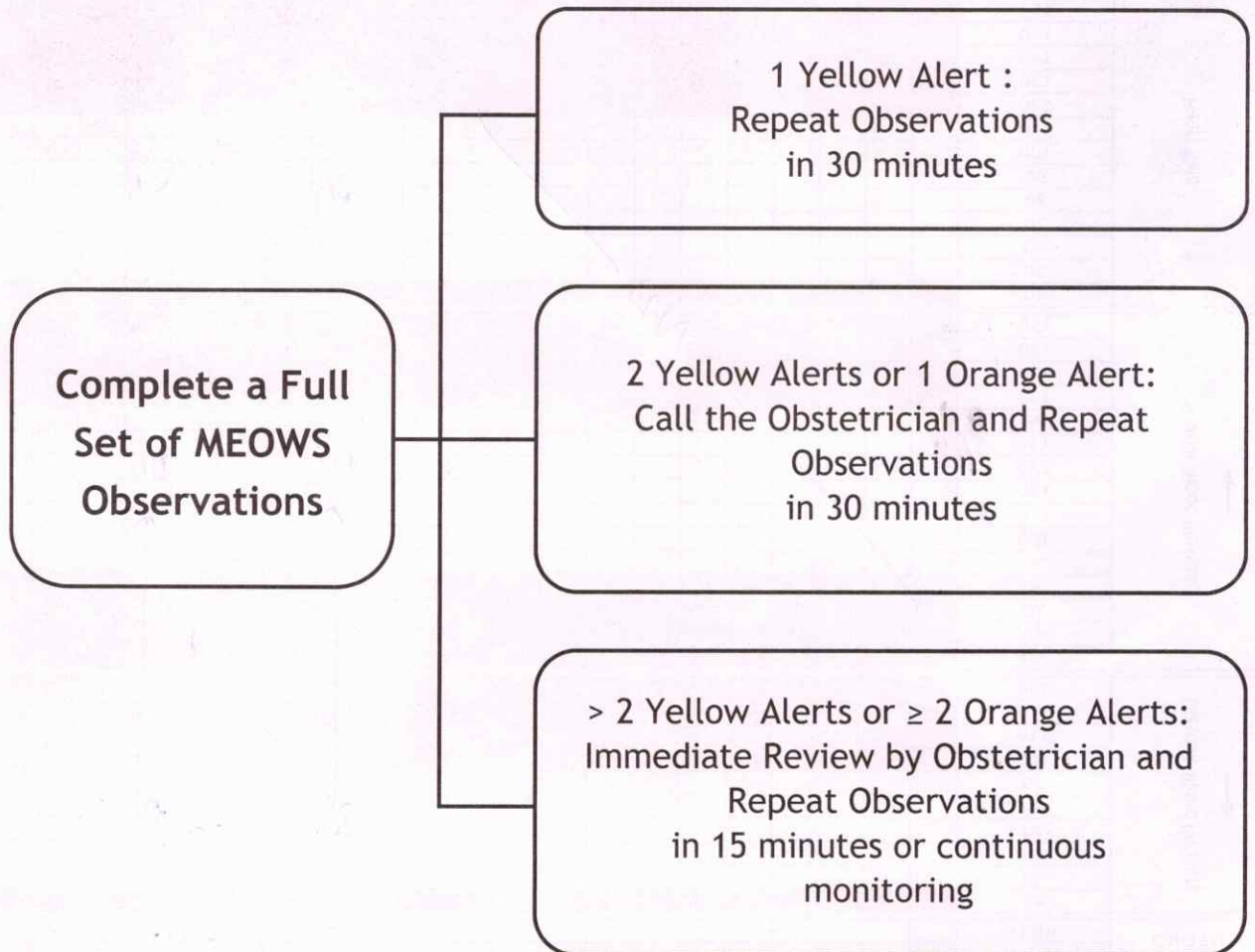
7:00pm - 12ml

7:30pm - 18ml

8pm - 24ml

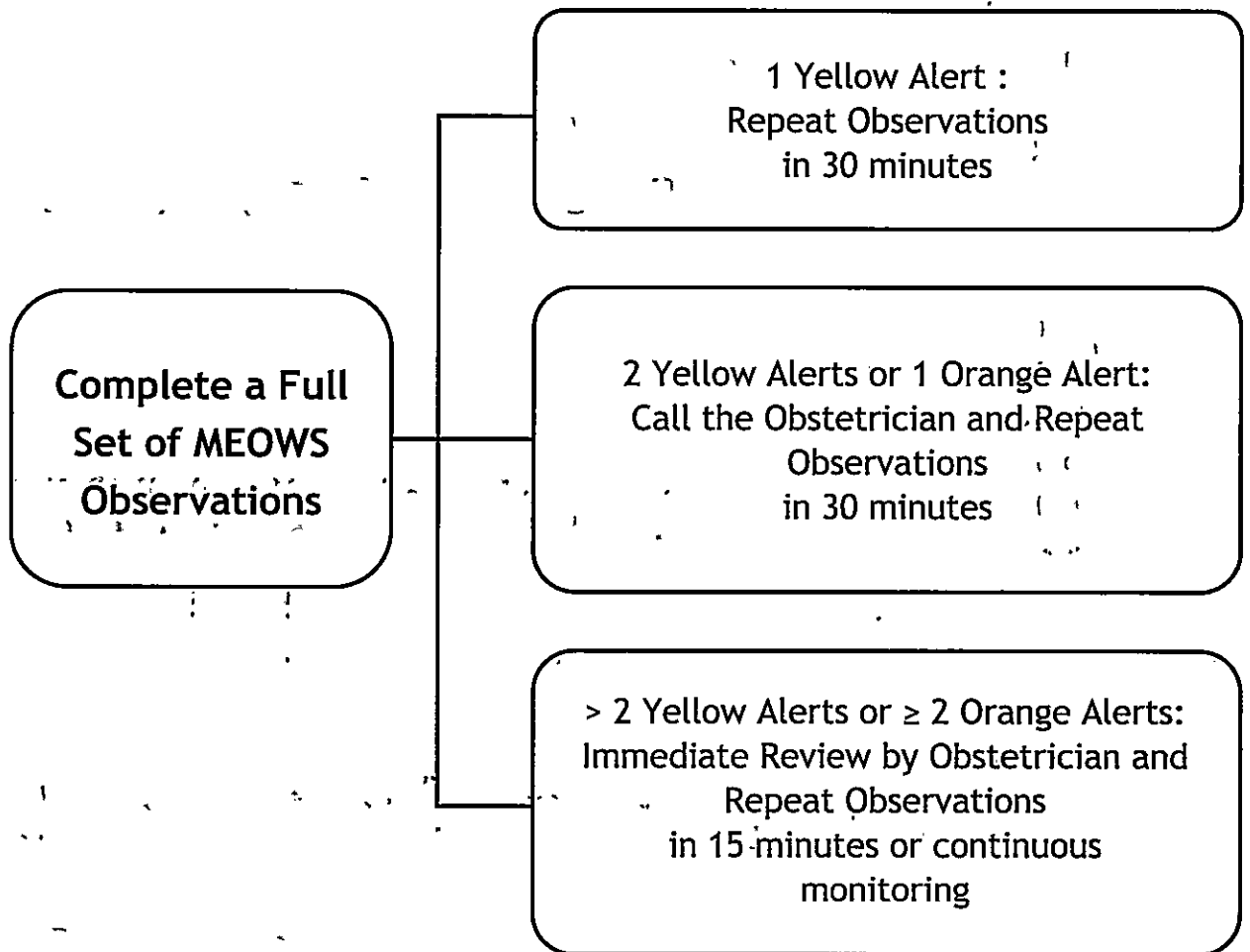
8:30pm - 30ml

Obstetrics and Gynaecology Early Warning Signs



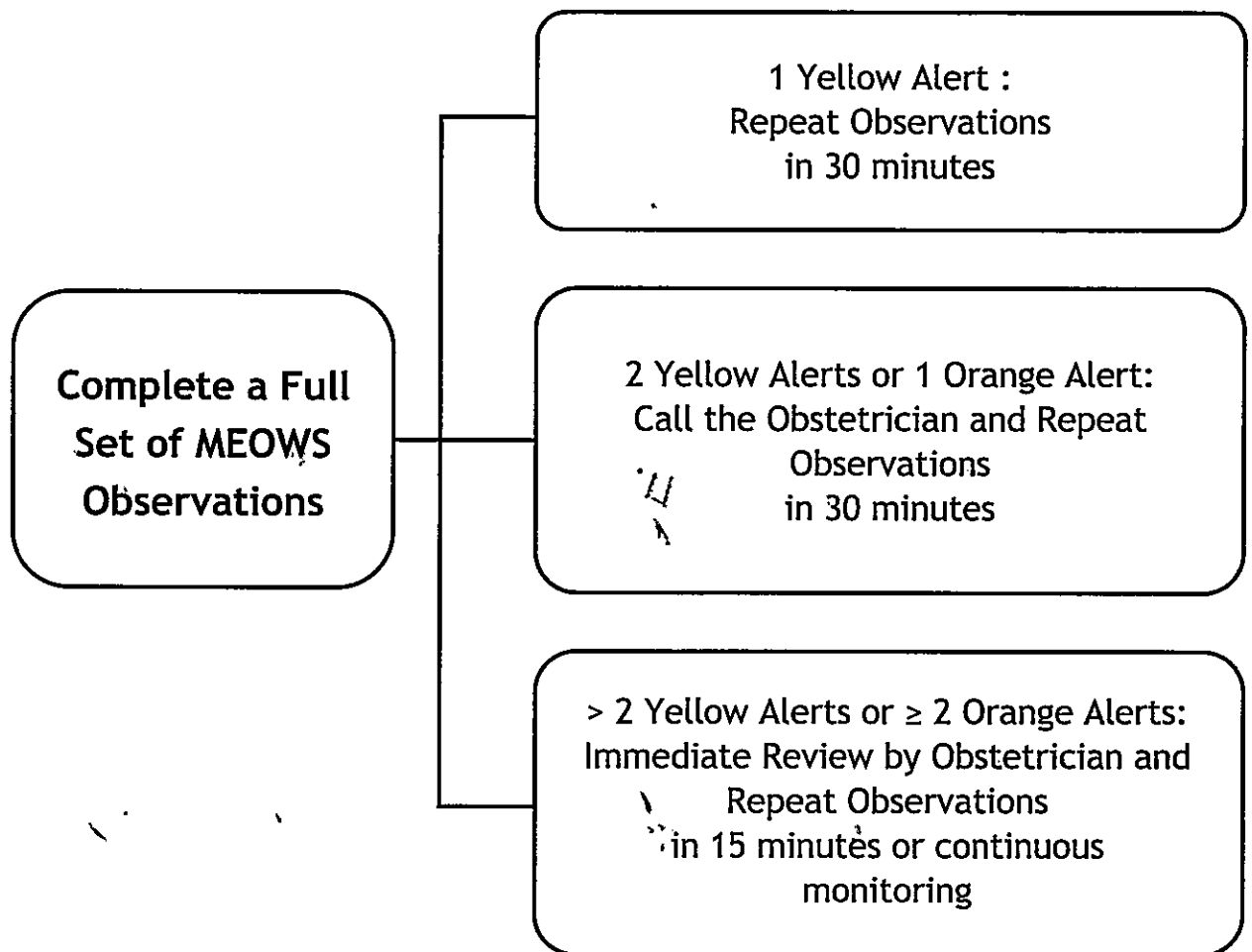
* The Modified Early Warning Score (MEOWS)

Obstetrics and Gynaecology Early Warning Signs



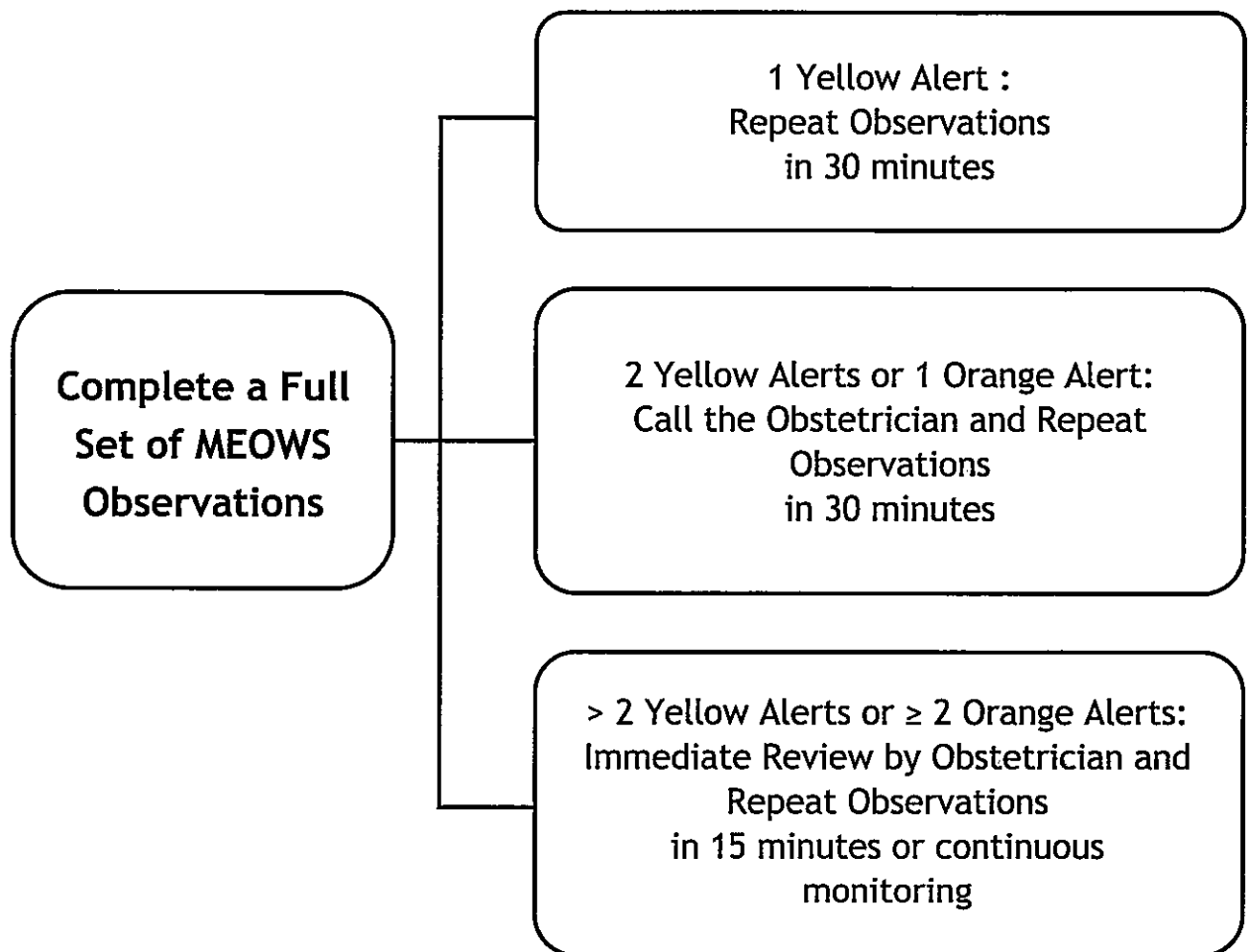
* The Modified Early Warning Score (MEOWS)

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)



FLUID CHART

Sheet No. : 1

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	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	H ₂ O											
	09:00 pm												
	10:00 pm	H ₂ O											
	11:00 pm												
	12:00 am												
	01:00 am	H ₂ O											
Total Intake : Taken						Total Output : Passed							
	02:00 am												
	03:00 am	H ₂ O											
	04:00 am												
	05:00 am	H ₂ O											
	06:00 am												
	07:00 am	Water											
Total Intake : Taken						Total Output : Passed							
Total 24 hrs. Intake						Total 24 hrs. Output			100ml.				



FLUID CHART

Sheet No. : 9

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

8/6/26		Intake				Output					IV Site Thrombophlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am							/		✓	1		
	09:00 am	H ₂ O								✓	1		
	10:00 am									✓	1		
	11:00 am	H ₂ O					NA			✓	1	Li	
	12:00 pm	coconut water											
	01:00 pm												
Total Intake : <u>taken</u>						Total Output : <u>passed</u>							
	02:00 pm									✓	1		
	03:00 pm	H ₂ O								✓	1		
	04:00 pm									✓	1		
	05:00 pm	H ₂ O					NA			✓	1	h	
	06:00 pm	RL		PK									
	07:00 pm	RL		100ml									
Total Intake : <u>taken</u>						Total Output : <u>passed</u>							
	08:00 pm	RL + syro	B	100ml							1		
	09:00 pm	RL + syro	B	100ml							1		
	10:00 pm	RL + syro	B	100ml							0		
	11:00 pm	RL	B	100ml			NA				1	D	
	12:00 am	RL	B	100ml							1		
	01:00 am	RL	B	100ml									
Total Intake : <u>600ml</u>						Total Output : <u>passed</u>							
	02:00 am	RL	Waste	100ml							1		
	03:00 am	RL	waste	100ml							0		
	04:00 am	RL		100ml						900ml	1		
	05:00 am	RL	waste	100ml			PA				1		
	06:00 am	RL		100ml							1		
	07:00 am	RL		100ml						100ml	1		
Total Intake : <u>600ml</u>						Total Output : <u>passed</u>							
Total 24 hrs. Intake				Total 24 hrs. Output				1000ml					



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			
9/6/20	08:00 am	Te	100ml										
	09:00 am	RL	100ml						200ml				Empty
	10:00 am	RL	100ml										ALU
	11:00 am	RL	100ml										
	12:00 pm	RL	Soup	100ml									
	01:00 pm	RL		100ml						800ml			Empty 1:20pm
Total Intake : taken						Total Output :							
9/6/20	02:00 pm	RL	100ml										
	03:00 pm	RL	100ml										
	04:00 pm	RL	100ml										
	05:00 pm	RL	100ml										
	06:00 pm	RL		100ml						600ml			Empty
	07:00 pm	RL		100ml									6:40pm
Total Intake :						Total Output : U-							
9/6	08:00 pm												
	09:00 pm								150ml				Empty
	10:00 pm												sumove
	11:00 pm												Idley
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
9/6	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							

HNH-00014208
 Mrs RUCHI LAHOTI IP26-00006531
 08-08-1997 28 Y 10 M 1 D (F)
 Dr. MEENA UGALE



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				
10/6/26			Mouth	I.V	N.G								
	08:00 am											(kw)	
	09:00 am		Idly										
	10:00 am												
	11:00 am		khichdi										
	12:00 pm												
01:00 pm													
Total Intake :						Total Output : U-2						17-0	
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake								Total 24 hrs. Output					



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			0	0	0	-	NA	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			NA	NA	-	-	NA	-	-	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			NA	NA	-	-	NA	-	-	
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			NA	NA	-	-	NA	-	-	
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			NA	NA	-	-	NA	-	-	
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	-	-	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 : Amisha

Signature of Ward In Charge :

Signature : Name : Kasturi

HNH-00014208 IP26-00006531
 Mrs RUCHI LAHOTI
 08-08-1997 28 Y 10 M 1 D (F)
 Dr. MEENA UGALE



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	10/6 DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0									
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	NP									
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	NP									
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	NA									
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	NA									
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	NA									
Signature of the Nurse				(K)									

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 :

HNH-00014208 IP26-00006531
 Mrs RUCHI LAHOTI
 08-08-1997 28 Y 9 M 30 D (F)
 Dr. MEENA UGALE



BRADEN 'Q' SCALE



Date: 2/6 8/6 8/6 9/6
 Time: 8PM 8AM 11 8AM

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

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

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

TOTAL SCORE

Evaluator's Name

28 28 28 28
 (Signature) (Signature) (Signature) (Signature)

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-00014208
 Mrs RUCHI LAHOTI
 08-08-1997 28 Y 10 M 1 D (F)
 Dr. MEENA UGALE

IP26-00006531

BRADEN 'Q' SCALE



Date : 10/6
 Time : 11/6

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			
"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			
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4			
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4			
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			
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4			
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4			
TOTAL SCORE					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



Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	2/6	8/6	8/6/26	Fall Risk Grading		
		Score	8 AM	8 AM	NI			
History of Falling (immediately or w/in 3 months)	Yes	25				Risk Level	Morse Fall Score (MFS)	Action
	No	0	0					
Secondary Diagnosis (more than one diagnosis)	Yes	15			15	Low Risk	0 - 24	Standard Fall Precaution
	No	0	0					
Ambulatory Aid	Furniture	30				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0	0				
IV / Heparin Lock or Saline	Yes	20	20	20	20	High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	No	0	0					
GAIT / Transferring	Impaired	20				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0	0	0	0			
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0	0					
Total Morse Fall Scale Score:			20	20	35			
Signature				fi				

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



Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	9/6	9/6	10/6	Fall Risk Grading		
		Score	8AM	10pm	10am	Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25				Low Risk	0 - 24	Standard Fall Precaution
	No	0						
Secondary Diagnosis (more than one diagnosis)	Yes	15				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
Ambulatory Aid	Furniture	30				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0	0	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			fm	R	Q			

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



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
7/6	9Am	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	Ⓢ
7/6	11Am	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	Ⓢ
8/6	2Am	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	Ⓢ
8/6	8Am	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	Ⓢ
8/6	2Pm	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	Ⓢ
8/6	6pm	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	Ⓢ
8/6/26	11Pm	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	Ⓢ
9/6/26	1Am	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	Ⓢ
9/6/26	10Am	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	Ⓢ
10/6/26	10am	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	Ⓢ

Re-assessment Frequency:

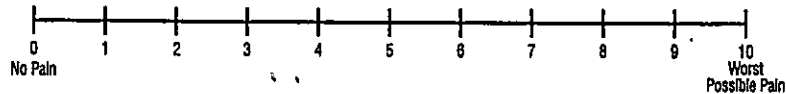
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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' brawn 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



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



URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 8/6

Date of Removal:

Parameters	Date	Shift Time	8/6 2pm	8/6 8AM	8/6 M1				
Need for the Catheter			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input 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 type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Usage of Sterile Equipment			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the Collection bag below the level of bladder			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input 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 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
Is Catheter dated as policy			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input 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
Collecting bag is been emptied regularly?			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input 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 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
Is the line removed as Policy?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Performance of Perineal Care			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input 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 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 type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of the Nurse			Sujatha	Sujatha					
Signature of the Nurse			Suj	Suj					



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis: <i>prim 34 weeks feta</i>	Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:					
BACKGROUND	Area	<i>2/6 LDR</i>	<i>8/6</i>	<i>8/6/26</i>	<i>9/6</i>	<i>10/6</i>	
	Shift Time	<i>NI</i>	<i>8AM</i>	<i>NI</i>	<i>8AM</i>	<i>NI</i>	
	Medical Condition (Any special condition to be noted):	<i>MI</i>	<i>liquid</i>	<i>NA</i>	<i>NA</i>	<i>NA</i>	
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	
	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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	<i>98.4</i>	<i>97.7</i>	<i>97.4</i>	<i>97.7</i>	<i>98.0</i>
		Res:	<i>20</i>	<i>20</i>	<i>20bmt</i>	<i>20b/m</i>	<i>21b</i>
		SpO ₂ :	<i>99.1</i>	<i>99.1</i>	<i>99.1</i>	<i>98.5</i>	<i>99.1</i>
		Pulse:	<i>82</i>	<i>85</i>	<i>85bmt</i>	<i>85b/m</i>	<i>86b</i>
		BP:	<i>116/71</i>	<i>110/75</i>	<i>107/60</i>	<i>110/75</i>	<i>115/80</i>
	Fall Risk Score:	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	
Pain Score:	<i>-</i>	<i>-</i>	<i>0/10</i>	<i>-</i>	<i>-</i>		
Recommendations	Safety Needs:	<i>-</i>	<i>NA</i>	<i>NA</i>	<i>NA</i>	<i>Yes</i>	
	Physiotherapy	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Others Specify:	<i>-</i>	<i>NA</i>	<i>-</i>	<i>NA</i>	<i>NA</i>	
	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	
	Other Special Orders / Medications:	<i>-</i>	<i>NA</i>	<i>-</i>	<i>NA</i>	<i>NA</i>	
Post Operative Procedure Special Orders:		<i>-</i>	<i>NA</i>	<i>-</i>	<i>NA</i>	<i>NA</i>	
Handed Over By Name :		<i>Madh</i>	<i>Sialka</i>	<i>dkhils</i>	<i>Sialka</i>	<i>Sandya</i>	
Signature :		<i>(Signature)</i>	<i>(Signature)</i>	<i>(Signature)</i>	<i>(Signature)</i>	<i>(Signature)</i>	
Date:		<i>8/6</i>	<i>8/6/26</i>	<i>9/6/26</i>	<i>9/6/26</i>	<i>10/6</i>	
Time:		<i>8AM</i>	<i>2PM</i>	<i>8AM</i>	<i>2PM</i>	<i>2PM</i>	
Taken Over By Name :		<i>Sialka</i>	<i>dkhils</i>	<i>Sialka</i>	<i>Sandya</i>		
Signature :		<i>(Signature)</i>	<i>(Signature)</i>	<i>(Signature)</i>	<i>(Signature)</i>		
Date:		<i>8/6/26</i>	<i>8/6/26</i>	<i>9/6/26</i>	<i>9/6/26</i>	<i>10/6/26</i>	
Time:		<i>8PM</i>	<i>8PM</i>	<i>8AM</i>	<i>8PM</i>		

Patient Sticker



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

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

HNH-00014208 IP26-00006531
 Mrs RUCHI LAHOTI
 08-08-1997 28 Y 9 M 30 D (F)
 Dr. MEENA UGALE



NURSING CARE RECORD



Date: 2/6

- 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				N/A			
Afternoon							
Night	8AM	Plan for vital	8AM	vital checked & recorded	vital is normal	PT is stable	Rudh
		Plan for chart		Maintain chart			
	8AM	Plan for medication	8AM	All medication given			

HNF-00014208 IP26-00006531
 Mrs RUCHI LAHOTI
 08-08-1997 28 Y 9 M 30 D (F)
 Dr. MEENA UGALE



NURSING CARE RECORD



Date: 8/6

- 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	8am	→ Assessed the pt condition	Ilochart maintained	patient is stable	Si
	To	→ plan for vitals → plan for Ilochart	To	→ vital are checked & recorded			
	2pm	→ plan for medication	2pm	→ all medication given			Sujata
Afternoon		—		day - duty	—		
Night	8pm	→ ASSESS the pt condition	8pm	→ Assessed the pt condition	pt is stable	maintain Ilo chart & record	AKUB
	8pm	→ monitor the vitals & record → Administration of medication → maintain Ilo chart & record	8pm	→ monitor the vitals & record → Administered medication as per chart → maintain Ilo chart & record			



NURSING CARE RECORD

Date: 9/6

- 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	8AM	→ Assessed the pt condition	I/O chart maintained	Patient is stable	Li
	To 9PM	→ plan for vitals → plan for I/O chart	To 9PM	→ vital are checked & recorded → I/O chart maintained → all medication given			
Afternoon	Day Duty →						
Night	8pm 8AM	- Admin the pt condition - Monitor vitals & I/O chart - drug as per chart		→ Assessed the pt condition - Monitored vitals & I/O chart - druged as per chart	pt is stable	Rechecked vitals	J

MNH-00014208 IP26-00006531
 Mrs RUCHI LAHOTI 28 Y 10 M 1 D (F)
 08-08-1997
 Dr. MEENA UGALE



NURSING CARE RECORD



Date: 10/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8pm 9pm	Assess the pt. condition monitor vitals maintain I/O chart. - DBF Drug as per chart	8pm 10 2pm	- Assess the pt condition - Monitor s/e v/s - maintain s/e I/O Drug as per chart.	- Now patient is stable	- Rechecked the v/s	(Signature)
Afternoon							
Night							



LABOUR AND DELIVERY NURSING ASSESSMENT

Date of Admission: 21/6/26

Baseline Information:

Admission From: ER OPD Admission Desk Others: specify

Primary Language: Telugu English Hindi Others

Do you require an interpreter? Yes No

Source of Information: Patient Family Others

Personal belonging if any: Jewelry Nose Ring Bangles Anklets Finger Ring Bracelets
 handed over to

Allergies: Yes No Medications Blood Transfusion Food Other:
 If yes, identify

Chief Complaints: Doctor Notified on Admission: Yes No
MVD & BMLSCS Name of the Doctor: Dr. Veeng.
 Time Notified:

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>M.H.</u>	<u>M.H.</u>	<u>M.H.</u>

Blood Group: O+ve LMP: 15/9/25 EDD: 24/6/26 Gestational age during admission: 32 weeks

Contractions: Vaginal Discharge:

Obstetric History: G P 1 L A Previous LSCS

Height: Weight: BMI:

Temp: 98.6 HR: 87 RR: 20 BP: 110/72 SpO₂: 99%

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

<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Rh Incompatibility	<input type="checkbox"/> Fertility Treatment
<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Previous LSCS	<input type="checkbox"/> Preterm Labour
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Gestational Hypertension	<input type="checkbox"/> Others: (Specify)
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Bad Obstetric History	
<input type="checkbox"/> Anemia	<input type="checkbox"/> Obesity (BMI)	
	<input type="checkbox"/> Twins / Multiple Pregnancy	



Abnormalities Detected

- Heart Disease
- Hypertension
- Diabetes
- Stroke
- Seizures
- Kidney disease
- Liver disease
- Other

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

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

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

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

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

- Overweight
- Poor Appetite > 3 Days
- Needs Therapeutic Diet.
- Under Weight
- Diabetes Mellitus
- No Abnormality Detected

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

Inform consultant for positive criteria

SOCIAL SCREENING:

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

Social History: Lives With

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: Ruchi

Orientation not given Reason: NA

Nurse Signature: Madhu

Nurse Name: madhumita

Date & Time: 21/6/26 @ 9pm



OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 21/6 Time of Arrival: 9:10 AM Time Seen by Nurse: 9:15 AM

1) Level of Consciousness: Conscious Semi-Conscious Unconscious

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

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

3) Vital Signs: Temperature: 98.4 Pulse: 82 RR: 20 SpO₂: 99 BP: 116/71 Weight:

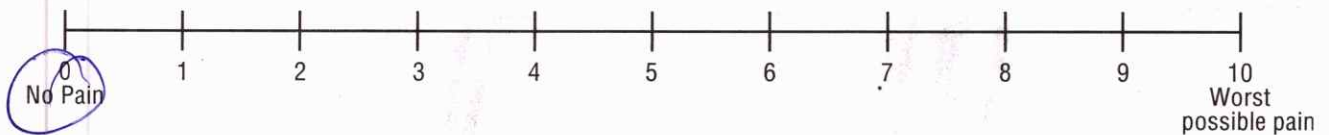
4) Gestational Criteria:

Gravida:	G	P	L	A
----------	---	---	---	---

LMP: 15/9/25 EDD: 24/6/26 Gestational Age: 27 weeks

Uterine Contraction	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> NA	Onset	Time	Frequency:
Membrane Rupture	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> NA	Onset	Time	Fluid Color:
Vaginal bleeding	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> NA	Onset	Time	Amount:
Pre Eclampsia Symptoms	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> NA	If Yes specify: Headache / Visual Symptoms / Pain Abdomen / Vomiting		
Good fetal Movement	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA	If No specify:		

5) Pain Screening: Numerical Pain Scale (NPS)



- Location:
- Duration: 3 hrs Days / Weeks/ Months (Strike out which is not applicable)
- Character:
- Frequency:
- Interventions: Nil

6) Past History:

- a) Surgeries: Nil
- b) Medical: Nil



1) **History:** No, If Yes :

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

9) **Prenatal Medical History:**

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

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

OTAS	Level 1 (Resuscitative)	Level 2 (Emergent)	Level 3 (Urgent)	Level 4 (Less Urgent)	Level 5 (Non Urgent)
Level 1 (Resuscitative)	Immediate	≤ 15 minutes	≤ 30 minutes	≤ 60 minutes	≤ 120 minutes (2 Hours)
Re-Assessment	Continuous Nursing Care	Every 15 Minutes	Every 15 Minutes	Every 30 Minutes	Every 60 Minutes
Labour / Fluid	Imminent Birth	Suspected Pre-term Labour / PPRM < 37 Weeks	Signs of Active Labour > 37 weeks	Signs of Early Labour/ SRM > 37 weeks	Discomforts of Pregnancy
Bleeding	Active Vaginal bleeding with/ without abdominal pain	Bleeding associated with cramping (<spotting) <37 weeks	Bleeding associated with cramping (>spotting) >37 weeks	Spotting	
Hypertension	Seizure activity	Hypertension > 160/110 and / or headache, visual disturbance, RUQ pain	Mild hypertension > 140/90 with/without associated signs and symptoms		
Fetal Assessment	Abnormal FHR tracing Non-Fetal Movement	Atypical FHR tracing, abnormal dopplers Diseased fetal movement			
Others	<ul style="list-style-type: none"> • Acute onsite severe abdominal pain • Altered level of consciousness • Cord prolapse • Severe respiratory distress • Suspected sepsis 	<ul style="list-style-type: none"> • Major trauma • Shortness of breath • Unplanned and unattended birth 	<ul style="list-style-type: none"> • Abdominal/back pain greater than expected in pregnancy • Flank pain / hematuria • Nausea /vomiting and /or diarrhea with suspected dehydration 	<ul style="list-style-type: none"> • Ongoing assessment from out patient clinic (for hypertension, blood work) • Minor trauma (minor MVC/fall) • Nausea/Vomiting and /or diarrhea • Signs of infection (ie dysuria ,cough, fever, chills) 	<ul style="list-style-type: none"> • Anything that does not seem to pose threat to mother or fetus • Cervical ripening • Out patient placenta previa protocols • Pre-booked visits (ie Rh and progesterone injections, NST • Assessment for version • Rashes

Time seen by Doctor: 9.20am

Nurse Name : Madhumi Ta Nurse Signature: Madhu

Date: 21/6/26 Time: 9.15



BREAST FEEDING HANDOVER AND ASSESSMENT FORM

1. Breastfeeding initiated?
 a. Yes b. No

2. If No, Reason

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

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

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



Feeding Positions:
Cross Cradle



Feeding Positions:
Football / Clutch

6. Was the position explained:

- a. Yes
- b. No

7. For Caesarian mothers:

- a. Mother is required sit and feed from the 4th feed
- b. Please explain football hold

8. NICU admission:

- a. Mother needs to stimulate her breast for 2 min every 2 hours

9. Additional notes:

Continuity of Care:

Date: 9/6/26

→ Assess the baby condition
→ DBF 2nd half & burping
→ maintain I/D chest exam
→ provide warm care to the baby

Handover given by *skate*

Handover taken by

Signature *skate*

Signature

Date & Time: 9/6/26

Date & Time:

SURGICAL SAFETY CHECKLIST

HNH-00014208 IP26-00006531
 Mrs RUCHI LAHOTI
 08-08-1997 28 Y 9 M 30 D (F)
 Dr. MEENA UGALE



Surgeon : Meenakshi
 Asst. Surgeon : Dr. P. S. Thakur
 Anaesthetist : Dr. Geethanjali
 Scrub Nurse : S. Sangeetha

Age : Gender :
 Name :



Date : 8/6/26 In-time : 9:30p Out-time : 10:30p

Before Induction of Anaesthesia >>

Before Skin Incision >>


Before Patient Leaves Operating Room

SIGN IN		Time: <u>9:30p</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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Blood Units Reserved	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Has Antibiotic Prophylaxis been given within the last 60 minutes?		
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Signature : <u>[Signature]</u>		
Name : <u>Dr. Geethanjali</u>		

TIME OUT		Time: <u>9:40p</u>
Confirm all team members have introduced themselves by Name and Role <input 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 checked="" 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? <input type="checkbox"/> Yes <input checked="" 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		
Power Supply, Earthing, Power Backup and functioning of equipment checked. <input type="checkbox"/> Yes <input type="checkbox"/> No		
Signature : <u>[Signature]</u>		
Name : <u>Sangeetha</u>		

SIGN OUT		Time: <u>10:30p</u>
Nurse Verbally Confirms with the Team:		
The Name of the Procedure Recorded	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
The Specimen is Labelled (including patient name)	<input checked="" 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 checked="" 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 checked="" type="checkbox"/> No		
Signature : <u>[Signature]</u>		
Name : <u>Dr. Aranya Thohan</u>		

PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00014208 IP26-00006531 Mrs RUCHI LAHOTI 08-08-1997 28 Y 9 M 30 D (F) Dr. MEENA UGALE 		Date & Time of Admission 7/6/26	Date & Time of Transfer Order 8/6/26 @ 10:30am
		Transfer Ordered by Dr. Geethagali	Reason for Transfer observation
From Unit OT	To Unit mu post	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	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 Sangeetha		Name of Person Ordered Transfer Dr. Geethagali	
Patient & Clinical Records Received by :		Akshita	
Date & Time of Patient Received :		9/6/26 @ 10:30am	

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

- Unavailable Bed Nurse not Available Available Bed not ready

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE



Patient Name : Mrs. Reehi Lahoti Gender: Male Female Age : 28 yrs
 UHID No : HSM-00014203 Date : 8/6/26

Instruction:

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

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

EMERGENCY LOWER SEGMENT CAESAREAN SECTION
 upon Reehi Lahoti
 (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
- 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 Meena Upale

Consentee :

Signature : [Signature]
 Name : Mrs. Reehi Lahoti
 Date & Time : 8/6/26 @ 9pm

Patient Attendant :

Signature : [Signature]
 Name : Akhay Mardada
 Relationship with Patient: husband
 Date & Time : 8/6/26 @ 9pm

Witness :


Signature : [Signature]
 Name : Akhila
 Date & Time : 8/6/26

Doctor (who is taking the consent) :

Signature : [Signature]
 Name : Drama Hiron
 Date & Time : 8/6/26 @ 9:00pm

PATIENT TRANSFER FORM



Patient Name & UHID No. HNH-00014208 IP26-00006531 Mrs RUCHI LAHOTI 08-08-1997 28 Y 9 M 30 D (F) Dr. MEENA UGALE 		Date & Time of Admission 7/6/26 @ 9:147PM	Date & Time of Transfer Order 8/6/26 @ 9:15PM
		Transfer Ordered by DR. manisha	Reason for Transfer GM - LSCS
From Unit Pre - post	To Unit -	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 30	Number of Imaging Films -	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	RI - 500ml	1	
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Sis. Akhila		Name of Person Ordered Transfer DR. Romy Thomas	
Patient & Clinical Records Received by : Sangeeta			
Date & Time of Patient Received :			

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

- Unavailable Bed
 Nurse not Available
 Available Bed not ready

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE



Patient Name : Age : Gender : Male Female

UHID NO: Surgeon Name:

Anaesthesiologist :

Operative procedure planned :

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 :

Comments:

- Doctor to document in medical record also if necessary (Cross-out if not applicable)

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient the above mentioned operation / Diagnostic / Therapeutic procedures

I authorize and give consent for anaesthesia (Regional / General Anesthesia / Monitored Anesthesia Care as considered appropriate by the anaesthetic team.

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, risk, benefits and alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anesthesia.

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

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

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

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

- Pregnant : Yes No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

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

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

Patient / Patient Attendant :

Signature :

Name : Miss. Ruchi Lakoti

Relationship with Patient:

Date & Time : 9/6/26

Witness :

Signature : [Signature]

Name :

Date & Time : 9/6/26

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Gethajal?

Date & Time :

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



Name: Mrs. Ruchi Lalwari Age: 28 yr. Sex: Female UHID.No: ANU 00014208

Date: 08/06/26 Time: 2:20 pm Proposed Operation: Emergency caesarean section

Diagnosis: Bimbi 37th weeks c hypothyroidism c oligohydramnios

B.P / CRT: 115/65^{with} H.R: 82/min Weight: 82kg ASA Physical Status: 1 2 3 4 5

Laboratory Data:

Hgb: 10.2 g/dl Glucose: Protein: HIV: X-Ray:
 PCV: Urea: Alb: HBS Ag: } NR ECG:
 WBC: 13.8 K Creat: Total Bill: HCV: } 0 positive 2D Echo:
 Plate: 4.5 L Na: Dir. Bill: Blood group: 0 positive Stress/Angio:
 PT: K: LDH: T3 T4 Other:
 PTT: Ca++: Alk phos: T4 TSH:
 INR: Mg++: Amylase: TSH:
 Cl-: SGOT/SGPT:

Allergies: NKDA

Medical History: CVS: no active cardiorespiratory complaints Placenta: posterior

RESP: no H/O DM/HTN/TB/asthma, Diabetes: 0 upper eqm

CNS:

Renal: 0

Hepatic / GE: Physical Activity: METS > 4

Others: K/O hypothyroidism: 4 yrs.

Past Anaesthetic History:

Physical Exam:

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

Lungs: clear (+), clear no loose teeth

Heart: S1 (+)

CNS: 4ms (+)

Pregnant: Yes No NA Venous Access Site: (+) Spine Exam for regional: midline

Anaesthetic Plan: MAC REGIONAL GA-ETT LMA (2) 4 (N) spaces left

Peri-Operative Plan Explained to the Patient: Yes No

CURRENT MEDICATIONS	DOSAGE
T. THYROXINE	125 mcg OD.

- Pre-Operative Instructions: Breakfast-upna @ 7AM coconut water @ 12PM
- DVT Prophylaxis:
 - NIL ORAL $\left\{ \begin{array}{l} \text{Water / ORS 2 Hours} \\ \text{Others 6 Hours} \end{array} \right.$
 - Informed Consent: Standard High Risk
 - Post Operative Pain Management: Discussed with Patient
 - Other Instructions: consent to be taken

Signature: [Signature] Name: DR. M. VIJAYATHA

HNH-00014208 IP26-00006531
 Mrs RUCHI LAHOTI
 08-08-1997 28 Y 9 M 30 D (F)
 Dr. MEENA UGALE

ANAESTHESIA CHART



Pre Induction Assessment:

Change in Patient Condition: Yes No Fasting Status: _____

Physical Status: Patient Identified Consent Present Chart Reviewed

H.R.: 85/min B.P./CRT: 110/70/2mmty SpO₂: 99.1% @ RA R.R.: 12 Last Feed: _____

Pre-OP Diagnosis: Placenta previa & digoxinemia Operation: Emergency C/S Date: 8/6/2026

Surgeon: Dr. Meena Ugale Anaesthesiologist: Dr. Anshu Jaiswal Technician: Sai chander

TIME	9:20pm	9:40pm	10:20pm																	
N ₂ O / AIR / O ₂ LPM																				
HALO / SO / SEVO																				
Drugs:																				
Antibiotic																				
Suppository																				
Diclofenac 100mg																				
Tramadol 100mg																				
Blood Loss																				
Apron																				
NOTES																				
FI ₀₂ / SaO ₂	100%	100%	100%	100%	100%	100%														
ETCO ₂	SR	SR	SR	SR	SR	SR														
ECG																				
Temperature																				
Urine Output	80ml																			
Fluids																				
Blood	2 OR																			
B.P.	240																			
V Systolic	220																			
A Diastolic	200																			
X Mean	180																			
Heart Rate	160																			
Tourniquet on Time	140																			
Tourniquet off Time	120																			
Throat Pack In	100																			
Throat Pack Out	80																			
	60																			
	40																			
	20																			
	10																			
	0																			

LAB Values

ABG _____

GRBS _____

Others _____

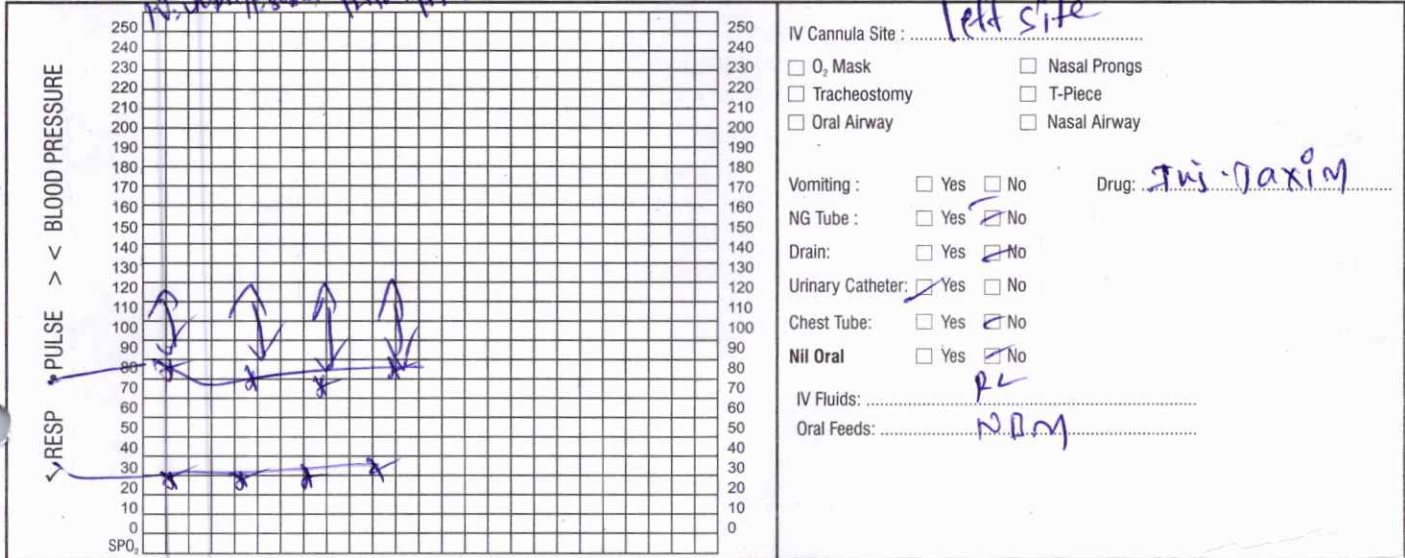
<input type="checkbox"/> Equipment Checked and Functional <input checked="" type="checkbox"/> BP <input type="checkbox"/> Cuff Site: _____ <input type="checkbox"/> Art Site: _____ <input type="checkbox"/> EKG Lead <input type="checkbox"/> Temp Site <input type="checkbox"/> FIO ₂ Monitor <input type="checkbox"/> Agent Monitor <input checked="" type="checkbox"/> Pulse Oximeter <input type="checkbox"/> Capnograph <input type="checkbox"/> Ventilator <input type="checkbox"/> Nerve Stimulator Position: _____ <input type="checkbox"/> Pressure Points Checked Eye Care: <input type="checkbox"/> Oint <input type="checkbox"/> Tape <input type="checkbox"/> Padding <input type="checkbox"/> Awake	Temp: <input type="checkbox"/> HME <input type="checkbox"/> Fluid Warmer <input type="checkbox"/> Cling Film <input type="checkbox"/> OH Warmer <input type="checkbox"/> Hugger's <input type="checkbox"/> Cotton Wool <input type="checkbox"/> Other Times: Anaes Start: 9:30pm OP Start: 9:30pm OP End: 10:30pm Leave OR: 10:40pm Anaesthesia: <input type="checkbox"/> GA <input type="checkbox"/> Monitored Anaesthesia Care <input checked="" type="checkbox"/> Regional Line (Size & Location) <input type="checkbox"/> CVP: _____ <input type="checkbox"/> ART: _____ <input type="checkbox"/> IV: 18G @ left wrist <input type="checkbox"/> IV: _____ <input type="checkbox"/> IV: _____	Induction <input type="checkbox"/> IV <input type="checkbox"/> Inhal <input type="checkbox"/> Pre O ₂ <input type="checkbox"/> RSI <input type="checkbox"/> Others <input type="checkbox"/> Mask <input type="checkbox"/> SGA <input type="checkbox"/> Airway <input type="checkbox"/> Oral <input type="checkbox"/> Nasal ETT# _____ at _____ cm <input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Cuff <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Topical <input type="checkbox"/> Drug: _____ <input type="checkbox"/> Awake <input type="checkbox"/> Direct Vision <input type="checkbox"/> Video Laryngoscopy <input type="checkbox"/> Stylette / Bougie <input type="checkbox"/> Fiberoptic Blade# _____ Attempts: _____ Difficulty Why? _____ <input type="checkbox"/> Bilat = BS <input type="checkbox"/> Semi-Closed Circle <input type="checkbox"/> Closed Circle <input type="checkbox"/> Other	Regional: <input checked="" type="checkbox"/> Extremity <input type="checkbox"/> Spinal <input type="checkbox"/> Epidural <input type="checkbox"/> Caudal Specify: _____ Others: _____ Position: _____ Site: _____ Needle Size: 25 G @ Depth: _____ Parasthesia <input type="checkbox"/> Yes <input type="checkbox"/> No Catheter at skin _____ cm Drug Name & Conc: 0.5% Bupivacaine Bolus: 2ml + 2ml Infusion: Bolus + 2ml/hr Block Level: T6 Comments: _____ Transportation to <input type="checkbox"/> PACU <input type="checkbox"/> ICU <input type="checkbox"/> Other Relaxant Reversed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA Name of the Doctor: Dr. Anshu Jaiswal Signature of the Doctor: _____
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HNH-00014208 IP26-00006531
 Mrs RUCHI LAHOTI
 08-08-1987 28 Y 10 M 1 D (F)
 Dr. MEENA UGALE



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Dr. Akhila Time Received : 10:40 PM Time Discharged :



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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
9/6	10:30 PM	0/10	NA	<u>[Signature]</u>
9/6	11:30 PM	0/10	NA	<u>[Signature]</u>
10/6	12 AM	0/10	NA	<u>[Signature]</u>
10/6	5 AM	0/10	NA	<u>[Signature]</u>

Pain Tool Used: N PASS FLACC Wong Baker NPS

Anaesthesiologist Name : Dr. Ayesha

Anaesthesiologist Signature: [Signature]

Date & Time: 10/6/26

PACU Nurse Name : AKHILA

PACU Nurse Signature: [Signature]

Date & Time: 10/6/26

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

Transferred to Unit by (PACU): f100x

Date & Time: 10/6/26

INDUCTION OF LABOR CONSENT

Name: Mrs. Ruchi Lahoti Age: 25y Gender: Male Female
UHID.No : HNL-00016208 Date: 8/6/26

You are scheduled for an induction of labor on 8/6/26 (date) at 37⁺⁵ (weeks of gestation).

The reason for your induction is Low liquor:

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

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

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

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

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

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

Patient
Signature: [Signature]
Name: Mrs. Ruchi Lahoti
Date & Time: 8/6/26 @ 6am

Patient Attendant:
Signature: [Signature]
Name: Sunita Lahoti
Relationship with Patient: Mother
Date & Time: 8/6/26 @ 6am

Doctor:
Signature: [Signature]
Name: Dr. G. Veena
Date & Time: 8/6/26 @ 6am

Witness
Signature: [Signature]
Name: Madhumita
Date & Time: 8/6/26 @ 6am

INFORMED CONSENT FOR VAGINAL BIRTH

Patient Name : Mrs. Ruchi Laboti UHID No : ANH-00014208

Gender: Male Female Date : 8/6/26 Time : 6am

I hereby authorized the performance of the following procedure:

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

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

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

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

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

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

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

Name of the Doctor performing the procedure: Dr. Meena Ugale

Consentee :
Signature : [Signature]
Name : Mrs. Ruchi Laboti
Date & Time : 8/6/26 @ 6am

Patient Attendant :
Signature : [Signature]
Name : Sunita Laboti
Relationship with Patient: Mother
Date & Time : 8/6/26 @ 6am

Witness :
Signature : [Signature]
Name : Madhumi
Date & Time : 8/6/26 @ 6am

Doctor (who is taking the consent) :
Signature : [Signature]
Name : Dr. G. Vane
Date & Time : 8/6/26 @ 6am



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CROSS CONSULTATION FORM

Doctor Name : Dr. padmaja Date : 9/6/26 Time : 12pm

Diagnosis : LSCS

Hospital : RCH - HMNR

Type of Referral :

- Emergency
- Urgent
- Non Urgent

Referred for : Opinion Co-Management Transfer of care

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature:

Findings and Recommendations :

Lactation care Plan

- Short flat Nipple's formed ~~are~~ both side
- Less colostrum seen
- Aim for deep latch as demonstrated in cross cradle / cradle hold.
- ~~make~~ make baby suck 15 - 20 mins each side every 2 - 2 1/2 hours.
- Advice Direct Breast feeding
- use nipple's shield & direct latch
- stimulate baby continuously while feeding.

Consultant :

Name : Sathwika G Signature : [Signature] Date & Time : 9/6/26, 12pm

HNH-00014208 IP26-00006531
Mrs RUCHI LAHOTI
08-08-1997 28 Y 10 M 1 D (F)
Dr. MEENA UGALE



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NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 9/6/26 Time: 12pm

Origin: Indian Height: 5'7cm Weight: 82kg BMI: ~ 26 kg/m²
 ~ 28 kg/m²
 ~ 30 kg/m²
Food Allergies: NO 27 Kdm²

Diagnosis: LSCS

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

Diet Advised:

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

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

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

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

Patient's / Attendant's

Signature: [Signature]

Name: Ruchi

Date & Time: 9/6/26; 12pm

Dietician's

Signature: [Signature]

Name: Sathwik

Date & Time: 9/6/26; 2pm

