Dr. Bdithaarika

ESTIMATION SLIP

1575

Date: 6/6/26 UHID / IP No.: HNH -00013092 Sl No.

Name of Patient: Mrs. P.t.v. Lakshmi Age: 40Y Gender: F

Father's / Husband's Name: Mr. Madhu Sudhan Corporate / Occupation:

Address: Phone: 9700983515 Email:

Procedure / Plan: Hysteroscopic Polypectomy EDD/Dos: June-26

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

TARIFF INFORMATION:

Particulars	Package Amounts (Rs.)	
Room Category	Normal Delivery	LSCS
Multi Shared Ward		
Shared Ward	Hysteroscopi Polypectomy	
Twin Shared Ward		
Private Room	65L → Including Everything	
Super Deluxe Room		
Suite Room		
Package includes (Package starts from the time of admission)	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee and Labour Ward Charges	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee Anesthetist's Fees and OT Charges
	Length of Stay for:	Length of Stay for:
	Pharmacy up to	Pharmacy up to
	Investigations up to	Investigations up to
Others		

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

Initial Minimum Deposit: 50,000/- Admission

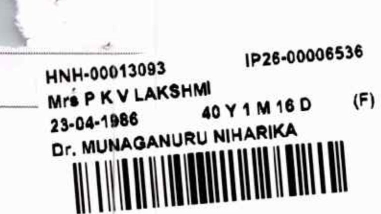
REMARKS:

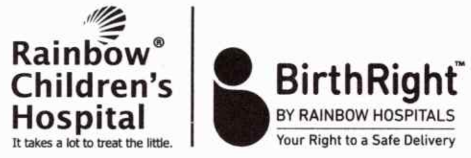
1. Room eligibility is purely subject to TPA approval and the Package / Room Tariff starts from the time of admission. The estimated amount may Change according to duration of stay, medical condition, investigations, pharmacy and any other procedure.
2. Proportionate difference of bill amount is applicable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

DECLARATION

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

Signature of the Client	Signatory Relationship: Self	Signature of the financial Counselor





SURGERY DETAILS

Date : 08-06-26

Patient Name: Mrs. P.K.V Lakshmi Date of Birth: 23/4/1986. Age: 40yrs

Gender: Female Ward : OT - I UHID No.: ~~HNH~~ -00013093

Date of Surgery: 08-06-26 ☑ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Hysteroscopic Polypectomy.

Time in : 9:30 Am Time Out : 10:15 Am.

		NAME	AMOUNT
1.	Surgeon	: Dr. Niharika	
2.	Anaesthetist	: Dr. Veenitha	
3.	Assistant Surgeon	:	
4.	OT Technician	: Saichandu	
5.	Circulating Nurse	: Pooja	
6.	Assistant Nurse	: Sushila.	

Mrs P K V LAKSHMI (40 Y 1 M 16 D/ F)
ENDOMETRIA
INV04329
HN26009520ENDO
HNH-00013093

Special Equipment: ☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others Hysteroscopy Instrument charges (26-0000205212)

Signature of the Surgeon: Niharika Signature of Circulating Nurse: Pooja

Order No: 26-000020520 4 Order by: Sushila 8/6/26 @ 10:56Am.

HNH-00013093 IP26-00006536
Mrs P K V LAKSHMI
23-04-1986 40 Y 1 M 16 D (F)
Dr. MUNAGANURU NIHARIKA

hysteroscopy
polypectomy

CONSUMABLES OF OT

Circulating staff : .... Technician : Sai Chandra Date : 8/6/26 Time : ....

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			~~Major~~ Pack General	✓		Inj Vit.K		
~~LMA~~ I-gel (3)		01	Sutures			Cord Clamp		
ECG leads : (A) / P / N		03				Suction Catheter		
HME filter : A / P / N						Feeding Tube		
Syringes : 10 cc		04				Vaccum Suction Set		
05 cc		04	Gloves 6½ S.G	1		Surgical Gloves		
02 cc		04	Encore 6½	✓		Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade			Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL		02	Cautery pencil					
NS : 10ml / 100ml / 500ml / (1000ml)		02	Koochies					
Inj Midaz		01	Ointments					
O2 mask (A)		01	Suction Catheter					
Fentanyl		01	Cap, Mask	10+10				
Morphine			Gauze Pack 7.5x7.5	2				
Ketamine			Mop Pack	4				
Propofol		03	Steristrip					
Rocuronium			Underpad	1				
Glycopyrolate		01	Draw sheet					
Myopyrolate			Abgel					
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
Nasal Airway 26		01	~~Tegaderm~~ T.U.R.P Set	1				
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg		01	Vaccum Suction set					
Justin : 12.5 mg / 25mg / (100mg)		01	Plastic Bed Sheet	4				
Tab. Misoprost : 200mg			Betadine Solution	4				
Vaccum Suction		01	Microshield	2				
Inj PCM		01	Cotton Balls	4				
			Latex Gloves	20				
			Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 26-000020521 / 1 5210 Ordered by : Archana 8/6/26 @ 11:33 Am

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

Rainbow Childrens Hospital-Himayatnagar

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

ELECTRONIC MEDICINE PRESCRIPTION

MRN	: HNH-00013093	**Name**	: Mrs P K V LAKSHMI
Age / Sex	: 40 Y 1 M 16 D / Female	**Doctor**	: MUNAGANURU NIHARIKA
Adm/Reg Date/Time	: 08/06/2026 08:31	**Payor**	: SELFPAY
Order Date	: 08/06/2026 11:15	**Ordernumber**	: 26-0000205211
Visit ID	: IP26-00006536	**Ward/Bed No**	: 4F -OT / LDR-416
Patient Address	: 3-1-362 nimaboliadda, Kachiguda, Hyderabad, Telangana, INDIA, 500027		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	POVINANZ SOLUTION 10% 100 ML		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
2	SUPRIDOL SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
3	E.C.G ELECTRODES (ADULT)	ELECTRODES ADULT	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
4	NITRILE EXAMINATION GLOVES P F- MEDIUM	NITRILE GLOVES M	1 Nos	/ Once Daily	10 Days		10 Nos	Dispensed
5	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	Oral / Once Daily	1 Days		4 Nos	Dispensed
6	FACE MASK 3 LAYER - ELASTIC	FACE MASK 3 LAYER	1 Nos	/ Once Daily	10 Days		10 Nos	Dispensed
7	SURGEON CAP(FEMALE)	FEMALE CAP	1 Cap	/ Once Daily	10 Days		10 Cap	Dispensed
8	THEMIPYRRNOM 0.2MG INJ		1 Nos	Injection / 1-2 TIMES A DAY	1 Days		1 Nos	Dispensed
9	DSYRINGE 5ML.(NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
10	GAUZE 7.5X7.5 12 PLY (5 NOS)	GAUZE 7.5X7.5 12 PLY 5 NOS	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
11	NS 100ML ACCULIFE - EH		1 mL	Injection / 1-2 TIMES A DAY	1 Days		2 mL	Dispensed

MUNAGANURU NIHARIKA

Reg No : APMC/FMR/74828

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

Note

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

*** Do not refill medicines.**

Rainbow Childrens Hospital-Himayatnagar

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

ELECTRONIC MEDICINE PRESCRIPTION

MRN	: HNH-00013093	Name	: Mrs P K V LAKSHMI
Age / Sex	: 40 Y 1 M 16 D / Female	Doctor	: MUNAGANURU NIHARIKA
Adm/Reg Date/Time	: 08/06/2026 08:31	Payor	: SELFPAY
Order Date	: 08/06/2026 11:15	Ordernumber	: 26-0000205210
Visit ID	: IP26-00006536	Ward/Bed No	: 4F -OT / LDR-416
Patient Address	: 3-1-362 nimaboliadda, Kachiguda, Hyderabad, Telangana, INDIA, 500027		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	NASOPHARYNGEAL TUBES 26	NASOPHARYNGEAL TUBE26	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
2	RL 500 ML CLOSED SYSTEM	RINGER LACTATE 500ML CLOSED	1 Bottle	/ Once Daily	2 Days		2 Bottle	Dispensed
3	IRRIGATTO(T.U.R SET)	IRRIGATTO(T.U.R SET)	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
4	GENERAL SURGICAL KIT (MEDITAKE)	GENERAL SURGICAL KIT	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
5	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
6	BACTOPREP SOLUTIONS 100 ML	CHLORHEXIDINE GLUCONATE2% &ALCOHOL80% 500	1 mL	/ Once Daily	2 Days		2 Nos	Dispensed
7	MEZOLAM INJ 5 MG 5 ML		1 Vial	Injection / Once Daily	1 Days		1 Vial	Dispensed
8	COTTON BALLS 2 GM 5 NOS	COTTON BALLS 2G- 5 NOS	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
9	JUSTIN SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
10	RELIPARA(PARACETAMOL) 1000MG 100ML BOTTLE		1 Nos	Injection / Once Daily	1 Days		1 Nos	Dispensed
11	MCT-ROF 100MG 10ML		1 Nos	Injection / Once Daily	1 Days		3 Nos	Dispensed
12	Encore Microptic gloves-6.5		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
13	OxygenMask With Tubing - Adult ROMSONS-FC		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
14	VACCUME SUCTION SET	VACCUME SUCTION SET	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
15	DSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed

MUNAGANURU NIHARIKA

Reg No : APMC/FMR/74828

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Note

* This prescription is valid only for specified duration.

* Do not refill medicines.

Printed Date/Time : 08/06/2026 12:25 Printed By : SUNKARI SANGEETHA

Name	Mrs P K V LAKSHMI	UHID	HNH-00013093
Father/Guardian	Mr T MADHU SUDHAN	Age/Gender	40 Y 1 M 16 D/ Female
Address	3-1-362 nimaboliadda, Kachiguda, Hyderabad, Telangana, INDIA, 500027		
IP No	IP26-00006536	Admission Date	08-06-2026
Ref Doctor	Self.		
Discharge Date	08.06.2026		

DISCHARGE SUMMARY

Consultants :
Dr. MUNAGANURU NIHARIKA
MBBS/MS/Mch
APMC/FMR/74828

Diagnosis: PRIMARY INFERTILITY WITH POR

HYSTEROSCOPIC POLYPECTOMY DONE ON 08.06.2026

History: She has been admitted for hysteroscopic polypectomy.She is a case of Primary infertility with POR. USG 12.01.2026 uterus-AV, M/S. 8.4x3.9x3.9 ET-6.82 hyperechoic mass of1.14x0.98cm arising from anterior uterine wall with broad base s/o polyps.

Menstrual History:- AOM:15 years
LMP- 25.05.2026
Previous cycles: Regular / 28-30 days cycles/4 days flow/clots-/dysm-

Obstetric History: Nil
Medical History: Nil
Surgical History: Lap appendicitis DONE ON 2009
Allergies: Nil
Family History: Husband-DM

Investigations: Enclosed.
Blood group: "B" Positive

Surgery Notes:
Operation performed:
HYSTEROSCOPIC POLYPECTOMY UNDER GENERAL ANAESTHESIA

HIMAYATHNAGAR Emergency: 040 - 48873000 BANJARA HILLS (JCI, NABH & NABL Accredited) Emergency: 040 - 4466 5555, 91009 25516 HYDERNAGAR (NABH Accredited) Emergency: 040 - 4246 2300 KONDAPUR OUTPATIENT CLINIC (JCI Accredited-IVF) Emergency: 040 - 4246 2100 SECUNDERABAD (NABH Accredited) Emergency: 040 - 4246 2200 KONDAPUR Emergency: 040 - 4246 2400 L B NAGAR (NABH Accredited) Emergency: 040 - 7111 1333 NANAKRAMGUDA Emergency: 040-69113233
1800 2122 www.rainbowhospitals.in

Name	Mrs P K V LAKSHMI	UHID	HNH-00013093
IP No	IP26-00006536	Admission Date	08-06-2026

Indication: ENDOMETRICAL POLYPECTOMY

Operative findings:

- Cervix normal.
- Canal normal.
- Cavity: A small broad based polyp seen on the right anterior lateral wall of uterus. Polyp cut with scissors
- Cavity size adequate
- Bilateral Osita seen
- Biopsy sending for HPE

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

Advice:

1. Tab. Augmentin duo 650mg twice daily till 12.06.2026(9am - 9pm) after food.
2. Tab. Hifenac -P twice daily till 10.06.2026 (7am-3pm-10pm) after food.
3. Tab. Folvite 5 mg once daily
4. Tab. Pantodac 40 mg (Pantoprazole 40mg) once daily (7am) before food till 12.06.2026
5. Tab. Regesterone 10mg twice daily till 14.06.2026

Review consultation with **Dr. MUNAGANURU NIHARIKA**, on **Day 2 of next cycle** Gynec OPD with **HPE report** at Rainbow Children's Hospital with prior appointment **(Review consultation will be charged).**

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, immunization and safe parenting, 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

Name	Mrs P K V LAKSHMI	UHID	HNH-00013093
IP No	IP26-00006536	Admission Date	08-06-2026

website **www.rainbowhospitals.in**

Registrar/Resident/C.M.O

Consultants :
Dr. MUNAGANURU NIHARIKA
MBBS/MS/Mch
APMC/FMR/74828

HNH-00013093 IP26-00006536
Mrs P K V LAKSHMI
23-04-1986 40 Y 1 M 16 D (F)
Dr. MUNAGANURU NIHARIKA

DEFICIENCY CHECK LIST OF CASE SHEET

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

Doc. No. : RCH/ FRM / GENERAL / 126

Signature and Date : [signature] 8/6/26 12:30 pm

(P.T.O)

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU / 2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

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 : IP26-00006536 **Admit Date** : 08-Jun-2026 **Admit Time** : 08:31 AM **UHID** : HNH-00013093

Patient Details :

Patient Name	: Mrs P K V LAKSHMI	**Age**	: 40 Y 1 M 16 D
Guardian	: Mr T MADHU SUDHAN	**DOB**	: 23-04-1986
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 3-1-362 nimaboliadda Kachiguda Hyderabad Telangana INDIA 500027	**Phone No**	: 9700983515/ 9573666526
		E-mail	: madhumudiraj45@gmail.com

Admission Details :

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

Contact Details :

Name	: Mr T MADHU SUDHAN	**Relationship**	: W/O
Contact Address	: 3-1-362 nimaboliadda Kachiguda Hyderabad Telangana INDIA 500027	**Phone No**	: 9700983515

Signature

Doctor Details :

Doctor Name	: Dr. MUNAGANURU NIHARIKA	**Specialisation**	: INFERTILITY
Referral Doctor	: Self.	**Phone No**	:
Co-Consultant	:		

Payment Details :

		Deposit Amount	: 50000.00
Payment Mode	: Cash	**Payor Name**	: SELFPAY

ACTIVITY RECORD FOR BILLING

Name : HNH-00013093 IP26-00006536
Mrs P K V LAKSHMI
23-04-1986 40 Y 1 M 16 D (F)
Dr. MUNAGANURU NIHARIKA

UHID No ________ Consultant: ____________ Dept : __________

Date of A________ Date of Discharge : _________ Time: _________

Room / Bed No : __________ Ward : __________ Suggested Billable bed type : ______________

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
8/6/26	9:20AM	pre & post	(OT)	Ali / Puja
8/6/26	10:20am	OT	pre-post	Puja / Sujatha

Cross Consultation Visit

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

Docu. No. RCH/FRM/GENERAL/145

INVESTIGATIONS

Date	Investigations	Order No.	Signature
8/6/26	CBP	9515	Alu
8/6/26	Biopsy for Histopathology	9520	
		Cross checked done	
		8/6/26.	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
8/6/26	Cardiac monitore	10:20AM	1:00pm	5194	Ali
8/6/26	Infusion pump				
8/6/26	oxygen		11:00AM		
			cross checked done 8/6/26		

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
8/6	IV placement	(1)	205181	[illegible]
8/6/20	PAC	(1)	205180	[illegible]

cross checked done
8/6/20

ANY OTHER INFORMATION

....

....

....

....

....

....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00013093 IP26-00006536
Mrs P K V LAKSHMI
23-04-1986 40 Y 1 M 16 D (F)
Dr. MUNAGANURU NIHARIKA

I.P. A[...] GYNECOLOGY

Date of Admission : 8/6/2026 Time of Admission :

Allergies: ☑ Not know any drug allergies

PRESENTING COMPLAINTS :

Admitted for hysteroscopic polypectomy.

Case of Primary infertility c POR.

USG 12/1/2026 - Ut ≃ AV, m/s 8.4 x 3.9 x 3.9 cm.
ET - 6.8 2 hyperechoic mass of 1.14 x 0.98 cm. arising from anterior uterine wall c broad base. s/o polyps

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : 15 yr.	Parity : Nulliparous
Previous Periods :	Mode of Delivery : —
LMP : 25/5/26	Last Child Birth : —
Contraception :	

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
Nil	Lap appendicitis done on 2009

Docu. No. : RCH /FRM / CLINICAL / 086 (P.T.O)

HNH-00013093 IP26-00006536
Mrs P K V LAKSHMI
23-04-1986 40 Y 1 M 16 D (F)
Dr. MUNAGANURU NIHARIKA

Husband - DM.

MEDICATION HISTORY:

Nil
8/6/2026

INITIAL ASSESSMENT :

Date 8/6/26 Ht. ______ Wt. ______ BMI ______ B.P 110/80 mmHg Pallor ______ CVR ______ Respiratory System ______ Thyroid ______	Breasts Not done Abdominal Examination soft	Local/Speculum Examination Not done Bimanual Pelvic Examination Not done.

PROVISIONAL DIAGNOSIS : Primary Infertility c̄ POR.

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT
B+ve 14/1/26 12.1 / 5.4×10³ / 2.6 HIV HbsAg HCV VDRL } NR.	Hysteroscopic polypectomy - NBM - Informed consent - PAC - send CBP - shift to OT on call.

Name of the Doctor : Dr. M. Niharika

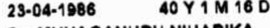
Signature of Doctor ______

Date & Time : 8/6/2026.

HNH-00013093 IP26-00006536
Mrs P K V LAKSHMI
23-04-1986 40 Y 1 M 16 D (F)
Dr. MUNAGANURU NIHARIKA

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/6/2026	c/s/by. Dr. Naveena	
7:00pm		
	O/E GC - fair	Adv
	Afebrile	- Soft diet
	Vitals - stable	- Adequate hydration
	PA: soft, NT	- Ambulation
	L/E: no bleeding	- m/c & P/SOS
	patient can be discharged	

HNH-00013093 IP26-00006536
Mrs P K V LAKSHMI

23-04-1986 40 Y 1 M 16 D (F)
Dr. MUNAGANURU NIHARIKA

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

OPERATION THEATER NOTES

Patient's Name : Mrs. P.K.V Lakshmi Age : 40yrs Gender : Female

UHID.: .... I.P.No. : .... Weight : ....

Surgeon : Dr. M. Niharika	Asst. Surgeon :
Anesthetist :	OT Nurse :

Surgical Procedure : Hysteroscopic Polypectomy

Indications for Surgery : Endometrial Polyp

Date : 08-06-26	Start Time : 9:30Am	End Time : 10:15Am

PRE-OPERATIVE PREPARATION :

OPERATION NOTES:

Cervix - normal
Canal - normal
Cavity - Endometrium - An small broad based polyp seen on the right anterior-lateral wall of uterus.
Polyp cut with scissors.
Cavity size adequate
B/L ostia seen
PB sending for HPE

Niharika

POST - OPERATIVE ORDERS :

- T. Augmentin duo 650mg
  1 — 1 x5d
- T. Hifenac-P
  1 — 1 x2days
- T. Pan 40mg
  1 — x5d
- T. Regestrone 10mg 1 — 1 x 7days.
- T. Folvite 5mg
  1 —

Dr-M-Niharika

Consultant Surgeon's Name

Niharika.

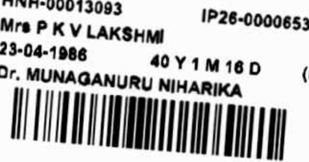
Consultant Surgeon's Signature

Date : ....Time : ....

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Niharika
Asst. Surgeon :
Anaesthetist : Dr. Samir
Scrub Nurse : Sr. Susheela

Patient Name :
UHID No. :
Date : 8/6/26


HNH-00013093 IP26-00006536
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23-04-1986 40 Y 1 M 16 D (F)
Dr. MUNAGANURU NIHARIKA

Gender : F
10.15am

Before Induction of Anaesthesia ➤ ➤

SIGN IN Time: 9.20AM

Patient Has Confirmed

- Identity ☑ Yes ☐ No
- Site ☑ Yes ☐ No
- Procedure ☑ Yes ☐ No
- Consent ☑ Yes ☐ No

Site Marked ☐ Yes ☐ No ☑ NA

Anaesthesia Safety Check Completed ☑ Yes ☐ No

Pulse Oximeter on Patient & Functioning ☑ Yes ☐ No

Does Patient have a:

- Known Allergy? ☐ Yes ☑ No

Difficult Airway / Aspiration Risk?

- Yes, & Equipment / Assistance Available ☐ Yes ☑ No

Risk of > 500ml Blood Loss (7ml/kg In Children)?

- Yes, and Adequate Intravenous Access and Fluids Planned ☐ Yes ☑ No ☐ NA
- Blood Units Reserved ☐ Yes ☑ No ☐ NA

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

Signature : [signature]

Name : DR. M.VINEETHA.

Before Skin Incision ➤ ➤

TIME OUT Time: 9:30am

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

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm

- Correct Patient (Check ID Band) ☑ Yes ☐ No
- Correct Site ☑ Yes ☐ No
- Correct Procedure ☑ Yes ☐ No

Anticipated Critical Events

Surgeon Reviews:

- What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? ☑ Yes ☐ No ☐ NA

Anaesthesia Team Reviews:

Are There Any Patient-specific Concerns? ☐ Yes ☑ No ☐ NA

Nursing Team Reviews:

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

Is Essential Imaging Displayed? ☑ Yes ☐ No ☐ NA

Signature : [signature]

Name :

Before Patient Leaves Operating Room

SIGN OUT Time: 10:20am

Nurse Verbally Confirms with the Team:

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

To Surgeon, Anaesthetist and Nurse:

What are the key concerns for recovery and management of this patient? ☑ Yes ☐ No

Signature : Niharika

Name :

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

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23-04-1986 40 Y 1 M 16 D (F)
Dr. MUNAGANURU NIHARIKA

RESULT SHEET

Date	8/6/26.					
Time						
Hb	12.1					
PCV	34. 3					
RBC	4.22					
WBC	5.44					
N/L						
Platelets	225					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

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

Culture and Sensitivities : ....

....

....

....

Radiology : USG : ....

X-Ray : ....

ECHO : ....

CT : ....

MRI ....

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

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Mrs P K V LAKSHMI
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MEDICATION RECONCILIATION FORM

Drug Allergies: .... ☑ Not known any Drug Allergies

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

Shifting From: .... Shifted to: ....

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Mn

Date & Time : 8/6/26 8:50 AM

Nurse Name & Signature: Afaq Ali

Date & Time : 8/6/26 @ 8:15 AM

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Mrs P K V LAKSHMI
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Dr. MUNAGANURU NIHARIKA

DRUG CHART

Date of Admission: .... Drug Allergies: .... ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

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

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

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

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

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23-04-1986 40 Y 1 M 16 D (F)
Dr. MUNAGANURU NIHARIKA

REGULAR PRESCRIPTIONS

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

DRUG : Inj CEFOTAXIME				Date/Time	8/6
Dose	Route	Frequency	Start Date		
1g	IV	BD	8/6/21		
Name & Signature of the Doctor Starting the Drugs:				10AM	
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

DRUG : TAB. PARACETAMOL				Date/Time
Dose	Route	Frequency	Start Date	
1gm	PO	6 HRLY	08/06	
Name & Signature of the Doctor Starting the Drugs: DR. M VINEETHA				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG : TAB. TRAMADOL				Date/Time
Dose	Route	Frequency	Start Date	
100 mg	PO	8 HRLY	08/06	
Name & Signature of the Doctor Starting the Drugs: DR. M.VINEETHA				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

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

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. MUNAGANURU NIHARIKA

Weight. .... Ward. LDR

...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
8/6/26	9:10 AM	Inj PANTOPRAZOLE	40mg	IV	[signature]	[signature]
8/6/26	9:10AM	Inj METOCLOPROMIDE	10mg	IV	[signature]	Sujatha [signature]
08/06	9.45AM	INJ. PARACETAMOL	1gm	IV	[signature]	[signature]
08/06	10.10 AM	SUPP. DICLOFENAC	100 mg	PR	[signature]	[signature]
08/06	10.10AM	SUPP. TRAMADOL	100 mg	PR	[signature]	[signature]
08/06	9.50AM	INJ TRANEXAMIC ACID	1gm	IV	[signature]	[signature]

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

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Dr. MUNAGANURU NIHARIKA

I.V. FLUIDS CHART

Weight. .... Ward. UDr

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
08/06	9.10 AM	RINGER LACTATE	IV	500 ml/hr	[signature]	[signature]	08/06	[signature]	[signature]
08/06	9.55 AM	RINGER LACTATE	IV	500 ml/hr	[signature]	[signature]	8/6		[signature]
		STOP							

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

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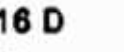
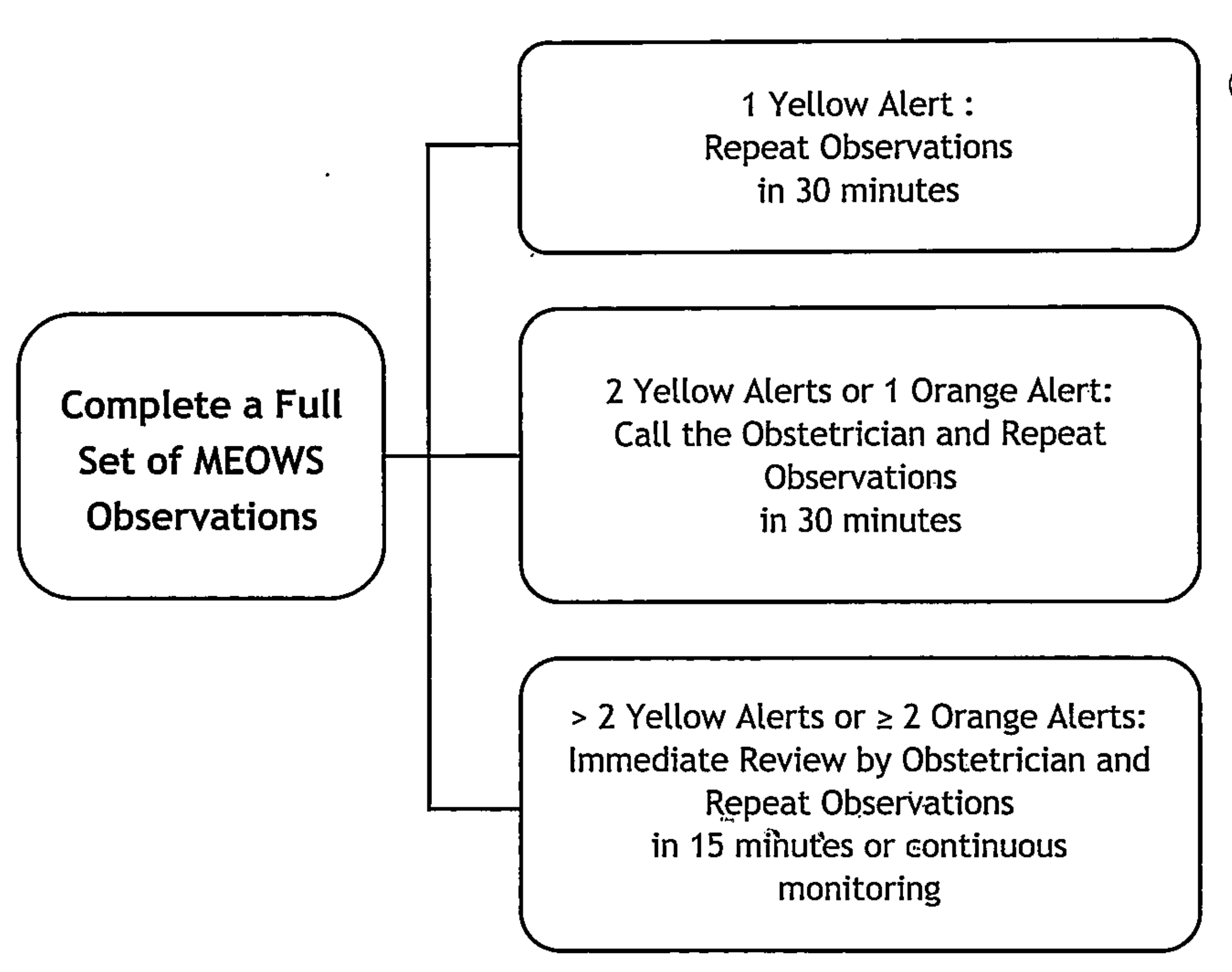


Early Warning Observation Score Chart - Obstetrics

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

	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
8/6/26	Date																								
RESP (write rate in corresp. box)	> 30																								
	21 - 30																								
	11 - 20	20	20	20	20	20																			
	0 - 10																								
Saturations	94 - 100 %	98	99	100	98	96																			
	< 94 %																								
Administered O_2 (L/min.)																									
Temp°c	40																								
	39																								
	38																								
	37																								
	36	36.4/97F			–	97.6																			
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80	84	80		80	81																			
	70																								
	60			64																					
	50																								
	40																								
Systolic Blood Pressure ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110	108	110																						
	100			98	96																				
	90					94																			
	80																								
	70																								
	60																								
	50																								
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70	74	65	64	65	70																			
	60																								
	50																								
	40																								
NEURO RESPONSE [✓]	Alert	–	–		–	–																			
	Voice																								
	Pain																								
	Unresponsive																								
URINE mls / hour	> 30		–		–																				
	< 30																								
Proteinuria	Protein + +																								
	Protein > + +																								
Lochia	Normal		–																						
	Heavy / Foul																								
Liquor	Clear / Pink		–																						
	Green																								
TOTAL YELLOW SCORES		0	0	0	0	0																			
TOTAL ORANGE SCORES		0	0	0	0	0																			
Nurse Initial		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]																			

Obstetrics and Gynaecology Early Warning Signs



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

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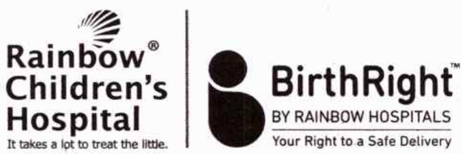

FLUID CHART

Sheet No. : 1

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

		Intake				Output					IV Site Thrombo-phlebitis Score	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		Sign. Nurse
			Mouth	I.V	N.G							
8/6	08:00 am	RL	N	100ml						✓		
	09:00 am	RL	[illegible]	100ml						✓		
	10:00 am	RL	N	100ml							0	
	11:00 am	RL		100ml				0				
	12:00 pm	RL	Sips	100ml						✓		
	01:00 pm	RL		100ml								
Total Intake :		Taken				Total Output :				Passed		
8/6/26	02:00 pm											
	03:00 pm											
	04:00 pm					D/C						
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						

Total 24 hrs. Intake	

Total 24 hrs. Output	

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23-04-1986 40 Y 1 M 16 D (F)
Dr. MUNAGANURU NIHARIKA

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 Thrombo-phlebitis Score	Sign. Nurse
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						

Total 24 hrs. Intake			Total 24 hrs. Output	

Docu. No. : RCH /FRM / CLINICAL / 092

CHECKLIST FOR THROMBOPHLEBITIS

8/6/26.

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

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 : [signature] Name : Anusha

Signature of Ward In Charge :

Signature : [signature] Name : Kasturi

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

HNH-00013093 1P26-00006536
Mrs P K V LAKSHMI
23-04-1986 40 Y 1 M 16 D (F)
Dr. MUNAGANURU NIHARIKA

CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

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

Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time / Score	8/6/26 8Am		
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0	0		
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0			
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0	0		
IV / Heparin Lock or Saline	Yes	20	20		
	No	0	0		
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0			
Mental Status	Forgets limitations	15			
	Oriented to own ability	0	0		
Total Morse Fall Scale Score:			20		
		Signature	[signature]		

Fall Risk Grading

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

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

Docu. No. : RCH /FRM / CLINICAL / 006

HNH-00013093 IP26-00006536
Mrs P K V LAKSHMI
23-04-1986 40 Y 1 M 16 D (F)
Dr. MUNAGANURU NIHARIKA

BRADEN 'Q' SCALE

				Date :		8/6		
				Time :		8Am		
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.		4		
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4		
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4		
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4		
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4		
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.		4		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4		
				TOTAL SCORE		28		
				Evaluator's Name		[signature]		

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

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

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

HNH-00013093 IP26-00006536
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Rainbow® Children's Hospital
It takes a lot to treat the little.

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PAIN ASSESSMENT FORM

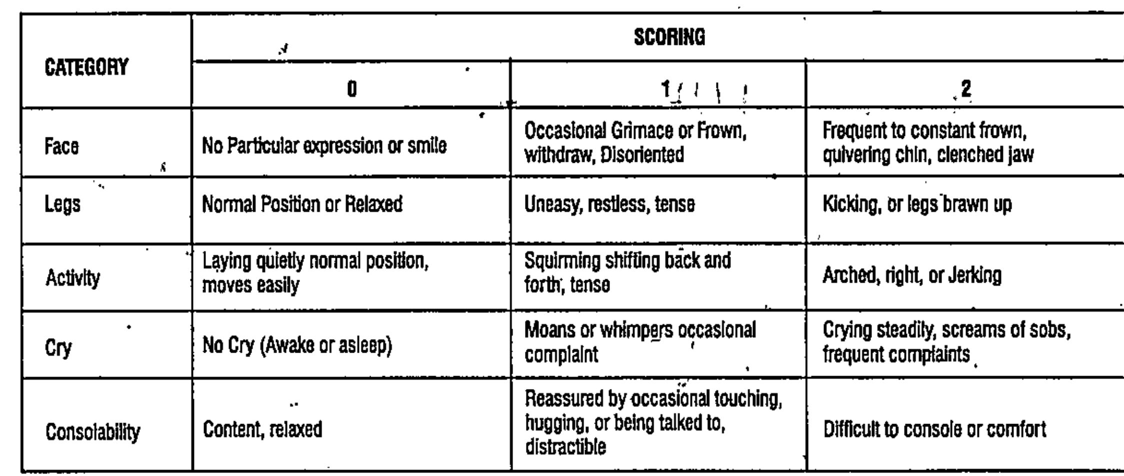
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
8/6	8Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
8/6	10AM	0/10	None	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
8/6/26	1pm	0/10	None	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
		D/c		☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

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

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)



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

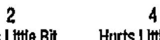
Numerical Pain Scale (Obstetric and Gynecology)

0 No Pain — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 Worst Possible Pain

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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not Irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO_2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO_2 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO_2 less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



0 No Hurt — 2 Hurts Little Bit — 4 Hurts Little More — 6 Even More — 8 Hurts Whole Lot — 10 Hurts Worst

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NURSING SHIFT HAND OVER FORM - WARD

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

SITUATION	Diagnosis: Hysteroscopy polypectomy			Any Infection: ☐ Yes ☐ No ☑ Not Known If Yes Specify:			
BACKGROUND	Area / Shift Time	8/6/26 M6					
	Medical Condition (Any special condition to be noted):	–					
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98°F					
	Res:	20					
	SpO_2:	99%					
	Pulse:	82					
	BP:	116/71					
	Fall Risk Score:	L					
	Pain Score:	–					
Recommendations	Safety Needs:	–					
	Physiotherapy	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	–					
	Special Diet:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	–					
Post Operative Procedure Special Orders:		–					
Handed Over By Name :		Sujata					
Signature :		S					
Date:		8/6					
Time:		2Pm					
Taken Over By Name :		D/k					
Signature :							
Date:							
Time:							

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

Patient Sticker

NURSING SHIFT HAND OVER FORM - WARD

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

<table>
<tr><td>SITUATION</td><td colspan="3">Diagnosis:</td><td colspan="4">Any Infection: ☐ Yes ☐ No ☐ Not Known
If Yes Specify: ....</td></tr>
<tr><td rowspan="2">BACKGROUND</td><td>Area / Shift Time</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Medical Condition
(Any special condition to be noted):</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td rowspan="9">ASSESSMENT</td><td>Allergy:</td><td>☐ Yes ☐ No</td><td>☐ Yes ☐ No</td><td>☐ Yes ☐ No</td><td>☐ Yes ☐ No</td><td>☐ Yes ☐ No</td><td>☐ Yes ☐ No</td></tr>
<tr><td>Tubes/Drains/Catheter:</td><td>☐ Yes ☐ No</td><td>☐ Yes ☐ No</td><td>☐ Yes ☐ No</td><td>☐ Yes ☐ No</td><td>☐ Yes ☐ No</td><td>☐ Yes ☐ No</td></tr>
<tr><td>Vital Signs: Temp:</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Res:</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>SpO_2:</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Pulse:</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
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<tr><td>Fall Risk Score:</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Pain Score:</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td rowspan="5">Recommendations</td><td>Safety Needs:</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Physiotherapy</td><td>☐ Yes ☐ No</td><td>☐ Yes ☐ No</td><td>☐ Yes ☐ No</td><td>☐ Yes ☐ No</td><td>☐ Yes ☐ No</td><td>☐ Yes ☐ No</td></tr>
<tr><td>Others Specify:</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Special Diet:</td><td>☐ Yes ☐ No</td><td>☐ Yes ☐ No</td><td>☐ Yes ☐ No</td><td>☐ Yes ☐ No</td><td>☐ Yes ☐ No</td><td>☐ Yes ☐ No</td></tr>
<tr><td>Other Special Orders / Medications:</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="2">Post Operative Procedure Special Orders:</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="2">Handed Over By Name :</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="2">Signature :</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
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<tr><td colspan="2">Time:</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

Patient Name : P K V lakshmi Gender: ☐ Male ☑ Female Age : 40 yr.

UHID No : HNH-00013093. Date : 8/6/2026

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

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

HYSTEROSCOPY POLYPECTOMY

upon

Mrs P.K.V Lakshmi (Name of the Patient)

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

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

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

excessive bleeding, infection, injury to adjacent organs, Need for blood & blood product transfusion

My signature on this form indicates that

1. I have read and understood the information provided in this form
2. My doctor had adequately explained to me the operation or procedure along with the complications written above, along with the risks, benefits and other information.
3. I have had a chance to ask my surgeon questions.
4. I have received all the information I desire concerning the operation or procedure and
5. I authorize the consent to the performance of the operation or procedure.

Name of the Doctor who is performing the Surgery / Procedure: ....

Consentee :

Signature : [signature]

Name : P.K.V. Lakshmi

Date & Time : 08/06/26 8:50AM

Witness :

Signature : [signature]

Name : Alati

Date & Time : 8/6/26 8:50AM

Patient Attendant :

Signature : [signature]

Name : Madhu Sudhan

Relationship with Patient: Husband

Date & Time : 8:50Am

Doctor (who is taking the consent) :

Signature : [signature]

Name : Dr. Durga

Date & Time : 8/6/26 8:50AM

Docu. No. : RCH /FRM / CLINICAL / 027

CONSENT FORM FOR ~~GENERAL /~~ REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

Patient Name : P.K.V. Lakshmi .... Age : 40yr .... Gender : Male ☐ Female ☑

UHID NO: HNH-00013093 .... Surgeon Name: ....

Anaesthesiologist : Dr. Samir / Dr. Vineetha ....

Operative procedure planned : Hysteroscopic polypectomy ....

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief without numbness can be achieved by infusing weak solutions of local anesthetics arid narcotic drugs to particular parts of the body after surgery or injury, using catheters.

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

☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure

☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma / Renal Tubular Aacidosis

☐ Incapacitating Cronic Obstructive Pulmonary Disease

☐ Others : Desaturation, Bronchospasm, Laryngospasm ....

Comments : ....

- Doctor to document in medical record also if necessary (Cross-out if not applicable)

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient P.K.V. Lakshmi .... the above mentioned operation / Diagnostic / Therapeutic procedures .... Hysteroscopic polypectomy ....

I authorize and give consent for anaesthesia (☐ Regional / ☑ General Anesthesia / ☐ Monitored Anesthesia Care as considered appropriate by the anaesthetic team. c̄ LMA.

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, risk, benefits and alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anesthesia.

I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, asthmatic reactions, headaches.

I authorize the anaesthetic team to perform any additional procedures (for example, Central Venous Pressure line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter in need arises.

I understand that the above mentioned consultant anesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

- Pregnant : ☐ Yes ☑ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

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

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

Patient / Patient Attendant :

Signature : [signature]

Name : P.K.V. Lakshmi

Relationship with Patient: Self

Date & Time : 08/06/2026 9:00AM

Witness :

Signature : [signature]

Name : Madhu Sudhan

Date & Time : 8/6/26 9:00AM

Doctor (who is taking the consent) :

Signature : [signature]

Name : DR. M. VINEETHA

Date & Time : 08/06/26 9:00AM

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

Name: P.K.V. Lakshmi Age: 40 yrs Sex: female UHID.No: HN4-00013093.

Date: 08/06/26 Time: 8:35 AM. Proposed Operation: Hysteroscopic polypectomy

Diagnosis: uterine polyp.

B.P / CRT: 104/77 mmHg. H.R: 69/min Weight: .... ASA Physical Status: ☐ 1 ☑ 2 ☐ 3 ☐ 4 ☐ 5

SpO2: 99% on RA

Laboratory Data:

Hgb: 12.1	Glucose:	Protein:	HIV: NR	X-Ray:
PCV:	Urea:	Alb:	HBS Ag: NR	ECG:
WBC: 5.44	Creat:	Total Bill:	HCV: NR	2D Echo:
Plate: 2.25	Na:	Dir. Bill:	Blood group:	Stress/Anglo:
PT:	K:	LDH:	T3	Other: Hyperechoic mass of 1.14 x 0.9 cm from anterior wall c broad base s/o polyp
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH	
	Cl -:	SGOT/SGPT:	**Allergies:** NKDA.	

Medical History: CVS: no active cardio respiratory complaints

RESP: no H/o DM/HTN/TB/Asthma Diabetes: ⊖

CNS: no H/o CVA/TIA.

Renal:

Hepatic / GE: ⊖. Physical Activity: METS > 4.

Others: H/o IVF - oocyte Retrieval - in 2021 & sedation.

Past Anaesthetic History: H/o Hysteroscopic & SAB - uneventful in March/April 2026. polypectomy (3-4 yrs back).

Physical Exam:

Airway: MP 1 ⓶ 3 4 Mouth Opening: 3F Mentohyoid Distance: ⓝ Neck: ⓝ Teeth: Intact no loose teeth

Lungs: B/L AE ⊕, clear

Heart: S1S2 ⊕

CNS: HMF ⊕

Pregnant: ☐ Yes ☑ No ☐ NA Venous Access Site: accessible Spine Exam for regional: ⓝ. midline spaces felt

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

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

CURRENT MEDICATIONS	DOSAGE
T. Ecospirin	75mg HS last dose on 05/06/26

Pre-Operative Instructions: water @ 4:40 AM.

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours, Others 6 Hours — explained.
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☑ Discussed with Patient
5. Other Instructions:
   - CBP

Signature: [signature] Name: DR. M. VINEETHA.

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

HNH-00013093 IP26-00006536
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Dr. MUNAGANURU NIHARIKA

ANAESTHESIA CHART

Pre Induction Assessment: 9.25 AM

Change in Patient Condition: ☐ Yes ☑ No	Fasting Status: Adequate

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

H.R: 98/min	B.P / CRT: 120/70 mmHg	SpO_2: 100%	R.R: 16/min	Last Feed:

Pre-OP Diagnosis: Uterine polyp Operation: Hysteroscopic polypectomy Date: 08/06/26

Surgeon: Dr. Niharika Anaesthesiologist: Dr. Vineetha Technician: Mr. Chandra

TIME	9.35	(45)	10.00 (15) (30)
N_2O/AIR/O_2 LPM	>>	>>	
HALO /SO/SEVO 1.1	>>	>>	
Drugs:			
MIDAZOLAM	2mg		
PROPOFOL	100mg		
FENTANYL	100mcg		
PARACETAMOL	1gm		
TRANEXAMIC ACID		1gm	
FIO_2 / SaO_2	100	100	100
$ETCO_2$	37	37	37
ECG	SR	SR	SR
Temperature			
Urine Output			
Fluids / Blood: RL	500ml/hr →		

Antibiotic: CEFOTAXIM 1gm IV
Suppository: TRAMADOL 100mg, DICLOFENAC 100mg
Blood Loss
NOTES

B.P
V Systolic
Λ Diastolic
X Mean
• Heart Rate
Tourniquet on Time
Tourniquet off Time
Throat Pack In
Throat Pack Out

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

LAB Values: ABG / GRBS / Others

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

Position: Lithotomy
- ☑ Pressure Points Checked

Eye Care:
- ☐ Oint
- ☑ Tape
- ☐ Padding
- ☐ Awake

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

Times:
Anaes Start: 9.30 AM
OP Start: 9.40 AM
OP End: 10.00 AM
Leave OR: 10.15 AM

Anaesthesia:
- ☑ GA c Igel
- ☐ Monitored Anaesthesia Care
- ☐ Regional

Line (Size & Location)
- ☐ CVP: ....
- ☐ ART: ....
- ☑ IV: (L) DH 20G.
- ☐ IV: ....
- ☐ IV: ....

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

- ☐ Mask ☑ SGA Igel-3.
- ☐ Airway ☐ Oral ☐ Nasal
- ETT# .... at .... cm
- ☐ Oral ☐ Nasal ☐ Cuff
- ☐ Tracheostomy ☐ Topical
- ☐ Drug: PROPOFOL
- ☐ Awake ☐ Direct Vision
- ☐ Video Laryngoscopy ☐ Stylette / Bougie
- ☐ Fiberoptic

Blade# .... Attempts: ....
Difficulty Why? ....

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

Regional:
Extremity Specify: ....
☐ Spinal ☐ Epidural ☐ Caudal
Others: ....
Position: ....
Site: ....
Needle Size: .... Depth: ....
Parasthesia ☐ Yes ☐ No
Catheter at skin .... cm
Drug Name & Conc: ....
Bolus: ....
Infusion: ....
Block Level: ....
Comments: ....

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

Name of the Doctor: DR. M. VINEETHA
Signature of the Doctor: [signature]

HNH-00013093 IP26-00006536
Mrs P K V LAKSHMI
23-04-1986 40 Y 1 M 16 D (F)
Dr. MUNAGANURU NIHARIKA

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Alai Time Received : 10:20 AM Time Discharged : 12:30 PM

RESP • PULSE ^ v BLOOD PRESSURE chart (250 to 0, SPO2)

IV Cannula Site : Left hand

- [x] O2 Mask
- [ ] Nasal Prongs
- [ ] Tracheostomy
- [ ] T-Piece
- [ ] Oral Airway
- [ ] Nasal Airway

Vomiting : ☐ Yes ☑ No Drug: ....

NG Tube : ☐ Yes ☑ No

Drain: ☐ Yes ☑ No

Urinary Catheter: ☐ Yes ☑ No

Chest Tube: ☐ Yes ☑ No

Nil Oral ☑ Yes ☐ No

IV Fluids: RL

Oral Feeds: NBM

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
8/6/26	10:20AM	0/10	Normal	[signature]
8/6/26	11:20AM	0/10	Normal	[signature]
8/6/26	12:20AM	0/10	Normal	[signature]
8/6/26	1:20AM	0/10	Normal D/C	[signature]

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

Reassessment Frequency:

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

Anaesthesiologist Name : Niharika

Anaesthesiologist Signature: [signature]

Date & Time: 8/6/26 1:00 PM

PACU Nurse Name : Alai

PACU Nurse Signature: [signature]

Date & Time: 8/6/26 @ 12:30 PM

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

Date & Time: 8/6/26 1:00 pm

Patient Sticker

Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : ....

Any other issues :

a) ....

b) ....

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

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

Catheter Removed by and Tip Inspected : ....

Patient Satisfaction : ....

Discharge /Shifting ordered by

Doctor Signature: ....

Doctor Name: ....

Date and Time : ....

PATIENT TRANSFER FORM

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00013093 IP26-00006536 Mrs P K V LAKSHMI 23-04-1986 40 Y 1 M 16 D (F) Dr. MUNAGANURU NIHARIKA	8/6/26 @ 8:31AM	8/6/26 9:20 [illegible]
	Transfer Ordered by DR. DUA	**Reason for Transfer** Hysteroscopy polypectomy
From Unit pre & post	**To Unit** OT	**Information to Attendant** Yes ☐ No ☐
Number of Sheets in Clinical File 28	**Number of Imaging Films** —	**Personal belongings including clinical documents. If any handed over to attendant** Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
S/s Alew / Alew	DR DUA

Patient & Clinical Records Received by : 10070 8/6/26 @ 9:25AM

Date & Time of Patient Received :

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

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

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

PATIENT TRANSFER FORM

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00013093 IP26-00006536 Mrs P K V LAKSHMI 23-04-1986 40 Y 1 M 16 D (F) Dr. MUNAGANURU NIHARIKA	8/6/26 @ 8:31 am	8/6/26 @ 10:20 Am
	Transfer Ordered by	Reason for Transfer
	Dr. veerather	observation
From Unit	To Unit	Information to Attendant
OT	pre - post	Yes ☑ No ☐
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant
2	—	Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
pooja	Dr. Veeristha.

Patient & Clinical Records Received by : [signature] 10:30 AM

Date & Time of Patient Received : 8/6/26.

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

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

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

HNH-00013093 IP26-00006536
Mrs P K V LAKSHMI
23-04-1986 40 Y 1 M 16 D (F)
Dr. MUNAGANURU NIHARIKA

NURSING CARE RECORD

Date: 8/6

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am ↓ 9am	→ Plan for vital → Plan for I/O chart. → Plan for medication.	8Am ↓ 9am	→ vital checked & recorded → Maintain I/O chart. → All medication given	→ Vital is normal	→ Pt is stable	Swapna [illegible]
Afternoon							
Night							

Patient Sticker

NURSING CARE RECORD

Date: ....

Goals

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

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

Rainbow Children's Hospital

BirthRight by Rainbow

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

GENERAL CONSENT FOR TREATMENT

Patient Name:	Mrs P K V LAKSHMI	Age :	40 Y 1 M 16 D
IP No:	IP26-00006536	Sex:	Female
Consultant:	Dr. MUNAGANURU NIHARIKA	Ward/Bed No:	4F -OT/LDR-416

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

Patient, be deemed advisable or necessary.

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

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

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

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

Note:
1 We do not allow use of medication brought from outside by the patient.
2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.
(Receivers Signature:.................)

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

Signature of Patient/Relative: [signature]

Name: T. Madhu Sudham
Relationship: Hasband
Date: 08/06/2026 Time: 8:31 AM.
Wittness Name: Yaseen ali khan
Wittness Signature: [signature]

Patient Address:
3-1-362 nimaboliadda Kachiguda
Hyderabad Telangana INDIA 500027