

Dr. Padmajay



(300) Room

**ESTIMATION SLIP**

Date : 21/5/26 UHID / IP No. : KNH-00011823 SI No. 1528  
 Name of Patient : Mrs. Sonakdi Agarwal Age: 28/12 Gender: F  
 Father's / Husband's Name : Mr. Yash Agarwal Corporate / Occupation : \_\_\_\_\_  
 Address : Balkatpur Phone : 9121826697 Email : \_\_\_\_\_  
 Procedure / Plan : ND/LSCS EDD/Dos: June-26  
 MODE OF PAYMENT :  SELF  TPA : \_\_\_\_\_  GIPSA : \_\_\_\_\_ OTHER

**TARIFF INFORMATION :**

Particulars	Package Amounts (Rs.)	
	Normal Delivery	LSCS
Room Category		
Multi Shared Ward		
Shared Ward		
Twin Shared Ward		
Private Room →	1.45k	1.60k
Super Deluxe Room →	1.60k	1.75k
Suite Room →	2.60k (M+B) (2.50)	
Package includes (Package starts from the time of admission)	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee and Labour Ward Charges	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee Anesthetist's Fees and OT Charges
	Length of Stay for : <u>2 Days</u>	Length of Stay for : <u>3 Days</u>
	Pharmacy up to <u>9,000/-</u>	Pharmacy up to <u>12,000/-</u>
<u>LBP, NST</u> ⊕	Investigations up to <u>2,500/-</u>	Investigations up to <u>3,000/-</u>
Others	<u>Well baby care</u>	<u>2k to 3k</u>

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

Initial Minimum Deposit : 80% Advance

**MARKS :**

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

**DECLARATION**

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

Signature of the Client: \_\_\_\_\_  
 Signature of the Client: Yash Agarwal  
 Signatory Relationship: \_\_\_\_\_  
 Signature of the financial Counselor: \_\_\_\_\_



HNH-00011823 IP26-00006593  
Mrs SONAKSHI AGARWAL  
09-07-1997 28 Y 11 M 7 D (F)  
Dr. PADMAJA YELISETTY



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

BirthRight™  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

### SURGERY DETAILS

Date : 16/6/26

Patient Name: Mrs. Sonakshi Agarwal Date of Birth: 9/7/1997 Age: 28 Yrs

Gender: F Ward : OT UHID No.: HNH - 00011823

Date of Surgery: 16/6/26  OT-1  OT-2  OT-3  OT-4  OBG OT-1  OBG OT-2

Name of the Surgery : Elective LSCS + SA.

Time in : 9:20 Am

Time Out : 10:30 Am

	NAME	AMOUNT
1. Surgeon	Dr. Padmaja Yelisetty	
2. Anaesthetist	Dr. Akhila	
3. Assistant Surgeon	Dr. Poojanka / Dr. Durga	
4. OT Technician	Chaichandhu	
5. Circulating Nurse	S. Sangeetha / Dr. Karuna / Nataraj	
6. Assistant Nurse	Sr. Sushela	

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

Signature of the Surgeon  
*Padmaja*

Signature of Circulating Nurse  
*Karuna*

Order No: 26-0000206966

Order by: Sushela 16/6/26

@ 11:12 Am

1941

1941

1941  
1941  
1941

1941  
1941  
1941

1941  
1941  
1941



Ch-MSL

CONSUMABLES OF OT

Circulating staff: Kosune Technician: Sai Chandu Date: 15/6/26 Time: \_\_\_\_\_

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube			Major Pack <u>MSL</u>		<u>01</u>	Inj Vit.K		<u>01</u>
LMA			Sutures <u>2347, 2317</u>		<u>2 + 4</u>	Cord Clamp		<u>02</u>
ECG leads : A / P / N	<u>03</u>		<u>2318, 1326</u>			Suction Catheter <u>NO-8</u>		<u>01</u>
HME filter : A / P / N			<u>3650</u>			Feeding Tube <u>NO-5</u>		<u>01</u>
Syringes : 10 cc	<u>02</u>		Tip cleaner		<u>01</u>	Vaccum Suction Set		<u>01</u>
05 cc	<u>03</u>		Gloves <u>S.G 6/8</u>		<u>03</u>	Surgical Gloves <u>SG 6.5</u>		<u>01</u>
02 cc	<u>04</u>		PF(7)		<u>01</u>	Gauze Pack <u>7.5</u>		<u>02</u>
01 cc			Encode 6/8		<u>01</u>	Syringe 1ml / 2ml		<u>02</u>
Cautery plate : A / P / N	<u>01</u>		Surgical blade	<u>22</u>	<u>01</u>	Surgical Blade # 20		<u>02</u>
IV set			NG tube			Koochies (S)		<u>01</u>
RL	<u>03</u>		Cautery pencil		<u>01</u>	<u>SG 7.5</u>		<u>02</u>
NS : 10ml / 100ml / 500ml / 1000ml			Koochies <u>XXL</u>		<u>01</u>	Powder free <u>70</u>		<u>02</u>
<u>Bupropion</u>	<u>01</u>		Ointments			<u>D water</u>		<u>02</u>
<u>Atropine</u>	<u>01</u>		Suction Catheter					
Fentanyl			Cap, Mask	<u>10</u>	<u>10</u>			
Morphine			Gauze Pack <u>10cm x-ray</u>	<u>02</u>	<u>14</u>			
Ketamine			Mop Pack <u>7.5</u>		<u>2</u>			
Propofol			Steristrip			Order no.		
Rocuronium			Underpad	<u>2</u>		<u>26-00020675/976</u>		
Glycopyrolate		<u>01</u>	Draw sheet			<u>HNH-00015999</u>		
Myopyrolate			Abgel		<u>1</u>			
Ondansetron	<u>01</u>		Foleys catheter <u>16F</u>		<u>01</u>			
Pencan 25g/ Spinal Needle 22	<u>01</u>		Urobag		<u>01</u>			
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)	<u>01</u>		Romodrain bag					
Antibiotics			Bandage					
<u>Oxytocin</u>		<u>04</u>	Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg	<u>01</u>		Vaccum Suction set		<u>01</u>			
Justin : 12.5 mg / 25mg / 100mg	<u>01</u>		Plastic Bed Sheet <u>Aprons</u>		<u>4</u>			
Tab. Misoprost : 200mg			Betadine Solution		<u>2</u>			
<u>S. glove G.S</u>	<u>01</u>		Microshield		<u>21</u>			
<u>gauze 7.5</u>	<u>01</u>		Cotton Balls		<u>1</u>			
			Latex Gloves		<u>20</u>			
			Ramdione Scrub					
			<u>Sara</u> <u>D-water</u>		<u>2</u>			

Surgeon \_\_\_\_\_ Anaesthesiologist \_\_\_\_\_ Nurse \_\_\_\_\_ OT Technician \_\_\_\_\_

Order No. : 26-00020675/976 Ordered by : Eushela 16/6/26 @

11:38 AM

17 17

1  
2  
3

17 17 17

17 17 17  
17 17 17  
17 17 17

17 17 17  
17 17 17  
17 17 17  
17 17 17

17 17  
17 17

17 17  
17 17  
17 17

17 17  
17 17  
17 17

17 17  
17 17  
17 17  
17 17

17 17



**ELECTRONIC MEDICINE PRESCRIPTION**

MRN : HNH-00011823 Name : Mrs SONAKSHI AGARWAL  
 Age / Sex : 28 Y 11 M 7 D / Female Doctor : PADMAJA YELISETTY  
 Adm/Reg Date/Time : 16/06/2026 08:27 Payor : SELFPAY  
 Order Date : 16/06/2026 11:37 Ordernumber : 26-0000206975  
 Visit ID : IP26-00006593 Ward/Bed No : 4F -OT /LDR-416  
 Patient Address : GURU GANESH RESIDENCY, Barkatpura, Hyderabad, Telangana, INDIA, 500027

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	COTTON BALLS 2 GM 5 NOS		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
2	URCBAG (ADULT)-URODYNE		1 Nos	External / 1-2 TIMES A DAY	1 Days		1 Nos	Dispensed
3	MOPS 30X30 8PLY 5S X-RAY	MOPS 30X308 PLYDATT	1 Nos	/ Once Daily	2 Days		2 Nos	Dispensed
4	CAUTERY PENCIL (ADVANCE)		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
5	POVINANZ SOLUTION 10% 100 ML		1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
6	BUPRIGESIC INJ AMP 0.3 MG 1ML	BUPRENORPHINE 0.3 MG 1ML INJ	1 Ampule	Injection / Once Daily	1 Days		1 Ampule	Dispensed
7	PENCAN 25G*3 1 2	PENCAN 25G*3 1 2	1 Nos	Injection / Once Daily	1 Days		1 Nos	Dispensed
8	VACCUME SUCTION SET		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
9	EVATOICIN (OXYTOCIN) INJ 5 IU 1 ML		1 Vial	Injection / Once Daily	1 Days		4 Vial	Dispensed
10	VICRYL 2-0 VP 2317	VICRYL 2-0 VP 2317	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
11	Monocryl 3-0 W3850		1 Nos	/ 1-2 TIMES A DAY	1 Days		1 Nos	Dispensed
12	E.C.G ELECTRODES (ADULT)	ELECTRODES ADULT	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
13	FOLEYS CATHETER 16-URCATH		1 Nos	Uretal / 1-2 TIMES A DAY	1 Days		1 Nos	Dispensed
14	JUSTIN SUPPOSITORIES 100 MG 5 S		1 Nos	Rectal / Once Daily	1 Days		1 Nos	Dispensed
15	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
16	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
17	BUPICAN HEAVY 80MG INJ 4ML		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
18	GAUZE 7.5X7.5 12 PLY (5 NOS)	GAUZE 7.5X7.5 12 PLY 5 NOS	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
19	Encore Micropic gloves-6.5		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
20	UNDERPADS 60X90 BUTTERFLY		1 Nos	External / 1-2 TIMES A DAY	1 Days		2 Nos	Dispensed
21	ONDOKIND INJ 4 MG 2 ML		1 Nos	/ Once Daily	1 Days		1 Vial	Dispensed
22	VICRYL PLUS 1 VP - (2347)	VICRYL PLUS 1 VP 2347	1 Nos	/ Once Daily	2 Days		2 Nos	Dispensed
23	SUPRIDOL SUPPOSITORIES 100 MG 5 S		1 Nos	Rectal / Once Daily	1 Days		1 Nos	Dispensed
24	DSYRINGE 5ML (NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
25	ABGEL SURGI PAD (BIG) (GELSPON)	ABGEL	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
26	DSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
27	SURGICAL BLADE 22	SURGICAL BLADE 22	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
28	TIP CLEANER ELECTRO BRASIVE(REF.E2401)		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
29	D WATER 10 ML AMPULE	DISTIL WATER10ML	1 Bottle	External / Once Daily	1 Days		2 Bottle	Dispensed
30	DISPOSABLE APRONS STERILE XL	DISPOSABLE APRON STERILE XL	1 Nos	/ Once Daily	4 Days		4 Nos	Dispensed
31	BACTOPREP SOLUTIONS 100 ML		1 mL	/ Once Daily	1 Days		1 Nos	Dispensed
32	ADULT DIAPERS-XXL		1 Nos	External / 1-2 TIMES A DAY	1 Days		1 Nos	Dispensed
33	PREGELLED SURGICAL PLATES(ADULT)	PREGELLED PLATED ADULT	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed

PADMAJA YELISETTY

Reg No : 52427

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

Note

\* This prescription is valid only for specified duration.

\* Do not refill medicines.





**ELECTRONIC MEDICINE PRESCRIPTION**

MRN : HNH-00015999 Name : Baby Of SONAKSHI AGARWAL  
 Age / Sex : 0 Y 0 M 0 D 2 H / Female Doctor : SPANDANA PASUPULETI  
 Adm/Reg Date/Time : 16/06/2026 10:12 Payor : SELFPAY  
 Order Date : 16/06/2026 11:51 Ordernumber : 26-0000206980  
 Visit ID : IP26-00006595 Ward/Bed No : 4F -OT / CRDL-HNPDA-415-1  
 Patient Address : GURU GANESH RESIDENCY, Barkatpura, Hyderabad, Telangana, INDIA, 500027

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	KOOCHES LARGE 5 s		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
2	DSYRINGE 1ML (NIPRO)	SYRINGE 1ML	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
3	GAUZE 7.5X7.5 12 PLY (5 NOS)	GAUZE 7.5X7.5 12 PLY 5 NOS	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
4	CORD CLAMP-ALPHAMEDICARE		1 Nos	External / 1-2 TIMES A DAY	1 Days		2 Nos	Dispensed
5	EASYCLOT-K1 1MG INJ 0.5 ML		1 Nos	Injection / 1-2 TIMES A DAY	1 Days		1 Nos	Dispensed
6	INFANT FEEDING TUBE-5	INFANT FEEDING TUBE 5	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
7	SGLOVE # 7.5 (SURGICARE)	SURGICAL GLOVES 7.5	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
8	VACCUME SUCTION SET		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
9	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
10	SUCTION CATHETER 6 ROMSONS		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
11	D WATER 10 ML AMPULE	DISTIL WATER10ML	1 Bottle	External / Once Daily	1 Days		2 Bottle	Dispensed
12	SURGICAL BLADE 20	SURGICAL BLADE 20	1 Nos	/ Once Daily	2 Days		2 Nos	Dispensed

**SPANDANA PASUPULETI**

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

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

\* Do not refill medicines.



**Name** Mrs SONAKSHI AGARWAL **UHID** HNH-00011823  
**Father/Guardian** Mr YASH AGARWAL **Age/Gender** 28 Y 11 M 7 D/ Female  
**Address** GURU GANESH RESIDENCY, Barkatpura, Hyderabad, Telangana, INDIA, 500027  
**IP No** IP26-00006593 **Admission Date** 16-06-2026  
**Ref Doctor** Self.  
**Discharge Date** 19.06.2026

### DISCHARGE SUMMARY

**Consultant:**

**Dr. PADMAJA YELISETTY**  
**MBBS, MD, MRCOG, FRCOG**  
**52427**

**Diagnosis: PRIMIGRAVIDA WITH 38+1 WEEKS FOR ELECTIVE LOWER SEGMENT CAESAREAN SECTION**

**ELECTIVE LOWER SEGMENT CESAREAN SECTION DONE ON 16.06.2026**

**History:**

LMP: 20.09.2025

Obstetric formula: Primi

EDD: 28.06.2026

Gestation at admission: 38<sup>+1</sup> weeks

Name	Mrs SONAKSHI AGARWAL	UHID	HNH-00011823
IP No	IP26-00006593	Admission Date	16-06-2026

**Obstetric History:**

G1 - Present pregnancy, Spontaneous conception.

**Medical History:** Nil

**Surgical History:** Nil

**Family History :** Both parents: HTN

**Allergies :** Nil

**Antenatal Details:**

Mrs SONAKSHI AGARWAL was booked to Rainbow hospital at 6<sup>+6</sup> weeks of gestation. She had regular antenatal checkups and investigations as advised.

NT scan was normal, FTS was low risk. TIFFA was normal. Scan done on 03.06.2026 showed Single live intrauterine fetus at 36<sup>+4</sup> weeks with cephalic EFW: 27338gm (30%) AC: 24% with AFI: 13cm, with posterior high placenta, persistent right umbilical vein with normal Doppler. She was admitted at 38<sup>+1</sup> weeks for Elective LSCS.

**Investigations:** Enclosed.

Blood group: "B" Positive

**Management: Course in hospital:**

She was prepared for elective C- section with indwelling Foley's catheter and IV canula under aseptic conditions. Written informed consent for surgery taken. Preanesthetic check up done. Anesthetic premedication (IV Pantop and Perinorm) given. Antibiotic prophylaxis with Inj. Taxim 1 gm IV given. Patient shifted to theatre.

**Surgery Notes:**

Name Mrs SONAKSHI AGARWAL UHID HNH-00011823  
IP No IP26-00006593 Admission Date 16-06-2026

Under spinal anesthesia she was painted and draped as per hospital protocol. Abdomen opened in layers. The parietal and visceral peritoneum carefully opened after identifying the urachus. Bladder was reflected. A Lower segment curvilinear incision given on the uterus. Baby delivered. Cord clamped and cut and cord blood collected for blood grouping and Rh typing. Baby handed over to pediatrician. Placenta delivered with controlled cord traction. Uterus closed in layers. Hemostasis secured. Instruments and swab count checked. Rectus sheath closed. Skin closed with subcuticular sutures. Wound dressing done. Vagina cleaned with Betadine solution after expelling clots. Misoprostol 800 mcg given per rectum as prophylaxis against Postpartum hemorrhage. Patient was shifted out of theatre to post operative recovery room.

#### Delivery Details:

Date : 16.06.2026  
Time of Delivery : 09:42am  
Type of Delivery : Elective LSCS  
Indication : Maternal request  
Anaesthesia : Spinal

#### Baby Details:

Date : 16.06.2026  
Time : 09:42am  
Sex : Female  
Weight : 2.8kg  
Apgar : 8,9  
Gestational Age: 38<sup>+1</sup> weeks

Name	Mrs SONAKSHI AGARWAL	UHID	HNH-00011823
IP No	IP26-00006593	Admission Date	16-06-2026

NICU Admission: No

**Post-Operative Notes:**

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

**Advice:**

1. Tab. Taxim O 200mg twice daily till 22.06.2026 (9am-9pm) after food.
2. Tab. Calpol (Paracetamol 500mg) 2 tablets thrice daily till 20.06.2026 (8am-2pm-10pm) after food.
3. Tab. Voveran (Diclofenac-50mg) 1 tablet thrice daily till 20.06.2026 (9am-3pm-11pm) after food.
4. Tab. Pantodac (Pantoprazole - 40mg) 1 tablet twice daily till 22.06.2026 (7am-7pm) before food.
5. Tab. Livogen (Elemental Iron - 50mg, folic acid 1.5mg) once daily (7am) for three months before breakfast.
6. Tab. Shelcal (Elemental Calcium 500mg, vitamin D3 250 IU) once daily (2pm) till breast feeding after food.
7. Nebasulf Powder for local application.

Name Mrs SONAKSHI AGARWAL UHID HNH-00011823  
IP No IP26-00006593 Admission Date 16-06-2026

Review with **Dr. PADMAJA YELISETTY**, after 2 weeks on 03.07.2026 at Rainbow Children's Hospital with prior appointment (**Review consultation will be charged**).

**For Women Who Have Had a Cesarean Section  
Care of the wound:**

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

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

Patient/ Attender

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

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

Name

Mrs SONAKSHI AGARWAL

UHID

HNH-00011823

IP No

IP26-00006593

Admission Date

16-06-2026

**Consultant:**

**Dr. Padmaja Yelisetty,**  
MBBS, MD, MRCOG, FRCOG  
52427

  
**Registrar/Resident/C.M.O**



ADMISSION SHEET

Registration Details :



Admission No : IP26-00006593      Admit Date : 16-Jun-2026      Admit Time : 06:27 AM      UHID : HNH-00011823

Patient Details :

Patient Name : Mrs SONAKSHI AGARWAL      Age : 28 Y 11 M 7 D  
Guardian : Mr YASH AGARWAL      DOB : 09-07-1997  
Gender : Female      Religion :  
Occupation :      Martial Status :  
Address (H) : GURU GANESH RESIDENCY Barkatpura      Phone No : 8121876697/ 9553599595  
Hyderabad Telangana INDIA 500027      E-mail :  
SONAKSHIAGARWAL09@GMAIL.COM

Admission Details :

Bed Type : TWIN SHARING      Bed No : LDR-416      Ward Name : 4F -OT  
Room No : LDR-416      Admission Type : First Visit

Contact Details :

Name : Mr YASH AGARWAL      Relationship : W/O  
Contact Address :      Phone No : 8121876697

  
Signature

Doctor Details :

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

Payment Details :

Deposit Amount : 150000.00  
Payment Mode : DC/CC Card      Payor Name : SELFPAY

HNH-00011823 IP26-00006593  
 Mrs SONAKSHI AGARWAL  
 09-07-1997 28 Y 11 M 8 D (F)  
 Dr. PADMAJA YELISETTY




## DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	1			
6	Doctors progress sheets	1			
7	Nursing plan of care and handover sheets	1			
8	Consultation sheet				
9	General consent for treatment	4			
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaesthesia notes (Pre Anaesthesia & post)				
22	Neonatal Admission/Delivery/Physical Exam	1			
23	Medication Reconciliation	1			
24	Emergency Triage record				
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart	3			
30	Intake and Out take chart (fluid chart)	3			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart				
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale				
38	Braden Q Scale				
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	<i>Bilal</i>	1			
	<i>Shrey</i>	6			
	<b>Total No. of Pages</b>	<u>28</u>			

*Y. Daisf* (P.T.O)  
 19/6/20

**ACTIVITY RECORD FOR BILLING**

Name: **HNH-00011823** **IP26-00008593**  
**Mrs SONAKSHI AGARWAL**  
**09-07-1997** **28 Y 11 M 7 D** (F)  
**Dr. PADMAJA YELISETTY**

UHID No:  Consultant: \_\_\_\_\_ Dept: \_\_\_\_\_

Date of Admission: \_\_\_\_\_ Date of Discharge: \_\_\_\_\_ Time: \_\_\_\_\_

Room / Bed No: \_\_\_\_\_ Ward: \_\_\_\_\_ Suggested Billable bed type: \_\_\_\_\_

**WARD TRANSFERS**

Date	Time	From	To	Signature of Nurse
16/6/26	9AM	Pre-post	OT	A. Saseetha
16/6/26	10:20AM	OT	Pre-post	Natalia
16/6	3:30PM	Pre-post	(308)	Swati

**Cross Consultation Visit**

	Doctors Name	Date	Order No.	Signature
1	Dr. S. Tejaswi	16/6/26	7074	Swati
2				
3				
4				
5				
6				
7				
8				
9				
10				

Cross checked done by Swati





**PROCEDURE**

Date	Procedure	Quantity	Order No.	Signature
16/6/26	IV placement	①	6943	Ali
16/6/26	Catheterization	①	6943	
12/6/26	PAC	①	12948	[Signature]
<del>cross checked done</del>				
16/6/26 (5:30pm)	NHA	①	207073	[Signature]
<del>cross checked done by mahi</del>				

**ANY OTHER INFORMATION**

.....

.....

.....

.....

.....

.....

Date : \_\_\_\_\_ Time : \_\_\_\_\_ Prepared By : \_\_\_\_\_

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



# IP ADMISSION SHEET FOR OBSTETRICS

**Presenting Complaints**

Came for elective UC

LMP: 20/9/25 EDD:  
 Corrected EDD: 28/6/26 GA: 38<sup>W</sup> wh

**Obstetric Formula:**

Primie

**Obstetric History:**

G: PP, spontaneous conception  
 Booked @ 6<sup>th</sup> wh

Menstrual History: Regular:  Yes  No

**Obstetric Examination**

Fundal Height: 36cm  
 Ut. Activity:  Relaxed  Mild  Mod  Severe  
 Liquor:  Adequate  Oligo  Poly  
 PP:  Cephalic  Breech Others \_\_\_\_\_  
 Head Fifths Palpable: \_\_\_\_\_

**Present Pregnancy Record:**

unremarkable

FHS:  Normal  Tachy  Brady  Absent

**RISK FACTORS:**

**Per Speculum Examination** Not done

Draining:  Present  Absent  Bleeding  
 Colour of Liquor:  Clear  Meconium  Blood Stained

**Vaginal Examination** Not done

Cervix:  Long  Partially effaced  Effaced  
 Os: Closed \_\_\_\_\_ Dilated \_\_\_\_\_

Height: 157 cm

Weight: 68.9 kg

Allergies: Nil

Breast:  Normal  Abnormal

**General Examination:**

Consciousness: d/c  
 Pallor: (-)  
 Icterus: (+)  
 Edema: (-)  
 Temp: afebrile  
 PR: 90/min  
 BP: 120/80 mmHg  
 DTR: (N)  
 CVS: A2 (+)  
 RS: RAS (+)  
 Liver/Spleen: (N)  
 Urine Output: (N)

Membranes:  Present  Absent  
 Liquor:  Clear  Meconium  Blood Stained  
 Presenting Part:  Vertex  Breech  Others  
 Sutton:  -3  -2  -1  0  +1  +2  
 Pelvis:  Adequate  Doubtful

**DIAGNOSIS**

Primie / 38<sup>W</sup> wh / for elective UC



Family History: both parents: HIV	Surgical History: NR
Medical History: NR	Medication History: Pac, Iron / Calcium / Vit-D
Plan of Care: <ul style="list-style-type: none"><li>- NPO</li><li>- Consent for surgery</li><li>- PAC</li><li>- NR</li><li>- Monitor vitals</li><li>- CBR to be checked</li><li>- Preparation of patient</li><li>- prep medication</li><li>- Foley's catheterization</li><li>- shift to or on call</li><li>- Inform for</li></ul>	Investigations: <ul style="list-style-type: none"><li>CB for WBC</li><li>HIV</li><li>HBsAg</li><li>HCV</li><li>VDRL</li></ul> NR  3/6/24 : RWK 3044 w/h, exhale, GFW 27338m, 30% Ac: 24'. AF: 13mm, posterior high persistent right umbilical vein & portal

Doctor Name: Dr Ranjeeth Reddy  
Signature: Ranjeeth  
Date & Time: 16/6/26 @ 8AM

Consultant Name: Dr Padmaja Y  
Signature: Padmaja Yelisetty  
Date & Time: 16/6/26 @ 8AM

HNH-00011823 IP26-00006593  
 Mrs SONAKSHI AGARWAL  
 09-07-1997 28 Y 11 M 7 D (F)  
 Dr. PADMAJA YELISETTY



## CAESAREAN SECTION OPERATIVE NOTES

Surgeon's Name: <u>Dr. Padmaja Yelisetty</u>	Date of Delivery: <u>16/06/2026</u>
Assistant Surgeon: <u>Dr. Pnyadaeshini / Dr. Dua</u>	Time of Delivery: <u>9:42 pm</u>
Anaesthetist's Name: <u>Dr. Samir</u>	Gender of Baby: <u>Female</u>
Type of Anaesthesia: <u>Spinal</u>	Weight of Baby: <u>2.8 Kg</u>
Neonatologist: <u>Dr. Tejeswi / Dr. Shreegan</u>	AGPAR Score: <u>8, 9</u>
Scrub Nurse: <u>Susheela</u>	NICU Admission: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Pre-Operative Diagnosis: Primigravida with 38w 1 day POG, came for Elective LSCS

Elective       Emergency      Indication: Maternal Request

Urgency

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

Decision time: .....      Knief to rectus: .....

CTG Description: Reactive

If there was a delay give the reasons: .....

Surgical Procedure: Elective LSCS

Post Operative Diagnosis: Pt. on PODO following Elective LSCS

Peri-Operative Complications: —

Amount of Blood Loss: —      Blood Transfused (in ML):

Name and Number of Surgical Specimen sent for examination:

Baby delivered by - Dr. Padmaja.  
 Uterine Closure - Dr. Priyadarshini

**Examination Findings when Appropriate:**

Presentation:  Cephalic  Breech  Other ..... Cervical Dilatation: ..... cm  
 5th Palpable: ..... <sup>5/5th</sup> Fetal Position: .....  
 Station:  -3  -2  -1  0  +1  +2 Moulding:  None  +  ++  +++  
 Caput:  +  ++  +++ <sup>no</sup> Meconium:  None  +  ++  +++  
 Bladder Catheterized:  Yes  No Urine:  Clear  Blood Stained

Skin Incision:  Pfannenstiel  Transverse  Midline  Other .....  
 Uterine Incision:  Lower Segment  Classical  Inverted T  J Incision  
 Previous Scar:  Intact  Thinned out  Ruptured  No Scar  
 Incision Through Placenta:  Yes  No  
 Delivery of head:  Manual  Forceps  
 Liquor:  Clear  Meconium:  I  II  III  Blood  Offensive  Not Offensive  
 Delivery of Placenta:  Manual  CCT .....  Complete  Incomplete  Piecemeal  
 Cord Appearance: ..... <sup>Normal</sup> Cord around the neck  Yes  No  
 Appearance of placenta: ..... <sup>Normal</sup> Cavity explored  Yes  No  
 Uterus, tubes and ovaries:  Normal  Not Normal Sterilization:  Yes  No

Uterine Closure:  One Layer  Two Layers ..... <sup>Vicryl No-1</sup> Suture  
 Peritoneal Closure:  Pelvic  Abdominal  None ..... <sup>Vicryl No-1</sup> Suture  
 Sheath Closure: <sup>Yes</sup> ..... <sup>Vicryl No-1</sup> Suture  
 Fat Closure:  Yes  No ..... <sup>Monocryl No-1</sup> Suture  
 Skin Closure:  Subcuticular  Mattress ..... <sup>Monocryl No-1</sup> Suture  
 Vaginal Evacuated  Yes  No  
 Drain:  Yes  No  Remove in ..... days  Await instructions  
 Catheter  Yes  No  Remove in ..... days  Await instructions  
 Swap & Instruments count correct?  Yes  No  Post-op Antibiotics  Yes  No  
 Intra-Operative Antibiotics Cover:  Yes  No  Thromboprophylaxis  Yes  No

Post-Operative Notes: .....  
 - NBM till 6 hours  
 - IV fluids  
 - IV Antibiotics for 24 hours.  
 - Analgesics & thromboprophylaxis as per AXON  
 - I/O charting  
 - monitor vitals  
 - w/f PV bleed  
 Inform sct:

Doctor Name: Dr. Padmaja Doctor Signature: Y. Padmaja  
 Date & Time: 16/6/26

# SURGICAL SAFETY CHECKLIST

Surgeon : *Dr. Padmaja*  
 Asst. Surgeon : *Dr. Priyadarshini*  
 Anaesthetist : *Dr. Akhila*  
 Scrub Nurse : *Sr. Sushudan*

HNH-00011823 IP26-00006593  
 Mrs SONAKSHI AGARWAL  
 09-07-1997 28 Y 11 M 7 D (F)  
 Dr. PADMAJA YELISETTY



Age : *28y* Gender : *F*  
 Surgery Name : *Ch. HSG*  
 Date : *16/6/26* In-time : *9:05* Out-time : *10:00*



## Before Induction of Anaesthesia >>

SIGN IN	Time: <i>9:05 AM</i>
<b>Patient Has Confirmed</b>	
Identity	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Site	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Procedure	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Consent	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Site Marked</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA
<b>Anaesthesia Safety Check Completed</b>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Pulse Oximeter on Patient &amp; Functioning</b>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Does Patient have a:</b>	
Known Allergy?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>Difficult Airway / Aspiration Risk?</b>	
Yes, & Equipment / Assistance Available	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>Risk of &gt; 500ml Blood Loss (7ml/kg In Children)?</b>	
Yes, and Adequate Intravenous Access and Fluids Planned	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
Blood Units Reserved	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
<b>Has Antibiotic Prophylaxis been given within the last 60 minutes?</b>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Signature : <i>[Signature]</i>	
Name : <i>DR. AKHILA.K</i>	

## Before Skin Incision >>

TIME OUT	Time: <i>9:35 AM</i>
<b>Confirm all team members have introduced themselves by Name and Role</b>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Surgeon, Anaesthesia Professional and Nurse Verbally Confirm</b>	
Correct Patient (Check ID Band)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Correct Site	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Correct Procedure	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Anticipated Critical Events</b>	
<b>Surgeon Reviews:</b>	
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss?	<i>Bleeding 1 hour soon</i> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
<b>Anaesthesia Team Reviews:</b>	
Are There Any Patient-specific Concerns?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
<b>Nursing Team Reviews:</b>	
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
<b>Is Essential Imaging Displayed?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Power Supply, Earthing, Power Backup and functioning of equipment checked.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Signature : <i>[Signature]</i>	
Name : <i>Ramona @ 9:35 AM</i>	

## Before Patient Leaves Operating Room

SIGN OUT	Time: <i>10:30 AM</i>
<b>Nurse Verbally Confirms with the Team:</b>	
The Name of the Procedure Recorded	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
The Specimen is Labelled (including patient name)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
Whether there are any Equipment Problems to be addressed	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
<b>To Surgeon, Anaesthetist and Nurse:</b>	
What are the key concerns for recovery and management of this patient?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Signature : <i>[Signature]</i>	
Name : <i>Dr. Priyadarshini</i>	

# PATIENT TRANSFER FORM

HNH-00011823 IP26-00006593  
Mrs SONAKSHI AGARWAL  
09-07-1997 28 Y 11 M 7 D (F)  
Dr. PADMAJA YELISETTY



Date & Time of Admission <i>16/6/26 @ 6:27am</i>		Date & Time of Transfer Order <i>16/6/26 @ 10:30AM</i>
Treating Consultant Name <i>Dr. Padmaja</i>	Transfer Ordered by <i>Dr. Akhila</i>	Reason for Transfer <i>Observation</i>
From Unit <i>R</i>	To Unit <i>Pre-post</i>	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File <i>32</i>	Number of Imaging Films <i>—</i>	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what ?
Medications / Consumables / Surgicals / Hand over		
Sl.No.	Item Name	Quantity
1.	<i>Ru</i>	<i>01</i>
2.		
3.		
4.		
5.		
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
Name & Signature of Person who is Transferring <i>Karuna</i>		Name of Person Ordered Transfer <i>Dr. Akhila</i>
Patient & Clinical Records Received by : <i>Anusha</i>		
Date & Time of Patient Received : <i>16/6/26 @ 10:30AM</i>		

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

Handwritten text at the top of the page, possibly a title or header.

Handwritten text on the left side of the page.

Handwritten text on the right side of the page.

Handwritten text in the center of the page.

Small handwritten mark or symbol.

Small handwritten mark or symbol.

Small handwritten mark or symbol.



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16.6.26 10:30am	c/s/b Dr. Priyadarshini P.L. / POD-'0' / EL. USG OIE Pt. cu Ge-fan /afebise P° / PE° P-R-59bpm. B-P-114/68mmHg HIL-NAD PLA-soft ut well retracted Plv No active bleeding.	1. NBM for 6hrs 2. Do flush & pain medication as per anon 3. Monitor vitals for every 30mts 4. Do chart 5. w/f bleeding Plv 6. follow drug chart 7. Inform SOS
16/6/2026 1:40pm	c/s/b Dr. Naveera o/c GC-fair Afebrile, SpO <sub>2</sub> : 100% on RA PR: 60bpm BP: 101/68mmHg PA: ut. well retracted Soft, NT. Dressing: dry & clean Bowel sounds: present. ILE: PV bleeding wNL. Babe: mother side Ulo: 100mlthi clear	- Sips of water. Plv liquid diet - Soft diet at 10pm - drugs: as charting - w/f. PV bleeding. - Urine I/O charting. - Monitor Vitals - Inform SOS

Kindly shift the patient to room

Dr. Priyadarshini  
 Dr. Naveera



# PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/6/26 12:30 PM	cls/B Dr. Veena <u>POD-0 / P, L<sub>1</sub> / CI-LSCS</u>	
Baby @ ms	Pt is stable, No c/o o/e GC-fair BP - 114/72 mmHg PR - 80 bpm SpO <sub>2</sub> - 98% on RA P/A - Ut well retracted BS (+) L/E - BWNL U/O - 50ml/hr, clear	Adv - Liquid diet - Soft diet @ 10pm - Drugs as charted - Adequate hydration - Vital monitoring - No charting - Foley's removal c/m @ 6am (Not willing now) - Inform SOS NB - Suckling for 1st 9pm
B/c Breasts Soft ms (+)		
17/6/26 8 AM	cls/B Dr. Veena <u>POD-1 / P, L<sub>1</sub> / CI-LSCS</u>	
Baby @ ms	Pt is stable, No c/o o/e GC-fair, Afebrile Pallor (-) Vitals - stable P/A - Ut well retracted BS (+) L/E - BWNL <del>o/e</del>	Adv - Soft diet - Drugs as charted - Vital monitoring - Adequate hydration - Ambulation 3rd hourly - Inform SOS NB - Moutun @ 8 AM.
B/c Breast - soft ms (+)		
W ✓ F ✓ S X		





**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
17/06/2026	C/S/B Dr. Dua	
7:30pm	POD-1 P/L (EL-LSCS)	
	No complaints	
	GC Fair, Afebrile. BP: 105/69 mmHg	<p style="text-align: center;"><u>Adv</u></p> <ul style="list-style-type: none"> <li>✓ Soft diet</li> <li>✓ Adequate hydration</li> <li>✓ Drugs as charted</li> <li>✓ Ambulation</li> <li>✓ Open dressing t/m</li> <li>✓ W/P excessive P/V bleed</li> <li>✓ Monitor vitals</li> <li>✓ Inform sos.</li> </ul>
passed urine 4 flatus	PR: 81 bpm H/C: NAD	
Stool Not passed	P/A Uterus Retracted well L/E - P/V bleed WNL.	
	Baby & Mother.	
	<i>[Signature]</i>	NB Sunanda
18/6/2026	C/S/B Dr. Dua	
8AM	POD-2 P/L (EL-LSCS)	
	No complaints	
	Pt comfortable.	<p style="text-align: center;"><u>Adv</u></p> <ul style="list-style-type: none"> <li>✓ soft Regular diet</li> <li>✓ Adequate hydration</li> <li>✓ Drug as charted</li> <li>✓ Ambulation</li> <li>✓ W/P excessive P/V bleed</li> <li>✓ Monitor vitals</li> <li>✓ Inform sos</li> <li>✓ Open dressing today</li> </ul>
Passed urine flatus & stool	GC Fair Afebrile BP: 103/91 mmHg	
	PR: 73 bpm. SpO <sub>2</sub> 98% on RA.	
Baby & Mother.	H/C NAD P/A uterus retracted well	
	4/5 P/V bleed WNL.	<i>[Signature]</i>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/6/26 10:55am	CLS/B POD-2 / P.U / EL. USS No complaints OIE p/cu Ac fair / a febrile P <sup>o</sup> / PE <sup>o</sup> PR - 77bpm BP - 110/70 H/C NAD P/A - ut well retracted BS (+) Soft Plv No active bleeding	Dr. Priyadarshini 1. Normal diet 2. Ambulation + plenty of oral fluids 3. Follow drug chart 4. Monitor vitals 5. W/F bleeding Plv 6. Perform SS
BA BF (+) BL Breast soft UV FV SV	Adv ASD (Open dressing)	NB. Moulded @ 12pm. Dr. Priyadarshini
18/6/26 3pm.	CLS/B Dr. Veena POD-2 / P.U / EL. USS No clo, Ac fair, Pallor (-) vitals - stable P/A - ut well retracted BS (+) Ue - BUNE ASD (Open dressing) done ✓	Adv - Regular diet - Vital monitoring - Drugs as charted - Ambulation - Adequate hydration - Perform SS
UV FV SV Baby @ ms BL Breast soft ms (+)		

*[Handwritten signature]*



**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
18/06/2026 6:30pm	cls/by: Dr Naveena	
U-✓	OLG GC-fair	Ado
F-✓	Afebrile	- Regular diet
S-✓	PR: 81bpm	- Adequate hydration
	BP: 116/79 mmHg	- drugs as charted
	Cvslrs: NAD	- Ambulation
	PA: ut. retracted well	- w/f PV bleeding
	Soft NT	- Monitor Vitaly
	LSCS wound clean & healthy	- Inform SOS
	ILE: PC bleeding wNL	
	Baby: Mother side	
	BL breasts: soft secretions ⊕	Dr Naveena

IP26-0006593  
 HNH-00011823  
 Mrs SONAKSHI AGARWAL  
 08-07-1997 28 Y 11 M 7 D (F)  
 Dr. PADMAJA YELISETTY



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/06/2026 7:30am	cls by	Dr. Naveena
	<p>GLE GC-fair</p> <p>Alebrile</p> <p>PR: 82 bpm</p> <p>BP: 124/88 mmHg</p> <p>U-V ✓</p> <p>F-V ✓</p> <p>S-V ✓</p> <p>CUSRS: NAD</p> <p>PA: ut. retracted well.</p> <p>Soft, NT</p> <p>LSCS wound: clean &amp; healthy.</p> <p>UE: PV bleeding WNL</p>	<p>Adv</p> <ul style="list-style-type: none"> <li>- Regular diet</li> <li>- Adequate hydration</li> <li>- drugs as charted</li> <li>- Ambulation</li> <li>- wlf PV bleeding</li> <li>- Monitor vitals</li> <li>- Inform SOS</li> </ul> <p style="text-align: right;">NB Sneha C 8 PM</p>
	<p>Baby: Mother side</p> <p>BL breasts: soft</p> <p>Secretions (+)</p>	<p>Dr. Naveena</p>
	<p>It can be discharged</p>	







HNH-00011823 IP26-00006593  
 Mrs SONAKSHI AGARWAL  
 09-07-1997 28 Y 11 M 7 D (F)  
 Dr. PADMAJA YELISETTY



308



### RESULT SHEET

Date	16/6/28				
Time	7:13AM				
Hb	12.5				
PCV	35.5				
RBC	4.38				
WBC	9.69				
N/L					
Platelets	154				
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					
		Biye				
	HIV					
	HbsAg					
	HAcid					

Culture and Sensitivities : .....

.....

.....

.....

Radiology :      USG : .....

                         X-Ray : .....

                         ECHO : .....

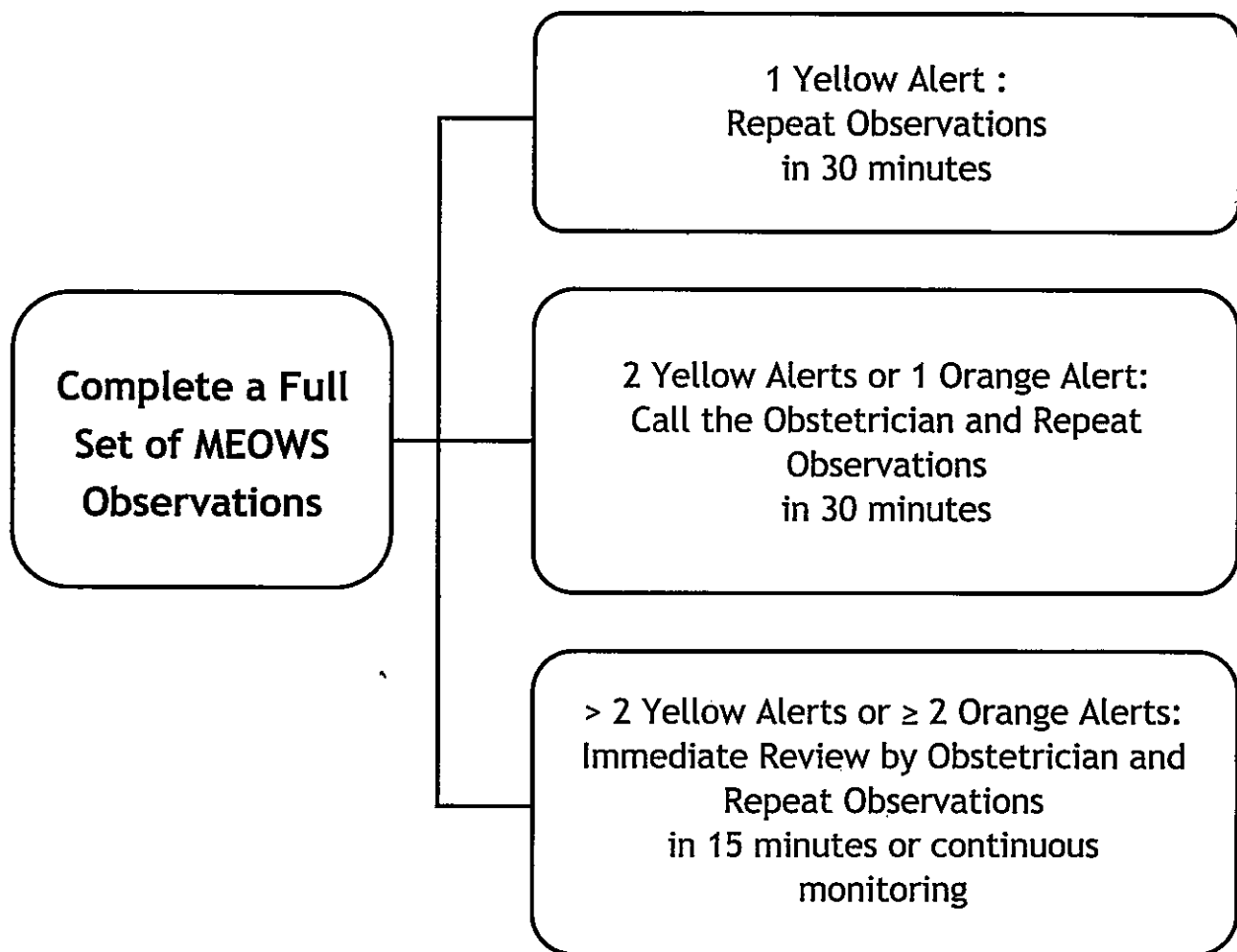
                         CT : .....

                         MRI : .....

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



## Obstetrics and Gynaecology Early Warning Signs



\* The Modified Early Warning Score (MEOWS)

HNH-00011823 IP26-00006593  
 Mrs SONAKSHI AGARWAL  
 09-07-1997 28 Y 11 M 7 D (F)  
 Dr. PADMAJA YELISSETTY



Patient

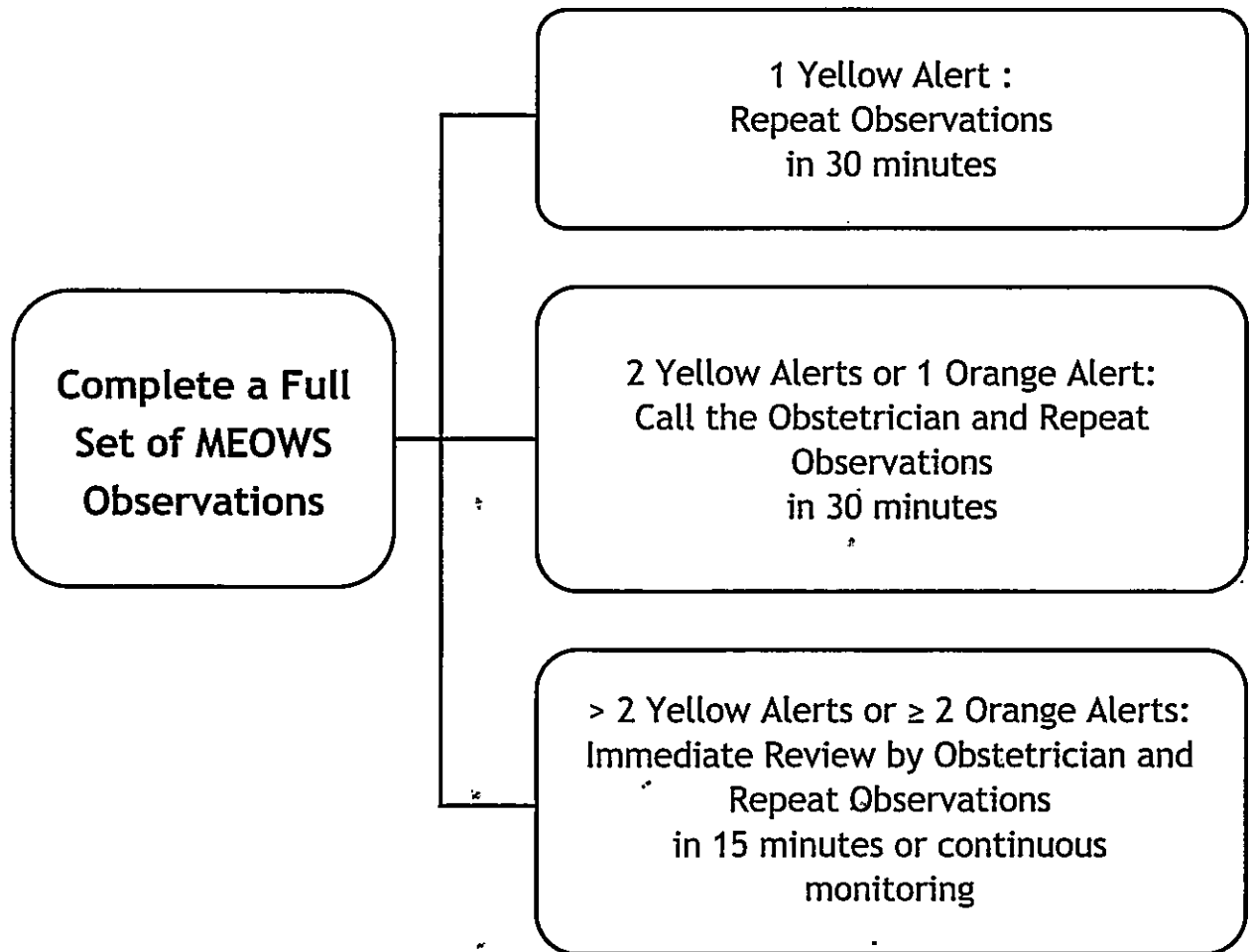
## Early Warning Observation Score Chart - Obstetrics

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																											
Saturations	94 - 100 %			99%				99%					99%				99%				99%							
	< 94 %																											
Administered O <sub>2</sub> (L/min.)																												
Temp °C	40																											
	39																											
	38																											
	37																											
	36			98.1°F				98.4°F					98.1°F				98.1°F				98.1°F						96.0°F	
	< 35																											
Heart Rate	170																											
	160																											
	150																											
	140																											
	130																											
	120																											
	110																											
	100																											
	90																											
	80			64				79					91				70				71						73	
	70																											
Systolic Blood Pressure	190																											
	180																											
	170																											
	160																											
	150																											
	140																											
	130																											
	120																											
	110																											
	100																											
	90																											
80																												
70																												
60																												
50																												
40																												
Diastolic Blood Pressure	130																											
	120																											
	110																											
	100																											
	90																											
	80																											
70																												
60																												
50																												
40																												
NEURO RESPONSE [✓]	Alert																											
	Voice			✓				✓					✓			✓				✓						✓		
URINE mls / hour	> 30			✓				✓				✓			✓				✓							✓		
	< 30																											
Proteinuria	Protein ++																											
	Protein > ++																											
Lochia	Normal			✓				✓					✓			✓				✓						✓		
	Heavy / Foul																											
Liquor	Clear / Pink																											
	Green																											
TOTAL YELLOW SCORES				0				0						0					0							0		
TOTAL ORANGE SCORES				0				0						0					0							0		
Nurse Initial				[Signature]				[Signature]					[Signature]					[Signature]							[Signature]			

17/6/26

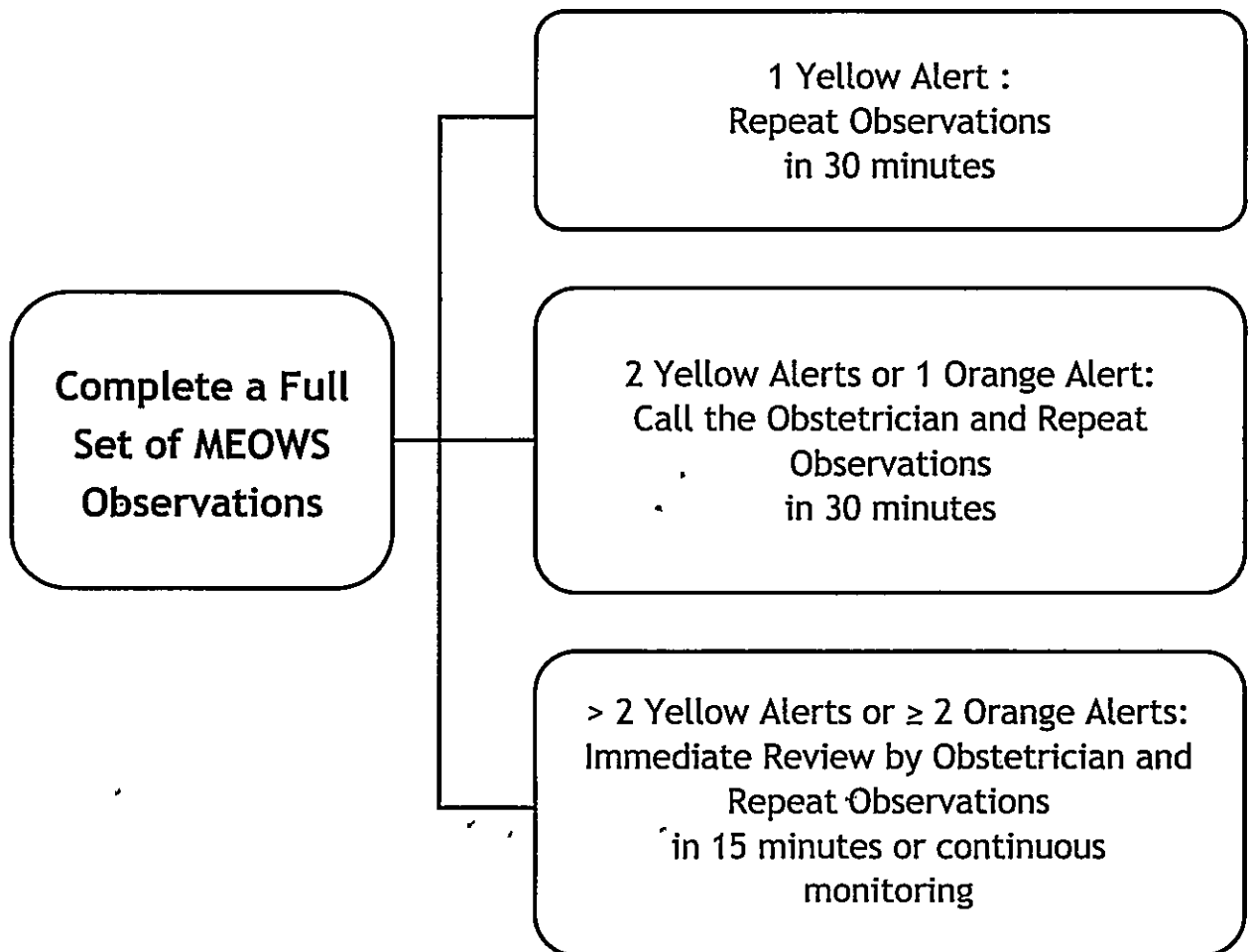
## Obstetrics and Gynaecology Early Warning Signs



\* The Modified Early Warning Score (MEOWS)



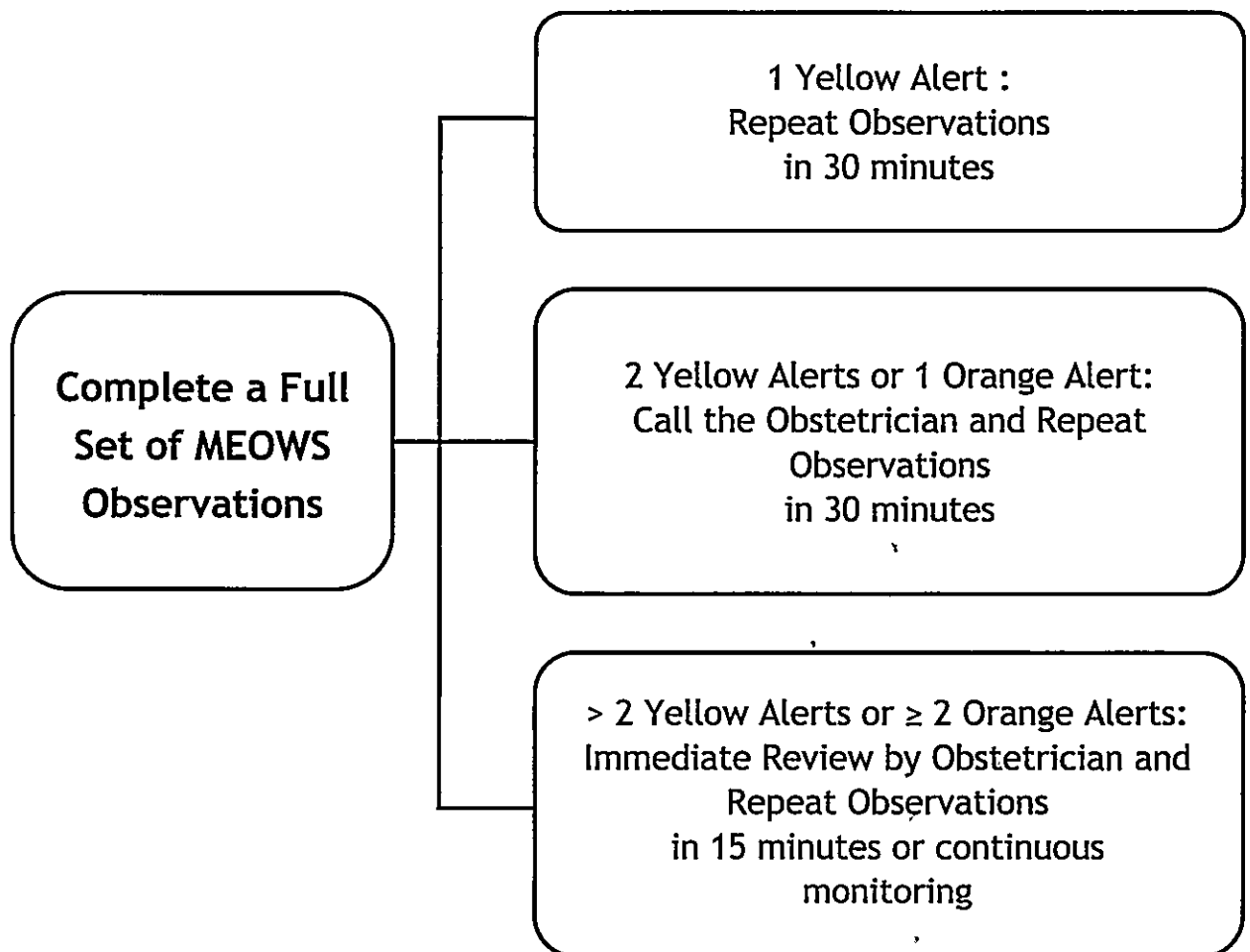
## Obstetrics and Gynaecology Early Warning Signs



\* The Modified Early Warning Score (MEOWS)



## Obstetrics and Gynaecology Early Warning Signs



\* The Modified Early Warning Score (MEOWS)



# FLUID CHART

Sheet No. : .....

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

Date	Time	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage			Urine
			Mouth	I.V	N.G							
16/6/28	08:00 am	RL		100ml								
	09:00 am	RL	M	100ml								
	10:00 am	RL		100ml								
	11:00 am	RL	B	100ml						600ml		Empty 10:30
	12:00 pm	RL	M	100ml						200ml		Empty 12:30
	01:00 pm	RL	M	100ml								
<b>Total Intake :</b>					<b>Total Output :</b>					700ml		
16/6	02:00 pm	RL		100ml						150ml		Empty
	03:00 pm	RL	H2O	100ml								
	04:00 pm	RL		100ml						100ml		
	05:00 pm	RL		100ml								
	06:00 pm	RL	soup	100ml						100ml		6:21
	07:00 pm	RL		100ml								
<b>Total Intake :</b>					<b>Total Output :</b>							
16/6/28	08:00 pm			100ml								
	09:00 pm			100ml								
	10:00 pm	RL	idly	100ml								
	11:00 pm		H2O	100ml								
	12:00 am			100ml								
	01:00 am			100ml						500ml		Empty
<b>Total Intake :</b>					<b>Total Output :</b>					600ml		
17/6/28	02:00 am			100ml								
	03:00 am			100ml								
	04:00 am	RL		100ml								
	05:00 am			100ml								
	06:00 am			100ml								
	07:00 am			100ml						600ml		Empty
<b>Total Intake :</b>					<b>Total Output :</b>					600ml		

**Total 24 hrs. Intake**      2400 ml

**Total 24 hrs. Output**      2250 ml



# FLUID CHART

Sheet No. : .....

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

		Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
<b>17/6/20</b>	08:00 am				/							
	09:00 am	Uroma			/							
	10:00 am	+ H <sub>2</sub> O			/				✓			
	11:00 am				/							
	12:00 pm				/							
	01:00 pm					/						
<b>Total Intake :</b>					<b>Total Output : U - 1 M -</b>							
<b>17/6/20</b>	02:00 pm				/							
	03:00 pm	Whisk + H <sub>2</sub> O			/				✓			
	04:00 pm				/							
	05:00 pm				/							
	06:00 pm				/							
	07:00 pm					/						
<b>Total Intake :</b>					<b>Total Output : U - 1 M -</b>							
<b>17/6/20</b>	08:00 pm				/							
	09:00 pm	Whisk + H <sub>2</sub> O			/							
	10:00 pm				/				✓			
	11:00 pm				/							
	12:00 am				/		✓					
	01:00 am					/						
<b>Total Intake :</b>					<b>Total Output : U - 1 M -</b>							
<b>18/6/20</b>	02:00 am				/							
	03:00 am				/							
	04:00 am	H <sub>2</sub> O			/				✓			
	05:00 am				/							
	06:00 am				/							
	07:00 am					/				✓		
<b>Total Intake :</b>					<b>Total Output : U - 1 M -</b>							

**Total 24 hrs. Intake**

**Total 24 hrs. Output**

HNH-00011823 IP26-00006593

Mrs SONAKSHI AGARWAL

09-07-1997 28 Y 11 M 7 D (F)

Dr. PADMAJA YELISETTY

Patient:



# FLUID CHART

Sheet No. : .....

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

Date	Time	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
18/6/26	08:00 am									0	}	
	09:00 am	Jelly				0				0		
	10:00 am	H <sub>2</sub> O		NA		0		NA		0		
	11:00 am					0				0		
	12:00 pm					0				0		
	01:00 pm						0			0		
<b>Total Intake :</b>						<b>Total Output : U-</b>					<b>M-</b>	
18/6/26	02:00 pm									0	}	
	03:00 pm	Jelly				0				0		
	04:00 pm	H <sub>2</sub> O				0		NA		0		
	05:00 pm					0			2	0		
	06:00 pm					0				0		
	07:00 pm						0			0		
<b>Total Intake :</b>						<b>Total Output :</b>						
18/6	08:00 pm									0	}	
	09:00 pm	Rice				0				0		
	10:00 pm					0				0		
	11:00 pm	Jelly				0				0		
	12:00 am	H <sub>2</sub> O				0				0		
	01:00 am						0			0		
<b>Total Intake :</b>						<b>Total Output :</b>					<b>U- M-</b>	
19/6	02:00 am									0	}	
	03:00 am					0				0		
	04:00 am	A <sub>2</sub> O				0				0		
	05:00 am					0				0		
	06:00 am	H <sub>2</sub> O				0				0		
	07:00 am						0			0		
<b>Total Intake :</b>						<b>Total Output :</b>					<b>U- M-</b>	

**Total 24 hrs. Intake**

**Total 24 hrs. Output**

HNM-00011623 IP26-00006593  
 Mrs SONAKSHI AGARWAL (F)  
 08-07-1997 28 Y 11 M 8 D  
 Dr. PADMAJA YELISSETTY



# FLUID CHART

Sheet No. : .....

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
19/6	08:00 am											S	
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>						U - M -	
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							

<b>Total 24 hrs. Intake</b>	
-----------------------------	--

<b>Total 24 hrs. Output</b>	
-----------------------------	--

HNH-00011823 IP26-00006593  
 Mrs SONAKSHI AGARWAL  
 09-07-1997 28 Y 11 M 7 D (F)  
 Dr. PADMAJA YELISETTY



# NURSING CARE RECORD



Date: 16/6/26

**Goals**

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am	<ul style="list-style-type: none"> <li>- Assess the patient condition</li> <li>- plan for vital &amp; record</li> <li>- plan for lochart</li> </ul>	8am	<ul style="list-style-type: none"> <li>- assessed the patient condition</li> <li>- maintain vital &amp; record</li> <li>- Maintain lochart</li> </ul>	patient stable	vital record	
Afternoon	day						
Night	8pm to 8am	<ul style="list-style-type: none"> <li>- Assess the pt condition</li> <li>- monitor the v/s</li> <li>- maintain the I/O</li> <li>- Drug as per chart</li> </ul>	8pm to 8am	<ul style="list-style-type: none"> <li>- Assess the pt condition</li> <li>- monitor the v/s</li> <li>- main the I/O</li> <li>- Drug as per chart</li> </ul>	Now pt is stable	Rechecked the v/s	

Patient St

HNH-00011823  
 Mrs SONAKSHI AGARWAL  
 09-07-1997 28 Y 11 M 7 D (F)  
 Dr. PADMAJA YELISETTY



IP26-00006593

# NURSING CARE RECORD



Date: 17/6/26

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM	→ Assess the general condition of pt → Monitor vitals → Maintain I/O chart → Administer medication.	8AM	→ Assess the general condition of pt → Monitor vitals → Maintain I/O chart → Administer medication.	Pt is stable.	Re assess vitals.	
	2PM						
Afternoon	<span style="font-size: 2em; font-family: cursive;">Day</span>						
Night	8PM to 8AM	- Assess the pt condition - monitor the v/s - maintain the I/O - Drug as per chart	8PM to 8AM	- Assess the pt condition - monitor the v/s - maintain the I/O - Drug as per chart	- Now pt is stable	- Rechecked the v/s	

HNH-00011823 IP26-00006593  
 Mrs SONAKSHI AGARWAL  
 28 Y 11 M 7 D (F)  
 09-07-1997  
 Dr. PADMAJA YELISETTY

# NURSING CARE RECORD



Date: 18/6/26

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM	→ To assess the pt. condition → To check the vitals & record	8PM	→ To assessed the pt. condition → To checked the vitals & recorded	→ Patient is stable	→ Re-checked the vitals → I/O	Supriya
	2PM	→ To administer the medication as per drug chart → I/O chart maintain	2PM	→ To administered the medication as per drug chart → I/O chart maintained	→ Today open dressing to be done		
Afternoon	2PM	→ Assess the pt condition → Monitor vitals & I/O chart → drug as per chart → provide comfortable position.	8PM	→ Assesed the pt condition → monitored vitals & I/O chart → druged as per chart → provided comfortable position.	→ pt is stable → dressing is to be done.	→ Rechecked vitals	Sudha
	8PM	→ Assess the pt condition → monitor vitals & record → maintain I/O chart → provide the comfortable position.	8PM	→ Assesed the pt condition → monitored vitals & recorded → maintained I/O chart → provided the comfortable position.	→ pt is stable	→ monitor vitals	
Night	8AM	→ Medication given as per as doctor order.	8AM	→ Medication given as per as doctor order.	→ vitals normal.	→ maintain I/O chart.	Sudha

Patient Sticker

# NURSING CARE RECORD



Date: .....

**Goals**

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

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



## NURSING SHIFT HAND OVER FORM - WARD

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

SITUATION	Diagnosis: <span style="font-size: 2em; color: blue;">LSCS</span>	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known If Yes Specify: .....						
BACKGROUND	Area	16/6/26 MS	16/6/26 N1	17/6/26 MS	17/6/26 N1	18/6/26 MS	18/6/26 G2	
	Shift Time							
	Medical Condition (Any special condition to be noted):	-	-	-	-	-	-	
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	97.9	98.3 F	98.4 F	98. F	97.6 F	98.1 F
		Res:	20	20b/m	20b/m	20b/m	20b/m	20b/m
		SpO <sub>2</sub> :	100%	100%	100%	100%	99%	99.1
		Pulse:	86	82b/m	86b/m	82b/m	76b/m	77b/m
		BP:	110/70	110/70	120/72	124/76	125/81	120/80
Fall Risk Score:	2	=	-	-	-	-		
Pain Score:	2	=	-	-	"0"	"0"		
Recommendations	Safety Needs:	yes	yes	yes	yes	yes	yes	
	Physiotherapy	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Others Specify:	-	-	-	-	-	-	
	Special Diet:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Other Special Orders / Medications:		-	-	-	-	-	-	
Post Operative Procedure Special Orders:		-	-	-	-	-	-	
Handed Over By Name :		-	Swarada	Moutushi	Swarada	Moutushi	Apriza	
Signature :		Chanda	Swarada	Moutushi	Swarada	Moutushi	Apriza	
Date:		16/6/26	17/6/26	17/6/26	18/6/26	18/6/26	18/6/26	
Time:		8pm	8pm	8pm	2pm	2pm	8pm	
Taken Over By Name :		Swarada	Moutushi	Swarada	Moutushi	Apriza	Swarada	
Signature :		Swarada	Moutushi	Swarada	Moutushi	Apriza	Swarada	
Date:		16/6/26	17/6/26	17/6/26	18/6/26	18/6/26	18/6/26	
Time:		8pm	8AM	8pm	8AM	2pm	8pm	

HNH-00011823 IP26-00006593  
 Mrs SONAKSHI AGARWAL  
 09-07-1997 28 Y 11 M 7 D (F)  
 Dr. PADMAJA YELISETTY



## NURSING SHIFT HAND OVER FORM - WARD

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

<b>SITUATION</b>	Diagnosis: <i>EL. CSUS</i>	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known If Yes Specify: .....					
<b>BACKGROUND</b>	Area	<i>18/6</i>					
	Shift Time	<i>N1</i>					
	Medical Condition (Any special condition to be noted):	<i>EL. CSUS</i>					
<b>ASSESSMENT</b>	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:	<i>98.2°F</i>				
		Res:	<i>20</i>				
		SpO <sub>2</sub> :	<i>98%</i>				
		Pulse:	<i>80</i>				
		BP:	<i>112/62</i>				
Fall Risk Score:	<i>-</i>						
Pain Score:	<i>-</i>						
<b>Recommendations</b>	Safety Needs:	<i>-</i>					
	Physiotherapy:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Others Specify:	<i>-</i>					
	Special Diet:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Other Special Orders / Medications:	<i>-</i>					
Post Operative Procedure Special Orders:							
Handed Over By Name : <i>Sreha</i>							
Signature : <i>(Signature)</i>							
Date: <i>19/6</i>							
Time: <i>8 AM</i>							
Taken Over By Name :							
Signature :							
Date:							
Time:							



## CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	16/6/22 DAY-1			17/6/22 DAY-2			18/6 DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	NA	0	0	0	0					
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	NA	NA	NA	NA	NA	NA				
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	NA	NA	NA	NA	NA	NA				
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	NA	NA	NA	NA	NA	NA			Cannula Removed	
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	NA	NA	NA	NA	NA	NA				
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	NA	NA	NA	NA	NA	NA				
Signature of the Nurse													

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

Signature of Shift In Charge :  
 Signature : Name : Anushu

Signature of Ward In Charge :  
 Signature : Name : Karsten

HNH-00011823 IP26-00006893  
 Mrs SONAKSHI AGARWAL  
 09-07-1997 28 Y 11 M 7 D (F)  
 Dr. PADMAJA YELISETTY

Patient Stick



## CHECKLIST FOR THROMBOPHLEBITIS



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

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

Signature of Shift In Charge :

Signature of Ward In Charge :

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

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

Patient Sticker  
HNH-00011823 IP26-00006593  
Mrs SONAKSHI .GARWAL  
09-07-1997 28 Y 11 M 7 D (F)  
Dr. PADMAJA YELISETTY



# Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	16/6/26	16/6/26	17/6/26	Fall Risk Grading		
		Score	M5	N1	M5	Risk Level	Morse Fall Score (MFS)	Action
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				Low Risk	0 - 24	Standard Fall Precaution
	No	0	0	0	0			
Ambulatory Aid	Furniture	30				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0						
IV / Heparin Lock or Saline	Yes	20	20	20	20	High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0						
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0						
Total Morse Fall Scale Score:			20	20	20			
Signature			de	SA	AB			

Tick (✓) whichever precaution taken.

**Risk Level and Interventions**

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

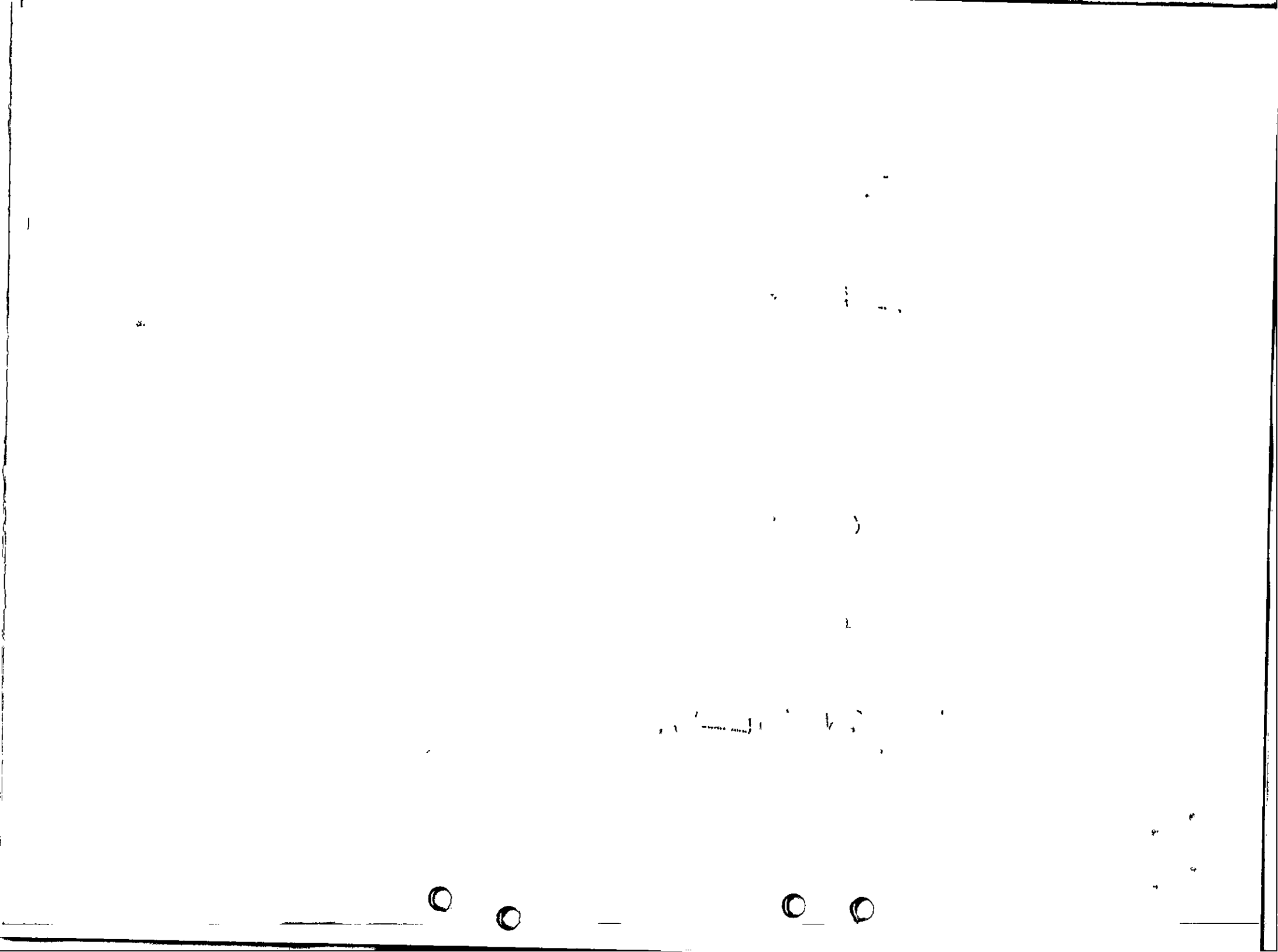
- Ensure patients use their prescribed eye glasses if any, in the hospital
- Use chairs with arm rests
- Use safety straps on stretchers and wheelchairs while transporting patients

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

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

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

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



HNH-00011823 IP26-00006593  
 Mrs SONAKSHI AGARWAL  
 09-07-1997 28 Y 11 M 7 D (F)  
 Dr. PADMAJA YELUSETTY



## Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	17/6/26	18/6/26	18/6/26	Fall Risk Grading		
		Score	M <sub>1</sub>	M <sub>2</sub>	G <sub>2</sub>	Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25				Low Risk	0 - 24	Standard Fall Precaution
	No	0	0	0	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0	0	0	0			
Ambulatory Aid	Furniture	30				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0	0	0			
IV / Heparin Lock or Saline	Yes	20				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0	0	0	0			
GAIT / Transferring	Impaired	20				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0	0	0	0			
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0	0	0	0			
Total Morse Fall Scale Score:			0					
		Signature	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>			

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



5

0 0 0 0 0 0 0

11/11/11 18/11/11 19/11/11

0

0

MNH-00011823 IP26-00006593  
 Mrs SONAKSHI AGARWAL  
 08-07-1997 28 Y 11 M 7 D (F)  
 Dr. PADMAJA YELISETTY



# Morse Fall Risk Assessment Form

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

Tick (✓) whichever precaution taken.

**Risk Level and Interventions**

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

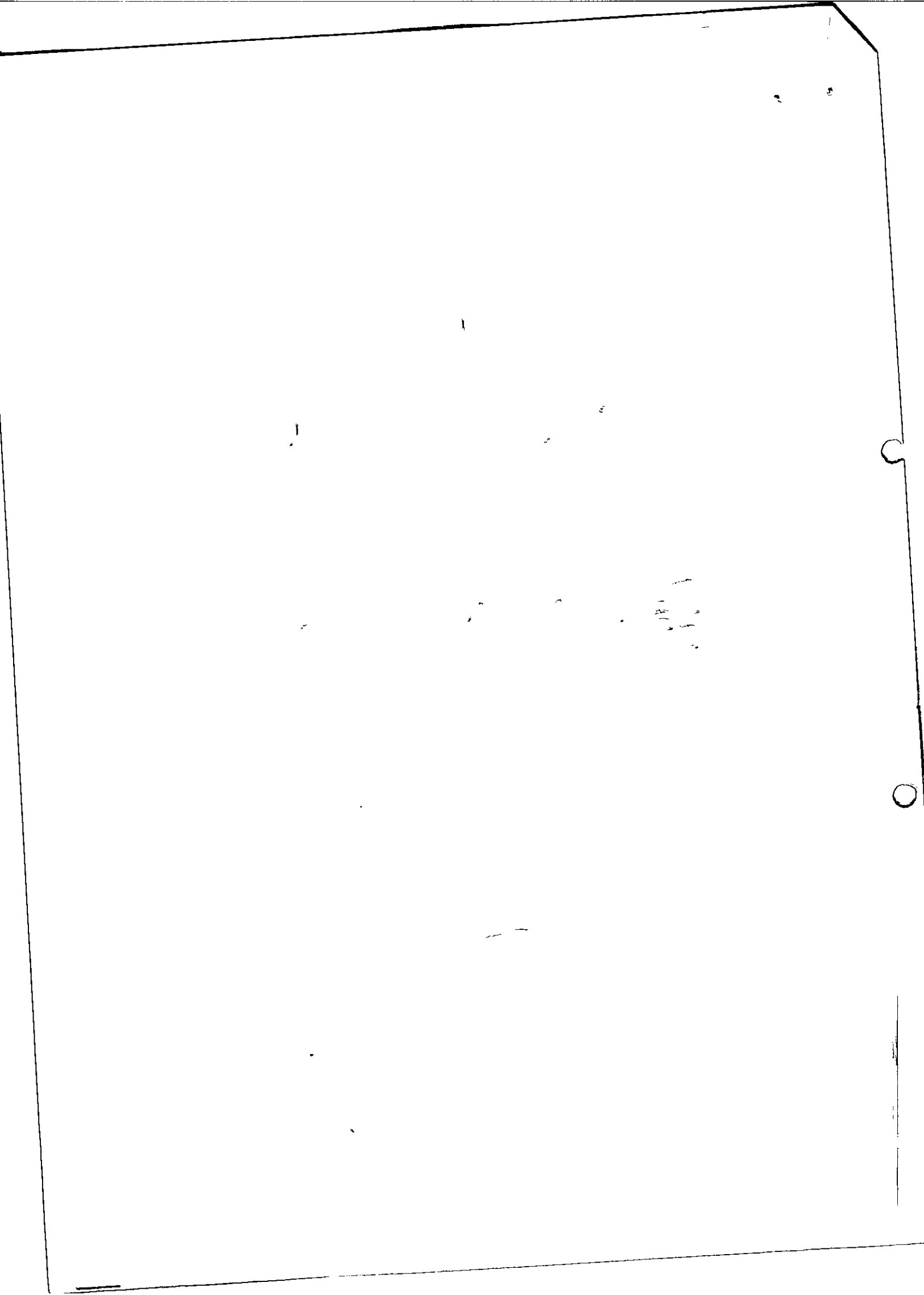
- Ensure patients use their prescribed eye glasses if any, in the hospital
- Use chairs with arm rests
- Use safety straps on stretchers and wheelchairs while transporting patients

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

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

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

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



HNH-00011623  
 Mrs SONAKSHI AGARWAL  
 09-07-1997  
 Dr. PADMAJA YELISSETTY  
 IP26-00006593  
 28 Y 11 M 7 D  
 (F)

# BRADEN 'Q' SCALE



		Date : 16/6/16 16/6/16 17/6/16 18/6/16						
		Time : 17/5 17/5 17/5 17/5						
Mobility	Immobile: Does not even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4

TOTAL SCORE	28	28	28	28
Evaluator's Name	Al	Al	Al	Al

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	<b>Support Surfaces</b> (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	<ul style="list-style-type: none"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	<ul style="list-style-type: none"> <li>• Use the Same Protocol as for "At Risk" Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> <li>• Follow the same protocol as for "Moderate Risk" Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	<ul style="list-style-type: none"> <li>• Use same protocol as for "High Risk" Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

HNH-00011823 IP26-00006593  
 Mrs SONAKSHI AGARWAL  
 08-07-1997 28 Y 11 M 7 D (F)  
 Dr. PADMAJA YELISETTY

# BRADEN 'Q' SCALE



Date: 18/6 18/6 18/6  
 Time: 10AM 2pm 8:30

Mobility	<b>1. Completely immobile:</b> Does not make even slight changes in body or extremity position without assistance.	<b>2. Very limited:</b> Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	<b>3. Slightly limited:</b> Makes frequent through slight changes in body or extremity position independently.	<b>4. No limitations:</b> Makes major and frequent changes in position without assistance.	4	4	4
"Activity The degree of physical activity"	<b>1. Bedfast :</b> Confined to bed	<b>2. Chairfast :</b> Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	<b>3. Walks occasionally:</b> Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	<b>4. All patients too young to ambulate; OR walks frequently:</b> Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	3
Sensory Perception	<b>1. Completely limited:</b> 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.	<b>2. Very limited:</b> 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.	<b>3. Slightly limited:</b> 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.	<b>4. No impairment:</b> Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4
Moisture Degree to which skin is exposed to moisture	<b>1. Constantly moist:</b> Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	<b>2. Very moist:</b> Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	<b>3. Occasionally moist:</b> Skin is occasionally moist, requiring linen change every 12 hours.	<b>4. Rarely moist:</b> Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4
<b>FRICION-SHEAR</b> <b>Friction</b> Occurs when Skin moves against support surfaces <b>Shear</b> Occurs when skin and adjacent bony surface slide across one another	<b>1. Significant problem:</b> Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	<b>2. Problem:</b> 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.	<b>3. Potential problem:</b> 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.	<b>4. No apparent problem:</b> Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4
Nutritional Usual food intake pattern	<b>1. Very Poor:</b> 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.	<b>2. Inadequate:</b> 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.	<b>3. Adequate:</b> 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.	<b>4. Excellent:</b> Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4

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

<b>TOTAL SCORE</b>	28	28	27
<b>Evaluator's Name</b>	[Signature]	[Signature]	[Signature]

Risk Score	Category	Action	<b>Support Surfaces</b> (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	<ul style="list-style-type: none"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	<ul style="list-style-type: none"> <li>• Use the Same Protocol as for “At Risk” Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> <li>• Follow the same protocol as for “Moderate Risk” Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	<ul style="list-style-type: none"> <li>• Use same protocol as for “High Risk” Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

HNH-00011823 IP26-00006593  
 Mrs SONAKSHI AGARWAL  
 09-07-1997 28 Y 11 M 7 D (F)  
 Dr. PADMAJA YELISETTY



# PAIN ASSESSMENT FORM

Date	Time	n Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
16/6	8Am	0/10	Lower	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	slu	SA
16/6	2Pm	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	SA
16/6	8Pm	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	SA
16/6	10pm	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	SA
17/6	2am	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	SA
17/6	6am	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	SA
17/6	10AM	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	SA
17/6	10pm	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	SA
18/6	2am	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	SA
18/6	6am	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	SA

**Re-assessment Frequency:**

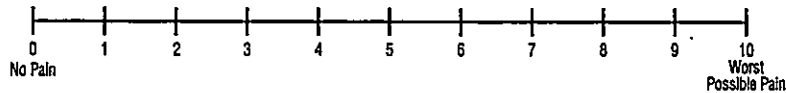
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
  - At least every 2 hours for the first 24 hours
  - Then every 4 hours.
  - Prior to pain pain-relieving intervention.
  - Within 30 – 60 minutes after pain relief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

# PAIN ASSESSMENT TOOLS

## FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

## Numerical Pain Scale (Obstetric and Gynecology)



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

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

## Wong - Baker (Pediatrics) Above 7 Years





## PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
18/6/26	10Am	0/10	NA	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input checked="" type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	
18/6/26	3pm	0/10	NA	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input checked="" type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
18/6	8pm	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
19/6	2Am	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
19/6	8Am	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

**Re-assessment Frequency:**

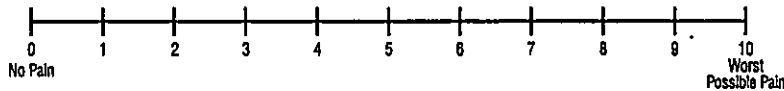
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
  - a) At least every 2 hours for the first 24 hours
  - b) Then every 4 hours.
  - c) Prior to pain relieving intervention.
  - d) Within 30 – 60 minutes after pain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

# PAIN ASSESSMENT TOOLS

## FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

## Numerical Pain Scale (Obstetric and Gynecology)



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

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

## Wong - Baker (Pediatrics) Above 7 Years



HNH-00011823 IP26-00006593  
 Mrs SONAKSHI AGARWAL  
 09-07-1997 28 Y 11 M 7 D (F)  
 Dr. PADMAJA YELISETTY



## URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 6/6 Date of Removal: 10/17/6

Parameters	Date	Shift Time						
Need for the Catheter			16/6 NG	16/6 NI				
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hand Hygiene			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Usage of Sterile Equipment			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the Collection bag below the level of bladder			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Check the Tube for Obstruction (Free of Kinking)			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is Catheter dated as policy			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Collecting bag is been emptied regularly?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	@ GAM Catheter		<input type="checkbox"/> Yes <input type="checkbox"/> No
Maintenance of closed system for the catheter			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dressing clean and dry?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the line removed as Policy?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Performance of Perineal Care			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Onset of New Fever			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asses for the leakage at the site of insertion			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of the Nurse			uwer	Sunganda				
Signature of the Nurse								



## MEDICATION RECONCILIATION FORM

Drug Allergies: NR  Not known any Drug Allergies

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

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

Shifting From: NA Shifted to: NA

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Tab Iron	1Tab	Po	OD		<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
2	Tab Calcium	1Tab	Po	POD		<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
3	Tab vit D	1Tab	Po	OD		<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

\* C- Continue, DC - Discontinue

### MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Danya Dhanma

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

Nurse Name & Signature: Chunika Kulkarni

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

11

11

11

11

11

11

11

11



11

11

11

11

11

11

11

11

11

11



11

11

11

11

11

11

11

HNH-00011823 IP26-00006593  
 Mrs SONAKSHI AGARWAL  
 09-07-1997 28 Y 11 M 7 D (F)  
 Dr. PADMAJA YELISETTY



# DRUG CHART

Date of Admission: 16/6/26 Drug Allergies: N/A  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)

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

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

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

VERIFIED BY : Name



REGULAR PRESCRIPTIONS

Weight. 68.9kg Ward. ....

Verified by Dr. Dhakshayani  
 Verified by Dr. Dhakshayani  
 Verified by Dr. Dhakshayani  
 Verified by Dr. Dhakshayani

<b>DRUG :</b> <u>IV CEFOTAXIM</u>				Date Time	<u>16/6</u>	<u>17/6</u>																
Dose	Route	Frequency	Start Date																			
<u>1gm</u>	<u>IV</u>	<u>BD</u>	<u>16/6/20</u>																			
Name & Signature of the Doctor Starting the Drugs: <u>[Signature]</u>				<u>[Signature]</u>																		
Additional Instructions: <u>x 24 hrs.</u>				<u>STOP (After morning dose)</u>																		
Daily Doctor's Endorsement by a Sign				<u>[Signature]</u>																		

<b>DRUG :</b> <u>T. PARACETAMOL</u>				Date Time	<u>16/6</u>	<u>17/6</u>	<u>18/6</u>	<u>19/6</u>														
Dose	Route	Frequency	Start Date																			
<u>1gm</u>	<u>oral</u>	<u>6<sup>th</sup>ly QID</u>	<u>16/6/20</u>																			
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Akhila K @mj</u>				<u>[Signature]</u>																		
Additional Instructions:				<u>[Signature]</u>																		
Daily Doctor's Endorsement by a Sign				<u>[Signature]</u>																		

<b>DRUG :</b> <u>T. DICLOFENAC</u>				Date Time	<u>16/6</u>	<u>17/6</u>	<u>18/6</u>	<u>19/6</u>														
Dose	Route	Frequency	Start Date																			
<u>50mg</u>	<u>oral</u>	<u>8<sup>th</sup>ly TID</u>	<u>16/6/20</u>																			
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Akhila K @mj</u>				<u>[Signature]</u>																		
Additional Instructions:				<u>[Signature]</u>																		
Daily Doctor's Endorsement by a Sign				<u>[Signature]</u>																		

<b>DRUG :</b> <u>T. TRAMADOL</u>				Date Time	<u>16/6</u>	<u>17/6</u>	<u>18/6</u>	<u>19/6</u>														
Dose	Route	Frequency	Start Date																			
<u>100mg</u>	<u>oral</u>	<u>8<sup>th</sup>ly TID</u>	<u>16/6/20</u>																			
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Akhila K @mj</u>				<u>[Signature]</u>																		
Additional Instructions:				<u>[Signature]</u>																		
Daily Doctor's Endorsement by a Sign				<u>[Signature]</u>																		



Verified by Dr. Dhakshayani

Verified by Dr. Dhakshayani

VERIFIED BY: Name

Sheet No: .....

### REGULAR PRESCRIPTIONS

Weight 68.9kg Ward .....

<b>DRUG :</b> Tab PANTOPRAZOLE				Date Time	16/6/20	16/6/20															
Dose	Route	Frequency	Start Dt.																		
40mg	PO	OD	16/6/20																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
<b>Daily Doctor's Endorsement by a Sign</b>																					

<b>DRUG :</b> CEFEXIME				Date Time	17/6/20	17/6/20															
Dose	Route	Frequency	Start Dt.																		
200mg	PO	BD	17/6/20																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
<b>Daily Doctor's Endorsement by a Sign</b>																					

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

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



Weight: 68.9 kg 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.	

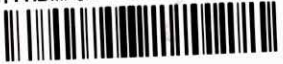
VARIABLE DOSE	Date Time	Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.	
DRUG :		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route	Start Date	Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Name & Signature of the Doctor		Dose		Dose		Dose		Dose	
		Dr. Sign.		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
16/6/26	9AM	Sy PAN DOPEARS 65	40mg	IV	Romo	Mouji (M)
16/6/26	9AM	Sy PANORM	10mg	IV	Romo	Mouji (M)
16/6/26	10:20AM	SUP-DICLOFENAC	100mg	PR	@hij	Natasha Shashidhar
16/6/26	10:20AM	SUP-TRAMADOL	100mg	PR	@hij	Natasha Shashidhar
17/6/26	1am	INJ-ONDENSETRON	4mg	IV	@	(S) (S)
17/6/26	10PM	DULCOLAX SUPPOSITORY	1tab	PR	HP	(S) (S)

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

Dr. Dhakshayani



I.V. FLUIDS CHART

Weight. 68.9kg Ward. ....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign		
16/6/26	7:30 AM	RINGER LACTATE	IV	100 ml/hr	Planus	[Signature]	16/6	[Signature]	[Signature]		
16/6/26	9:15 AM	RINGER LACTATE	IV	1000ml hr	@mj	[Signature]	16/6	@mj	[Signature]		
16/6/26	9:45 AM	RINGER LACTATE	IV	2000ml hr	@mj	[Signature]	16/6	@mj	[Signature]		
16/6/26	10:15 AM	RINGER LACTATE	IV	100ml hr	@mj	[Signature]	16/6	[Signature]	[Signature]		
16/6	12 PM	RINGER LACTATE	IV	100ml	[Signature]	[Signature]		[Signature]	[Signature]		
16/6	6 PM	RINGER LACTATE	IV	100ml/hr	[Signature]	[Signature]		[Signature]	[Signature]		
16/6	9 PM	RINGER LACTATE	IV	100ml/hr	[Signature]	[Signature]		[Signature]	[Signature]		
17/6	1:30 AM	RINGER LACTATE	IV	100ml/hr	[Signature]	[Signature]		[Signature]	[Signature]		
		STOP	[Signature] 12/6/20								

Signature  
VERIFIED BY : Name



## OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 16/6/20

**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:** EL-LSCE Doctor Notified on Admission:  Yes  No  
 Name of the Doctor: D.P. Leamy  
 Time Notified: .....

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

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

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

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

**Previous LSCS:** .....

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

**Family History:**  No Abnormalities Detected

Heart Disease  Hypertension  Diabetes  Stroke  Seizures  Kidney disease

Liver disease  Other .....

**Vital Signs / Measurements:** Temp: 97.4 HR: 87 RR: 20  
 BP: 110/73 Weight: ..... Height: ..... BMI: .....

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



PHYSICAL ASSESSMENT

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

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

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

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

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING:  No Abnormality Detected

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

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

Inform consultant for positive criteria

SOCIAL SCREENING:

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

Social History: Lives With .....

Orientation has been given regarding the following aspects:

- Call Bell in Reach:  Yes  No
- Waste Disposal Explained:  Yes  No
- Infusion Pump:  Yes  No
- Hand Hygiene Explained:  Yes  No
- Others

Above information given to ..... patient  
Name of Person Orientation was given to: ..... Sonakshi  
Orientation not given Reason: ..... NA

Nurse Signature: ..... Alati

Nurse Name: ..... Alati

Date & Time: ..... 16/6/26 @ 9 AM



# OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 16/6/20 Time of Arrival: 8 AM Time Seen by Nurse: 8-10 AM

1) Level of Consciousness:  Conscious  Semi-Conscious  Unconscious

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

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

3) Vital Signs: Temperature: 98.6 F Pulse: 84 RR: 20 SpO<sub>2</sub>: 100 BP: 110/70 Weight: .....

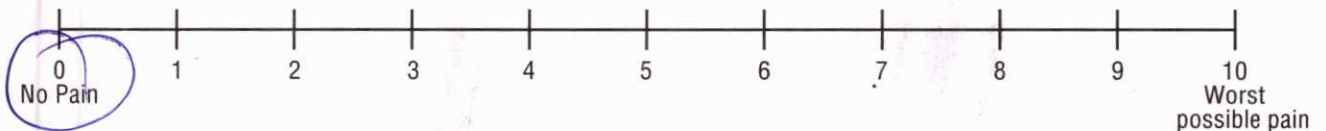
4) Gestational Criteria:

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

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

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

5) Pain Screening: Numerical Pain Scale (NPS)



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

6) Past History:

- a) Surgeries: None
- b) Medical: .....

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	<ul style="list-style-type: none"> <li>• Acute onsite severe abdominal pain</li> <li>• Altered level of consciousness</li> <li>• Cord prolapse</li> <li>• Severe respiratory distress</li> <li>• Suspected sepsis</li> </ul>	<ul style="list-style-type: none"> <li>• Major trauma</li> <li>• Shortness of breath</li> <li>• Unplanned and unattended birth</li> </ul>	<ul style="list-style-type: none"> <li>• Abdominal/back pain greater than expected in pregnancy</li> <li>• Flank pain / hematuria</li> <li>• Nausea /vomiting and /or diarrhea with suspected dehydration</li> </ul>	<ul style="list-style-type: none"> <li>• Ongoing assessment from out patient clinic (for hypertension, blood work)</li> <li>• Minor trauma (minor MVC/fall)</li> <li>• Nausea/Vomiting and /or diarrhea</li> <li>• Signs of infection (ie dysuria ,cough, fever, chills)</li> </ul>	<ul style="list-style-type: none"> <li>• Anything that does not seem to pose threat to mother or fetus</li> <li>• Cervical ripening</li> <li>• Out patient placenta previa protocols</li> <li>• Pre-booked visits (ie Rh and progesterone injections, NST</li> <li>• Assessment for version</li> <li>• Rashes</li> </ul>

Time seen by Doctor: ..... 8:15 AM

Nurse Name : ..... Alati Nurse Signature: ..... Alati

Date: ..... Time: 8:15 AM

HNH-00011823 IP26-00006593  
Mrs SONAKSHI AGARWAL  
09-07-1997 28 Y 11 M 7 D (F)  
Dr. PADMAJA YELISETTY



308



## NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 16/6/26 Time: 5:30 pm

Origin: Indian Height: 157cms Weight: 68.9kg BMI:  ~ 26 kg/m<sup>2</sup>  
 ~ 28 kg/m<sup>2</sup>  
 ~ 30 kg/m<sup>2</sup>

Food Allergies: N.D.

Diagnosis: LSCS

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

Diet Advised:

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

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

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

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

Patient's / Attendant's

Signature: *Sonakshi*

Name: Sonakshi Agarwal

Date & Time: 16/6/26 ; 5:30 pm

Dietician's

Signature: *Sathwika*

Name: Sathwika G

Date & Time: 16/6/26 ; 5:30 pm





308

# CROSS CONSULTATION FORM

Doctor Name : Dr. padmaja yelisetty Date : 16/6/26 Time : 6pm

Diagnosis : LSCS

Hospital : RCH - HMNR

**Type of Referral :**

- Emergency
- Urgent
- Non Urgent

Referred for :  Opinion  Co-Management  Transfer of care

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

Signature: \_\_\_\_\_

**Findings and Recommendations :**

Lactation Care plan

- well formed breast & nipple's
- Adv DBF followed by burping
- Colostrum seen
- Demand feeding do not exceed 2 1/2 hours as per. early hunger cues
- stimulate baby while feeding.
- Aim for deep latch as demonstrated in by side lying down.

**Consultant :**

Name : Sathwika-G Signature : [Signature] Date & Time : 16/6/26 ; 6pm



## BREAST FEEDING HANDOVER AND ASSESSMENT FORM

1. Breastfeeding initiated?  
 a. Yes       b. No
2. If No, Reason .....
3. Nipple condition:  
 a. Nipple well formed  
 b. Flat nipple  
 c. Inverted nipple  
 d. Short nipple
4. Milk flow:  
 a. Good  
 b. Drops of colostrums  
 c. Dry
5. Steps for Positioning and attachment:  
 a. Baby goes to the breast  
 b. Mother always sits with a back support  
 c. Ear-shoulder-hip should be in a straight line  
 d. The baby takes a latch on the areola and not on the nipple



Feeding Positions:  
Cross Cradle



Feeding Positions:  
Football / Clutch

6. Was the position explained:

- a. Yes
- b. No

7. For Caesarian mothers:

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

8. NICU admission:

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

9. Additional notes: .....

Continuity of Care:

Date: 15/6

→ Assess the pt condition  
→ monitor vitals  
→ maintain 2lo chold  
→ Administer medications as for doctor orders.

Handover given by Mounika

Handover taken by Madhu


Signature [Signature]

Signature [Signature]

Date & Time: 16/6 19:20 @ 2M

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

# PATIENT TRANSFER FORM


Patient Name & UHID No. HNH-00011823 IP26-00006593 Mrs SONAKSHI AGARWAL 09-07-1997 28 Y 11 M 7 D (F) Dr. PADMAJA YELISETTY		Date & Time of Admission 16/6/26 @ 6:27 Am	Date & Time of Transfer Order 16/6/26 @ 3:28 Pm
		Transfer Ordered by Dr. Padmaja	Reason for Transfer OB 2
From Unit Pne & Post	To Unit (308)	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File Nil	Number of Imaging Films NST-1	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	RL	(1)	
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Madhuremita @ Madhu		Name of Person Ordered Transfer Dr. Padmaja	
Patient & Clinical Records Received by : Sneha 16/6/26 @ 3:28 Pm			
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

LSC

# PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00011823      IP26-00006593 Mrs SONAKSHI AGARWAL 09-07-1997      28 Y 11 M 7 D (F) Dr. PADMAJA YELISETTY 		Date & Time of Admission 16/6/26 @ 6:20 AM	Date & Time of Transfer Order 16/6/26 @ 9 AM
		Transfer Ordered by - Dr. Padmaja	Reason for Transfer EL - LSC
From Unit Pre-post	To Unit OP	Information to Attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Number of Sheets in Clinical File (35)	Number of Imaging Films (1)	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.	Plaster (1)		
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor :    Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Ss Anusha		Name of Person Ordered Transfer Dr. Padmaja	
Patient & Clinical Records Received by : Kareena			
Date & Time of Patient Received :    16/6/26 @ 9 AM			

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

Unavailable Bed

Nurse not Available

Available Bed not ready

HNH-00011823 IP26-00006593  
Mrs SONAKSHI AGARWAL  
09-07-1997 28 Y 11 M 7 D (F)  
Dr. PADMAJA YELISETTY

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

BirthRight™  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

# CONSENT FORM FOR GENERAL ANAESTHESIA / MONITORED ANAESTHESIA CARE

Patient Name : Sonakshi Agarwal Age : 28y Gender : Male  Female

UHID NO: HNH-00011823 Surgeon Name: Dr. Padmaja

Anaesthesiologist : Dr. Samir / Dr. Akhila

Operative procedure planned : Elective caesarean section

## 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 anaesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

**Specific High Risk (s)** : The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

- Heart disease       Hypertension       Diabetes mellitus       Renal failure  
 Hepatic disorders       Shock       Multiple organ failure       Polytrauma / Renal Tubular Acidosis  
 Incapacitating Chronic Obstructive Pulmonary Disease  
 Others : hypotension, Bradycardia, Shivering

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 Sonakshi Agarwal the above mentioned operation / Diagnostic / Therapeutic procedures Elective caesarean section

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 anaesthesia.

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 anaesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

- Pregnant :  Yes     No

**DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT**

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

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

**Patient / Patient Attendant :**

Signature : .....  
Name : .....  
Relationship with Patient : .....  
Date & Time : .....

**Witness :**

Signature : .....  
Name : .....  
Date & Time : .....

**Doctor (who is taking the consent) :**

Signature : .....  
Name : .....  
Date & Time : .....

# INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE



Patient Name : SONAKSHI AGARWAL Gender:  Male  Female Age : 28yrs.  
 UHID No : HNH - 00011823 Date : 16/6/26

**Instruction:**

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

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

EMERGENCY LAPAROSCOPIC RESECTION OF OVARIAN TUMOR  
 upon  
 (Name of the Patient) SONAKSHI AGARWAL

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

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

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

- hemorrhage, need for blood / blood product transfusion
- inadvertent injury to bowel / bladder, infection
- re-laparotomy, resulting prolonged hospital stay, DVT / VTE

**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 Padmaja Y

**Consentee :**  
 Signature : Sonakshi  
 Name : SONAKSHI  
 Date & Time : 16th JUNE 8:40AM

**Patient Attendant :**  
 Signature : Yash  
 Name : YASH  
 Relationship with Patient: HUSBAND  
 Date & Time : 16th JUNE 8:40AM

**Witness :**  
 Signature : Alati  
 Name : Alati  
 Date & Time : 16/6/26 @ 8:40AM

**Doctor (who is taking the consent) :**  
 Signature : Padmaja  
 Name : PADMAJA THODAN  
 Date & Time : 16/6/26 @ 8AM

1 2  
c 2 2 2 2

1 2 3 4 5 6 7 8  
9 10 11 12 13 14 15

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20  
21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20  
21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20  
21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20  
21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40

Department of Anaesthesiology  
**PRE-ANAESTHETIC EVALUATION**

HNH-00011823 IP26-00006593  
 Mrs SONAKSHI AGARWAL  
 09-07-1997 28 Y 11 M 7 D (F)  
 Dr. PADMAJA YELISETTY



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

16/6/26  
 9:00 AM  
 (Dr Padmaja)  
**BirthRight**  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

Name: Mrs. SONAKSHI AGARWAL Age: 28y Sex: Female UHID.No: HNH-00011823

Date: 12/6/26 Time: 9:30pm Proposed Operation: ELECTIVE LSCS

Diagnosis: Primi @ 34+6wks.

B.P / CRT: 120/65 H.R: 100/min Weight: 68.9kg ASA Physical Status:  1  2  3  4  5

**Laboratory Data:**

Hgb: 11.8/12.5 Glucose: ✓ Protein: ..... HIV: ..... X-Ray: .....  
 PCV: 33.5 Urea: ..... Alb: ..... HBS Ag: ✓ ECG: .....  
 WBC: 8480/1690 Creat: ..... Total Bill: ..... HCV: ✓ 2D Echo: .....  
 Plate: 1.91ach/154 Na: ..... Dir. Bill: ..... Blood group: B+ve Stress/Angio: .....  
 PT: ..... K: ..... LDH: ..... T3: ..... Other: .....  
 PTT: ..... Ca++: ..... Alk phos: ..... T4: .....  
 INR: ..... Mg++: ..... Amylase: ..... TSH: .....  
 Cl -: ..... SGOT/SGPT: .....  
 Allergies: NIL

placenta: Posterior high  
(03/6/26)

**Medical History:** CVS: ✓  
 RESP: ..... Diabetes: .....  
 CNS: NIL SIGNIFICANT  
 Renal: .....  
 Hepatic / GE: ..... Physical Activity: METS 2A  
 Others: ✓

**Past Anaesthetic History:**

**Physical Exam:**

Airway: MP 1 2 3 4 Mouth Opening: Adequate Mentohyoid Distance: 3FB Neck: (N) Teeth: (N) Alignment  
 Lungs: BAC (+), clear  
 Heart: S1S2 (+)  
 CNS: NAD  
 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
T. LIVOGEN	BD
T. SHELICAL	OD
T. Vit -D3	OD

**Pre-Operative Instructions:**  
 1. DVT Prophylaxis: Water / ORS 2 Hours  
 2. NIL ORAL Others 6 Hours Explained  
 3. Informed Consent:  Standard  High Risk  
 4. Post Operative Pain Management:  Discussed with Patient  
 5. Other Instructions: Consent due ✓

Signature: [Signature] Name: Dr. SK. Ayesh  
 Docu. No.: RCH/FRM / CLINICAL / 044



# ANAESTHESIA CHART



Pre Induction Assessment: 9:15AM.

Change in Patient Condition:  Yes  No Fasting Status: Adequate

Physical Status:  Patient Identified  Consent Present  Chart Reviewed

H.R: 68/min B.P / CRT: 108/69 SpO<sub>2</sub>: 99% R.R: 14 Last Feed: >6 hrs

Pre-OP Diagnosis: primi 38+1wks Operation: Elective UCS Date: 16/6/26

Surgeon: Dr. Padmaja / Dr. Prayadaashini Anaesthesiologist: Dr. Archana K Technician: Saichandu / Pallavi

TIME	9:15	9:45	10:15	10:30
N <sub>2</sub> O / AIR / O <sub>2</sub> LPM				
HALO / SO / SEVO				
Drugs:	Inj. OXYTOCIN 3IU+6IU			
Antibiotic				
Suppository				
Blood Loss				
FI <sub>O<sub>2</sub></sub> (Sa <sub>O<sub>2</sub></sub> )	99	98	99	97 95
ETCO <sub>2</sub>				
ECG	SR	SR	SR	SR
Temperature				
Urine Output				
Fluids Blood	RL ① → ② → ③ →			
B.P	120/80			
V Systolic	80			
A Diastolic	60			
X Mean	70			
Heart Rate	60			
Tourniquet on Time				
Tourniquet off Time				
Throat Pack In				
Throat Pack Out				

Suppository  
 SUP-DICLOFENAC  
 SUP-TRAMADOL 5  
 100mg

Blood Loss  
 ~500ml

NOTES  
 Fchw@  
 9:42AM  
 on  
 16/6/26

LAB Values

ABG

GRBS

Others

<input checked="" type="checkbox"/> Equipment Checked and Functional <input checked="" type="checkbox"/> BP <input checked="" type="checkbox"/> Cuff Site: <u>RU UL</u> <input type="checkbox"/> Art Site: <input checked="" type="checkbox"/> EKG Lead <input type="checkbox"/> Temp Site <input type="checkbox"/> FIO <sub>2</sub> Monitor <input type="checkbox"/> Agent Monitor <input checked="" type="checkbox"/> Pulse Oximeter <input type="checkbox"/> Capnograph <input type="checkbox"/> Ventilator <input type="checkbox"/> Nerve Stimulator  Position: <u>Supine</u> <input checked="" type="checkbox"/> Pressure Points Checked  Eye Care: <input type="checkbox"/> Oint <input type="checkbox"/> Tape <input type="checkbox"/> Padding <input checked="" type="checkbox"/> Awake	<b>Temp:</b> <input type="checkbox"/> HME <input type="checkbox"/> Fluid Warmer <input type="checkbox"/> Cling Film <input type="checkbox"/> OH Warmer <input type="checkbox"/> Hugger's <input checked="" type="checkbox"/> Cotton Wool <input type="checkbox"/> Other  <b>Times:</b> Anaes Start: <u>9:30AM</u> OP Start: ..... OP End: ..... Leave-OR: <u>10:30AM</u>  <b>Anaesthesia:</b> <input type="checkbox"/> GA <input type="checkbox"/> Monitored Anaesthesia Care <input checked="" type="checkbox"/> Regional  <b>Line (Size &amp; Location)</b> <input type="checkbox"/> CVP: ..... <input type="checkbox"/> ART: ..... <input checked="" type="checkbox"/> IV: <u>OU 18g</u> <input type="checkbox"/> IV: ..... <input type="checkbox"/> IV: .....	<b>Induction</b> <input type="checkbox"/> IV <input type="checkbox"/> Inhal <input type="checkbox"/> Pre O <sub>2</sub> <input type="checkbox"/> RSI <input type="checkbox"/> Others  <input type="checkbox"/> Mask <input type="checkbox"/> SGA <input type="checkbox"/> Airway <input type="checkbox"/> Oral <input type="checkbox"/> Nasal ETT# ..... at ..... cm <input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Cuff <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Topical <input type="checkbox"/> Drug: .....  <input type="checkbox"/> Awake <input type="checkbox"/> Direct Vision <input type="checkbox"/> Video Laryngoscopy <input type="checkbox"/> Stylette / Bougie <input type="checkbox"/> Fiberoptic Blade# ..... Attempts: ..... Difficulty Why? .....  <input type="checkbox"/> Bitat = BS <input type="checkbox"/> Semi-Closed Circle <input type="checkbox"/> Closed Circle <input type="checkbox"/> Other	<b>Regional:</b> Extremity Specify: ..... <input checked="" type="checkbox"/> Spinal <input type="checkbox"/> Epidural <input type="checkbox"/> Caudal Others: ..... Position: <u>Sitting</u> <u>13ly</u> Site: ..... Needle Size: <u>25g 1.5 inch</u> Depth: <u>5cm</u> Parasthesia <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Catheter at skin ..... cm Drug Name & Conc: <u>0.75 Bupivacaine</u> <u>heav</u> <u>2fm +</u> <u>Gomog Buprenorphin</u> Bolus: ..... Infusion: ..... Block Level: <u>T4</u> Comments: <u>Adequate</u>  Transportation to <input checked="" type="checkbox"/> PACU <input type="checkbox"/> ICU <input type="checkbox"/> Other Relaxant Reversed <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA Name of the Doctor: <u>Dr. Archana K</u> Signature of the Doctor: <u>[Signature]</u>
---	---	--	--

**POST-ANAESTHESIA CARE UNIT RECORD**

Received in PACU by : Mounika Time Received : 10:30 am Time Discharged : .....

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

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

**PAIN ASSESSMENT AND MANAGEMENT FORM**

Date	Time	Pain Score	Intervention	Signature
16/6	10:30 am	0/10	NA	Mouni
16/6	11 am	0/10	NA	Mouni
16/6	11:30 am	0/10	NA	Mouni
16/6	12 pm	0/10	NA	Mouni

Pain Tool Used:  N PASS  FLACC  Wong Baker  NPS

**Reassessment Frequency:**

- Every eight hours for all hospitalized patients.
- For post surgical patient, patient with chronic pain, patient with severe pain
  - Every 2 hours for first 24 hours
  - After 24 hours every 4 hours
  - Prior to pain relieving intervention
  - With in 30-60 minutes after pain relief intervention

Anaesthesiologist Name : Dr. Anshu R

Anaesthesiologist Signature: [Signature]

Date & Time: 16/6/26 @ 3 pm

PACU Nurse Name : Madhu

PACU Nurse Signature: [Signature]

Date & Time: 16/6/26 @ 3 pm

Transferred to Unit by (PACU): (308)

Date & Time: 16/6/26 @ 3 pm



**GENERAL CONSENT FOR TREATMENT**

Patient Name: Mrs SONAKSHI AGARWAL Age : 28 Y 11 M 7 D  
IP No: IP26-00006593 Sex: Female  
Consultant: Dr. PADMAJA YELISETTY Ward/Bed No: 4F -OT/LDR-416

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

Patient, be deemed advisable or necessary.

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

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

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

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

Note:

1 We do not allow use of medication brought from outside by the patient.

2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.

(Receivers Signature:.....)

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

Signature of Patient/Relative:

Name: YASH

Relationship: HUSBAND

Date: 16th JUNE :

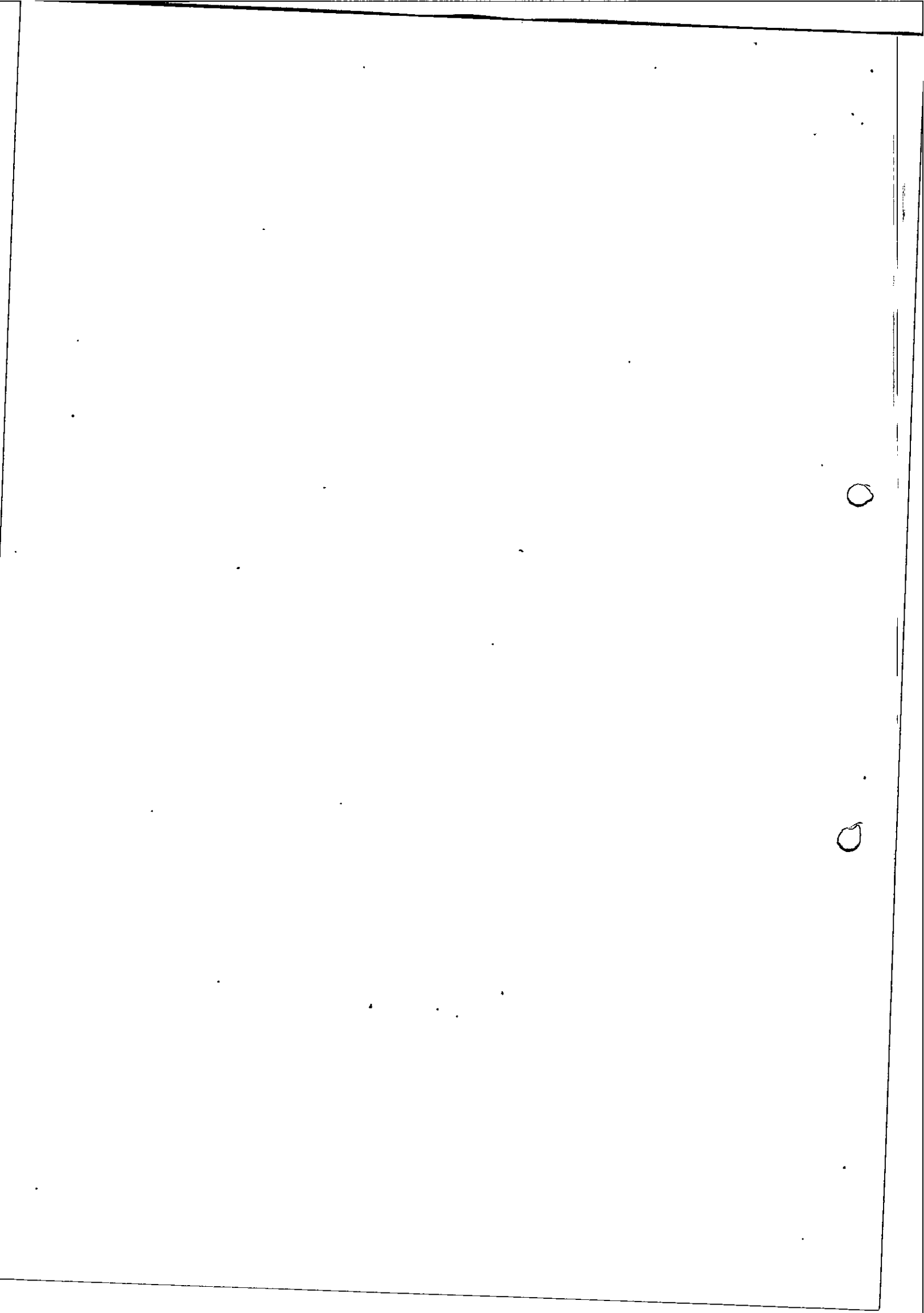
Time: 6.48 AM

Witness Name:

Witness Signature: Suresh Kumar

Patient Address:

GURU GANESH RESIDENCY Barkatpura  
Hyderabad Telangana INDIA 500027



HNH-00011823 IP26-00005593  
Mrs SONAKSHI AGARWAL  
08-07-1997 28 Y 11 M 7 D (F)  
Dr. PADMAJA YELISETTY

Rainbow  
Children's  
Hospital

BirthRight  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

## BILLING POLICY

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

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

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

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

### MODE OF PAYMENT & REFUNDS

- We accept payments by cash (up to Rs 1,99,999/- only ), cards, online transfer and Demand Drafts.
- All refund more than Rs.5,000/- will be refund through NEFT in three Bank working days.

  
Name & signature of Patient/Attendant

  
(Signature of Admission Desk executive)

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

### RAINBOW CHILDREN'S MEDICARE PRIVATE LIMITED

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

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

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

CIN: U85110 TG1998 PTC029914

email : [info@rainbowhospitals.in](mailto:info@rainbowhospitals.in)

[www.rainbowhospitals.in](http://www.rainbowhospitals.in)

