Dr. Ramya

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ESTIMATION SLIP

Date : 13/6/26 **UHID / IP No. :** RCWH.0000037019 **Sl No.** 1597

Name of Patient : Mrs. Shireen Sulemon Patel **Age:** 47yr **Gender:** F

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

Address : Abids **Phone :** 9848011033 **Email :**

Procedure / Plan : Hysteroscopy + EB **EDD/Dos:** June 26

MODE OF PAYMENT : ☑ **SELF** ☐ **TPA :** Care Insurance ☐ **GIPSA :** ☐ **OTHER**

TARIFF INFORMATION :

Particulars	Package Amounts (Rs.)	
Room Category	Normal Delivery	LSCS
Multi Shared Ward		
ared Ward		
Twin Shared Ward →	~~85k~~ +90k	
Private Room		
Super Deluxe Room	+ Pharmacy & Investigation Entire	
Suite Room	+ Non Payables	Entire
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 : 10,000 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 Sulemon 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

RCWH.0000057019 IP26-00006589
Mrs SHIREEN SULEMAN PIRANI
21-04-1979 47 Y 1 M 25 D (F)
Dr. KADIYALA RAMYA THEJA

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SURGERY DETAILS

Date : 15/06/26

Patient Name: Mrs. Shireen Suleman Date of Birth: 21-04-1979 Age: 47 yrs

Gender: female Ward : OT-2 UHID No.: RCWH.0000057019
IP26-00006589

Date of Surgery: 15/6/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : HYSTEROSCOPY & ENDOMETRIAL BIOPSY + SADAKS BLOCK

Time in : 2'15 pm Time Out : 3'10 pm

		NAME	AMOUNT
1.	Surgeon	~~Dr. SWATHI~~ / Dr. Ramya Theja	
2.	Anaesthetist	Dr. Sanidi	
3.	Assistant Surgeon		
4.	OT Technician	Sr. Pallavi Br. Sai	
5.	Circulating Nurse	Sr. Karuna, Sr. Natasha	
6.	Assistant Nurse	Sr. Babu	

Mrs SHIREEN SULEMAN PIRANI (47 Y 1 M 25 D/ F)
ENDOMETRIA
UNV04329
HN26009868ENDO

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

Signature of the Surgeon

(hysteroscopy instrument)

Karuna
Signature of Circulating Nurse

Order No: ~~26-0000206[illegible]~~ / 54 Order by: Arshavan 15/6/26 @ 15'58 pm

RCWH.0000057019 IP26-00006589
Mrs SHIREEN SULEMAN PIRANI
21-04-1979 47 Y 1 M 25 D (F)
Dr. KADIYALA RAMYA THEJA

Hysteroscopy + EB.

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CONSUMABLES OF OT

Circulating staff : Karunes Technician : [illegible] Date : 15/6/26 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	1		Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : (A) / P / N		03				Suction Catheter		
HME filter : A / P / N						Feeding Tube		
Syringes : 10 cc		02				Vaccum Suction Set		
05 cc		02	Gloves S.G 6½, 7	2+1		Surgical Gloves		
02 cc		02	Encore 6½	1		Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade			Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL		02	Cautery pencil					
NS : 10ml / 100ml / 500ml / (1000ml)		03	Koochies					
D5 [illegible] 02		01	Ointments					
			Suction Catheter					
Fentanyl			Cap, Mask	10+10				
Morphine			Gauze Pack 7.5 x 7.5	10				
Ketamine			Mop Pack	1				
Propofol			Steristrip					
Rocuronium			Underpad					
Glycopyrolate			Draw sheet					
Myopyrolate			Abgel					
Ondansetron		01	Foleys catheter					
Pencan (25g) / Spinal Needle 22		01	Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)		01	Romodrain bag					
Antibiotics			Bandage					
Inj Tranexamic		02	Tegaderm					
Suppositories			~~Ioban~~ T.V.R.P Set	1				
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set					
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution	2				
Gauze		01	Microshield	2				
Encore 6½ Glove		01	Cotton Balls	1				
			Latex Gloves	20				
			Ramdione Scrub					
			Saral					

Surgeon / Anaesthesiologist Nurse OT Technician

Order No. 26-00002068 57 / 56 Ordered by : Archana 15/6/26 @ 16:07pm

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

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040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	: RCWH.0000057019	**Name**	: Mrs SHIREEN SULEMAN PIRANI
Age / Sex	: 47 Y 1 M 25 D / Female	**Doctor**	: KADIYALA RAMYA THEJA
Adm/Reg Date/Time	: 15/06/2026 11:39	**Payor**	: CARE HEALTH INSURANCE LIMITED
Order Date	: 15/06/2026 16:06	**Ordernumber**	26-0000206856
Visit ID	: IP26-00006589	**Ward/Bed No**	: 4F -OT / PDA-412
Patient Address	: HNO.1-4-90/1,KHAJA WOLANE SHARLATE,,, Abids Road, Hyderabad, Telangana, INDIA, 500001		

No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	GENERAL SURGICAL KIT (MEDITAKE)	GENERAL SURGICAL KIT	1 Nos	/ Once Daily	1 Days		1 Nos	Ordered
2	BUPICAIN HEAVY 80MG INJ 4ML	BUPIVACAINE 80MG INJ	1 Nos	/ Once Daily	1 Days		1 Nos	Ordered
3	PENCAN 25G*3 1 2	PENCAN 25G*3 1 2	1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
4	COTTON BALLS 2 GM 5 NOS	COTTON BALLS 2G- 5 NOS	1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
5	NS 1000 ML CLOSED EUROFLEX	NORMALSALINE 1000ML CLOSED	1 Nos	External / Once Daily	1 Days		3 Nos	Ordered
6	ONDOKIND INJ 4 MG 2 ML	ONDANSETRON 4MG 2ML INJ	1 Nos	/ Once Daily	1 Days		1 Vial	Ordered
7	MEZOLAM INJ 5 MG 5 ML		1 Vial	External / Once Daily	1 Days		1 Vial	Ordered
8	E.C.G ELECTRODES (ADULT)	ELECTRODES ADULT	1 Nos	External / Once Daily	1 Days		3 Nos	Ordered
9	POVINANZ SOLUTION 10% 100 ML		1 Nos	External / Once Daily	1 Days		2 Nos	Ordered
10	BACTOPREP SOLUTIONS 100 ML	CHLORHEXIDINE GLUCONATE2% &ALCOHOL80% 500	1 mL	/ Once Daily	2 Days		2 Nos	Ordered
11	IRRIGATTO(T.U.R SET)	IRRIGATTO(T.U.R SET)	1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
12	MOPS 30X30 8PLY 5S X-RAY	MOPS 30X308 PLYDATT	1 Nos	/ Once Daily	1 Days		1 Nos	Ordered
13	Encore Microptic gloves-6.5		1 Nos	/ Once Daily	1 Days		2 Nos	Ordered
14	RL 500 ML CLOSED SYSTEM	RINGER LACTATE 500ML CLOSED	1 Bottle	/ Once Daily	2 Days		2 Bottle	Ordered
15	BIOXAMIC 500 MG INJ		1 Ampule	External / Once Daily	1 Days		2 Ampule	Ordered
16	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		2 Nos	Ordered

KADIYALA RAMYA THEJA

Reg No : TSMC/FMR/01458

* 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	: RCWH.0000057019	**Name**	: Mrs SHIREEN SULEMAN PIRANI
Age / Sex	: 47 Y 1 M 25 D / Female	**Doctor**	: KADIYALA RAMYA THEJA
Adm/Reg Date/Time	: 15/06/2026 11:39	**Payor**	: CARE HEALTH INSURANCE LIMITED
Order Date	: 15/06/2026 16:06	**Ordernumber**	: 26-0000206857
Visit ID	: IP26-00006589	**Ward/Bed No**	: 4F -OT / PDA-412
Patient Address	: HNO.1-4-90/1,KHAJA WOLANE SHARLATE,,, Abids Road, Hyderabad, Telangana, INDIA, 500001		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	DSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		2 Nos	Ordered
2	SGLOVE # 7.0(SURGICARE)	SURGICAL GLOVES 7.0	1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
3	NITRILE EXAMINATION GLOVES P F- MEDIUM	NITRILE GLOVES M	1 Nos	External / Once Daily	1 Days		20 Nos	Ordered
4	DSYRINGE 5ML.(NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		2 Nos	Ordered
5	SURGEON CAP(FEMALE) (PROTECTCARE)		1 Nos	External / Once Daily	1 Days		10 Nos	Ordered
6	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		2 Nos	Ordered
7	FACE MASK 3 LAYER - ELASTIC	FACE MASK 3 LAYER	1 Nos	External / Once Daily	1 Days		10 Nos	Ordered
8	GAUZE 7.5X7.5 12 PLY (5 NOS)	GAUZE 7.5X7.5 12 PLY 5 NOS	1 Nos	External / Once Daily	1 Days		3 Nos	Ordered

KADIYALA RAMYA THEJA

Reg No : TSMC/FMR/01458

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Note

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*** Do not refill medicines.**

Name	Mrs SHIREEN SULEMAN PIRANI	**UHID**	RCWH.0000057019
Father/Guardian	Mr SULEMAN	**Age/Gender**	47 Y 1 M 25 D/ Female
Address	HNO.1-4-90/1,KHAJA WOLANE SHARLATE,,, Abids Road, Hyderabad, Telangana, INDIA, 500001		
IP No	IP26-00006589	**Admission Date**	15-06-2026
Ref Doctor	Self.		
Discharge Date	16.06.2026		

DISCHARGE SUMMARY

Consultants :
Dr. Kadiyala Ramya Theja
MBBS/DNB
TSMC/FMR/01458

Diagnosis: POSTMENOPAUSAL BLEEDING WITH HYPOTHYROID

HYSTEROSCOPY + ENDOMETRIAL BIOPSY DONE ON 15.06.2026

History: She came with complains of postmenopausal bleeding on & off since 15-20 days associated with White discharge PV since 6-8 months. MRI (pelvis)- ET: 18mm, thickened with heterogenous areas - endometrial hyperplasia ,Right ovary and Left ovary not well seen.?atrophic , no pelvic adenopathy. She was Admitted for Hysteroscopy + Endometrial Biopsy.

Menstrual History:-
Attained Menopause 6 years ago, LCB-18 years

Obstetric History: P3L3, 3 LSCS, LCB- 18 Years ago, tubectomy

Medical History: Denovo hypothyroidism (not on treatment)
Family History: Both parents- DM
Surgical History: 3 lscs+ tubectomy
Allergies: Nil

Investigations: Enclosed.
Blood group: "B" Positive

Surgery Notes:
Operation performed: Hysteroscopy + Endometrial biopsy

Indication: Postmenopausal bleeding

Name	Mrs SHIREEN SULEMAN PIRANI	**UHID**	RCWH.0000057019
IP No	IP26-00006589	**Admission Date**	15-06-2026

Operative findings:

- Anterior and posterior vaginal wall retracted.
- Anterior lip of cx held and os dilated and hysteroscope inserted .
- Diffuse endometrial hyperplasia noted.
- Area of vascularity and mild necrosis seen at anterior endometrial wall (polypoidal growth).
- Endometrial currenting's taken in plenty and sent for HPE.
- Fundal endometrial calcifications noted.

Post-Operative Notes:

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

Advice:

1. Tab. Taxim O 200mg (Cefixime 200mg) twice daily till 20.06.2026 (9am - 9pm) after food.
2. Tab. Calpol 500mg (Paracetamol 500mg) (2tabs)thrice daily till 17.06.2026 (7am-3pm-10pm) after food.
3. Tab. Pantodac 40 mg (Pantoprazole 40mg) once daily (7am) before food till 20.06.2026
4. Tab. Zincovit once daily (2pm) for 1 month after food.
5. Tab. Tranexamic acid 500 mg thrice a day for 1 day .
6. Review with chest X-Ray ,Non CONTRAST Chest CT ,Mammogram, CECT Abdomen+Pelvis.
7. FT3, FT4 and TSH after 1 week .
8. Collect HPE Report.

Review consultation with **Dr. Kadiyala Ramya Theja**, after 10 days on 25.06.2026 at Rainbow Children's Hospital with prior appointment **(Review consultation will be charged).**

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

Patient/ Attender

In case of emergency like bleeding, fever kindly contact 9154865045 at Rainbow Children's hospital just dial one toll free number - 18002122.

Name	Mrs SHIREEN SULEMAN PIRANI	**UHID**	RCWH.0000057019
IP No	IP26-00006589	**Admission Date**	15-06-2026

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

Registrar/Resident/C.M.O

Dr. Kadiyala Ramya Theja
MBBS/DNB
TSMC/FMR/01458

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TEL NO :040-48873000
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006589 **Admit Date** : 15-Jun-2026 **Admit Time** : 11:39 AM **UHID** : RCWH.0000057019

Patient Details :

Patient Name	: Mrs SHIREEN SULEMAN PIRANI	**Age**	: 47 Y 1 M 25 D
Guardian	: Mr SULEMAN	**DOB**	: 21-04-1979
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Married
Address (H)	: HNO.1-4-90/1,KHAJA WOLANE SHARLATE,, Abids Road Hyderabad Telangana INDIA 500001	**Phone No**	: 9989011033
		E-mail	: na123@rainbowhospitals.in

Admission Details :

Type : TWIN SHARING **Bed No** : PDA-412 **Ward Name** : 4F -OT

Room No : PDA-412 **Admission Type** : First Visit

Contact Details :

Name : Mr SULEMAN **Relationship** : Husband

Contact Address : HNO.1-4-90/1,KHAJA WOLANE SHARLATE,, Abids Road Hyderabad Telangana INDIA 500001 **Phone No** : 9989011033

Signature

Doctor Details :

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

Payment Details :

Payment Mode : Cash **Deposit Amount** : 10000.00 **Payor Name** : CARE HEALTH INSURANCE LIMITED

PATIENT TRANSFER FORM

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RCWH.0000057019 IP26-00006589 Mrs SHIREEN SULEMAN PIRANI 21-04-1979 47 Y 1 M 25 D (F) Dr. KADIYALA RAMYA THEJA UHID No	Date & Time of Admission 15/6/26 @ 11:38	Date & Time of Transfer Order 15/6/26 @ 2:19pm
	Transfer Ordered by Dr. Veena	Reason for Transfer Hysteroscopy
From Unit LDR	To Unit OT	Information to Attendant Yes ☐ No ☐
Number of Sheets in Clinical File 30	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 — 100ml	(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
Sis. Mounika	Dr. Veena

Patient & Clinical Records Received by : Sangeetha

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

RCWH.0000057019 IP26-00006589
Mrs SHIREEN SULEMAN PIRANI
21-04-1979 47 Y 1 M 25 D (F)
Dr. KADIYALA RAMYA THEJA

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ACTIVITY RECORD FOR BILLING

Name :_____

UHID No. : _____ IP No : _____ Consultant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
15/6/26	2:10pm	LDR	OT	Nourbe/Sangeeth
15/6/26	3:30pm	OT	Pre-Post	Archana/Sindhu

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
15/6	Cardiac Monitor	3:15 pm	7PM	206885	Moni
15/6	Infusion pump		7PM		
				Cross checked	
					by
					Sujatha
					15/6/26
					7PM

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
15/6/26	IV placement		206886	
15/6/26	PAC (OP)		OS26-00 11935	Smitha

Cross checked by Smitha 15/6/26

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

RCWH.0000057019 IP26-00006589
Mrs SHIREEN SULEMAN PIRANI
21-04-1979 47 Y 1 M 25 D (F)
Dr. KADIYALA RAMYA THEJA

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I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 13/6/26 Time of Admission : 12pm

Allergies: Nil ☐ Not know any drug allergies (Penicillin allergy)

PRESENTING COMPLAINTS :

- Postmenopausal bleeding ∵ 15-20 days.
  ↓
  c/o WDPV ∵ 6-5 months
- MRI (Pelvis) – ET ~ 18mm, thickened c̄ heterogeneous ... areas
  s/o endometrial hyperplasia
  R/O Ca – ~~Atrophic~~

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : 25yrs.	Parity : $P_3 L_3$.
Previous Periods : Menopause ∵ 6yrs ago.	Mode of Delivery : 3LSCS.
LMP :	Last Child Birth : LCB - 18yrs.
Contraception : Tubectomy.	

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
Newly dx Hypothyroidism (not on Rx)	3 LSCS + Tubectomy

Mrs SHIREEN SULEMAN PIRANI
21-04-1979 47 Y 1 M 25 D (F)
Dr. KADIYALA RAMYA THEJA

FAMILY HISTORY:	MEDICATION HISTORY:
Both the parents - DM	Allergies to Penicillin

INITIAL ASSESSMENT :

Date 15/6/26	Breasts (N)	Local/Speculum Examination –
Ht. 140 Wt. 65 kg		
BMI 100/Obesity		
B.P		Bimanual Pelvic Examination –
Pallor (-)		
CVR S_1S_2 (+)	Abdominal Examination	
Respiratory System BL NVB	P/A - Soft.	
Thyroid (N)		

PROVISIONAL DIAGNOSIS : Postmenopausal women c PMB. | hypothyroidism

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT
Blood Group - "B positive" Hb - 13.1 g/dl Plt - 3.61 lkh WBC - 7.4k } 13/6/26 HIV HbsAg } NR HCV Urine c/s.	- Informed consent - Prepare parts - Inform OT / Anesthetist - Shift to OT on call

Name of the Doctor : Dr. Ramya Theja

Signature of Doctor

Date & Time : 15/6/26.

RCWH.0000057019 IP26-00006589
Mrs SHIREEN SULEMAN PIRANI
21-04-1979 47 Y 1 M 25 D (F)
Dr. KADIYALA RAMYA THEJA

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iRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes C/S/B D1.D1q	Doctor's Order
15/6/26 3:30 pm	POD-0	
	GC Fair Afebrile	Adv
	BP: 104/67 mmHg	- NBM
	PR: 84/m	- Drugs as charted
	P/A. Soft.	- Urine c/s to trace
	C/E-NAD.	- Vital Monitoring
		- Inform sos
		- Encourage to void
		- w/f excessive bleeding P/v.
15/6/2026 6:45pm	C/S/B D1.D1q. POD-0.	Adv
	GC Fair Afebrile	- Regular diet
	Vitals-WNL	- Drugs as charted
	P/A Soft	- Urine c/s to trace
	C/E NAD	- Vital Monitoring
File can be sent to discharge processing		- Inform sos.
		Encourage to void
		w/f excessive bleeding PV.

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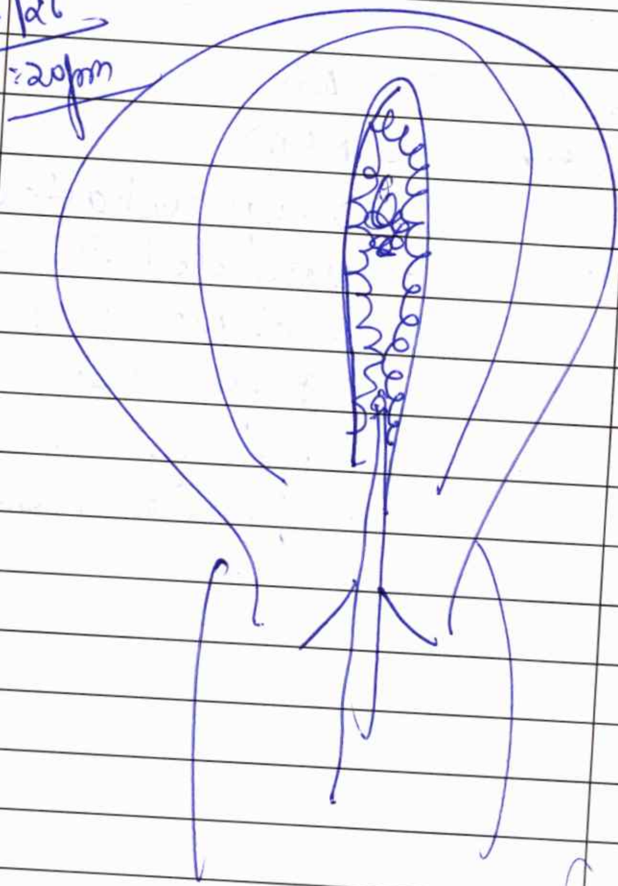
PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/6/26 3:20 pm		Counselled Mrs. Shireen's husband & her brother in law regarding the Intraop findings, the procedure, need for follow up. suspicion of malignancy & need for further procedure.
		- Chest X ray - NCCT chest - Mammogram - CECT Abdomen + pelvis
	Dr. RAMYA THEJA. V	- Thyroid profile → > rule
		noted by [signature] 15/6/26

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RCWH-0000057019 IP26-00006589
Mrs SHREEN SULEMAN PIRANI 47 Y 1 M 25 D (F)
21-04-1979
Dr. KADIYALA RAMYA THEJA

RESULT SHEET

OD

Date	11						
Time							
Hb	13.1						
PCV	39.3						
RBC	4.8						
WBC	7400						
N/L							
Platelets							
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						

Culture and Sensitivities : .....

.....

.....

.....

.....

Biology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

Others (ECG, Contrast Studies .....

RCWH.0000057019 IP26-00006589
Mrs SHIREEN SULEMAN PIRANI
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MEDICATION RECONCILIATION FORM

Drug Allergies: Penicillin allergy ☐ Not known any Drug Allergies

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

Shifting From: NA Shifted to: NA

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Tab THYRONORM	50mg	PO	OD	15/6/26 @ 6AM	☐ 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 @ 02pm

Nurse Name & Signature: Sujatha

Date & Time : 15/6/26 @ 4pm

IP26-00006589 RCWH.0000057019

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DRUG CHART

Date of Admission: 15/6/2026 Drug Allergies: Penicillin allergy ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

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

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

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

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

Mrs SHIREEN SULEMAN PIRANI
21-04-1979 47 Y 1 M 25 D (F)
Dr. KADIYALA RAMYA THEJA

REGULAR PRESCRIPTIONS

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

DRUG : ~~INJ TP~~

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG : INJ CEFOTAXIME

Dose	Route	Frequency	Start Date
1g	IV	BD	15/6

Name & Signature of the Doctor Starting the Drugs: Dr Anand

Additional Instructions: For 2 wks.

Daily Doctor's Endorsement by a Sign

Date / Time 15/6 10AM Morning 12PM 10PM

DRUG : Tab Pantoprazole

Dose	Route	Frequency	Start Date
40mg	PO	OD	15/6.

Name & Signature of the Doctor Starting the Drugs: Dr. Dhq

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG : Tab Paracetamol

Dose	Route	Frequency	Start Date
1g	PO	TID	15/6.

Name & Signature of the Doctor Starting the Drugs: Dr. Dhq

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

RCWH.0000057019 IP26-00006589
Mrs SHIREEN SULEMAN PIRANI
21-04-1979 47 Y 1 M 25 D (F)
Dr. KADIYALA RAMYA THEJA

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Sheet No: .....

REGULAR PRESCRIPTIONS

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

DRUG : Tab Tranexamic acid

Dose	Route	Frequency	Start Dt.
500mg	PO	TID	15/6

Name & Signature of the Doctor Starting the Drugs: Dr. Dna

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG : Tab MULTIVITAMIN.

Dose	Route	Frequency	Start Dt.
1 tab	PO	OD	15/6

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Dt.

ne & Signature of the Doctor
ing the Drugs:

al Instructions:

's Endorsement by a Sign

Date / Time

Signature

NTED BY : Name

Patient Sticker

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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 ....

Docu. No. : RCH /FRM / CLINICAL / 108

(P.T.

RCWH.0000057019 IP26-00006589
Mrs SHIREEN SULEMAN PIRANI
21-04-1979 47 Y 1 M 25 D (F)
Dr. KADIYALA RAMYA THEJA

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
15/6	12pm	INJ PANTOPRAZOLE	40mg	IV		Mouni
15/6	12pm	INJ METOCLOPRAMIDE	10mg	IV		Mouni
15/6	2:20pm	Inj. ONDANSETRON	4mg	IV		
15/6	2:25pm	Inj. TRANEXAMIC ACID	1gm	IV		

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

21-04-1979 47 Y 1 M 25 D (F)
Dr. KADIYALA RAMYA THEJA

I.V. FLUIDS CHART

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

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
15/6	12 AM	RINGER LACTATE	IV	100 ml/L					
15/6	3:30 pm								

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

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OPERATION THEATER NOTES

RCWH.0000057019 IP26-00006589
Mrs SHIREEN SULEMAN PIRANI
21-04-1979 47 Y 1 M 25 D (F)
Dr. KADIYALA RAMYA THEJA

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

UHID.: ..... No. :.....Weight : .....

Surgeon : Dr. Ramya	Asst. Surgeon : Dr. Swathi
Anesthetist :	OT Nurse :

Surgical Procedure :

HYSTEROSCOPY AND ENDOMETRIAL BIOPSY.

Indications for Surgery :

Post Menopausal bleeding

Date :	Start Time :	End Time :

PRE-OPERATIVE PREPARATION :

OPERATION NOTES: Position - Lithotomy.

↓ SAP Perineum. cleaned & draped.

- Anterior & posterior vaginal wall retracted
- Ant lip of cx held & dilated & hysteroscope inserted

DOF:- 1) Diffuse endometrial hyperplasia

2) Areas of vascularity & mild necrosis seen at Anterior Endometrial wall (polypoidal growth)

3) Endometrial curretings taken in plenty sent for HPE.

4) Fundal calcifications (+) on Endometrium.

POST - OPERATIVE ORDERS :

- NBM
- IV Antibiotic for 24hr.
- Tab Tranexamic acid 500mg TID for 1day.
- Tab Calpol 1g TID for 3day.
- Tab Zincovit 1tab x 1month.
- Tab Pantoprazole 40mg OD -

Dr RAHUL THOTA

.....

Consultant Surgeon's Name

.....

Consultant Surgeon's Signature

Date : 15/6/24 Time : 3:10pm

SURGICAL SAFETY CHECKLIST

Surgeon : [redacted] Dr. Ramyatheja
Asst. Surgeon : ....
Anaesthetist : Dr. Samir
Scrub Nurse : Bl. Balu

Patient Name
UHID No. :
Date : 15/6/26

RCWH.0000057019 IP26-00006589
Mrs SHIREEN SU[redacted]MAN PIRANI
21-04-1979 [redacted]7 Y 1 M 25 D (F)
Dr. KADIYALA RAMYA THEJA

Gender : F
...ie : 3:10 pm.
2:15 pm

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 2:10 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 : (signature)
Name : Dr. Aruna K.

Before Skin Incision ➤➤

TIME OUT Time: 2:15 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? ☑ Yes ☐ No ☐ NA

Anaesthesia Team Reviews:

Are There Any Patient-specific Concerns? ☑ 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 : Karuna
Name : Karuna (a)

Before Patient Leaves Operating Room

SIGN OUT Time: 3:10 pm

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

hysteroscopy sensor not working.

Signature : (signature)
Name : Dr Ramya theja

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

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PATIENT TRANSFER FORM

RCWH.0000057019 IP26-00006589
Mrs SHIREEN SULEMAN PIRANI
21-04-1979 47 Y 1 M 25 D (F)
Dr. KADIYALA RAMYA THEJA

	Date & Time of Admission	Date & Time of Transfer Order
	15/6/26 @ 11:39 AM	15/6/26 @ 3:30 PM
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr. Ramya Theja	Dr. Samir	Observation
From Unit	**To Unit**	**Information to Attendant**
OT	Pre-Part	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
Sr Karuna	Dr. Akhila

Patient & Clinical Records Received by : Sujatha

Date & Time of Patient Received : 15/6/26 @ 3:30 PM

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

☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

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OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 15/6/26 Time of Arrival: 12 pm Time Seen by Nurse: .....

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

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

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

3) **Vital Signs:** Temperature: 97F Pulse: 85 RR: 20 SpO_2: 99% BP: 110/74 Weight: .....

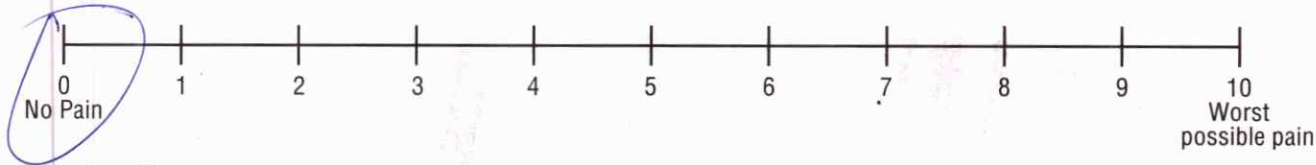
4) **Gestational Criteria:**

Gravida:	G	P	L	A

LMP: ..... EDD: ..... Gestational Age: .....

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

5) **Pain Screening:** **Numerical Pain Scale (NPS)**



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

.....

6) **Past History:**

a) Surgeries: .....

b) Medical: .....

Patient Sticker

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

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

9) **Prenatal Medical History:**

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

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

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

Time seen by Doctor: .....

Nurse Name : Syatha Nurse Signature: .....

Date: 15/6/22 Time: 5 p.m.

RCWH.0000057019 IP26-00006589
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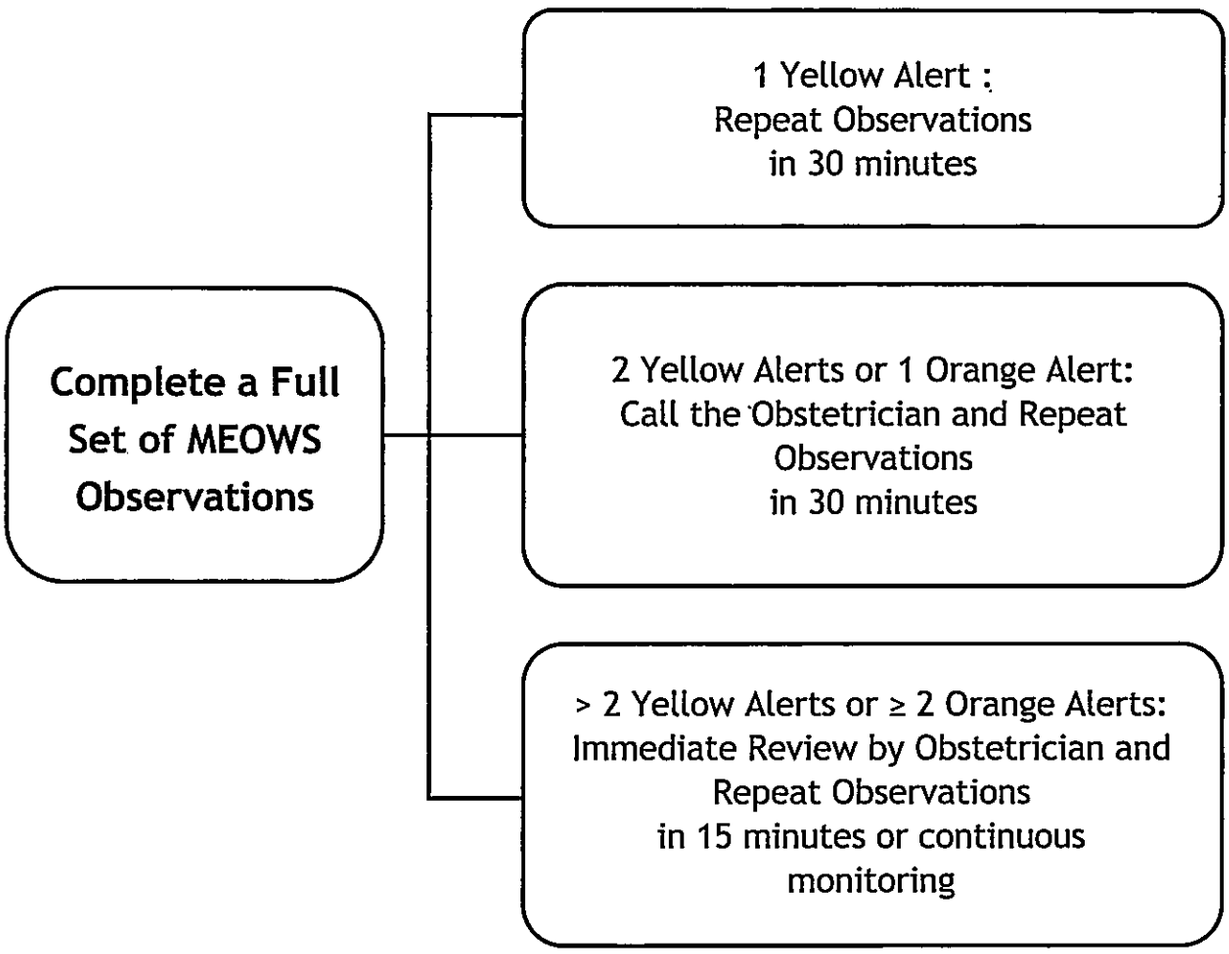
Early Warning Observation Score Chart - Obstetrics

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

15/6

		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 %						99		99	99	99	99	99													
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37																									
	36								97		98		98													
	35						37																			
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80								80		78	80	82													
	70						72																			
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120						119																			
	110								110		112		110													
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80						80		68		65		67													
	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													
Nurse Initial																										

Obstetrics and Gynaecology Early Warning Signs



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

RCWH.0000057019 IP26-00006589
Mrs SHIREEN SULEMAN PIRANI
21-04-1979 47 Y 1 M 25 D (F)
Dr. KADIYALA RAMYA THEJA

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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.

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
15/6/26												
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm	RL		100ml								
	01:00 pm	RL		100ml								
Total Intake :						**Total Output :**						
	02:00 pm	RL	NIL	100ml								
	03:00 pm	RL	B	100ml								
	04:00 pm	RL	NIL	100ml								
	05:00 pm	RL		100ml								
	06:00 pm	RL	H2O	100ml								
	07:00 pm	RL										
Total Intake :		taken				**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	

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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CHECKLIST FOR THROMBOPHLEBITIS

15/6

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	NM									
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	NM									
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	No									
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	NO									
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	NR									
			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 : .....

Patient Sticker

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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										
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 : ..... Name : .....

Signature of Ward In Charge :

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

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BRADEN 'Q' SCALE

					Date : 7/6			
					Time : [illegible]			
Mobility	...tely 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	28			
				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

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

Risk Score	Category	Action	Support Surfaces **(Please Note:** Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for **"At Risk"** Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for **"Moderate Risk"** Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for **"High Risk"** Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	15/6/26			Fall Risk Grading		
		Score	MS					
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				Low Risk	0 - 24	Standard Fall Precaution
Ambulatory Aid	Furniture	30						
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	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				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
Mental Status	Forgets limitations	15						
	Oriented to own ability	0						
Total Morse Fall Scale Score:			20					
		Signature						

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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PAIN ASSESSMENT FORM

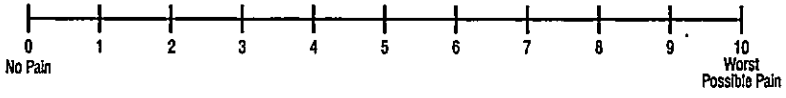
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
15/6	2pm	0/10	NR	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NP	[signature]
				☐ Continuous ☐ Intermittent	☐ 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		
				☐ 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: Apectroctomy Department: .... Date of Admission: ....

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

BACKGROUND	Area / Shift Time	15/6 NF					
	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					
	Res:	16					
	SpO_2:	99					
	Pulse:	82					
	BP:	110/76					
	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:	Nk					
Post Operative Procedure Special Orders:		–					
Handed Over By Name :		Hari					
Signature :		[signature]					
Date:		15/6					
Time:		8pm					
Taken Over By Name :							
Signature :							
Date:							
Time:							

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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

Date: 15/6

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am to 2pm	→ Assess the pt condition → monitor v/s → maintain I/O c/w	8Am to 2pm	→ Assess the pt condition → monitor vital → maintain	Now pt is stable	Re-check vital	Mou
Afternoon		——— Day ———					
Night							

Docu. No: RCH /FRM / CLINICAL / 148

Patient Sticker

NURSING CARE RECORD

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Date: .....

Goals

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

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

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : Mrs. Shireen Gender: ☐ Male ☐ Female Age : 47yrs

UHID No : RCWH-000057019 Date : 15/6/26

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)

HYSTEROSCOPY & ENDOMETRIAL BIOPSY

upon

(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, need for blood transfusion, inadvertent injury to bowel, bladder, 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. Ramya Theja / Dr. Swathi

Consentee :

Signature : Shireen

Name : Shireen

Date & Time : 15/6/26 @ 1pm

Witness :

Signature :

Name : DRAMYA THEJA

Date & Time : 15/6/26 @ 1pm

Patient Attendant :

Signature : Suleman

Name : Suleman

Relationship with Patient: Husband

Date & Time : 15/6/26 1PM

Doctor (who is taking the consent) :

Signature :

Name : Dr. G. Veena

Date & Time : 15/6/26 @ "Department

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : Mrs. Shireen Suleman Parani Age : 47y Gender : Male ☐ Female ☐

UHID NO: RCWH-57019 Surgeon Name: Dr. Ramya Theja

Anaesthesiologist : Dr. Vamil Erayath

Operative procedure planned : Hysteroscopy & Endometrial Biopsy

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 : nil significant

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 : Shireen

Name : Shireen

Relationship with Patient: .....

Date & Time : .....

Witness :

Signature : Sulaiman

Name : Sulaiman

Date & Time : 15/6/26 1·pm

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. Lamia Inayat

Date & Time : 15/6 at 12 pm

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: Mrs. SHIREEN SULEMAN PIRANI Age: 47y Sex: F UHID.No : RCWH-0000057019

Date: 13/6/26 Time: 4:10pm Proposed Operation: Hysteroscopy +EB

Diagnosis: Post menopausal Bleeding

B.P / CRT: 121/82 H.R: 87/m Weight: 64.7kg ASA Physical Status: ☐ 1 ☑ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 13.1	Glucose:	Protein: 7.4	HIV:	X-Ray:	
PCV: 39.3	Urea:	Alb: 4.1	HBS Ag: NR	ECG:	
WBC: 7400	Creat: 0.7	Total Bill: 0.7	HCV:	2D Echo:	
Plate: 3.62 lakh	Na: 141	Dir. Bill: 0.1	Blood group: B Positive	Stress/Anglo:	
PT: 15.5	K: 4.2	LDH:	T3	Other:	
PTT:	Ca++:	Alk phos: 85	T4		
INR: 1.07	Mg++:	Amylase:	TSH 9.431 uiu/ml		
	Cl-: 105	SGOT/SGPT: 16/16			

HbA1c - 5.4

Allergies: PENCILLIN ALLERGY

Medical History: CVS) NO H/O Chestpain, Syncope, SOB

RESP : H/O mild cold Diabetes : —

CNS : NIL SIGNIFICANT

Renal :

Hepatic / GE :

Physical Activity: METS > 4

Others : K/C/O Hypothyroid, stopped medication 2yrs ago after follow up

Past Anaesthetic History:

Physical Exam:

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

Lungs : BAE(+), Clear, SpO_2: 96% on RA

Heart: S1S2(+)

CNS: NAD

Pelvis USG : uterus anteverted, anteflexed ET - 14.8 mm, ill defined endo-myometrial junc & irregular branching s/o - MALIGNANCY, (Rt) Ovary not visualised

Pregnant: ☐ Yes ☑ No ☐ NA

Venous Access Site : peripheral (+)

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:
   (1) ECG, 2D Echo
   (2) Endocrine Opinion I/v/o ↑sed TSH
   (3) Review PAC

Signature: Name: Dr. SK Ayesha

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

RCWH.0000057019 IP26-00006589
Mrs SHIREEN SULEMAN PIRANI
21-04-1979 47 Y 1 M 25 D (F)
Dr. KADIYALA RAMYA THEJA

ANAESTHESIA CHART

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Pre-Induction Assessment: 2:15 pm

Change in Patient Condition: ☐ Yes ☑ No	Fasting Status: Adequate
Physical Status: ☑ Patient Identified	☑ Consent Present ☑ Chart Reviewed

H.R: 99	B.P / CRT: 117/59	SpO_2: 98	R.R: 14	Last Feed: 56 hrs

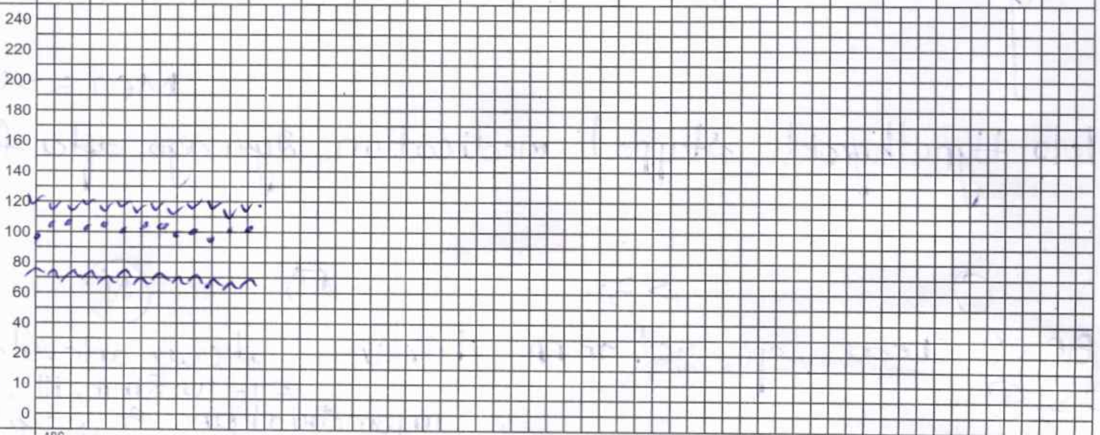
Pre-OP Diagnosis: Post Menopausal bleed Operation: Endometrial Biopsy Date: 15/6/26

Surgeon: Dr. Ramya Theja Anaesthesiologist: Dr. Samir / Dr. Abhishek Hysteroscopy Technician: Sai Chandu

TIME	2:15		2:45	3:10		Antibiotic
N_2O /AIR /O_2 LPM						—
HALO /SO /SEVO						Suppository
Drugs:						—
Inj. ONDANSETRON	4mg					Blood Loss
Inj. MIDAZOLAM	2mg					—
Inj. TRANEXAMIC ACID	1gm					NOTES
FIO_2 / SaO_2	98	96	97	98		—
$ETCO_2$						
ECG	SR	SR	SR	SR		
Temperature						
Urine Output						
Fluids / Blood	RL →	→	→	→		

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

Tourniquet on Time
Tourniquet off Time
Throat Pack In
Throat Pack Out



LAB Values
ABG
GRBS
Others

☑ Equipment Checked and Functional
☑ BP
☑ Cuff Site: (R) UL
☐ Art Site: ....
☑ EKG Lead
☐ 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

Times:
Anaes Start: 2:15pm
OP Start: ↓
OP End:
Leave OR: 3:10 pm.

Anaesthesia:
☐ GA
☐ Monitored Anaesthesia Care
☑ Regional

Line (Size & Location)
☐ CVP:
☐ ART:
☑ IV: (L) UL 20 G.
☐ 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
Site: L3 L4
Needle Size: 25G Whitacre Depth: 4cm
Parasthesia ☐ Yes ☑ No
Catheter at skin .... cm
Drug Name & Conc: 0.5% Bupivacaine heavy
Bolus: 2.5ml
Infusion: ....
Block Level: Adequate
Comments: ....

Transportation to
☑ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☑ NA
Name of the Doctor: Dr. Abhishek
Signature of the Doctor: [signature]

RCWH.0000057019 IP26-00006589
Mrs SHIREEN SULEMAN PIRANI
21-04-1979 47 Y 1 M 25 D (F)
Dr. KADIYALA RAMYA THEJA

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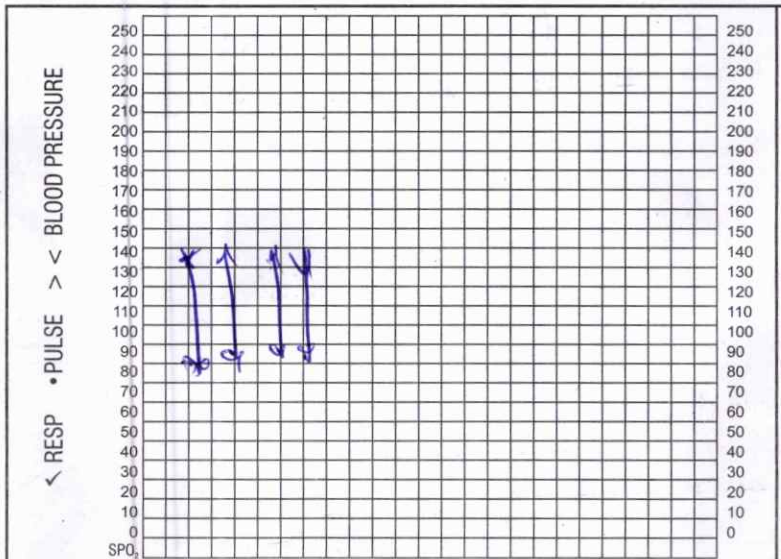
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Mounika Time Received : 3:30pm Time Discharged : .....



IV Cannula Site : left side

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

Vomiting : ☐ Yes ☐ No Drug: Tovinil

NG Tube : ☐ Yes ☐ No

Drain: ☐ Yes ☐ No

Urinary Catheter: ☑ Yes ☐ No

Chest Tube: ☐ Yes ☐ No

Nil Oral ☐ Yes ☐ No

IV Fluids: RL - 100ml

Oral Feeds: .....

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
15/6	3:30pm	0/10	Normal	Mouni
15/6	4pm	0/10	Normal	Mouni
15/6		0/10	Normal	
15/6			Normal	

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

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

Anaesthesiologist Name : .....

Anaesthesiologist Signature: .....

Date & Time: .....

PACU Nurse Name : Sujatha

PACU Nurse Signature: .....

Date & Time: 15/6/26 @ 6pm

Transferred to Unit by (PACU): .....

Date & Time: .....

Patient Sticker

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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		Maternal		FHR	Comments
			Left	Right	BP	Pulse		

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 : .....