Dr. Swapna

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ESTIMATION SLIP

Date : 12/6/26 **UHID / IP No. :** HNH-0001594S **Sl No.** 1535

Name of Patient : Mrs. Husna Syed **Age:** 31Yr **Gender:** F

Father's / Husband's Name : Mr. Moulasim **Corporate / Occupation :**

Address : Saidaba **Phone :** 9008715102 **Email :**

Procedure / Plan : MERPC / SERPC **EDD/Dos:** June

MODE OF PAYMENT : ☑ SELF ☐ TPA : ☐ GIPSA : ☐ OTHER

TARIFF INFORMATION :

Particulars	Package Amounts (Rs.)	
Room Category	Normal Delivery	LSCS
Multi Shared Ward		
Shared Ward	SERPC	MERPC
Twin Shared Ward	75k	60k
Private Room	Day Care	
Super Deluxe Room	+ pharmacy & Investigation Extra	
Suite Room		
Package includes (Package starts from the time of admission)	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee and Labour Ward Charges	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee Anesthetist's Fees and OT Charges
	Length of Stay for :	Length of Stay for :
	Pharmacy up to	Pharmacy up to
	Investigations up to	Investigations up to
Others		

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

Initial Minimum Deposit : 80% Advance time of Admission

REMARKS :

1. 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.
2. 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.
3. **Total baby charges are extra which include admission, pharmacy, vaccinations, investigations, disposables, consumables, equipments, speciality consultations, etc.**
4. 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
5. **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.**
6. 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.
7. 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
8. Tariffs are subject to revision
9. Kindly check your billing status on day to day basis at IP Billing Department.
10. Additional Charges on package are applicable for Non-working hours and Non-working days (sundays and public holidays)

DECLARATION

I Mulasim 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

Husband
Signatory Relationship

Signature of the financial Counselor

Name	Mrs HUSNA SYED	**UHID**	HNH-00015945
Father/Guardian	Mr MOUTASIM BILLAH	**Age/Gender**	31 Y 6 M 31 D/ Female
Address	16-2-866/a/1 jeevanjarjung colony, saidabad, Saidabad, Hyderabad, Telangana, INDIA, 500059		
IP No	IP26-00006585	**Admission Date**	14-06-2026
Ref Doctor	Self.		
Discharge Date	15.06.2026		

DISCHARGE SUMMARY

Consultant:
Dr. SWAPNA SAMUDRALA
69924

Diagnosis: G9P7L5D1A1 AT 13 WEEKS WITH ANOMALOUS FETUS FOR MEDICAL TERMINATION OF PREGNANCY

MEDICAL TERMINATION OF PREGNANCY BY MERPC done on 15.06.2026

History:

LMP: 15/03/26
EDD: 20/12/26

Obstetric formula: G9P7L5D1A1
Gestation at admission: 13 weeks

Obstetric History:

Name	Mrs HUSNA SYED	**UHID**	HNH-00015945
IP No	IP26-00006585	**Admission Date**	14-06-2026

1 - 2015 - IUFD at 8th Month, Induced Vaginal Delivery (No Reports)
2 - 2016 - PTNVD at 36 wks , Female, Wt 2.5 kg, A & H , Uneventful
3 - 2017 - FTND , Female, Wt 2.65 kg, A & H , Uneventful
4 - 2018 - FTND , Male, Wt 2.6 kg, A & H , Uneventful
5 - 2022 - FTND , Female, Wt 2.65 kg, A & H , Uneventful
6 - 2023 - 8 Wks - Missed Miscarriage , MERPC done
7 - 2023 - IUFD at 32 wks , Induced Vaginal Delivery
8 - 2024- FTND , Female, Wt 2.65 kg, A & H , Uneventful
9 - PP, Spontaneous Conception

Medical History: Nil
Family History: Nil
Surgical History: Nil
Allergies: Nil

Antenatal Details:

Mrs HUSNA SYED was booked to Rainbow hospital at 12^{+6} weeks of gestation. Previous ANC's elsewhere. NT Scan (11/6/26) - Single live fetus at 12^{+4} weeks with increased NT (7.16), Absent NB, Cystic Hygroma with Generalised Oedema with pleural / pericardial effusion, VSD. Couple Counselled and advised termination. Couple Counselled regarding further testing on POC Microarray. She took Tab mifepristone 600mg on 13.06.2026. She was admitted at 13 weeks for MTP by MERPC.

Investigations: Enclosed
Blood Group: "A " Positive

Name	Mrs HUSNA SYED	**UHID**	HNH-00015945
IP No	IP26-00006585	**Admission Date**	14-06-2026

Management: On admission her vitals were stable. Routine blood investigations were sent and traced. Consent taken for medical termination of pregnancy. Antibiotic prophylaxis Inj Taxim 1 gm was given. MERPC done with 3 doses of PGE1. She was closely monitored. She expelled products of conception at 10:15am. USG done for RPOC on 15.06.2026 showed No Retained products of conception,Heterogenous echogenic areas in low uterine cavity extending into cervical canal measuring 44x28x43mm s/o organised blood clots,cervical internal os open. Gentle currettage done and clots evacuated.Products of conception sent for Chromosomal Microarray,MCC and DNA storage. Her general condition was satisfactory and she was found to be fit for discharge. Medications were explained to the patient supplemented by written information.

Advice:

1. Tab Taxim O 200mg (Cefixime 200mg) twice daily after food (9am-9pm) till 19.06.2026
2. Tab Misoprostol 200 mcg twice daily (6am-6pm) for 2 days till 17.06.2026
3. Tab Pantop 40mg twice daily before food (7am-7pm) till 19.06.2026.
4. Tab Dolo 650mg SOS (for pain).
5. Tab Zincovit once daily at 2pm after food for 1 month.
6. Tab Livogen once daily at 7am for 1 month.
7. RPOC scan on day 4 of next cycle
8. Collect CMA,MCC and DNA storage reports.

Review with **Dr. SWAPNA SAMUDRALA** after **2 week** on **29.06.2026** at

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Name	Mrs HUSNA SYED	**UHID**	HNH-00015945
IP No	IP26-00006585	**Admission Date**	14-06-2026

Rainbow Children's Hospital with prior appointment **(Review consultation will be charged).**

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

Patient/ Attender

In case of emergency like bleeding, fever, 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**

Registrar/Resident/C.M.O

Consultant:
Dr. SWAPNA SAMUDRALA
MBBS, MS (OBG)
69924

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital

BirthRight by Rainbow

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

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006585 **Admit Date** : 14-Jun-2026 **Admit Time** : 11:33 PM **UHID** : HNH-00015945

Patient Details :

Patient Name	: Mrs HUSNA SYED	**Age**	: 31 Y 6 M 30 D
Guardian	: Mr MOUTASIM BILLAH	**DOB**	: 15-11-1994
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 16-2-866/a/1 jeevanjarjung colony, saidabad Saidabad Hyderabad Telangana INDIA 500059	**Phone No**	: 8008718102/ 7075186562
		E-mail	: na@gmail.com

Admission Details :

Bed Type : TWIN SHARING **Bed No** : LDR-416 **Ward Name** : 4F -OT

Room No : LDR-416 **Admission Type** : First Visit

Contact Details :

Name : Mr MOUTASIM BILLAH **Relationship** : W/O

Contact Address : **Phone No** : 8008718102

Signature

Doctor Details :

Doctor Name : Dr. SWAPNA SAMUDRALA **Specialisation** : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self. **Phone No** :

Co-Consultant :

Payment Details :

Payment Mode : Cash **Deposit Amount** : 50000.00

Payor Name : SELFPAY

HNH-00015945 IP26-00006585
Mrs HUSNA SYED
15-11-1994 31 Y 6 M 31 D (F)
Dr. SWAPNA SAMUDRALA

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I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : ..... Time of Admission : .....

Allergies: ..... ☐ Not know any drug allergies

PRESENTING COMPLAINTS :

G 9 P ~~7~~ L 5 D 2 A 1 with 13 wks POG with previous NVD with Anomalous ~~bb~~ fetus. Came for MERPC ± SERPC.

Anamoly: ↑sed NT (7.16), Absent Nasal bone, Cystic hygroma with Generalised Oedema with pleural / pericardial effusion (VSD).

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : 2014	Parity : G 9 P 8 L 5 D 2 A 1
Previous Periods : Regular	Mode of Delivery : NVD
LMP : 15/3/2026	Last Child Birth : 2024
Contraception : –	

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
Nil.	Nil

HNH-00015945 IP26-00006585
Mrs HUSNA SYED
15-11-1994 31 Y 6 M 31 D (F)
Dr. SWAPNA SAMUDRALA

FAMILY HISTORY:

Nil.

MEDICATION HISTORY:

Nil.

INITIAL ASSESSMENT :

Date 14/06/2026
Ht. 156cm Wt. 64.1kg.
BMI 26.3
B.P 103/66mm Hg.
Pallor Nil
CVR PR: 76bpm
Respiratory System BL NVBS
Thyroid normal.

Breasts

Normal
NAD

Abdominal Examination

Soft, NT

Local/Speculum Examination

not done

Bimanual Pelvic Examination

not done.

PROVISIONAL DIAGNOSIS : G9 P7L5D1 with 13wks PPG with Anomalous fetus for MTP

INVESTIGATIONS ORDERED

CBP (13/6/2026) BGT: A positive
Hb - 12gm%
TLC - 6.69
plt - 2.51
PCV - 33.5

HIV
HbsAg
HCV
} NR

FT4 - 1.33
TSH - 1.42

CUE - WNL.

RBS - 77

PLAN OF MANAGEMENT

Admission
MTP Consent
Parts Preparation
T. Misoprostol. 400 mcg PV stat
T/b 200mcg PO 4th hrly
Send: CBP, CUE, Urine ~~CS~~
FT4, RBS, HIV, HbsAg, Anti HCV

Name of the Doctor: Dr. Swapna. S.
Signature of Doctor
Date & Time : 14/06/2026

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ACTIVITY RECORD FOR BILLING

HNH-00015945
Mrs HUSNA SYED
IP26-00006585
15-11-1994
31 Y 6 M 31 D
(F)
Dr. SWAPNA SAMUDRALA

Name : _____

UHID No. : _____ Consultant: _____ Dept : _____

Date of Admission: _____ Date of Discharge : _____ Time: _____

Room / Bed No : _____ Ward : _____ Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
15/6/26	(MCC) meternal cell contamination	9866	
15/6/26	chromosomal micro ARRY 750K	9866	
15/6/26	DNA isolation storage.		
15/6/26	PROC scan	7205	Sj
			cross checked date

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
12/6/25	IV Placement	1	266726	Ali
12/6/25	MERPC		206822	Anitha

cross checked done

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00015945 IP26-00006585
Mrs HUSNA SYED
15-11-1994 31 Y 6 M 31 D (F)
Dr. SWAPNA SAMUDRALA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/6/2026 8:00am 7:30am	cls/by Dr. Naveena	
	O/E GC-fair.	Adv
	Afebrile, SpO_2-100% on RA	- Early breakfast ftb liquid
	PR: 82bpm	- Continue T. Misoprostol 200mcg PO 4thly
	BP: 96/66mmHg	- wlf Expulsion
	CVS/RS: NAD	- Monitor Vitals
	PA: soft, NT	- In/aem. SOS
	ut-12wks size	- Send POC for CMA (Medgenome)
	PE: PV bleeding	
	clots ++.	
		D. Naveena

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Mrs HUSNA SYED
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/6/26 10:05AM	c/s/B Dr. Veena - c/D/W Dr. Swapna	
	Pt. c/o Tsed abd. pain	
	o/e GC-fair	
	BP - 100/70mmHg	Adv
	PR - 86bpm	- Vital monitoring
	SpO2 - 100% on RA	- w/f excessive bleeding PV
	P/A - Soft.	- Inj. Oxytocin 20U IV @ fast flow
	P/V - Products of conception @ vaginal canal	- T. Misoprostol 600mcg P/R
	No active Bleeding P/V	- Inform SOS
	POC expelled along with Placenta.	- Scan for RPOC @ 11:30AM
	Bedside USG - Clots (+) @ fundal area ~ 3x3cm	
	T. Miso 600mcg P/R kept	

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

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Mrs HUSNA SYED
15-11-1994 31 Y 6 M 31 D (F)
Dr. SWAPNA SAMUDRALA

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...ESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/6/26 2:30 pm	USG pelvis → No RPOC	
	Echogenic areas - 4.4 x 2.8 x 4.3 cm. s/o blood clots.	
	Couple & attenders counselled.	
	O/E - G.C fair	Adv
	Afebrile	- T. Taxim - O 200 mg (BD) x 5 days
	O_2 Sat - 99% RA	
	PR - 90 b/m	- T. Misoprostol 200 µg twice daily x 2 days
	B.P - 90/60 mmHg	
	P/A - Soft	- T. Pan 40 mg OD x 5 days
	P/S - Cx OS open	- T. Livogen once daily (After) x 1 mth
POC sent for culture / HPE [illegible]	min products / clots removed	- Review x 2 wks.
Can be discharged.		[signature] (Dr. [illegible])

Noted by [signature] 15/6/26 @ 1pm

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00015945 IP26-00006585
Mrs HUSNA SYED
15-11-1994 31 Y 6 M 31 D (F)
Dr. SWAPNA SAMUDRALA

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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: ..... Shifted to: .....

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. G. Veena

Date & Time : 15/6/26 @ 9am

Nurse Name & Signature: Anusha L

Date & Time : 15/6/26 @ 9am

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

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DRUG CHART

Date of Admission: 14/6/26 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:				

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

Mrs HUSNA SYED IP26-00006585
15-11-1994 31 Y 6 M 31 D
Dr. SWAPNA SAMUDRALA (F)

REGULAR PRESCRIPTIONS

Weight. 64.1kg Ward. ....

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

HNH-00015945
Mrs HUSNA SYED
15-11-1994 31 Y 6 M 31 D (F)
Dr. SWAPNA SAMUDRALA
IP26-00006585

Weight. 64.1kg Ward. .....

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
15/6	12:00am	T. MISOPROSTOL	400mcg	PV		Cluedy Alath.
15/6	4:00am	T. MISOPROSTOL	200mcg	PO		Cluedy Alath
15/6	8:00am	T. MISOPROSTOL	200mcg	PO		Cluedy Alath
~~15/6~~	~~10:15AM 12PM~~	~~T. MISOPROSTOL~~	~~200mcg~~	~~PO~~		
15/6	10:15AM	T. MISOPROSTOL	600mcg	P/R		DY & Alath
15/6	1:20PM	INJ. CEFOTAXIME	1g (ADD)	IV		Alath

Verified by Dr. Dhakshayani

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

HNH-00015945 IP26-00006585
Mrs HUSNA SYED
15-11-1994 31 Y 6 M 31 D (F)
Dr. SWAPNA SAMUDRALA

I.V. FLUIDS CHART

Weight. 64.1kg Ward. .....

		nposition of I.V. Fluid , mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
15/6	7AM	RINGER LACTATE	IV	~~100ml/hr~~ FF			15/6		
15/6	10.30 AM	RINGER LACTATE + 20U OXYTOCIN.	IV	FF			15/6		

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

HNH-00015945 IP26-00006585
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OP Baby

RESULT SHEET

Date	13/6/26					
Time						
Hb	12.0					
PCV	33.5					
RBC	3.90					
WBC	6.69					
N/L						
Platelets	251					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Blood group						
HIV						
HbsAg MR						
HCV						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 14/6/26

Baseline Information:

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

Primary Language: ☐ Telugu ☐ English ☐ Hindi ☐ Others, specify .....

Do you require an interpreter? ☐ Yes ☐ No if Yes specify .....

Source of Information: ☐ Patient ☐ Family ☐ Others, specify .....

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

If yes , identify .....

Chief Complaints: .....

.....

.....

Doctor Notified on Admission: ☑ Yes ☐ No

Name of the Doctor: DR. Navpeena

Time Notified: .....

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

Past Medical History	Past Surgical History	Previous Hospital Admission
-	-	-

Gynecology Assessment: ☐ Not Applicable

Menstrual History: .....

Regular

Onset of Menarche: .....

Menstrual Cycle: ☐ Regular ☐ Irregular

Last Menstrual Period: .....

Gynecology Surgical History:

Caesarean Section: ☐ No ☐ Yes

Cervical Cerclage: ☑ No ☐ Yes

Ectopic Pregnancy: ☑ No ☐ Yes

Myomectomy: ☑ No ☐ Yes

Others: _____

Gynecological History:

Contraceptives: ☑ No ☐ Yes

Vaginal Discharge: ☑ No ☐ Yes

Post-Coital Bleeding: ☑ No ☐ Yes

Infertility: ☑ No ☐ Yes

If Yes Type: ☐ Primary ☐ Secondary

Obstetric History: G ..... P ..... L ..... A .....

Previous LSCS: .....

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

Family History: ☑ No Abnormalities Detected

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

☐ Liver disease ☐ Other .....

Vital Signs / Measurements: Temp: 97.6F HR: 87 RR: 20

BP: 107/73 Weight: ..... Height: ..... BMI: .....

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

HNH-00015945 IP26-00006585
Mrs HUSNA SYED
15-11-1994 31 Y 6 M 31 D (F)
Dr. SWAPNA SAMUDRALA

PHYSICAL ASSESSMENT

General Appearance: ☑ Healthy ☐ ill looking ☐ Anxious ☐ Agitated ☐ Others: .....

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

Risk of Pressure Sore: ☑ Yes ☐ No Score ..2.. (complete the Braden Q Sheet)

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

☐ Mobility problem ☐ Walking Problem ☑ No Abnormality Detected

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☑ No Abnormality Detected

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

☐ Under Weight ☐ Diabetes Mellitus ☐ Hyperemesis Gravidarum

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

☐ Others .....

Inform consultant for positive criteria

SOCIAL SCREENING:

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

Social History: Lives With ..Family member..

Orientation has been given regarding the following aspects:

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

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

Above information given to ..Patient..

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

Orientation not given Reason: .....

Nurse Signature: .....

Nurse Name: .....

Date & Time: ..13/6/2020 11:30 am

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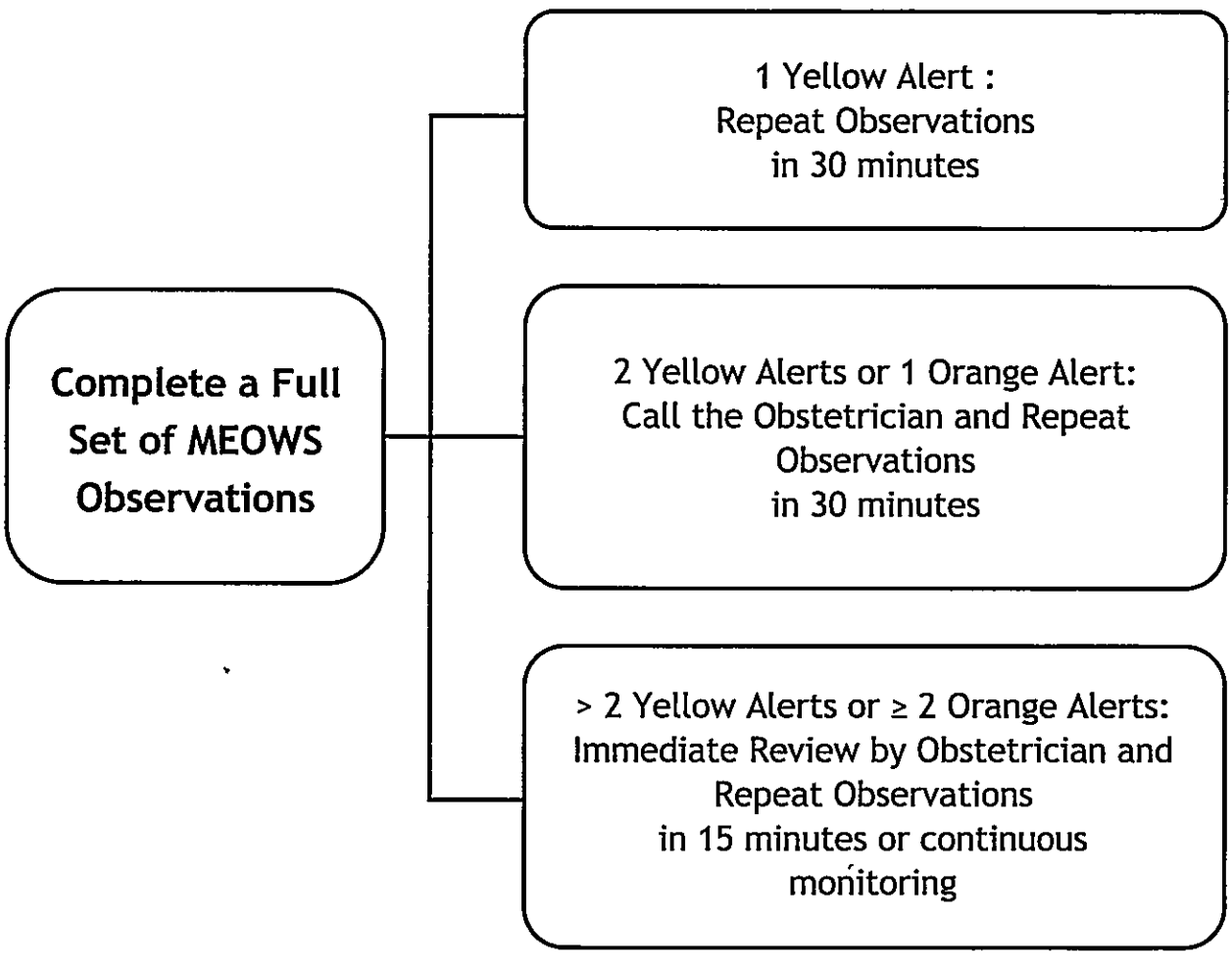
Early Warning Observation Score Chart - Obstetrics

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

12/6/26	Date																							
	Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																								
	21 - 30																								
	11 - 20																20		20		20		20		20
	0 - 10																								
Saturations	94 - 100 %																100		100		100		100		100
	< 94 %																								
Administered O_2 (L/min.)																									
Temp°c	40																								
	39																								
	38																								
	37																97.6F								
	36																								
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80																84		86		86		86		
	70																								
	60																								
	50																								
	40																								
Systolic Blood Pressue ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																104		115		106		100		106
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80																82		70		70		60		60
	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																	0		0		0		0		0
TOTAL ORANGE SCORES																	0		0		0		0		0
Nurse Initial																									

Obstetrics and Gynaecology Early Warning Signs



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

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		Date																							
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20			20	20	20	20		20		20															
	0 - 10																									
Saturations	94 - 100 %			98	99	98			99		98															
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°c	40																									
	39																									
	38						38																			
	37					37.2																				
	36										36.1															
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90			76	81	76			80		81															
	80																									
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressure ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120			114	106				111		116															
	110			90	90	90			90																	
	100																									
	90																									
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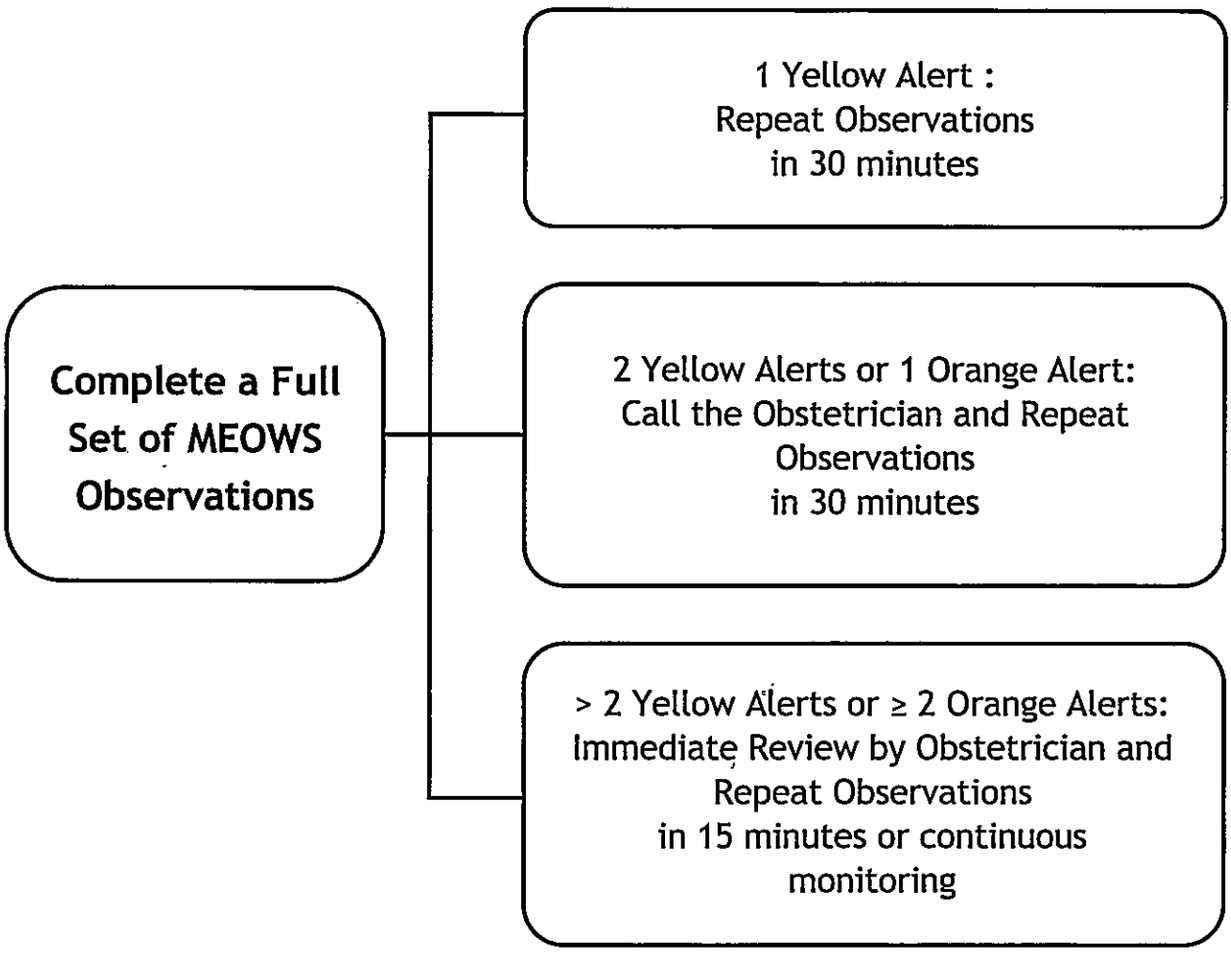
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70			71	81	70			73		84															
	60																									
	50																									
	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				0	0	0			0		0															
TOTAL ORANGE SCORES				0	0	0			0		0															
Nurse Initial																										

Obstetrics and Gynaecology Early Warning Signs



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FLUID CHART

Sheet No. : 1

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

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
14/6/18	08:00 pm								1			
	09:00 pm											
	10:00 pm								0		0	40 C
	11:00 pm								1			
	12:00 am											
	01:00 am											
Total Intake :		Taken				**Total Output :**				Passed		
15/6/18	02:00 am											
	03:00 am								1			
	04:00 am											Alt
	05:00 am								2			
	06:00 am											
	07:00 am	RL	RL	EF					1			
Total Intake :		Taken				**Total Output :**				Passed		

Total 24 hrs. Intake		Total 24 hrs. Output	

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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						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am	RL		100							1	
	09:00 am	RL		100								
	10:00 am	RL		100							0	
	11:00 am	D5 1/2 NS		FF								
	12:00 pm	D5 1/2 NS		FF						✓	1	
	01:00 pm	D5 1/2 NS		FF								
Total Intake :		Ranitin.				**Total Output :**				Passed		
	02:00 pm			W20								
	03:00 pm									✓	1	
	04:00 pm			W20								
	05:00 pm			W20							0	
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**				Passed		
	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	

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CHECKLIST FOR THROMBOPHLEBITIS

14/6/26

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

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

Signature of Shift In Charge :

Signature : ..... Name : .....

Signature of Ward In Charge :

Signature : ..... Name : .....

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

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

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Signature : ..... Name : .....

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Signature : ..... Name : .....

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	14/6/24 8pm	15/6/2024	
		Score		M.S	
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0	0		
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0			
IV / Heparin Lock or Saline	Yes	20			
	No	0			
GAIT / Transferring	Impaired	20	20	20	
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0			
Mental Status	Forgets limitations	15			
	Oriented to own ability	0			
Total Morse Fall Scale Score:			20	20	
		Signature	Abi		

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

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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BRADEN 'Q' SCALE

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					Date : 14/6 / 15/6		
					Time : 8pm / AM		
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4	
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	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	
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	
				TOTAL SCORE	28	28	
				Evaluator's Name	Alu		

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

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Your Right to a Safe Delivery

PAIN ASSESSMENT FORM

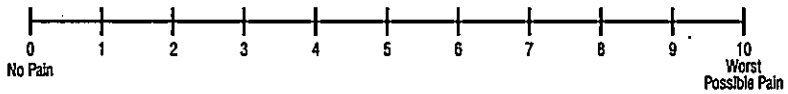
Date	Time	(0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
14/6/26	12Am	0/10	Normal	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
15/6/26	8Am	0/10	Normal	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
15/6	2Pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

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, right, 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

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, SaO_2	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

HNH-00015945 IP26-00006585
Mrs HUSNA SYED
15-11-1994 31 Y 6 M 31 D (F)
Dr. SWAPNA SAMUDRALA

NURSING CARE RECORD

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: 24/6/26

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							
Afternoon							
Night	8pm 3am	- Assess the Patient condition - plan for vital record - plan for Tracheostomy	8pm 3.AM	- Assessed the Patient condition - Maintain vital - Maintain Tracheostomy	- Patient Stable	- intact WNL	

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Date: 15/6/2026

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am | 2pm	→ Assess the pt condition → check the vital's → I/O chart Maintain → Plan for Medication	8am | 2pm	→ Assessed pt condition → Checked vital's 4hrs → Maintained I/O chart → given Medication as per doctor's order	pt is stable	vital's is Normal	Anusha
Afternoon				Daily			
Night							

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION	Diagnosis: MTP			Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:			
BACKGROUND	Area / Shift Time	15/6/26 8pm	15/6/26 AM				
	Medical Condition (Any special condition to be noted):	—	—				
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	97	98.1				
	Res:	20	20				
	SpO_2:	100	99%				
	Pulse:	86	87				
	BP:	120/70	120/80				
	Fall Risk Score:	~~0~~	—				
	Pain Score:	0/10	—				
Recommendations	Safety Needs:	Yes	yes				
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	—	—				
	Special Diet:	~~☐ Yes~~ ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	—	—				
Post Operative Procedure Special Orders:		—	—				
Handed Over By Name :		Aleena	Anu				
Signature :		Aleena	Anu				
Date:		15/6/26	15/6/26				
Time:		8am	2pm				
Taken Over By Name :		Anu	Nikitha				
Signature :							
Date:		15/6/26	15/6				
Time:		8am	2pm				

Docu. No. : RCH /FRM / CLINICAL / 097

Patient Sticker

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION	Diagnosis:					Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:	
BACKGROUND	Area / Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							

CONSENT FORM FOR MEDICAL TERMINATION OF PREGNANCY

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Your Right to a Safe Delivery

Patient Name : MRS. HUSNA SYED. Age : 31 YRS.

UHID No : HNH - 0001594S Date : 14/06/2026

I, the undersigned, Mrs. / Miss : HUSNA SYED W/o, D/o, C/o MOUTAS IM.

aged 31 YRS. years and residing at ..... request to terminate my pregnancy.

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

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

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

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

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

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

Name of the Doctor performing the procedure : Dr. SWAPNA SAMUDRALA.

Patient :

Signature : .....

Name : MRS. HUSNA SYED

Date & Time : 14/06/2026 @ 11:55pm.

Patient Attendant / Guardian :

Signature : .....

Name : MOUTAS IM

Relationship with Patient: Husband.

Date & Time : 14/06/2026 @ 11:55pm.

Doctor (who is taking the consent) :

Signature : .....

Name : Dr Naveena.

Date & Time : 14/06/2026 @ 11:55pm.

Witness :

Signature : .....

Name : Chenchrakala.

Date & Time : 14/6/26 at 11.55pm

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