

302
FC

Name Mrs KEERTHI MAYI BHANURI **UHID** HNH-00012125
Father/Guardian Mr VINOD KUMAR **Age/Gender** 30 Y 1 M 21 D/ Female
Address Uppal, Hyderabad, Telangana, INDIA, 500039
IP No IP26-00006630 **Admission Date** 23-06-2026
Ref Doctor Self.
Discharge Date 25.06.2026

DISCHARGE SUMMARY

Consultant:

Dr. P Priyadarshini,
MBBS, MS OBGY
63596

Co-Consultant :

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

Diagnosis: PRIMI AT 36⁺⁴ WEEKS WITH PRETERM PREMATURE RUPTURE OF MEMBRANES WITH GESTATIONAL DIABETES MELLITUS ON DIET WITH HYPOTHYROIDISM FOR DELIVERY.

SPONTANEOUS VAGINAL DELIVERY DONE ON 24.06.2026.

Name	Mrs KEERTHI MAYI BHANURI * UHID	HNH-00012125	
IP No	IP26-00006630	Admission Date	23-06-2026

History:

LMP: 10.10.2025

Obstetric formula: Primigravida

EDD: 17.07.2026

Gestation at admission: 36⁺⁴ weeks**Obstetric History:**

G1 - Present pregnancy, Spontaneous conception.

Medical History : Known case of Hypothyroidism since 8wks of gestational age and started on Thyronorm 12.5mg**Surgical History:** Laparoscopic Appendectomy- 2008**Family History :** Parents- T2DM,
Maternal Grandmother- HTN+T2DM,
Paternal Grandfather- T2DM**Allergies** : Nil**Antenatal Details:**

Mrs KEERTHI MAYI BHANURI was booked to Rainbow hospital at 6+1 weeks of gestation. She had regular antenatal checkups and investigations as advised. Diagnosed with Hypothyroidism at 8wks and started on T.Thyronorm 12.5mcg. NT scan normal, increased Resistance in Uterine Artery in Doppler. Started on T.Ecospirin 150 mg once daily(Stopped at 34⁺⁶weeks). eFTS was low risk. TIFFA was normal. History of UTI at 20⁺³ weeks and treated with oral Antibiotics. Cervical encerclage was put at 22⁺⁵ weeks in view of short cervix (24 mm). Diagnosed with Gestational Diabetes Mellitus at 27⁺² weeks in view abnormal OGTT(77/183/169) and was started on Diabetic Diet. Home sugar Monitoring done She was admitted at 34⁺⁶ weeks in view of threatened preterm labour ,cervical stitch removed and managed conservatively. Fetal surveillance done by serial growth scans. Growth scan done on 19.06.2026 showed single live

Name Mrs KEERTHI MAYI BHANURI UHID HNH-00012125
IP No IP26-00006630 Admission Date 23-06-2026

intrauterine fetus with cephalic presentation at 36 weeks, AFI- 9 cms, Placenta-posterior high, EFW- 2.527kg(22%), AC: 8%, Doppler- normal. She was admitted at 36+4 weeks with Preterm premature rupture of membranes.

Investigations: Enclosed
Blood Group: " O" Positive

Management: Course in hospital and Delivery Details:

At admission on clinical examination the vitals were stable, uterus was irritable, Perspeculum examination showed active clear leak. Pervaginal examination showed cervix was long and 2 finger dilated. Fetal well being was confirmed by an admission CTG which was found to be reactive. As per hospital protocol she was started on IV. Taxim in view of ruptured membranes. Informed consent taken for Induction of labour. Labour induced with 2 doses of PGE1. Partographic monitoring of labour was done. Patient opted for epidural analgesia at 3 cms dilatation for pain relief. The same was sited by an anesthetist after informed consent. Further augmentation was done by oxytocin infusion. She progressed to full dilatation at 10 am. Passive descent of fetal head was allowed for 10 mins post full dilatation. She was put into position for vaginal birth at 10:10 am. Parts painted with betadine solution and draped to ensure full asepsis. She was encouraged to bear down. At crowning of head episiotomy was given under local anesthesia (10 ml of 2 % xylocaine solution). Baby was delivered by spontaneous vaginal delivery, Cord clamped and cut and baby handed over to pediatrician. Cord blood collected for blood grouping and Rh typing. Placenta and membranes delivered completely with controlled cord traction. Prophylactic syntocinon given. Episiotomy inspected. No extensions or additional vaginal tears found. Episiotomy sutured in layers. Instrument and swab count checked. 600 mcg of misoprostol given per rectally as prophylaxis against post partum hemorrhage. Vagina cleaned with betadine solution.

Name	Mrs KEERTHI MAYI BHANURI	UHID	HNH-00012125
IP No	IP26-00006630	Admission Date	23-06-2026

Delivery Details:

Date : 24.06.2026
Time of Delivery: 10:14am
Type of Labour : Induced.
Type of Delivery: Induced vaginal delivery
Anesthesia : Epidural

Baby Details:

Date : 24.06.2026
Time : 10:14am
Sex : Female
Weight : 2.540kg
Apgar : 8,9
Gestational Age: 36⁺⁴ weeks
NICU Admission: No

Post-Partum Notes: She was closely monitored for post partum hemorrhage. Breast feeding initiated. Vitals were stable; patient ambulated; patient was encouraged for spontaneous voiding and was shifted to room. On PND 1 FBS AND PPBS done 87 Dietary advice given. Her postpartum period following that was uneventful. On first postpartum day episiotomy wound was healthy and intact. 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 (Cefixime 200mg) twice daily till 29.06.2026 (9am-9pm) after food.

Name Mrs KEERTHI MAYI BHANURI UHID HNH-00012125
IP No IP26-00006630 Admission Date 23-06-2026

2. Tab. Calpol 500mg (Paracetamol 500mg) (2tabs) thrice daily till 29.06.2026 (8am-2pm-10pm) after food.
3. Tab. Pantodac (Pantoprazole - 40mg) 1 tablet twice daily till 29.06.2026 (7am-7pm) before food.
4. Tab. Voveran 50 mg (Diclofenac 50mg) thrice daily till 29.06.2026 (9am-3pm-11pm) after food.
5. Tab. Livogen (Elemental iron - 50mg, folic acid 1.5mg) once daily (7am) for three months before breakfast.
6. Tab. Shelcal (Elemental Calcium 500 mg, vitamin D3 250 IU) once daily (2pm) till breast feeding after food.
7. Betadine ointment for local application.
8. Sy. Duphalac 15 ml (Lactulose 3.33gm/5ml) at bed time for one week.
9. Tab. Thyronorm 12.5 mcg once daily before breakfast
10. Review after 10 days with FBS and PPBS for Physician.
11. Review with Serum TSH FT3, FT3 AFTER 4 WEEKS.
12. Sitz bath for 1 week .

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

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

Review with **Dr. P PRIYADARSHINI** after **10** days on **06.07.2026** at Rainbow Children's Hospital with prior appointment (**Review consultation will be charged**).

Name	Mrs KEERTHI MAYI BHANURI	UHID	HNH-00012125
IP No	IP26-00006630	Admission Date	23-06-2026

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

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

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

Patient/ Attender

In case of emergency like bleeding, fever [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 KEERTHI MAYI BHANURI UHID

IP No

IP26-00006630

Admission Date

23-06-2026



HNH-00012125



Registrar/Resident/C.M.O

Consultant:

Dr. P Priyadarshini,
MBBS, MS OBGY
63596

11

HNH-00012125 IP26-00006630
Mrs KEERTHI MAYI BHANURI
03-05-1996 30 Y 1 M 21 D (F)
Dr. P. PRIYADARSHINI



SURGERY DETAILS

Date : 24/6/26

Patient Name: Mrs. Keerthi Date of Birth: 3-5-1996 Age: 30 Y

Gender: Female Ward: LDR UHID No: HNH-00012125

Date of Surgery: 24/6/26 OT-1 OT-2 OT-3 OT-4 OBG OT-1 OBG OT-2

Name of the Surgery: Normal delivery with epidural

Time in: 9:30 AM

Time Out: 10:30 AM

	NAME	AMOUNT
1. Surgeon	DR. Priyadarshini	
2. Anaesthetist		
3. Assistant Surgeon	DR. DVA	
4. OT Technician		
5. Circulating Nurse	Anusha D	
6. Assistant Nurse	Sujatha	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 26-0000207953

Order by: Sujatha

Handwritten text, possibly a list or notes, located in the upper left quadrant of the page.

Handwritten text, possibly a list or notes, located in the upper right quadrant of the page.

Handwritten text, possibly a list or notes, located in the middle section of the page.

Handwritten text, possibly a list or notes, located in the lower middle section of the page.

Handwritten text, possibly a list or notes, located in the lower left quadrant of the page.

Handwritten text, possibly a list or notes, located in the lower right quadrant of the page.



**Rainbow Childrens Hospital-Himayatnagar**

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar ,Hyderabad ,Telangana, INDIA ,500029.

TEL NO :040-48873000

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

Admission No : IP26-00006630 Admit Date : 23-Jun-2026 Admit Time : 11:40 PM UHID : HNH-00012125

Patient Details :

Patient Name	: Mrs KEERTHI MAYI BHANURI	Age	: 30 Y 1 M 21 D
Guardian	: Mr VINOD KUMAR	DOB	: 03-05-1996
Gender	: Female	Religion	:
Occupation	:	Martial Status	:
Address (H)	: Uppal Hyderabad Telangana INDIA 500039	Phone No	: 9014488571/ 9618773940
		E-mail	: vinod050393@gmail.com

Admission Details :

Bed Type	: TWIN SHARING	Bed No	: LDR-415	Ward Name	: 4F -OT
Room No	: LDR-415	Admission Type	: First Visit		

Contact Details :

Name	: Mr VINOD KUMAR	Relationship	: Husband
Contact Address	: Uppal Hyderabad Telangana INDIA 500039	Phone No	: 9014488571

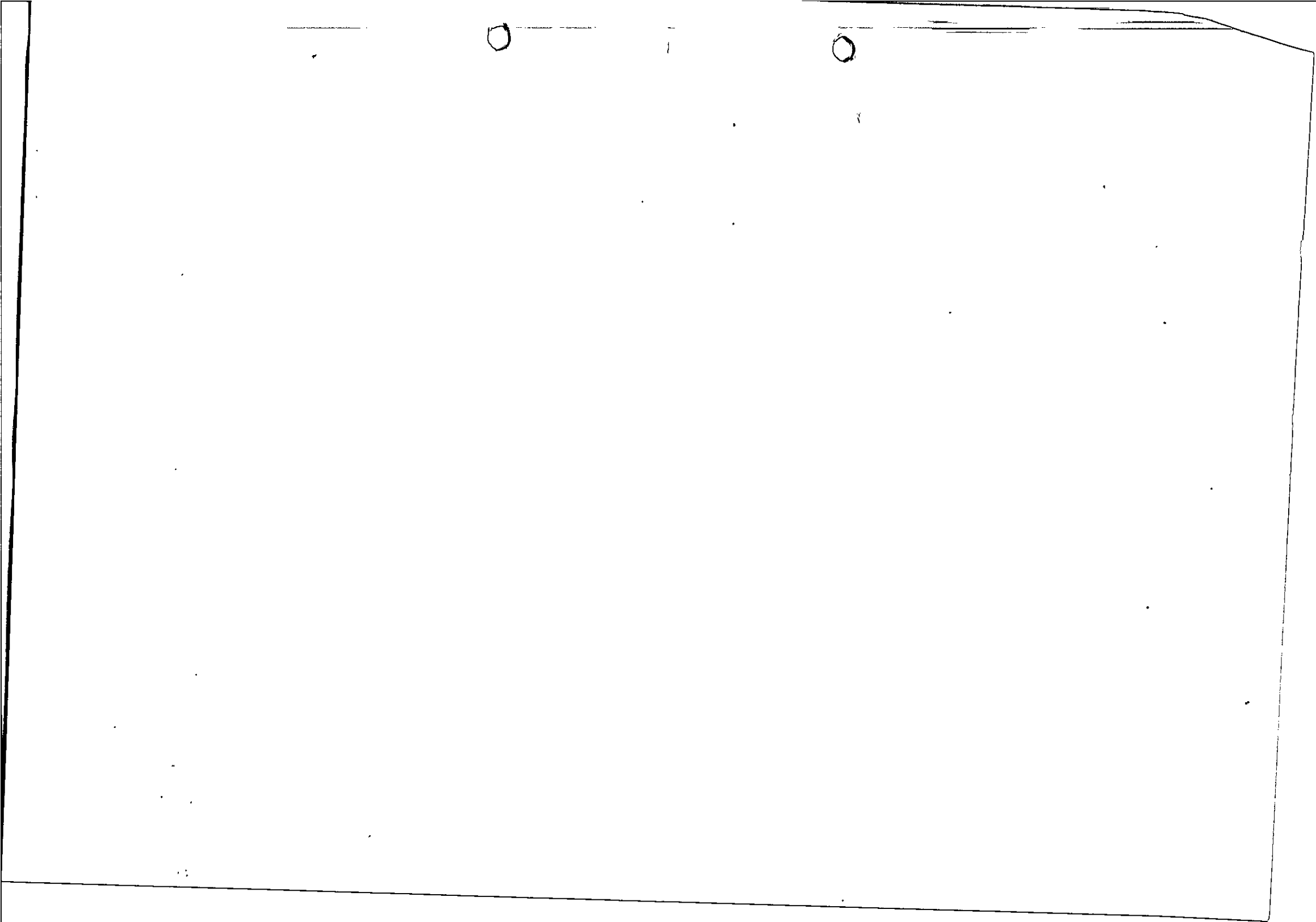
Signature

Doctor Details :

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

Payment Details :

Payment Mode	: DC/CC Card	Deposit Amount	: 20000.00
		Payor Name	: STAR HEALTH AND ALLIED INSURANCE CO LTD



PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00012125 IP26-00006630 Mrs KEERTHI MAYI BHANURI (F) 03-05-1996 30 Y 1 M 21 D Dr. P PRIYADARSHINI		Date & Time of Admission 23/6/26 @ 11:40pm	Date & Time of Transfer Order 24/6/26 @ 1:40pm
Transfer Ordered by DR. NAVEENA		Reason for Transfer observation	
From Unit LDR	To Unit Room	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 30	Number of Imaging Films 4	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.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Sis. Seetha		Name of Person Ordered Transfer DR. NAVEENA	
Patient & Clinical Records Received by : Sr. Scendhya			
Date & Time of Patient Received : 24/6/26 @ 1:45 pm ✓			

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

- Unavailable Bed Nurse not Available Available Bed not ready

ACTIVITY RECORD FOR BILLING

Name : _____
 UHID No. : _____
 Date of Admissic _____
 Room / Bed No : _____ Ward : _____ Suggested Billable bed type : _____

HNH-00012125 IP26-00006630
 Mrs KEERTHI MAYI BHANURI
 03-05-1996 30 Y 1 M 20 D (F)
 Dr. P PRIYADARSHINI



Consultant: _____ Dept : _____

Date of Discharge : _____ Time: _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
24/6	1:30pm	LDR	Room	Sujatha

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. S. Tejaswi	24/6/26	7980	[Signature]
2				
3	<i>cross checked done by Sujanya</i>			
4				
5				
6				
7				
8				
9				
10				

24/6/26 @ 06:02 pm



IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

Come in for delivery :- 2 hours
 PPM ⊕

Obstetric Formula: G₁

Obstetric History:

G-PP.

Present Pregnancy Record:

Booked @ 6+1
 NT ⊕ PLS - LR Tiffa ⊕
 Admitted - Cerclage @ 22⁺ = short ca.
 (removal) @ 34⁺
 Antenatal steroid covered (11/12/2020)
 Threatened Preterm

RISK FACTORS: New causally dx.

com @ 22⁺ (0477 deranged - on diet)

LMP: 10/10/2025

EDD:

Corrected EDD: 17/7/2026

GA: 36⁺4

Menstrual History: Regular: Yes No

Obstetric Examination

Fundal Height: ut ~ 36 wk

Ut. Activity: Relaxed Mild Mod Severe
 Irritable

Liquor: Adequate Oligo Poly

PP: Cephalic Breech Others _____

Head Fifths Palpable: _____

FHS: Normal Tachy Brady Absent

Per Speculum Examination

Draining: Present Absent Bleeding

Colour of Liquor: Clear Meconium Blood Stained

Vaginal Examination

Cervix: Long Partially effaced Effaced

Os: Closed Dilated 2F

Membranes: Present Absent

Liquor: Clear Meconium Blood Stained

Presenting Part: Vertex Breech Others

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

Pelvis: Adequate Doubtful

Height: 155 cm

Weight: 67.90 kg

Allergies: _____

Breast: Normal Abnormal

General Examination: Fair

Consciousness: Fair Pallor: ⊕

Icterus: ⊕ Edema: ⊕

Temp: Afebrile PR: -

BP: DTR: ⊕

CVS: JAMD RS BARE

Liver/Spleen: JAMD Urine Output: Adeq

DIAGNOSIS

Prim / 36⁺ wk / PPRom / com on diet / Hypothyroidism

Prim Delivery.



<p>Family History:</p> <p>Parents - DM Mat GF - H1N1 DM / Pat GF - DM</p>	<p>Surgical History:</p> <p>Laparoscopic Appendectomy 2008</p>
<p>Medical History:</p> <p>TB</p>	<p>Medication History:</p> <p>Tab Iron / Calcium Hydroxide (12.5mg)</p>
<p>Plan of Care:</p> <ul style="list-style-type: none"> - Admission NST - Ports prepared - Informed consent - Drugs as charted - NST 3rd hourly - FHS 2nd hourly - Send CBC - Check for blood availability - Tab magnesium 25mg PO @ 12PM 	<p>Investigations:</p> <p><u>BST - - O/Pve</u></p> <p>low throb vDRE trace } NR</p> <p><u>CBC (11/6/2026)</u></p> <p>Hb - 12.1 WBC - 7.39 Plt - 200</p> <p><u>USG (19/6/2026)</u></p> <p>SUP 136 # Vx</p> <p>PL - P/H AFI - 9cm</p> <p>AC ST EFW - 2.527kg (22x) UAD (2)</p> <p>Dr. Pamana Priyadarshini Consultant Gynecology Reg.</p>

Doctor Name: Dr. Manjula
 Signature: [Signature]
 Date & Time: 23/06/2026 @ 11:45pm

Consultant Name: Dr. Priyadarshini
 Signature: [Signature]
 Date & Time: 23/6/2026 @ 11:45pm

1

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/06/2016 4am	CIS/1b Dr Manoj Kumar AC - Fair Appearance Vitals stable P/A at ~36w Cephalic FHS PR L/E & P/V @ clearly	Adv - Regular Diet ; Adeq Hydration - Early breakfast → leguol diet - NST - 3 rd hourly - FHS monitoring 2 nd hourly - W/F Progress of labour - Inform SCS
	<div style="border: 1px solid black; padding: 5px;"> <p>2nd dose Tab misoprost 200mg P/O @ 4am</p> </div>	
		Dr Manoj Kumar
24/6/2016 5:50am	CIS/1b Dr Manoj Kumar CIS/1a Dr Priyadarshini	Adv - Re Early Breakfast - Adeq Hydration - leg diet - NST 3 rd hourly - FHS 2 nd hourly - W/F Progress of labour
	AC Fair Appearance Vitals stable P/A at ~36w mild Acly Cephalic FHS PR	
	3G 30-35s 10mm - P/O 3w Partly effaced / M ASSENT leg clear U=3	Counsel for Epidural Analgesia

Dr Manoj Kumar



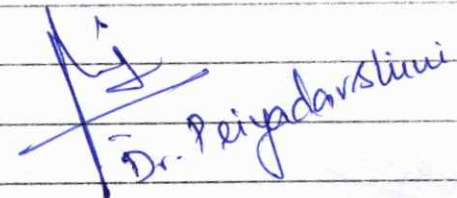
PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/6/2026 EAM	C/S/B DY. DWG	
	Primid 36 ⁺ 5 week PPRM GDM on MNT Hypothyroidism	
	C/c fair, Afebrile BP: 110/81 mmHg PR: 78 bpm. P/A wt = 3616g	<u>Adv</u> - liquid diet - Drugs as charted - NST 3rd hourly - FHR Monitor 1 hour - Adequate hydration - WFPOL - Inj Oxytocin 10 units in 100ml @ 6ml/hr started @ 8:30 AM
	2 nd doses of Misoprostol done: 2c/15-20/10 head 3/5 palpable P/v - cx 80% effaced os - 3cm ME. clearing clear liquor PR ✓ PL ✓ - 2 RA	



(2)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/6/2026 9:00 AM.	C/S / B Dr. Priyadarshini	
	Primie @ 36 ^{W5} week @ PPRM @ CDM on MN? @ Hypothyroidism	
	C/C Fair, Afebrile Vitals - Normal P/A wt @ 36wk cephalic. FNS ⊕	<u>Adv.</u> - Liquid diet - Drugs as charted. - NST 3 rd hours. - FHR Monitoring - Adequate hydration. - WFPOL.
	3c / 05 / 10. P/V. cx. effaced. os - 4-5cm. M ⊕. PP - 1. PR - A.	Inj oxytocin 10mt in 10RL @ 15ml/hr.
		 Dr. Priyadarshini
		Dr. Pampana Priyadarshini Consultant Obstetrics and Gynecology Reg. No: 63596



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/6/26 10:40 AM	C/S/B Dr. Priyadarshini PND-0.	<p>Adv</p> <ul style="list-style-type: none"> - Regular diet - Drugs as charted - Adequate hydration - w/f PV bleed - Monitor vitals - Inform cos
Baby & Mother.	<p>GC fair Afebrile BP- 106/54 mmHg P.R. - 97 bpm H/L NAD P/A uterus Retracted well. P/V NAB.</p>	
U/O - clear Adequate.		
	<p>Dr. Pampana Priyadarshini Consultant Obstetrics and Gynecology Reg. No. 63596</p>	<p><i>[Signature]</i> Dr. Priyadarshini</p>
24/6/26 1:15 PM	C/S/B Dr. Durg PND-0	<p>Adv</p> <ul style="list-style-type: none"> - Regular diet - Drugs as charted - Adequate hydration - w/f PV bleed - Monitor vitals - Inform cos - FBS, PPBS +/m.
Baby & Mother urine passed.	<p>GC Fair Afebrile BP: 111/66 mmHg. PR: 73 bpm. H/L NAD P/A uterus Retracted well P/V NAB</p>	
Pt can be shifted to Room		

[Signature]
 noted by Sr. Sankar
 24/6/26
 1:45 PM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/06/2026		
3:30pm	Teleconsultation done by Dr. Padmaja mam	
	Pili on PNDs foll. PTVD.	
	OLE GC-fair	Ado
	Afebrile SpO ₂ -100% on RA	Soft diabetic diet
	PR: 75 bpm	Adequate hydration
	BP: 106/72 mmHg	Ambulation.
U-L	Cus/RS: NAD	drugs as charted.
F	PA: ut. untracted well	w/ PV b. bleeding.
S	Soft, NT	FBS and PPBS
	LLE: PV bleeding	TLM
	WNL	Continue thyroid medication
	episiotomy wound: clean & healthy.	Rpt. FBS, PPBS, and TSH after 6 hrs
	Baby: Mother's side	Monitor Vitals
	Bilateral breasts: soft	Inform SOS
	Secretions (+)	

Dr. Naveena
 N/B - Supriya
 4pm @ 24/6/26

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/6/26 8pm	cls/B Dr. Veena <u>P, L PND-0. PT-NVD</u>	
Baby @ ms	PT is stable, No clo o/e Gc-fair, Afebrile Vitals - stable Pallor (-)	Adv <ul style="list-style-type: none"> Regular diet (Diabetic) Adequate hydration Ambulation Drugs as charted w/ excessive bleedng PU FBS & PPBS c/m (PND-1) vital monitoring perform SOS
uv sv	PIA - Ut well retracted L/E - B/N/L Ble Breasts - Soft, ms (+)	
25/6/26 7AM	cls/B Dr. Veena <u>P, L PND-0. PT-NVD</u>	N/B - Supine 24/6/26 @ 8:30pm
Baby @ ms	PT is stable, No clo o/e Gc-fair, Afebrile Pallor (-) Vitals - stable	Adv <ul style="list-style-type: none"> Regular diet (Diabetic) Ambulation Adequate hydration Drugs as charted PPBS to F/u. vital monitoring. NIPARE ant. L/A. (Clean before feeds) Plan for d/s today
FBS - single	PIA - Ut well retracted L/E - B/N/L Ble Breasts - Soft, ms (+) Nipple crack (+) (Both sides)	<ul style="list-style-type: none"> Plan for d/s today noted by mother
uv sv		



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/6/2026 10:20 am	C/S/B Dr. Priyadarshini P.U/PND- 11 SVD.	
B/L Breast soft B/E mother Uv Sv	O/E pt cu Gc-fau afebrile P°/PE° P.R-87 B.P- 110/70 H/L NAD	4 1. Normal diabetic diet 2. plenty of oral fluids 3. Ambulation 4. drugs as per chart 5. W/E bleeding Plv 6. PPBS to be done 7. Monitor vitals
Adv PPBS plan for discharge	PlA - ut well retracted & soft Plv No active bleeding	8. Inform S/I Dr. Priyadarshini Consultant Obstetrics and Gynaecology Reg. No. 62548
		noted by Sr. Sandhya 25/6/26 10:30 a



Keerthi Bhanuri



DRUG CHART

Date of Admission: 23/06/2020 Drug Allergies: Nil Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
 - Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
 - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
 - AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

Signature
Verified By : Name

REGULAR PRESCRIPTIONS

Weight. 67.90 Ward. LDR

DRUG : Inj CEFOTAXIME Date/Time 24/6

Dose	Route	Frequency	Start Date
1g	IV	BD	24/6

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

Additional Instructions:
 11pm Needle

Daily Doctor's Endorsement by a Sign

STOP by 25/6/20

DRUG : T. PANTOPRAZOLE Date/Time 25/6

Dose	Route	Frequency	Start Date
40mg	PO	OD	21/6

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

Additional Instructions:
 6AM Needle

Daily Doctor's Endorsement by a Sign

DRUG : T. DICLOFENAC Date/Time 24/6 25/6

Dose	Route	Frequency	Start Date
50mg	PO	TID	24/6

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

Additional Instructions:
 7am 10:30am 2:40pm 11pm Needle

Daily Doctor's Endorsement by a Sign

DRUG : T. PARACETAMOL Date/Time 24/6 25/6

Dose	Route	Frequency	Start Date
1g	PO	TID	24/6

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

Additional Instructions:
 6AM x Needle 11pm Needle

Daily Doctor's Endorsement by a Sign

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



Sheet No:

REGULAR PRESCRIPTIONS

Weight 69.9 Ward LDL

DRUG : T. THYROXINE				Date Time	<u>25/6</u>
Dose	Route	Frequency	Start Dt.		
<u>125mcg</u>	<u>PO</u>	<u>OD</u>	<u>25/6/26</u>		
Name & Signature of the Doctor Starting the Drugs:					
<u>[Signature]</u>					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : T. CEFEXIME				Date Time	<u>25/6</u>
Dose	Route	Frequency	Start Dt.		
<u>200mg</u>	<u>PO</u>	<u>BD</u>	<u>25/6/26</u>		
Name & Signature of the Doctor Starting the Drugs:					
<u>[Signature]</u>					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : NIPCARE OINTMENT				Date Time	<u>25/6</u>
Dose	Route	Frequency	Start Dt.		
<u>1g</u>	<u>LA</u>	<u>BD</u>	<u>25/6/26</u>		
Name & Signature of the Doctor Starting the Drugs:					
<u>[Signature]</u>					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG :				Date Time	
Dose	Route	Frequency	Start Dt.		
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

Signature

VERIFIED BY : Name



Sheet No:

REGULAR PRESCRIPTIONS

Weight 6700 Ward 108

VERIFIED BY : Mama Signature

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



SE	Date Time	Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.	

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

VARIABLE DOSE	Date Time	Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.	

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
23/6	11:30AM	INJ CEFOTAXIME	1g (AST)	IV	<u>[Signature]</u>	Madhu
24/6	12AM	Tab MISOPROSTOL	25mcg	P/O	<u>[Signature]</u>	Madhu
24/6	4AM	Tab MISOPROSTOL	25mcg	P/O	<u>[Signature]</u>	Madhu
24/6	11AM	Inj CEFOTAXIME	1g	IV	<u>[Signature]</u>	Sujatha
24/6	9:40AM	Inj DROTAVERINE HYDROCHLORIDE	40mg	IV	<u>[Signature]</u>	Anusha
24/6	9:40 AM	Inj HYOSCINE BUTYL BROMIDE	20mg	IV	<u>[Signature]</u>	Anusha
24/6	10:30 AM	T. Misoprostol	600mcg	PR	<u>[Signature]</u>	Sujatha
24/6	10:32AM	DICLOFENAC SUPPOSITORY	1Tab	PR	<u>[Signature]</u>	Anusha
24/6	10:30AM	Inj OXYTOCIN	10 unit	IM	<u>[Signature]</u>	Anusha

Signature

VERIFIED BY : Name

Dr. Dhakshayani



I.V. FLUIDS CHART

Weight: 69.00, Ward: LDR

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
24/6/26	7:00 AM	RINGER LACTATE	IV FF	FF	✓	Alia ✓	24/6	✓	✓
24/6	8 AM	RINGER LACTATE	IV FF	FF	✓	✓	24/6	✓	Li (M)
24/6	8:30 AM	RINGER LACTATE + OXYTOCIN	IV	6ml/hr	✓	Li Anusha D	24/6		Li (M)
<p>STOPPED 24/6/26</p>									

Signature

VERIFIED BY : Name



MEDICATION RECONCILIATION FORM

Drug Allergies: Not known any Drug Allergies

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

Shifting From: NA Shifted to: NA

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T. Iron	1 tab	P/O	OD	23/6	<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
2	T. Calcium	1 tab	P/O	OD	23/6	<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
3	T. Thyronom	12.5mg	P/O	OD	23/6	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : M. D. Moushe

Date & Time : 23/June/2020 @ 11.45pm

Nurse Name & Signature: Ashli A

Date & Time : 23/6/2020 11.45pm

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

HNH-00012125
 Mrs KEERTHI MAYI BHANURI
 03-05-1996 30 Y 1 M 20 D (F)
 Dr. P PRIYADARSHINI

IP26-00006630

302

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

RESULT SHEET

Date	11/6/28				
Time					
Hb	12.1				
PCV	34.6				
RBC	4.13				
WBC	7.39				
N/L					
Platelets	200				
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

HNH-00012125 IP26-00006630
 Mrs. KEERTHI MAYI BHANURI
 03-05-1996 30 Y 1 M 20 D (F)
 Dr. P. PRIYADARSHINI

302



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																										
	0 - 10																										
Saturations	94 - 100 %																										
	< 94 %																										
Administered O ₂ (L/min.)																											
Temp °C	40																										
	39																										
	38																										
	37																										
	36																										
	35																										
	< 35																										
Heart Rate	170																										
	160																										
	150																										
	140																										
	130																										
	120																										
	110																										
	100																										
	90																										
	80																										
	70																										
	60																										
	50																										
40																											
↑ Systolic Blood Pressure	190																										
	180																										
	170																										
	160																										
	150																										
	140																										
	130																										
	120																										
	110																										
	100																										
	90																										
	80																										
	70																										
60																											
50																											
↓ Diastolic Blood Pressure	130																										
	120																										
	110																										
	100																										
	90																										
	80																										
	70																										
60																											
50																											
40																											
NEURO RESPONSE [✓]	Alert																										
	Voice																										
	Pain																										
	Unresponsive																										
URINE mls / hour	> 30																										
	< 30																										
Proteinuria	Protein ++																										
	Protein > ++																										
Lochia	Normal																										
	Heavy / Foul																										
Liquor	Clear / Pink																										
	Green																										
TOTAL YELLOW SCORES																											
TOTAL ORANGE SCORES																											
Nurse Initial																											

Handwritten notes and scores in blue ink:

- At 10:00 AM: RESP 20, Sat 99, Temp 36.5, HR 84, SBP 111, DBP 72.
- At 2:00 PM: RESP 20, Sat 99, Temp 36.5, HR 88, SBP 116, DBP 72.
- At 6:00 PM: RESP 20, Sat 100, Temp 36.5, HR 86, SBP 129, DBP 87.
- At 7:00 PM: RESP 20, Sat 100, Temp 36.5, HR 93, SBP 134, DBP 83.
- Summary scores: Yellow scores 0, 0, 0; Orange scores 0, 0, 0.
- Nurse Initials: [Signature]

PHK 24/6/26

12:00 AM - 143 bpm

3:00 AM - 139 bpm

6 AM - 142 bpm

Obstetrics and Gynaecology Early Warning Signs

Complete a Full
Set of MEOWS
Observations

1 Yellow Alert :
Repeat Observations
in 30 minutes

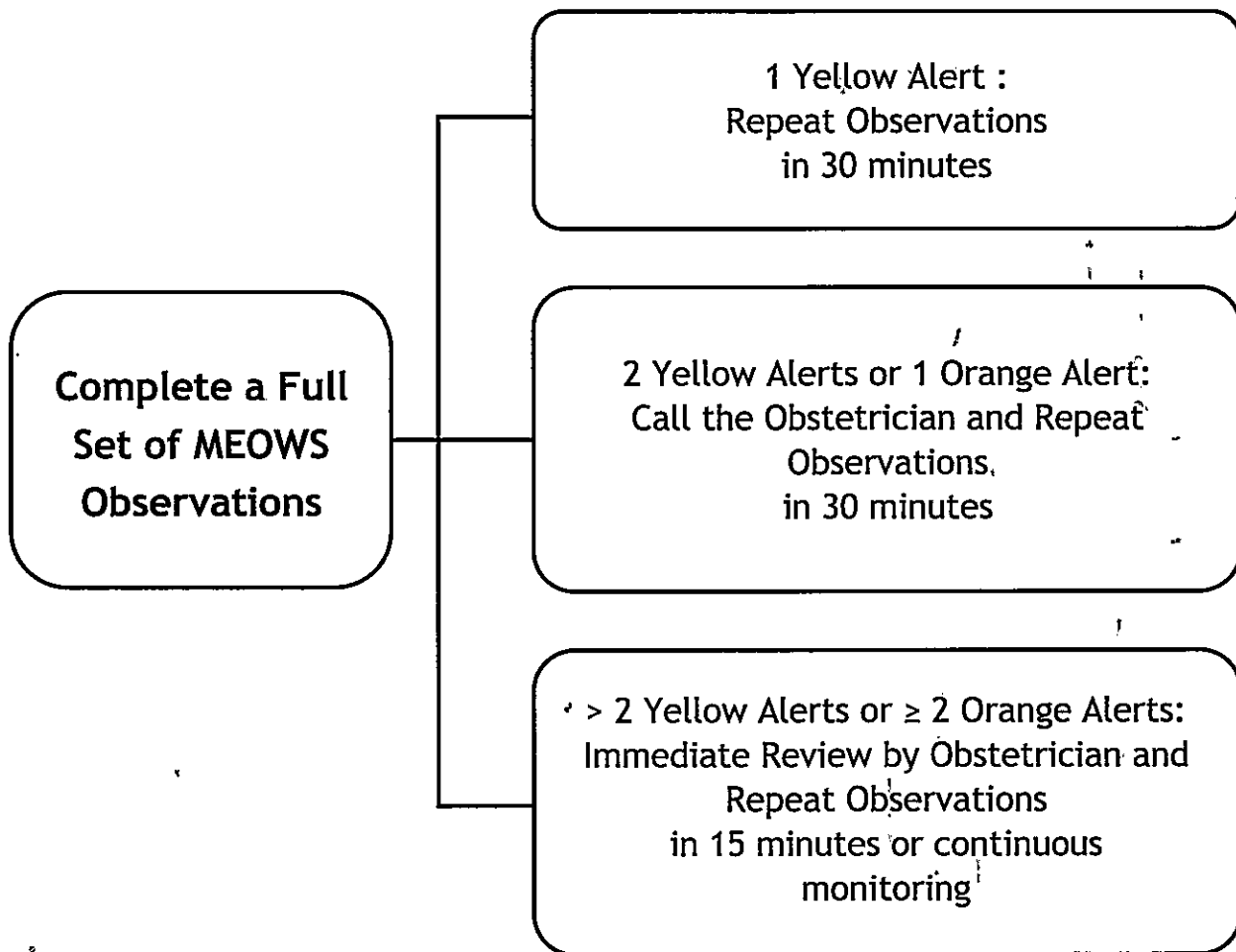
2 Yellow Alerts or 1 Orange Alert:
Call the Obstetrician and Repeat
Observations
in 30 minutes

> 2 Yellow Alerts or \geq 2 Orange Alerts:
Immediate Review by Obstetrician and
Repeat Observations
in 15 minutes or continuous
monitoring

* The Modified Early Warning Score (MEOWS)

**Obstetrics and Gynaecology
Early Warning Signs**

2/0/17



* The Modified Early Warning Score (MEOWS)



FLUID CHART

Sheet No. : 1

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						
Total 24 hrs. Intake						Total 24 hrs. Output						

HNH-00012125 IP26-00006630
 Mrs KEERTHI MAYI BHANURI
 03-05-1996 30 Y 1 M 20 D (F)
 Dr. P PRIYADARSHINI



FLUID CHART

Sheet No. :

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

Date	Time	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
21/6/26			Mouth	I.V								
	08:00 am	RL		100ml (plain)								
	09:00 am	RL + Synto 6ml		100ml "								
	10:00 am	RL		100ml "					500ml			
	11:00 am	RL		100ml								
	12:00 pm	RL		100ml					100ml			
01:00 pm												
Total Intake : 400ml					Total Output : 500ml							
24/6/26	02:00 pm											
	03:00 pm		Idly									
	04:00 pm		H2O									
	05:00 pm				NA							
	06:00 pm											
	07:00 pm											
Total Intake : Taken					Total Output : U-1 M-1							
21/6/26	08:00 pm											
	09:00 pm		Idly									
	10:00 pm		H2O									
	11:00 pm				NA							
	12:00 am											
	01:00 am											
Total Intake : Taken					Total Output : U-2 M-0 V-1							
25/6/26	02:00 am											
	03:00 am											
	04:00 am		H2O									
	05:00 am				NA							
	06:00 am											
	07:00 am											
Total Intake : Taken					Total Output : U-2 M-0 V-1							
Total 24 hrs. Intake												
Total 24 hrs. Output												

NURSING CARE RECORD

Date: 22/6/26

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							
Afternoon				NA			
Night	8pm	Assess the patient condition plan for vital & record	8pm	Assessed the patient condition Maintain vital & record	patient stable	vital record	Ala
	8am	plan for TPO chart.	8am	Maintain TPO chart			Ha

HNH-00012125 IP26-00006630
 Mrs KEERTHI MAYI BHANURI
 03-05-1996 30 Y 1 M 20 D (F)
 Dr. P PRIYADARSHINI

NURSING CARE RECORD



Date: 24/6/20

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM	→ Assess the pt condition → plan for vitals → plan for I/O chart → plan for medication	8AM	→ Assessed the pt condition → vital are checked & recorded → all medication given as per doctor's	I/O chart maintained	patient is stable	Li
	2PM		2PM				Sriathu
Afternoon	2PM	- Assess the pt condition - Monitor vitals - maintain I/O Chart - Medication Given as per drug chart	2PM	- Assessed the pt condition - monitored vitals - maintained I/O Chart - Medication Given as per drug chart	Pt is stable	Re-checked vitals	Mounika
	8PM		8PM				
Night	8PM	→ Assess the pt condition → Monitor vitals → Maintain I/O chart → Medication Give as per drug chart	8PM	→ Assessed the medication - monitored vital & recorded - Maintained I/O Chart → Administer Given as per doctor's order	Pt is stable	Re-checked vitals	Madhuri
	8AM		8AM				



CHECKLIST FOR THROMBOPHLEBITIS

22/6/26

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			24/6 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			NA	NA	NA	NA				
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				
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			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				
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				
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				
Signature of the Nurse						NA	NA	NA	NA				

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.

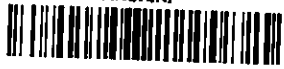
Signature of Shift In Charge :

Signature : Peri Name : Sujatha

Signature of Ward In Charge :

Signature : [Signature] Name : Karthikeyan

HNH-00012125 IP26-00006630
 Mrs KEERTHI MAYI BHANURI
 03-05-1996 30 Y 1 M 20 D (F)
 Dr. P PRIYADARSHINI



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 :



Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	23/6/24		Fall Risk Grading		
		Score	8 pm	8 AM	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			
Secondary Diagnosis (more than one diagnosis)	Yes	15			Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0					
Ambulatory Aid	Furniture	30			High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Crutches, Cane(S), Walker	15					
	None /Bed Rest /Nurse Assist	0					
IV / Heparin Lock or Saline	Yes	20	20	20	Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0					
GAIT / Transferring	Impaired	20			High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10					
	Normal /On Bed Rest /Immobile	0					
Mental Status	Forgets limitations	15			High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0					
Total Morse Fall Scale Score:			20	20			
		Signature	Alex	Qui			

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

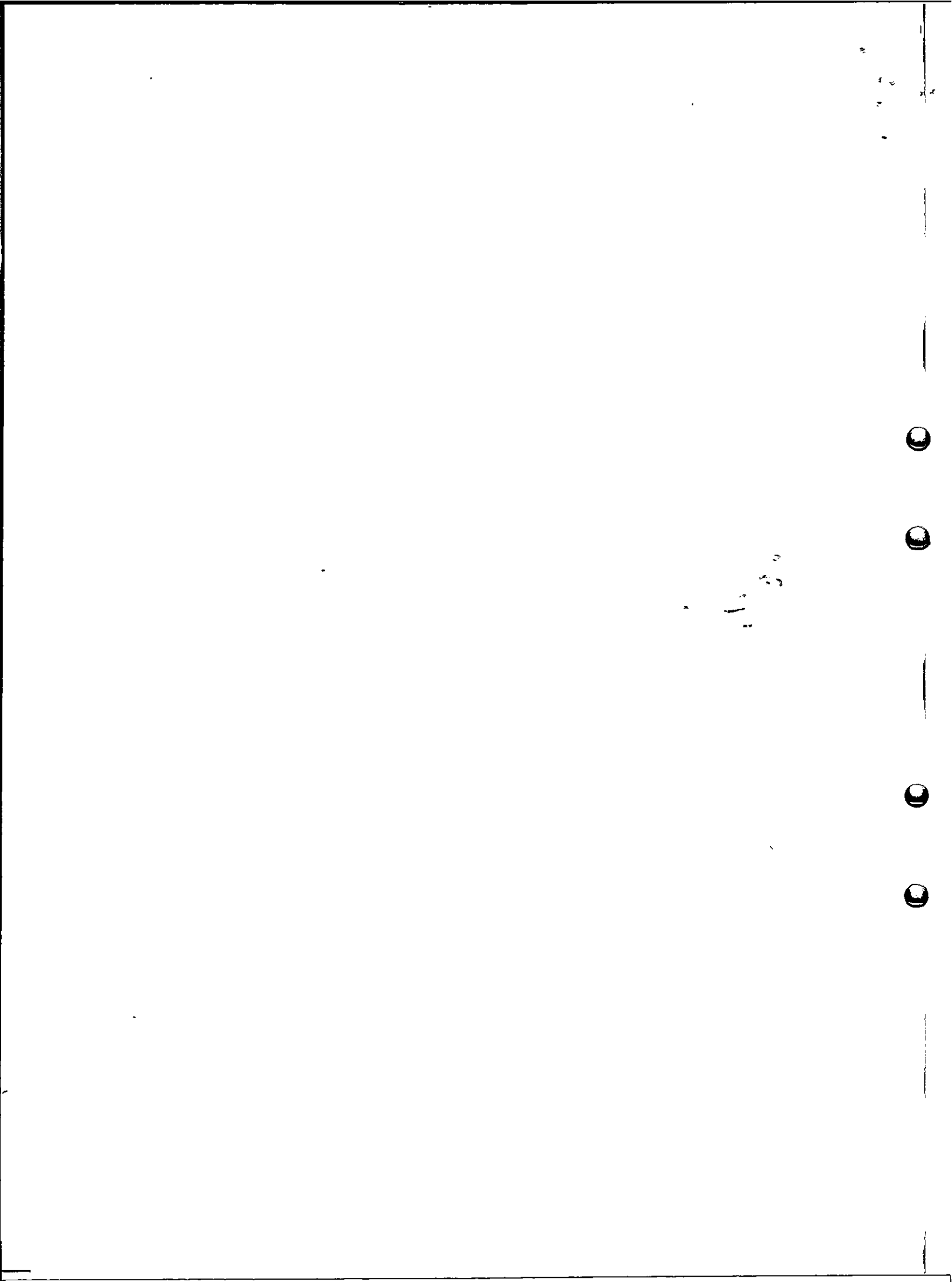
- Ensure patients use their prescribed eye glasses if any, in the hospital
- Use chairs with arm rests
- Use safety straps on stretchers and wheelchairs while transporting patients

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





BRADEN 'Q' SCALE

Date : 23/6 24/6 24/6 24/6
 Time : 8pm 8Am E2 N1

Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	7	7	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: Unresponsive to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4

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

TOTAL SCORE	27	28	28	28
Evaluator's Name	AL	Ri	10	ref

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



PAIN ASSESSMENT FORM

Date	Time	(0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
23/6/26	11pm	0/10	Abdom	<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	
24/6/26	2Am	0/10	Abdom	<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	
24/6/26	4Am	1/10	Abdom	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input checked="" 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	Breathe Breathe	
24/6/26	6Am	1/10	Abdom	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input checked="" 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	Breathe Breathe	
24/6/26	7Am	0/10	Abdom	<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	
24/6/26	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	
24/6/26	2pm	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	
24/6/26	6pm	0/10	NA	<input type="checkbox"/> Continuous <input checked="" 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 checked="" type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	
24/6/26	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	
				<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		

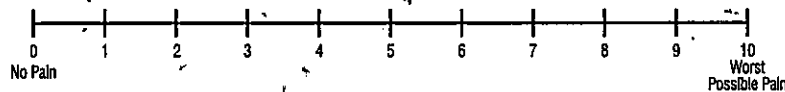
Re-assessment Frequency:
 1. Every eight hours for all hospitalized patients.
 2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 a) At least every 2 hours for the first 24 hours b) Then every 4 hours.
 c) Prior to pain pain-relieving intervention. d) Within 30 - 60 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, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years





URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 24/6/28

Date of Removal: 24/6/28 @ 12 PM

Parameters	Date	Shift Time							
			<u>24/6/28</u> <u>7 AM</u>						
Need for the Catheter	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the Collection bag below the level of bladder	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Check the Tube for Obstruction (Free of Kinking)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is Catheter dated as policy	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Collecting bag is been emptied regularly?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Maintenance of closed system for the catheter	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dressing clean and dry?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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 checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Performance of Perineal Care	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Onset of New Fever	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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	<u>DA</u>								
Signature of the Nurse	<u>DA</u>			<u>removed.</u>					

24/6/28 @
12 PM

20



20
21
22

20
16
4
6

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis: PPROM	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known If Yes Specify:
BACKGROUND	Area: 28/6/26	
	Shift Time	8pm
ASSESSMENT	Medical Condition (Any special condition to be noted):	NA
	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	
ASSESSMENT	Tubes/Drains/Catheter:	NA
	Vital Signs:	
	Temp:	98.6 98.6 98F 97.6F 98.5
	Res:	20 20 20b/min 20b/min
	SpO ₂ :	100 99% 99% 99%
	Pulse:	86 85 82b/min 83b/min
	BP:	129/84 110/75 112/79 113/69
Recommendations	Safety Needs:	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
	Others Specify:	- NA - -
	Special Diet:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Other Special Orders / Medications:		- NA - -
Post Operative Procedure Special Orders:		- NA FBS, PLBS T/M -
Handed Over By Name :		Aini Sujatha Supriya Madhvi
Signature :		[Signatures]
Date:		24/6/26 24/6/26 24/6/26 25/6/26
Time:		8AM 2pm 8pm 8AM
Taken Over By Name :		Anusha Supriya Madhvi
Signature :		[Signatures]
Date:		24/6/26 24/6/26 24/6/26
Time:		8AM 2pm 8pm

Patient Sticker



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

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

PARTOGRAPH

LABOUR

Labour: Spont. IOL-PGE 1 E2 Others

Indications for IOL-Accel: None Oxytocin

Memb. Rapture Type: SRM PROM ARM

Presentation: Vertex Breech Others

INTRA PARTUM COMPLICATION

Maternal: None Pyrexia HTN Others

Liquor: Adequate Oligo Poly Clear

Blood Meconium Cord:

Shoulder Dystocia: Yes No

DELIVERY DETAILS

Anesthesia: None Epidural

Non-epi: Local Spinal General

Del. Type: SVD Asst. Breech Twins

AVD: Outlet Low Forceps Ventouse
 Trails of Forceps

Indications:

Application, Locking & Traction:

Duration of Instrumentation:

No. of Pulls:

Catherised: Yes No

Type: Fileys Plain

Perineum: Intact Episiotomy Tear

Suture Material Used: *Rapid Vicryl No-1.*

STAGE III

Placenta: Normal Abnormal RP Clots

CCT Retained MRP

PPH: Atomic Traumatic None

Lacerations:

Cervical: *Noemat*

Perineal: *episiotomy sutured.*

Others:

Prophylaxis: Synocinon Prostin

Blood Loss:

Blood Transfusion:

Other Details (if any):

Rctal Examination: *Intact - sphincter*

DURATION OF LABOUR

1st Stage: *11 1/2 hr.*

2nd Stage: *14 min*

3rd Stage: *5 min*

Duration of Active Pushing: *10 min*

No. of VES: *2-3*

BABY DETAILS

Gender: *Female*

Weight: *2.540 kg*

APGAR: *8, 9*

Date and Time of Delivery: *24/6/26. 10:14 AM.*

LW Doctor: *Dr. Priyadaeshini, Dr. Dina*

LW Sister: *Kasthuri*

PARTOGRAPH

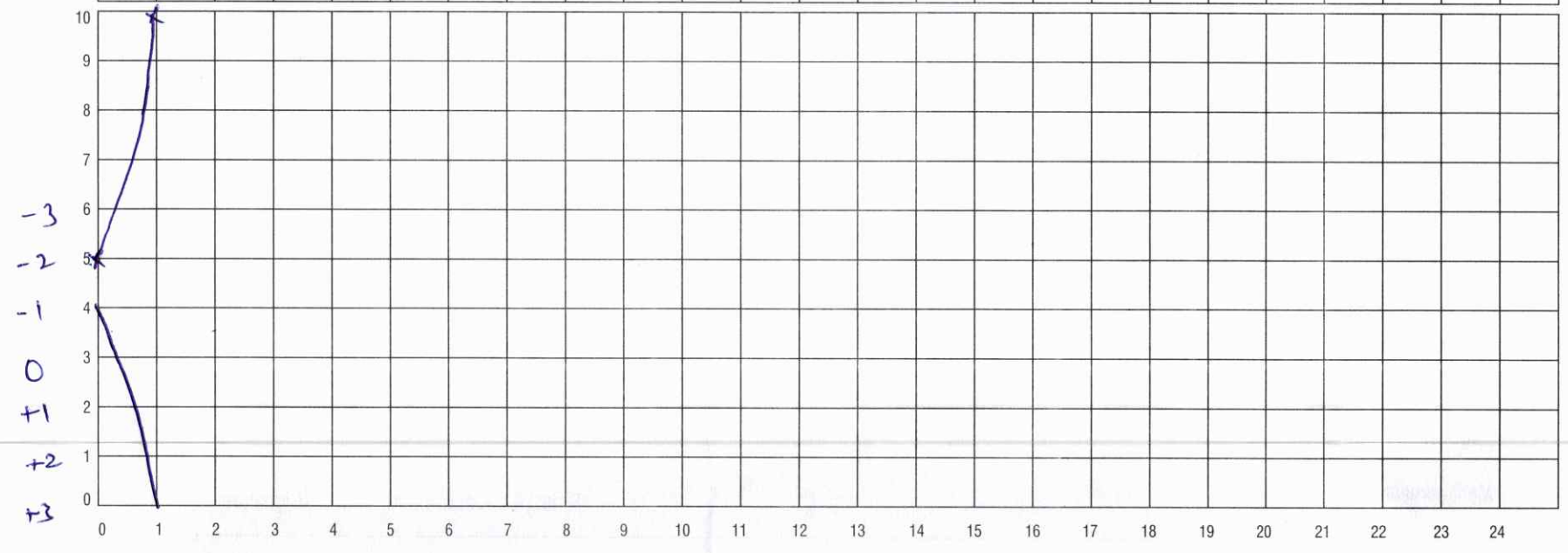
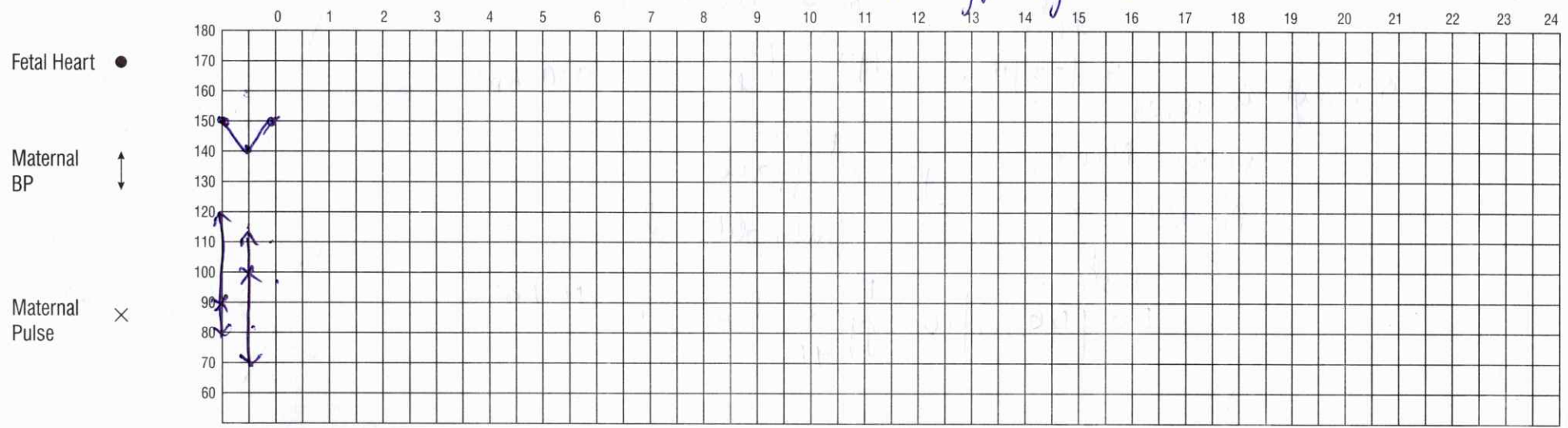
Name: Mrs Keesthi

Obstetrics Formula: Primi

Blood Group Type: O+ve

Memb. Ruptured: SROM PROM ARM

Risk Factors: CDM, Hypothyroid



9:30 AM

Record of Labor:

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

vitals - Normal
P/A ut = 36wk
cephalic
ANS ⊕
3c/25/10.

P/V effaced
os - 4-5cm M ⊖
PR - 1 PA A

Time: 9:30 AM

Signature:

[Signature]
Dr. Piyada, Sh

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

vitals - Normal
P/A ut = 36wk
cephalic
ANS ⊕
3c/45 sec/10.

P/V fully effaced
fully dilated
M ⊖ PR - 1 PA A

Time: 10 AM

Signature:

[Signature]
Dr. Piyada, Sh

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

Time:

Signature:

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

Time:

Signature:

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

Time:

Signature:



OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 23/6/26 Time of Arrival: 10:45 pm Time Seen by Nurse: 10:50 pm

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: 99.6 Pulse: 88 RR: 20 SpO₂: 100 BP: 110/83 Weight:

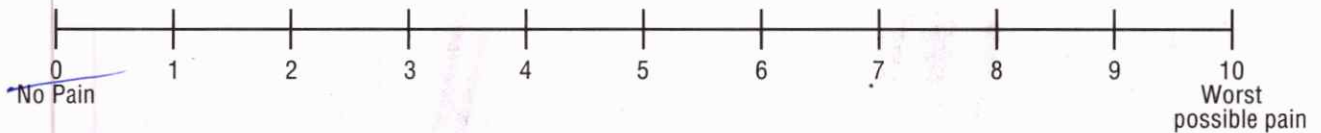
4) Gestational Criteria:

Gravida:	G <u> </u>	P <u> </u>	L <u> </u>	A <u> </u>
----------	-------------	-------------	-------------	-------------

LMP: 10/10/25 EDD: 17/7/26 Gestational Age: 36 + 4 weeks

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

5) Pain Screening: Numerical Pain Scale (NPS)



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

6) Past History:

- a) Surgeries: Laparoscopic Appendectomy 2008
- b) Medical:



7) Allergy: Yes No, If Yes :

8) Current Medications: Prenatal Vitamin None Others:

9) Prenatal Medical History:

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

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

Time seen by Doctor: 11:45 AM

Nurse Name : *Albi* Nurse Signature: *Albi*

Date: 28/6/20 Time: 11:00 PM



OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 22/6/28

Baseline Information:

Admission From: ER OPD Admission Desk Others, specify

Primary Language: Telugu English Hindi Others, specify

Do you require an interpreter? Yes No if Yes specify

Source of Information: Patient Family Others, specify

Allergies: Yes No Medications Blood Transfusion Food Other:

If yes, identify

Chief Complaints: Doctor Notified on Admission: Yes No
 PPROM Name of the Doctor: Dr Manisha
 Time Notified: 11:45 PM

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

Past Medical History	Past Surgical History	Previous Hospital Admission
—	—	—

<p>Gynecology Assessment: <input type="checkbox"/> Not Applicable</p> <p>Menstrual History: <u>Regular</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>Gynecology Surgical History:</p> <p>Caesarean Section: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes</p> <p>Cervical Cerclage: <input type="checkbox"/> No <input checked="" 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>Gynecological History:</p> <p>Contraceptives: <input type="checkbox"/> No <input checked="" 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>Infertility: <input type="checkbox"/> No <input checked="" 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: ROA

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: 97.00 HR: 87 RR: 20
 BP: 110/83 Weight: 69.90 Height: 15 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 0 (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore: Yes No Score 2/5 (complete the Braden Q Sheet)

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

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING: No Abnormality Detected

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

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

Inform consultant for positive criteria

SOCIAL SCREENING:

1. **Marital Status:** Single Married Divorced Widow

2. **Special Habits:** **Smoker:** Yes No **Alcohol Abuse:** Yes No **Drug Abuse:** Yes No

Social History: Lives With family members

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: Mrs. Keerthi Mayi

Orientation not given Reason:

Nurse Signature: Alex

Nurse Name: Alex

Date & Time: 23/6/2020 11:00 pm



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: NO

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

9. Additional notes:

Continuity of Care:

Date: 24/6/26

→ ASSESS the pt condition

→ vital are checked & recorded

→ ILO chart maintained

→ 2nd hault DBF given

Handover given by Lizalha

Handover taken by

Signature Li

Signature

Date & Time: 24/6/26 @ 2pm

Date & Time:

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



Name: Mrs. KEERTHI MAYI Age: 30 yrs Sex: female UHID.No: HNH-0012125
 Date: 24/06/2025 Time: 6:20 AM Proposed Operation: EPIDURAL ANALGESIA
 Diagnosis: PRIMI, 36⁺ wks, PPRom, GDM on Diet
 B.P/CRT: 110/80 H.R: 92/min Weight: 68 kgs ASA Physical Status: 1 2 3 4 5

11/6/25
 12-1
 34.6
 7390
 2-00

Laboratory Data:

Glucose: Protein: HIV: X-Ray:
 Urea: Alb: HBS Ag: NR ECG:
 Creat: Total Bill: HCV: 2D Echo:
 Na: Dir. Bill: Blood group: A+ve Stress/Angio:
 K: LDH: T3 Other:
 Ca++: Alk phos: T4
 Mg++: Amylase: TSH
 Cl-: SGOT/SGPT:

Allergies: NEDA

Medical History: CVS:

RESP: Diabetes: GDM on Diet
 CNS: NAD
 Renal:

Hepatic / GE:

Physical Activity:

Others: Hypothyroidism in pregnancy on 12.5mcg Thyronorm

Past Anaesthetic History: LAP APPENDICECTOMY in 2008

Physical Exam: Mod. Built & Nourished.

Airway: MP 1 2 3 4 Mouth Opening: Mentohyoid Distance: Neck: Teeth:

Lungs: S/L R/L, clear

Heart: S1 S2

CNS: NAD

Pregnant: Yes No NA Venous Access Site: Peripheral Spine Exam for regional:

Anaesthetic Plan: MAC REGIONAL GA-ETT LMA

Peri-Operative Plan Explained to the Patient: Yes No

CURRENT MEDICATIONS	DOSAGE
Thyronorm	12.5 mcg OD

Pre-Operative Instructions:

- DVT Prophylaxis :
- NIL ORAL
 ↳ Water / ORS 2 Hours
 ↳ Others 6 Hours
- Informed Consent: Standard High Risk
- Post Operative Pain Management: Discussed with Patient
- Other Instructions:

Signature: [Signature] Name: Dr. Saraviv

HNH-00012125 IP26-00006630
 Mrs KEERTHI MAYI BHANURI
 03-05-1996 30 Y 1 M 21 D (F)
 Dr. P PRIYADARSHINI



Department of Anesthesiology

EPIDURAL ANALGESIA RECORD

Date: 24/6/20 Time: 6:45 AM Procedure done by Dr. SAIRAS-V

CSE / Spinal / Epidural Position: SITTING Space: L3-L4 Technique (LOR/LOS) LOS

Depth: 3 1/2 cms Catheter at Skin: 9 cms Attempts: 01

Parasthesia: Yes/No if yes details: -

Solution Composition: 0.1% Bupivacaine + 2mcg/ml Fentanyl

- Any other issues:
- a)
 - b)

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level		Maternal		FHR	Comments
			Left	Right	BP	Pulse		
<u>6:50 AM</u>		<u>8 ml</u>			<u>110/80</u>	<u>92</u>	<u>144</u>	
<u>7:00 AM</u>	<u>6 ml/hr</u>				<u>110/70</u>	<u>76</u>	<u>146</u>	<u>pt comfortable</u>

Delivery Details: Time: 10:14 APGAR: 9 10 (SVD) Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected: tip intact

Patient Satisfaction: good

Discharge / Shifting ordered by
 Doctor Signature: [Signature]
 Doctor Name: Pranav

Date and Time:

CONSENT FOR SPECIAL PROCEDURES

Patient Name : Mrs. KEERTHI MAYI BHANUR Gender: Male Female
UHID No : HNH-0012125 Department : Date : 24/06/2026

I Mrs. KEERTHI MAYI BHANUR S/D/W/O.....

Here by give consent for procedure of : EPIDURAL LABOR ANALGESIA

For my patient, Named : Mrs. KEERTHI MAYI BHANUR

The doctors have clearly explained to me that the procedure has following possible complications:
UNILATERAL BLOCK, PATEMY BLOCK,
POST DURAL PUNCTURE HEMORRAGE

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :
.....
.....

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure : Dr. SAIRAS. ✓

Patient Attendant :
Signature : K. Vinod
Name : K. Vinod Kumar
Relationship with Patient : Spouse
Date & Time : 24/6/26 @ 6:30 AM

Witness :
Signature : Keerthi
Name : Keerthi Mayi
Date & Time : 24/6/26 6:30 AM.

Doctor (who is taking the consent) :
Signature : SV
Name : Dr. SAIRAS. ✓
Date & Time : 24/06/2026 6:30 AM.

ప్రత్యేక విధానాలకు సమ్మతి



రోగి పేరు లింగం పురుషుడు స్త్రీ

యు.హెచ్.ఐ.డి విభాగం తేదీ

నేను S/D/W/O

ఇక్కడ ప్రక్రియ కోసం సమ్మతి ఇవ్వడం ద్వారా

నా రోగికి, పేరు :

ఈ ప్రక్రియ కోసం ప్రత్యామ్నాయాలు, నష్టాలు మరియు ప్రయోజనాలు గురించి డాక్టర్ నాకు తెలిసిన భాషలో వివరించా

.....

.....

.....

నాకు తెలిసిన భాషలో పైన పేర్కొన్న విషయాన్ని నేను అర్థం చేసుకున్నాను మరియు ప్రక్రియకు సమ్మతిని తెలియజేస్తున్నాను.

ప్రక్రియ చేస్తున్న వైద్యుని పేరు :

సహాయకుడు(అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము

INDUCTION OF LABOR CONSENT

Name: Mrs Keerthi Bhanuri Age: 30y Gender: Male Female

UHID.No : TNH - 00012/26 Date: 23/June/2020

You are scheduled for an induction of labor on 23/June/2020 (date) at 30th (weeks of gestation).

The reason for your induction is SRom

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

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

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

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

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

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

Patient

Signature: B. Keerthi

Name: Mrs Keerthi Bhanuri

Date & Time: 23/06/2020 @ 11:45pm

Patient Attendant:

Signature: K. Vinod

Name: K. Vinod Kumar

Relationship with Patient: Husband

Date & Time: 23/06/2020 @ 11:45pm

Doctor:

Signature: M

Name: Dr Manoj

Date & Time: 23/06/2020 @ 11:45pm

Witness

Signature: Madhya

Name: Madhura Mitej

Date & Time: 23/6/20 @ 11:45pm

INFORMED CONSENT FOR VAGINAL BIRTH

Patient Name : Mrs. Keerthi Mayi Bhanuni UHID No : 4117-00012125

Gender: Male Female Date : 23/6/2020 Time :

I hereby authorized the performance of the following procedure:

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

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

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

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

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

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

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

Name of the Doctor performing the procedure:

Consentee :

Signature : B. Keerthi

Name : Mrs B. Keerthi Bhanuni

Date & Time : 23/06/2020 @ 11:45pm

Patient Attendant :

Signature : K. Vinod

Name : K. Vinod Kumar

Relationship with Patient : Husband

Date & Time : 23/06/2020 @ 11:45pm

Witness :

Signature : Madhu

Name : Madhusmita

Date & Time : 23/6/20 @ 11:45pm

Doctor (who is taking the consent) :

Signature : M. Mamshe

Name : Dr Mamshe

Date & Time : 23/June/2020 @ 11:45pm

26-0000207935

NARCOTIC PRESCRIPTION FORM (PATIENT COPY)

Patient Name: MRS. Keerthi Mayji Bhanuni Age: 30y Gender: Female
 UHID No: HNH-00012125 IP No: 26-00006630 Date: 24/6/26 Time: 6:30 AM
 Diagnosis: NVD LDR

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/ML	<u>100 MCG</u>	<u>1 Amples</u>
2.	Morphine Sulphate Inj. 15mg/ML		
3.	Remifentanil Hydrochloride Inj. 2MG		
4.	Remifentanil Hydrochloride inj. 1MG		

Doctor Name: Dr. Samir Doctor Registration No: 67529
 Signature: [Signature]

NARCOTIC DISPENSING FORM APPENDIX 4 – FORM NO. 3E

(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: 26-00006630 Date: 24/6/26
 Aadhaar No. of the Patient (Optional):

Name :	Remarks
<u>MRS. Keerthi Mayji Bhanuni</u>	<u>Uppal Hyderabad Telangana INDIA 500039</u>
2. Complete postal address (with contact number, if any)	
3. Brief description of the illness	<u>NA</u>
4. Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	<u>NA</u>
5. Details of essential Narcotic drug dispensed	

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
<u>24/6</u>	<u>Fentanyl</u>	<u>1</u>	<u>[Signature]</u>	

Dispensed by (Name & ID No.): Sania (018442) Signature: Sania
 Received by (Name & ID No.): Madhumita @ 015724 Signature: Madhu

Time:

INH-00012125 IP26-00006630

Mrs KEERTHI MAYI BHANURI
13-05-1996 30 Y 1 M 21 D (F)
Dr. P PRIYADARSHINI



302



NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 24/6/26 Time: 5 PM

Origin: Indian Height: 155cms Weight: 67-90kg BMI: ~26 kg/m²
 ~28 kg/m²
 ~30 kg/m²

Food Allergies: NO

Diagnosis: NVD

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

Diet Advised:

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

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

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

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

Patient's / Attendant's

Signature: [Signature]

Name: Keerthi

Date & Time: 24/6/26 ; 5 PM

Dietician's

Signature: [Signature]

Name: Sathwika G

Date & Time: 24/6/26 ; 5 PM



302

CROSS CONSULTATION FORM

Doctor Name : Dr. Priyadarshini Date : 24/6/26 Time : 5 PM

Diagnosis : NVD

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
- colostrum seen
- suck & latch observed
- make baby suck 15-20 mins on each side every 2nd hrs
- stimulate baby continuously while feeding

Consultant :

Name : Sathwika . G Signature : Sathwika . G Date & Time : 24/6/26 ; 6 PM