HNH-00016124 IP26-00006641
Mrs ANURADHA GABBITA
13-08-1973 52 Y 10 M 12 D (F)
Dr. RAJANI KUMARI

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SURGERY DETAILS

Date : 25/6/26

Patient Name: Mrs. Anuradha Gabbita Date of Birth: 13-08-1973 Age: 52

Gender: Female Ward : OT - 2 UHID No.: HNH-0001612.4

Date of Surgery: 25/6/26 ☑ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Dilatation & Curettage

Time in : 12:00Pm Time Out : 12:30 pm

	NAME	AMOUNT
1. Surgeon	: Dr. Rajani Kumari	
2. Anaesthetist	: Dr. Samir	
3. Assistant Surgeon	:	
4. OT Technician	: Sr. Saraswathi	
5. Circulating Nurse	: Sr. Karuna	
6. Assistant Nurse	: Sr. Natasha. Sr. Archana	

Mrs ANURADHA GABBITA (52 Y 10 M 12 D/F)
TISSUE
NINV00215
HN26010325020

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

Mr. Dhanusha For Dr. Rajani
Signature of the Surgeon

Karuna
Signature of Circulating Nurse

Order No: 26-000026813 1

Order by: Sushila 25/6/26 @ 12.51 Pm.

HNH-00016124 IP26-00006641
Mrs ANURADHA GABBITA
13-08-1973 52 Y 10 M 12 D (F)
Dr. RAJANI KUMARI

D&C

CONSUMABLES OF OT

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Circulating staff : Karuna Technician : Pallavi Date : 25/6/26 Time :

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			~~Major Pack~~ General kit		01	Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : A / P / N						Suction Catheter		
HME filter : A / P / N						Feeding Tube		
Syringes : 10 cc		02				Vaccum Suction Set		
05 cc		02	Gloves SG 6.5		03	Surgical Gloves		
02 cc		02	Encore 6.5		01	Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade			Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL		01	Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml		01	Koochies XXL		01			
			Ointments					
			Suction Catheter					
Fentanyl			Cap, Mask		10+10			
Morphine			Gauze Pack 10X10		01			
Ketamine			Mop Pack 1 Pack		01			
Propofol			Steristrip					
Rocuronium			Underpad		01			
Glycopyrolate			Draw sheet					
Myopyrolate			Abgel					
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22		01	Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)		01	Romodrain bag					
Antibiotics			Bandage					
			Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set		01			
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet Aprons		3			
Tab. Misoprost : 200mg			Betadine Solution		01			
			Microshield		V			
			Cotton Balls		01			
			Latex Gloves		20			
			Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 26-00020813 4/133 Ordered by : Archana 25/6/26 @ 12:59 pm

Doc. No. : RCH / FRM / GENERAL / 125

Rainbow Children's Hospital

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-00016124	**Name**	: Mrs ANURADHA GABBITA
Age / Sex	52 Y 10 M 12 D / Female	**Doctor**	: RAJANI KUMARI
Adm/Reg Date/Time	25/06/2026 08:41	**Payor**	: MEDI ASSIST INSURANCE TPA PVT LTD
Order Date	25/06/2026 12:58	**Ordernumber**	: 26-0000208133
Visit ID	IP26-00006641	**Ward/Bed No**	: 4F -OT / PPO-417
Patient Address	: 3-103/39, plot no :39, sarada krupa, ganeshnagar colony chengicherla, hyd, Boduppal, Hyderabad, Telangana, INDIA, 500092		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	FACE MASK 3 LAYER ELASTIC	FACE MASK 3 LAYER	1 Nos	External / Once Daily	1 Days		10 Nos	Dispensed
2	POVINANZ SOLUTION 10% 100 ML		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
3	NITRILE EXAMINATION GLOVES P F- MEDIUM		1 Nos	External / Once Daily	1 Days		20 Nos	Dispensed
4	RL 500 ML CLOSED SYSTEM	RINGER LACTATE 500ML CLOSED	1 Bottle	/ Once Daily	1 Days		1 Bottle	Dispensed
5	SURGEON CAP(FEMALE) (PROTECTCARE)		1 Nos	External / Once Daily	1 Days		10 Nos	Dispensed

RAJANI KUMARI

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

Note

*** This prescription is valid only for specified duration.**

*** Do not refill medicines.**

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040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	HNH-00016124	**Name**	: Mrs ANURADHA GABBITA
Age / Sex	52 Y 10 M 12 D / Female	**Doctor**	RAJANI KUMARI
Adm/Reg Date/Time	25/06/2026 08:41	**Payor**	. MEDI ASSIST INSURANCE TPA PVT LTD
Order Date	. 25/06/2026 12:58	**Ordernumber**	· 26-0000208134
Visit ID	: IP26-00006641	**Ward/Bed No**	: 4F -OT / PPO-417
Patient Address	: 3-103/39, plot no :39, sarada krupa, ganeshnagar colony chengicherla, hyd, Boduppal, Hyderabad, Telangana, INDIA, 500092		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	MOPS 30X30 8PLY 5S X-RAY	MOPS 30X308 PLYDATT	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
2	BUPICAIN HEAVY 80MG INJ 4ML		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
3	PENCAN 25G*3 1 2	PENCAN 25G*3 1 2	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
4	DSYRINGE 5ML.(NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
5	ADULT DIAPERS-XXL		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
6	DISPOSABLE APRONS STERILE XL	DISPOSABLE APPRON STERILE XL	1 Nos	/ Once Daily	3 Days		3 Nos	Dispensed
7	DSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
8	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
9	VACCUME SUCTION SET		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
10	GENERAL SURGICAL KIT (MEDITAKE)		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
11	Encore Microptic gloves-6.5		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
12	BACTOPREP SOLUTIONS 100 ML		1 mL	/ Once Daily	1 Days		1 Nos	Dispensed
13	UNDER PAD 60X90 10's Pack - MEDICUBE		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
14	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
15	COTTON BALLS 2 GM 5 NOS		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
16	NS 500ML CLOSED BOTTLE		1 Bottle	External / Once Daily	1 Days		1 Bottle	Dispensed
17	GAUZE PACK STERILE 10X10X12 PLY 5S	GAUZE PACK STERILE 10X10X12 PLY 5 PACK	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed

RAJANI KUMARI

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Note

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Name	Mrs ANURADHA GABBITA	**UHID**	HNH-00016124
Father/Guardian	Mr G.V.RAMACHANDRA RAO	**Age/Gender**	52 Y 10 M 12 D/ Female
Address	3-103/39, plot no :39, sarada krupa, ganeshnagar colony chengicherla, hyd, Boduppal, Hyderabad, Telangana, INDIA, 500092		
IP No	IP26-00006641	**Admission Date**	25-06-2026
Ref Doctor	Self.		
Discharge Date	25.06.2026		

DISCHARGE SUMMARY

Consultant:
Dr. RAJANI KUMARI
MD (OBGYN)

Diagnosis: PERIMENOPAUSAL P2L2 WITH PREVIOUS 2 LSCS WITH ABNORMAL UTERINE BLEEDING WITH K/C/O HYPERTENSION FOR FURTHER EVALUATION.

DIAGNOSTIC DILATATION AND CURETTAGE DONE ON 25.06.2026

History: She has complaints of irregular cycles since 6 month, associated with clots, not associated with dysmenorrhea, not relieved with medication. USG done on 17.06.2026 showed mild bulky uterus, AV, ET 15.3mm with mildly thickened endometrium with small anterior myometrial uterine fibroid 11x10mm, thin walled cyst measuring 33x22mm; simple right ovarian cyst; mild hepatomegaly with grade 1 fatty liver. She was admitted for diagnostic

Name	Mrs ANURADHA GABBITA	**UHID**	HNH-00016124
IP No	IP26-00006641	**Admission Date**	25-06-2026

dilatation and curettage.

Menstrual History:-
LMP- 05.06.2026
Previous cycles: Irregular

Obstetric History: P2L2, 2 LSCS, LCB- 27 years

Medical History: K/C/O HTN:- 1.5 years (On Tab. CINOD- 5mg OD)
Family History: Parents DM, Father HTN
Surgical History: 2 LSCS- 1995, 1999; tubectomised

Allergies: Nil

Investigations: Enclosed.
Blood group: "B" Positive

Surgery Notes:
Operation performed: **DIAGNOSTIC DILATATION AND CURRETTAGE DONE UNDER SPINAL ANAESTHESIA**

Indication: PERIMENOPAUSAL BLEEDING WITH AUB

Operative findings:
- Cervix healthy.
- UCL 5 inches
- Uterine cavity regular except anterior wall irregular.
- Plenty (polypoidal) of curetting obtained.
- Sample saved and sent for HPE

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Name	Mrs ANURADHA GABBITA	**UHID**	HNH-00016124
IP No	IP26-00006641	**Admission Date**	25-06-2026

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

Advice:

1. Tab. Taxim O 200mg (Cefixime 200mg) twice daily till 29.06.2026 (9am - 9pm) after food.
2. Tab Chymoral Forte (Chymotrypsin +trypsin) thrice daily (8am-3pm-10pm) till 29.06.2026
3. Tab. Pantodac 40 mg (Pantoprazole 40mg) once daily (7am) before food till 29.06.2026
4. Tab. Zincovit once daily (2pm) for 1 month after food.
5. Continue Antihypertensive as earlier.
6. Tab. Calpol 500mg (Paracetamol 500mg) SOS (for pain)
7. Tab Tranexamic acid 500mg SOS (for bleeding)
8. Collect HPE report

Review consultation with Dr. RAJANI KUMARI, with HPE report in Gynec OPD at rainbow Children's Hospital (**Review consultation will be charged**).

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

Patient/ Attender

Name	Mrs ANURADHA GABBITA	**UHID**	HNH-00016124
IP No	IP26-00006641	**Admission Date**	25-06-2026

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

Registrar/Resident/C.M.O

Consultant:
Dr. RAJANI KUMARI
MD (OBGYN)

10:00am

25/6/26

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ESTIMATION SLIP

Date : 22/6/26 UHID / IP No. : _____ Sl No. 1632

Name of Patient : G. Anuradha Age: 52 Gender: F

Father's / Husband's Name : Mr. Ramchandra Rao Corporate / Occupation : _____

Address : _____ Phone : 9246791762 Email : _____

Procedure / Plan : D&C. 7660241122. EDD/Dos: _____

MODE OF PAYMENT : ☐ SELF ☑ TPA : CARE HEALTH. ☐ GIPSA : _____ OTHER

TARIFF INFORMATION :

Particulars	Package Amounts (Rs.)	
Room Category	Normal Delivery	LSCS
Multi Shared Ward		
Shared Ward		
Twin Shared Ward		
Private Room	70,000/- + Pharmacy + Investigations extra.	
Super Deluxe Room		
Suite Room		
Package includes (Package starts from the time of admission)	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee and Labour Ward Charges	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee Anesthetist's Fees and OT Charges
	Length of Stay for :	Length of Stay for :
	Pharmacy up to	Pharmacy up to
	Investigations up to	Investigations up to
Others		

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

Initial Minimum Deposit : Rs. 10,000/- Advance.

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 G. Anuradha. 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.

G. Anuradha	Self	
Signature of the Client	Signatory Relationship	Signature of the financial Counselor

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ACTIVITY RECORD FOR BILLING

Name :_____

HNH-00016124 IP26-00006641
Mrs ANURADHA GABBITA
13-08-1973 52 Y 10 M 12 D (F)
Dr. RAJANI KUMARI

UHID No. : _____ IP ant: _____ Dept : _____

Date of Admission: _____ Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
25/6/26	11:50 Am	Pre-Post	OT	Sujatha / Kavya
25/6/26	12:30	OT	pre-post	

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

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
25/6	Cardiac monitor	12:30 pm	2pm	208142	[illegible]
25/6	Infusion pump				

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
25/6	IV placement	1	208079.	Anushed
[illegible]	PAC (OP)		26-000 917017	Anushed

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00016124 IP26-00006641
Mrs ANURADHA GABBITA
13-08-1973 52 Y 10 M 12 D (F)
Dr. RAJANI KUMARI

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I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 25/06/2026. Time of Admission : .....

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

PRESENTING COMPLAINTS :

Irregular ~~periods~~ cycles :- 6 month.
a/w heavy flow., clots passage.

LLMP - Jan 2026
↓
~~April~~ 2026
↓
June 2026 → continuous & heavy flow.
since 1month.

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage :	Parity : P2L2.
Previous Periods : Irregular. LLMP: Jan 2026.	Mode of Delivery : 2 LSCS.
LMP : ~~5~~/6/26. ~~April~~ 2026	Last Child Birth : 2 Year.
Contraception :	

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
K/C/O HTN :- 1 1/2 yr. on Tab CINOD - 5mg OD	LSCS - 2 yr back.

HNH-00016124 IP26-00006641
Mrs ANURADHA GABBITA
13-08-1973 52 Y 10 M 12 D (F)
Dr. RAJANI KUMARI

FAMILY HISTORY:	MEDICATION HISTORY:
father - HTN DM Mother - DM.	T. CINOD - 5mg OD.

INITIAL ASSESSMENT :

Date 25/6/26. Ht. ____ Wt. ____ BMI ____ B.P ____ Pallor - CVR S1S2 (+) Respiratory System BAE (+) Thyroid ____	Breasts Not done. Abdominal Examination soft.	Local/Speculum Examination Not done Bimanual Pelvic Examination Not done.

PROVISIONAL DIAGNOSIS : Perimenopausal P_2L_2 c 2LSCS c AUB-L

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT
Blood Group - B+ve. 17/6 Hb. 13g%. Plt - 2.7. WBC - 10,250. HIV, HBsAg, HCV] NR. USG. 17/6/26. Ut - AV, mild bulky ms 91x42x56 mm. Small ant. myometrial fibroid m/s 11x10mm. ET - 15.3 mm. Rt ovary - ~~thin walled cyst~~ m/s 33x22mm noted.	- Informed consent - Prepare parts - PAC - Uniform OT / Anesthetist - Pre-op medications as charted - Shift to OT on call.

Name of the Doctor : Dr. Rajani Kumari Signature of Doctor ____

Date & Time : 25/6/26

HNH-00016124 IP26-00006641
Mrs ANURADHA GABBITA
13-08-1973 52 Y 10 M 12 D (F)
Dr. RAJANI KUMARI

(1)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/6/2026	C/s/b Dr	Mamata.
12:30pm	POD-0	
	GC - Fair Afebrile	Adv
	Vitals Stable	- NBM x 24hr
	BP: 100/60 mmHg	- Drugs as charted
	PR: 70bpm.	- W/F vitals & BPV
	P/A soft	- Encourage to Pass urine
	LE NAD	after regaining sensations
		- Inform SOS
	pt can be sent for discharge processing	[signature]

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : Mrs. G. Anuradha Age : 52y Gender : Male ☐ Female ☑

UHID NO: MNH-16124 Surgeon Name: Dr. Rajani Kumari

Anaesthesiologist : Dr. Lanni Gnayath

Operative procedure planned : D & C

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 arid 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 Aacidosis

☐ Incapacitating Cronic Obstructive Pulmonary Disease

☑ Others : Hypothyroid

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 : G. Anuradha

Name : Anuradha

Relationship with Patient: Self

Date & Time : 25/6/26

Witness :

Signature : GV Rao

Name : G V Rama chandra Rao

Date & Time : 25th June 26. 9.40 am

Doctor (who is taking the consent) :

Signature :

Name : Dr Sanjeevnayak

Date & Time : 25/6 at 9 a.m.

Duty Mobile: 9246160961

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

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Name: Mrs. G. Anuradha Age: 52y10m Sex: F UHID.No : HNH-00016124

Date: 23/6/26 Time: 2pm Proposed Operation: D&C (on 25/6 @10AM ↓ Dr-Rajani Kumari)

Diagnosis: AUB

B.P / CRT: 136/83 mmHg H.R: 70bpm Weight: 70.1kgs ASA Physical Status: ☐ 1 ☑ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 13.0g%	RBS-179 mg/dL.	Protein: 7.4	HIV:	X-Ray:	
PCV:	Urea:	Alb: 3.9	HBS Ag:	ECG: NSR.	
WBC: 10,250 cells.	Creat: 0.56 mg/dL	Total Bill: 0.4 <0.07 0.33	HCV:	2D Echo:	
Plate: 2.72 lakh	Na:	Dir. Bill:	Blood group:	Stress/Anglo:	
PT: 15.5	K:	LDH:	T3	Other:	
aPTT: 37.2	Ca++:	Alk phos: 115	T4		
INR: 1.17	Mg++:	Amylase:	TSH 7.475 µIU/ml		
BT – 2' 30" CT – 5' 00"	Cl -:	SGOT/SGPT: 17/14			

Allergies: NKDA.

Medical History: CVS : Known Hypertensive since 1½yr on Tab. CINOD 5MG 0–0–1

RESP : No active/Recent URTI/B.Asthma/P.TB/Breathlessness/Chest pain Diabetes :

CNS : No TIA/CVA/Seizures

Renal : (N) Bowel & bladder habits

Hepatic / GE : Physical Activity: Active [N4HA-I]

Others :

Past Anaesthetic History: 2 prev. LSCS. LSA, LCB – 27yrs back, Uneventful. Tubectomised.

Physical Exam:

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

Lungs : B/L AE (+) Clear.

Heart: S1S2 (+)

CNS: NAD

Pregnant: ☐ Yes ☑ No ☐ NA | Venous Access Site : accessible | Spine Exam for regional : Midline.

Anaesthetic Plan: ☐ MAC ☑ REGIONAL ☐ GA-ETT ☐ LMA

Peri-Operative Plan Explained to the Patient: ☑ Yes ☐ No

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours; Others 6 Hours
3. Informed Consent: ☐ Standard ☐ High Risk
4. Post Operative Pain Management: ☐ Discussed with Patient
5. Other Instructions:
   - Consent Pending
   - Thyroid Profile to be done (as TSH is high)
   - Other blood tests as advised by Surgeon
   - PAC to be Reviewed.
   - anti-hypertensive to be continued.

Signature: B de Name: Dr. Brunda

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

HNH-00016124 IP26-00006641
Mrs ANURADHA GABBITA
13-08-1973 52 Y 10 M 12 D (F)
Dr. RAJANI KUMARI

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No

Fasting Status: adequate

Physical Status: ☑ Patient Identified ☑ Consent Present ☑ Chart Reviewed

H.R: 89/m | B.P / CRT: 101/63 | SpO_2: 100% | R.R: 18/m | Last Feed: >4 hours

Pre-OP Diagnosis: AVB | Operation: D & C | Date: 25/6

Surgeon: Dr RK | Anaesthesiologist: Dr Ramu | Technician: Pallavi

TIME	1200	1230
N_2O /AIR /O_2 LPM		
HALO /SO /SEVO		
Drugs:	Inj. NIDAN 4mg	2mg iv
FIO_2 / SaO_2	100 100	
$ETCO_2$		
ECG	SR SR	
Temperature		
Urine Output		
Fluids	RL	
Blood		

Antibiotic –

Suppository –

Blood Loss –

NOTES

B.P
V Systolic
Λ Diastolic
X Mean
• Heart Rate

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

240 220 200 180 160 140 120 100 80 60 40 20 10 0

LAB Values
ABG
GRBS
Others

☑ Equipment Checked and Functional
☑ BP
☐ Cuff Site: ... (L) UL
☐ Art Site: ...
☑ EKG Lead 3 leads
☐ Temp Site
☐ FIO_2 Monitor
☐ Agent Monitor
☑ Pulse Oximeter
☐ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position: Lithotomy
☑ Pressure Points Checked

Eye Care:
☐ Oint
☐ Tape
☐ Padding
☑ Awake

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

Times:
Anaes Start: 12pm
OP Start: ...
OP End: ...
Leave OR: 1230pm

Anaesthesia:
☐ GA
☑ Monitored Anaesthesia Care
☑ Regional

Line (Size & Location)
☐ CVP: ...
☐ ART: ...
☑ IV: 20G (R) UL
☐ IV: ...
☐ IV: ...

Induction
☐ IV ☐ Inhal
☐ Pre O_2 ☐ RSI
☐ Others

☐ Mask ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
ETT# ... at ... cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug: ...

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

☐ **Bilat = BS**
☐ Semi-Closed Circle
☐ Closed Circle
☐ Other

Regional:
Extremity Specify: ...
☑ Spinal ☐ Epidural ☐ Caudal
Others: ...
Position: sitting - saddle
Site: L3-4
Needle Size: 25G (P) Depth: ...
Parasthesia ☐ Yes ☐ No
Catheter at skin ... cm
Drug Name & Conc: 10MG BUPIVACAINE
Bolus: ...
Infusion: ...
Block Level: T10 - adq.
Comments: ...

Transportation to
☑ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☑ NA

Name of the Doctor: Dhanu
Signature of the Doctor: ...

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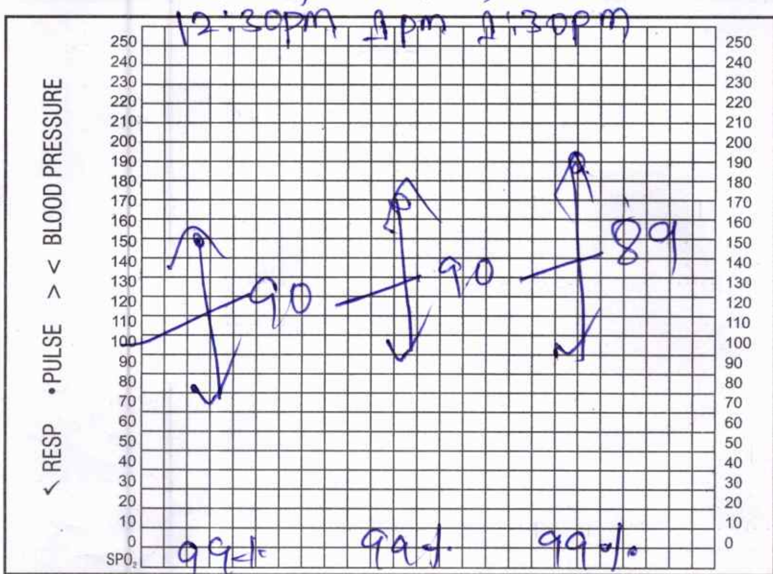
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Anushed Time Received : 12:30PM Time Discharged : ....



IV Cannula Site : (R)

☐ O_2 Mask ☐ Nasal Prongs
☐ Tracheostomy ☐ T-Piece
☐ Oral Airway ☐ Nasal Airway

Vomiting : ☐ Yes ☑ No Drug: Inj Taxim.
NG Tube : ☐ Yes ☑ No
Drain: ☐ Yes ☑ No
Urinary Catheter: ☐ Yes ☑ No
Chest Tube: ☐ Yes ☑ No
Nil Oral ☑ Yes ☐ No

IV Fluids: RL
Oral Feeds: NBM.

POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	MINUTES 30	60	90	OUT	SCORING INTERPRETATION
Able to move 4 extremities voluntary or on command Able to move 2 extremities voluntary or on command Able to move 0 extremities voluntary or on command	= 2 = 1 = 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 Dyspnea or limited breathing Apneic	= 2 = 1 = 0	RESPIRATION		2	2	2		
BP ± 20 of Pre Anaesthetic leve BP ± 20-50 of Pre Anaesthetic leve BP ± 50 of Pre Anaesthetic leve	= 2 = 1 = 0	CIRCULATION		2	2	2		
Fully awake Arousable on calling Not responding	= 2 = 1 = 0	CONSCIOUSNESS		2	2	2		
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0	COLOR		2	2	2		
		TOTAL		9	10	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
25/6	12:30pm	0/10	NO Pain	Anushed
25/6	1pm	0/10	NO pain	
25/6	1:30pm	0/10	No pain	
25/6	2pm	0/10	No pain	

Pain Tool Used: ☐ N PASS ☐ FLACC ☐ Wong Baker ☑ NPS

Anaesthesiologist Name : Dr. Manir
Anaesthesiologist Signature: [signature]
Date & Time:

PACU Nurse Name : Chandrakala
PACU Nurse Signature: Ch
Date & Time: 25/6/26 at 2pm

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

Transferred to Unit by (PACU): ....
Date & Time: 25/6/26

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: ..... Time: ..... Procedure done by .....

CSE /Spinal /Epidural Position : ..... Space :..... Technique (LOR/LOS) .....

Depth: ..... Catheter at Skin: ..... Attempts : .....

Parasthesia : Yes/No if yes details : .....

Solution Composition : .....

Any other issues :

a) .....

b) .....

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level Left Right	Maternal BP	Maternal Pulse	FHR	Comments

Delivery Details : Time : ..... APGAR: ..... SVD / Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected : .....

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : Mrs. G. Anuradha Gender: ☐ Male ☐ Female Age : .....

UHID No : AMA-0001624 Date : 25/6/26

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)

.....

DILATATION & CURETTAGE

..... upon .....

MRS. ANURADHA G. (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.

Excessive bleeding P/v, need for transfusion of blood or blood products, Uterine perforation.

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. Rajani Kumari

Consentee :

Signature : G. Anuradha

Name : G. Anuradha

Date & Time : 25th June 2026 8.50 AM

Witness :

Signature : Anushed Anushed

Name :

Date & Time : 25/6/2026

Patient Attendant :

Signature : GVRao

Name : GV Ramachandra Rao

Relationship with Patient: Husband

Date & Time : 25th June 2026 8.50 AM

Doctor (who is taking the consent) :

Signature :

Name : Dr. Dna.

Date & Time : 25/6/26 @

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OPERATION THEATER NOTES

HNH-00016124 IP26-00006641
Mrs ANURADHA GABBITA
13-08-1973 52 Y 10 M 12 D (F)
Dr. RAJANI KUMARI

Patient's Name : ....Age : ....Gender : ....

UHID.: .... o. :...Weight : ....

Surgeon : Dr Rajani Kumari	Asst. Surgeon :
Anesthetist : Dr Samir	OT Nurse : Archana / Natasha

Surgical Procedure :

Dilation Curettage.

Indications for Surgery :

Perimenopausal Bleeding / AUB L

Date : 25/06/2026	Start Time : 12:00 pm	End Time : 12:30 pm

PRE-OPERATIVE PREPARATION :

IV Antibiotics given
↓ AAP, Parts Painted & Draped

OPERATION NOTES:

Cervix healthy
UCL - 5 inches
Uterine cavity regular except Anterior wall irregular
Plenty of curetting obtained c̄ Polypoidal (Polypoidal),
Sample saved & sent for HPE

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POST - OPERATIVE ORDERS :

- NBM x 2-4h
- Vital monitory
- Drugs as charted
- NJF Bleedy PIV.
- Inform SMO

Discharge Adv-

1. Cefixime 200mg BD x 5d
2. Calpol (if fever) 7.0 x 3d
3. Pantop 40mg OD x 5d
4. Chymoral Forte TID x 5d
5. Review c HPE report

Dr. Rajani Kumari

Consultant Surgeon's Name

Consultant Surgeon's Signature

Date : 25/06/2022 Time : .....

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Rajani
Asst. Surgeon :
Anaesthetist : Dr Samir
Scrub Nurse : Sr Natasha, Sr Archana

HNH-00016124 IP26-00006641
Mrs ANURADHA GABBITA
13-08-1973 52 Y 10 M 12 D (F)
Dr. RAJANI KUMARI

.... Age : 52 ..... Gender : F .....
Name :
Date : 26/6/26 ..... In-time : 12:00 pm ..... Out-time : 12:30 pm

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 12 pm

Patient Has Confirmed
- Identity ☑ Yes ☐ No
- Site ☑ Yes ☐ No
- Procedure ☑ Yes ☐ No
- Consent ☑ Yes ☐ No

Site Marked ☐ Yes ☐ No ☐ NA

Anaesthesia Safety Check Completed ☑ Yes ☐ No

Pulse Oximeter on Patient & Functioning ☑ Yes ☐ No

Does Patient have a:
- Known Allergy? ☐ Yes ☑ No

Difficult Airway / Aspiration Risk?
- Yes, & Equipment / Assistance Available ☐ Yes ☑ No

Risk of > 500ml Blood Loss (7ml/kg In Children)?
- Yes, and Adequate Intravenous Access and Fluids Planned ☐ Yes ☐ No ☐ NA
- Blood Units Reserved ☐ Yes ☐ No ☐ NA

Has Antibiotic Prophylaxis been given within the last 60 minutes? ☑ Yes ☐ No ☐ NA

Signature : Dr Samir

Name :

Before Skin Incision ➤➤

TIME OUT Time: 12:12 Pm

Confirm all team members have introduced themselves by Name and Role ☑ Yes ☐ No

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm
- Correct Patient (Check ID Band) ☑ Yes ☐ No
- Correct Site ☑ Yes ☐ No
- Correct Procedure ☑ Yes ☐ No

Anticipated Critical Events

Surgeon Reviews:
- What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? 15 minutes Minimal ☐ Yes ☐ No ☐ NA

Anaesthesia Team Reviews:
- Are There Any Patient-specific Concerns? Hypertension ☑ Yes ☐ No ☐ NA

Nursing Team Reviews:
- Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☑ Yes ☐ No ☐ NA

Is Essential Imaging Displayed? ☐ Yes ☐ No ☐ NA

Signature : Rajani

Name : Karuna @ 12:12 Pm

Before Patient Leaves Operating Room

SIGN OUT Time:

Nurse Verbally Confirms with the Team:
- The Name of the Procedure Recorded ☑ Yes ☐ No
- That Instrument, Sponge and Needle Counts are Correct (or Not Applicable) ☑ Yes ☐ No ☐ NA
- The Specimen is Labelled (including patient name) ☑ Yes ☐ No ☐ NA
- Whether there are any Equipment Problems to be addressed ☐ Yes ☑ No ☐ NA

To Surgeon, Anaesthetist and Nurse:
- What are the key concerns for recovery and management of this patient? ☑ Yes ☐ No

Signature : Dr Manisha (for Dr. Rajani)

Name :

Doc. No. : RCH / FRM / CLINICAL / 111

PATIENT TRANSFER FORM

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Patient Name & UHID No	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016124 IP26-00006641 Mrs ANURADHA GABBITA 13-08-1973 52 Y 10 M 12 D (F) Dr. RAJANI KUMARI	25/6/26	25/6/26
	Transfer Ordered by Dr. Samir	Reason for Transfer Observation
From Unit OT	To Unit Pre-Post	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☑ 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 ☑ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Karuna	Dr. Samir.

Patient & Clinical Records Received by : Chandrakala

Date & Time of Patient Received : 25/6/26 at

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

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016124 IP26-00006641 Mrs ANURADHA GABBITA 13-08-1973 52 Y 10 M 12 D (F) Dr. RAJANI KUMARI	25/6/26 @ 8:41AM	25/6/26 @ 11:50AM
	Transfer Ordered by	**Reason for Transfer**
	DR. manisha	DSC
From Unit	**To Unit**	**Information to Attendant**
LDR	OT	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
30	–	Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	RL - 500ml	1
2.		
3.		
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
S/s. Anusha D	DR. Dua.

Patient & Clinical Records Received by: Kavya [signature] 25/6/26

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

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

HNH-00016124 IP26-00006641
Mrs ANURADHA GABBITA
13-08-1973 52 Y 10 M 12 D (F)
Dr. RAJANI KUMARI

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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. CLINIDIPINE	5mg	PO	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 : 25/6/26 @

Nurse Name & Signature: Srijatha

Date & Time : 25/6/26

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

HNH-00016124 IP26-00006641
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DRUG CHART

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

HNH-00016124 IP26-00006641
Mrs ANURADHA GABBITA
13-08-1973 52 Y 10 M 12 D (F)
Dr. RAJANI KUMARI

REGULAR PRESCRIPTIONS

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

DRUG : INJ. CEFOTAXIME

Dose	Route	Frequency	Start Date
1g	IV	BD	25/6/26

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time	25															
	11:30 AM															
	11AM															
	1PM															

STOP

DRUG : DICLOFENAC

Dose	Route	Frequency	Start Date
50mg	P/O	TID	25/6

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-00016124 IP26-00006641
Mrs ANURADHA GABBITA
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Dr. RAJANI KUMARI

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REGULAR PRESCRIPTIONS

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

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

DRUG :				Date ➤ / Time ▼
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date ➤ / Time ▼
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date ➤ / Time ▼
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date ➤ / Time ▼
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

HNH-00016124 IP26-00008641
Mrs ANURADHA GABBITA
13-08-1973 52 Y 10 M 12 D (F)
Dr. RAJANI KUMARI

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Sheet No. ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

DRUG :				Date ➤ / Time ▼														
Dose	Route	Frequency	Start Dt.															
Name & Signature of the Doctor Starting the Drugs:																		
Additional Instructions:																		
Daily Doctor's Endorsement by a Sign																		

DRUG :				Date ➤ / Time ▼														
Dose	Route	Frequency	Start Dt.															
Name & Signature of the Doctor Starting the Drugs:																		
Additional Instructions:																		
Daily Doctor's Endorsement by a Sign																		

DRUG :				Date ➤ / Time ▼														
Dose	Route	Frequency	Start Dt.															
Name & Signature of the Doctor Starting the Drugs:																		
Additional Instructions:																		
Daily Doctor's Endorsement by a Sign																		

DRUG :				Date ➤ / Time ▼														
Dose	Route	Frequency	Start Dt.															
Name & Signature of the Doctor Starting the Drugs:																		
Additional Instructions:																		
Daily Doctor's Endorsement by a Sign																		

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

HNH-00016124 IP26-00006641
Mrs ANURADHA GABBITA
13-08-1973 52 Y 10 M 12 D (F)
Dr. RAJANI KUMARI

Weight. ..... 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
25/6/26	11:35AM	INJ. PANTAPRAZOLE	40mg	IV		Sujatha Anusha.D
25/6/26	11:35AM	INJ. METOCLOPRAMIDE	10mg	IV		Sujatha Anusha.D

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

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I.V. FLUIDS CHART

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

		osition of I.V. Fluid ntion ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
25/6/26	9 PM	RINGER LACTATE	IV	100ml/hr			25/6		
25/6	12PM	RINGER LACTATE	IV	100 ml/hr			25/6		
25/6	1PM	RINGER LACTATE	IV	150			25/6		

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

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RESULT SHEET

Date (OP)	16/6/26					
Time						
Hb	13.0					
PCV	39.5					
RBC	4.46					
WBC	10250					
N/L						
Platelets	2.72					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
blood group	B positive					
HIV						
HCV	NR					
VDRL						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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OBSTETRICS / GYNECOLOGY
NURSING INITIAL ASSESSMENT FORM

Date of Admission: 25/6/26

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: D/E

Doctor Notified on Admission: ☐ Yes ☐ No

Name of the Doctor: .....

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: .....

.....

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: 98.6 HR: 90 RR: 20

BP: 140/84 Weight: ..... Height: ..... BMI: .....

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

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PHYSICAL ASSESSMENT

General Appearance: ☐ Healthy ☐ Ill looking ☐ Anxious ☐ Agitated ☐ Others: .....

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

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

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

☐ Mobility problem ☐ Walking Problem ☐ No Abnormality Detected

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☐ No Abnormality Detected

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

☐ Under Weight ☐ Diabetes Mellitus ☐ Hyperemesis Gravidarum

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

☐ Others .....

Inform consultant for positive criteria

SOCIAL SCREENING:

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

Social History: Lives With .....

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 ..... Family

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

Orientation not given Reason: ..... Patient

Nurse Signature: .....

Nurse Name: .....

Date & Time: 25/6/26

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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	N	100ml								
	09:00 am	RL	B	100ml								
	10:00 am	RL	M	100ml							0	Anusha
	11:00 am	RL	N	100ml						✓		
	12:00 pm	RL	B	100ml								
	01:00 pm	RL	M	100ml								
Total Intake :		Taken				**Total Output :**				passed		
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

Patient Sticker

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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											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

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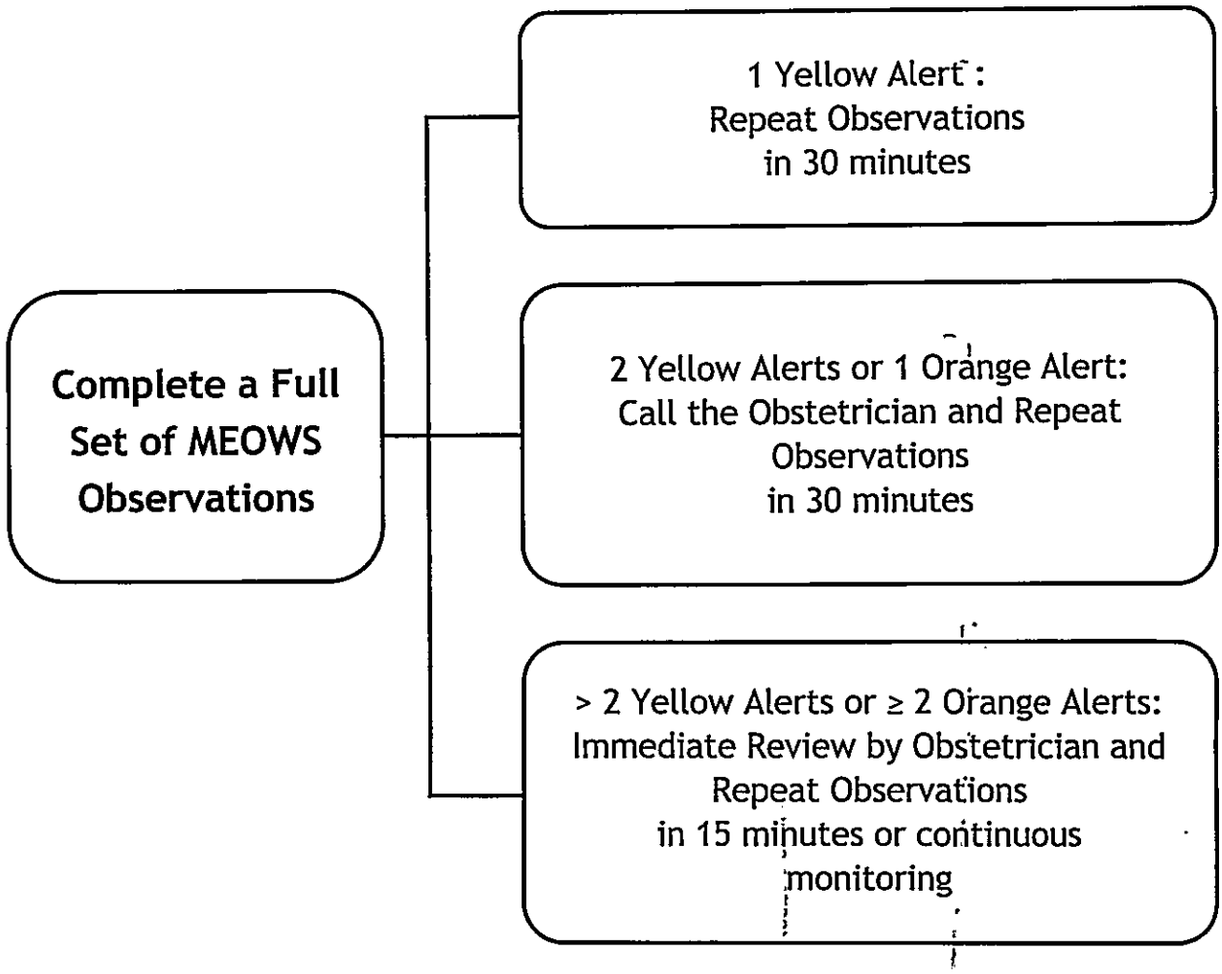
Early Warning Observation Score Chart - Obstetrics

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

		Date																							
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20			20			20	20	20																	
	0 - 10																									
Saturations	94 - 100 %			99			99	99																		
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37		✓				—	—																		
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90			90			80	82																		
	80																									
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130			120			110	112																		
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70			70			85	86																		
	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																		
TOTAL ORANGE SCORES			0				0	0																		
Nurse Initial			RD				RD	RD																		

Obstetrics and Gynaecology Early Warning Signs



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

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

Signature of Shift In Charge :
Signature : Anusha D. Name : Anusha

Signature of Ward In Charge :
Signature : Kasturi Name : Kasturi

Patient Sticker

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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										
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4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3										
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4										
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous 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.

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

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Morse Fall Risk Assessment Form

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

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 : 25/6			
				Time : M6			
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		
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		
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		
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	24		
				Evaluator's Name			

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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Mrs ANURADHA GABBITA
13-08-1973 52 Y 10 M 12 D (F)
Dr. RAJANI KUMARI

Rainbow® Children's Hospital
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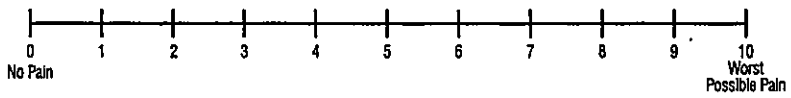
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
25/6	9AM	0/10		☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA.	Archer
				☐ 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		
				☐ 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

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NURSING SHIFT HAND OVER FORM - WARD

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

SITUATION

Diagnosis: D&C.

Any Infection: ☐ Yes ☐ No ☐ Not Known
If Yes Specify: .....

BACKGROUND

Area / Shift Time	25/6 M6					
Medical Condition (Any special condition to be noted):	NA					

ASSESSMENT

Allergy:	☐ Yes ☐ ~~No~~ ✓	☐ 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	☐ Yes ☐ No
Vital Signs: Temp:	98.6F						
Res:	20						
SpO_2:	99%						
Pulse:	90						
BP:	140/84						
Fall Risk Score:	—						
Pain Score:	—						

Recommendations

Safety Needs:	—						
Physiotherapy	☐ Yes ☐ ~~No~~ ✓	☐ 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	☐ Yes ☐ No
Other Special Orders / Medications:	NA						
Post Operative Procedure Special Orders:	—						
Handed Over By Name :	—						
Signature :	Ankur						
Date:	18/8/25						
Time:	2PM						
Taken Over By Name :							
Signature :							
Date:							
Time:							

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:							

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NURSING CARE RECORD

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Date: .....

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 2pm	plan for vitals plan for Admission plan for part prepare.	8AM 2pm	vitals Normal. Admission done part prepare done.	Normal	stable	
Afternoon							
Night							

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- ☐ Any Others. Specify.....

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