Dr. Swathi

Rainbow® Children's Hospital — It takes a lot to treat the little.
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ESTIMATION SLIP

Date : 3/6/26 **UHID / IP No. :** HNH-D0015266 **Sl No.** 1561

Name of Patient : Mrs. Swathi Innani **Age:** 40y **Gender:** F

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

Address : Nalayanguda **Phone :** 9739724748 **Email :** 9986645023

Procedure / Plan : Left Oophorectomy N TLH+BSO **EDD/Dos:** June-26

MODE OF PAYMENT : ☐ SELF ☑ TPA : United India + M.A ☐ GIPSA : _____ OTHER

TARIFF INFORMATION :

Particulars	Package Amounts (Rs.)	
Room Category	Normal Delivery	LSCS
Multi Shared Ward	Left Oophorectomy	OR TLH+BSO
Shared Ward		
Twin Shared Ward	1.30 k 2 (stay)	
Private Room		
Super Deluxe Room	+ Pharmacy &	Investigation Extra
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 : 10,000/- Advance at time 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 Deepak Innani 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.

Deepak — Signature of the Client

Husband — Signatory Relationship

Signature of the financial Counselor

HNH-00015766 IP26-00006507
Mrs SWATHI INNANI
09-12-1965 40 Y 5 M 27 D (F)
Dr. SWATHI H V

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SURGERY DETAILS

Date : 05-06-26

Patient Name: Mrs. Swathi Innani Date of Birth: 9/12/1965 Age: 40yrs

Gender: female Ward : OT UHID No.: HNH-00015766
IP26 — 00006507

Date of Surgery: 5/6/26 ☐ OT -1 ☐ ~~OT -2~~ ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Total Laparoscopic Hysterectomy +
B/L Salpingo oophorectomy.

Time in : 8:30am Time Out : 10:45am.

		NAME	AMOUNT
1.	Surgeon	: Dr. Swathi	
2.	Anaesthetist	: Dr Samir	
3.	Assistant Surgeon	: Dr. Nageshwar (pending)	
4.	OT Technician	: Br Saichandu, Sr Saraswathi	
5.	Circulating Nurse	: Sr. Rija, Sr. Natasha	
6.	Assistant Nurse	: Sr. Prabavathi, Sr. Archana.	

Mrs SWATHI INNANI (40 Y 5 M 27 D/ F)
UTERS NINV00213 HN26009362UTERS

Mrs SWATHI INNANI (40 Y 5 M 27 D/ F)
OTHERS NINV04329 HN26009364032

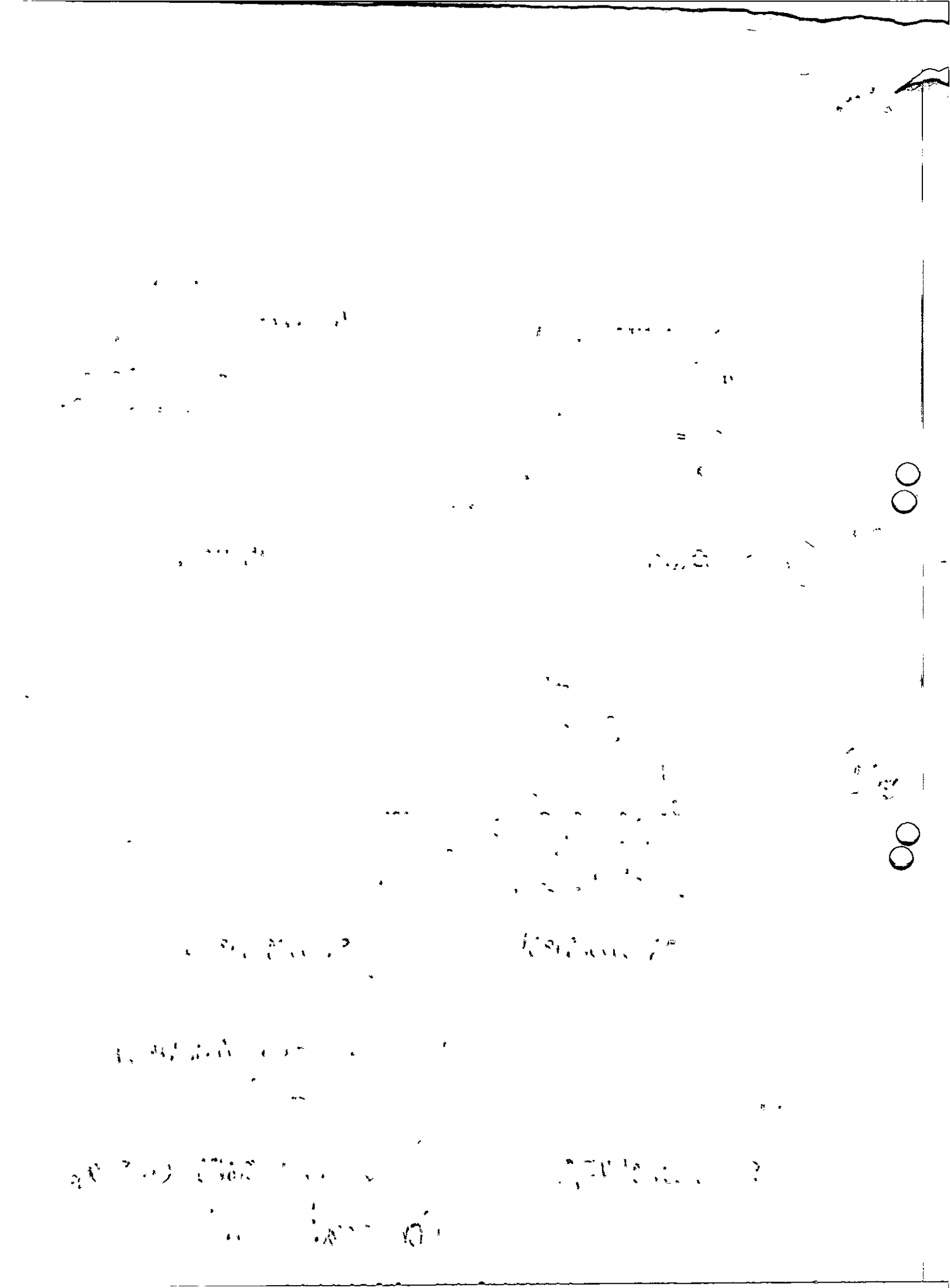
Special Equipment: ☑ Laparascopy (26-0000204501) ☐ Broncoscope ☑ Harmonic (26-0000204503) ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others ..Vessel Seles — 26-0000204504

Signature of the Surgeon

Natasha
Signature of Circulating Nurse

Order No: 26-0000204475 Order by: Sandya 5/6/26 @ 3:30pm

(Or record saved)



HNH-00015766 IP26-00006507
Mrs SWATHI INNANI
09-12-1985 40 Y 5 M 27 D (F)
Dr. SWATHI H V

TLH + BSO

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CONSUMABLES OF OT

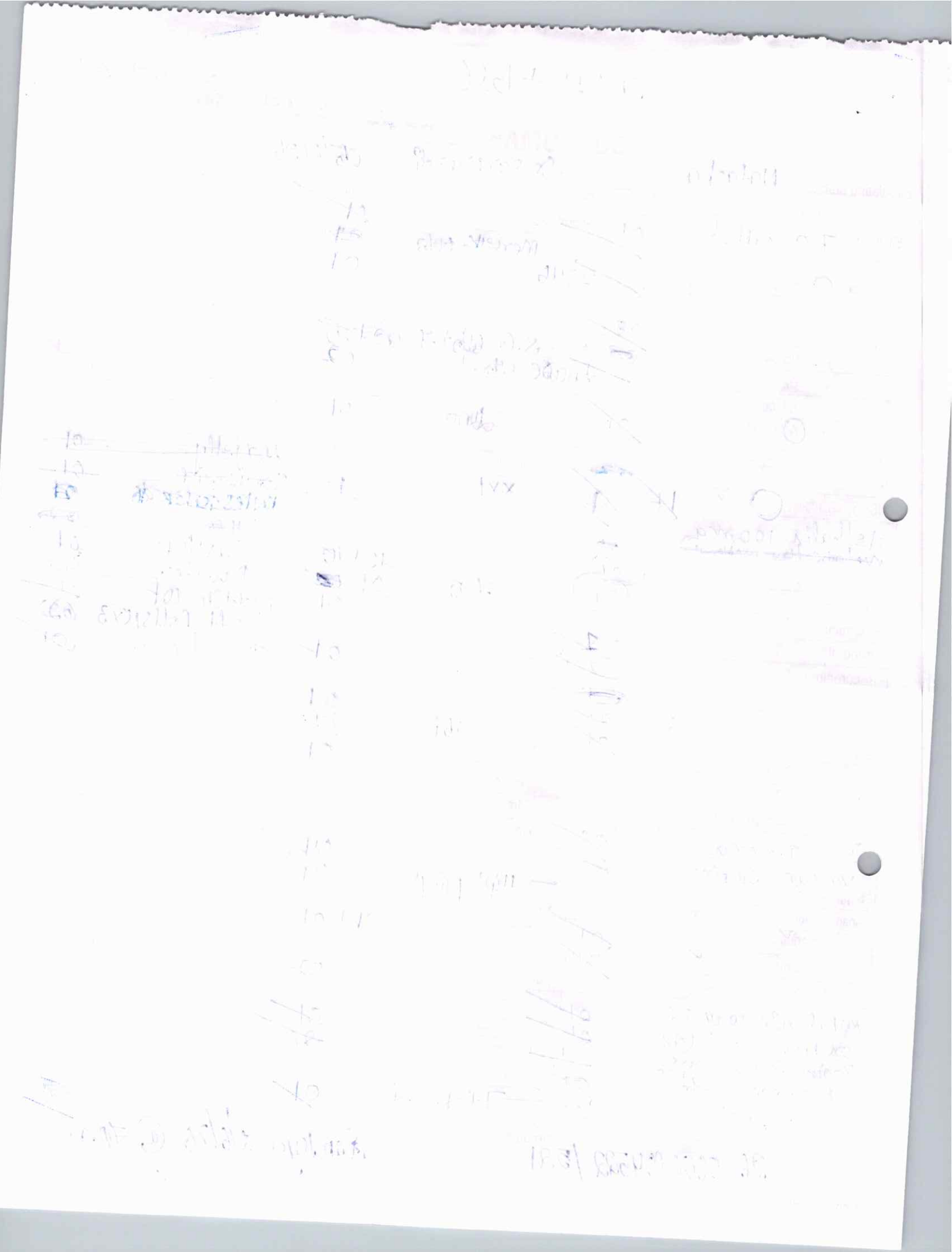
Circulating staff : Natasha Technician : Sr. Saraswathi Date : 05/6/26 Time :

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube 7.0 cuffed		01	Major Pack		01	Inj Vit.K		
LMA			Sutures ~~Mersilk 5062~~		~~01~~	Cord Clamp		
ECG leads (A) / P / N		3	2346		01	Suction Catheter		
HME filter : A / P / N						Feeding Tube		
Syringes : 10 cc		03				Vaccum Suction Set		
05 cc		~~03~~	Gloves S.G 6½+7	~~02~~	05	Surgical Gloves		
02 cc		~~03~~	Encare 6½		02	Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate (A) / P / N		01	Surgical blade 20no		01	Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL		~~03~~	Cautery pencil		1	Loxfelly		01
NS : 10ml / 100ml / (500ml) / 1000ml	4	04	Koochies XXL		1	Transofix		01
Asthalin 100mcg		01	Ointments			~~[illegible]~~		~~01~~
~~nebulization mask~~ (P)		~~01~~	Suction Catheter			~~10cc~~		~~02~~
Fentanyl		(01)	Cap, Mask	10	10	Savlon		01
Morphine		(01)	Gauze Pack 7.5	01	~~01~~	D water		02
Ketamine			Mop Pack		01	Nelaton 10F		01
Propofol		01	Steristrip			Soft Rolls 15x3		(02)
Rocuronium		02	Underpad		01	Skin stapler		01
Glycopyrolate		~~01~~	Draw sheet					
Myopyrolate		01	Abgel		01			
Ondansetron		01	Foleys catheter 16F		01			
Pencan 25g/ Spinal Needle 22			Urobag		01			
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics Tranexa		03	Bandage					
vaccum suction		01	Tegaderm		04			
Suppositories			~~Ioban~~ Hip leggings		01			
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg		01	Vaccum Suction set	01	01			
Justin : 12.5 mg / 25mg / 100mg		01	Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution		02			
Nasal air way 26		01	Microshield					
oxygen mask (A)		01	Cotton Balls		01			
200cm High pressure line		01	Latex Gloves		20			
Kapmex forte		01	Ramdione Scrub					
Lox patch		01	~~Saral~~ T.U.R Set		01			

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 26-0000204522/521 Ordered by : Sandeep 5/6/26 @ 7pm

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-00015766	**Name**	: Mrs SWATHI INNANI
Age / Sex	: 40 Y 5 M 27 D / Female	**Doctor**	: SWATHI H V
Adm/Reg Date/Time	: 05/06/2026 07:18	**Payor**	: MEDI ASSIST INSURANCE TPA PVT LTD
Order Date	: 05/06/2026 18:12	**Ordernumber**	: 26-0000204522
VisitID	: IP26-00006507	**Ward/Bed No**	: 4F -OT / LDR-415
Patient Address	: HNO:3-4-423/424,F-106,SYMPHONY ROYAL APARTMENTS, Narayanguda, Hyderabad, Telangana, INDIA, 500029		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	FACE MASK 3 LAYER - ELASTIC	FACE MASK 3 LAYER	1 Nos	/ Once Daily	10 Days		10 Nos	Dispensed
2	SGLOVE # 7.0(SURGICARE)	SURGICAL GLOVES 7.0	1 Nos	External / Once Daily	1 Days		5 Nos	Dispensed
3	SURGEONS CAP	SURGEONS CAP	1 Cap	Oral / Once Daily	10 Days.		10 Cap	Dispensed
4	SAVLON 100 ML		1 Bottle	/ Once Daily	1 Days		1 Bottle	Dispensed
5	ROCUNIUM INJ 50 MG 5 ML		1 Nos	/ Once Daily	2 Days		2 Vial	Dispensed
6	UNDERPADS 60X90 BUTTERFLY		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
7	GAUZE 7.5X7.5 12 PLY (5 NOS)	GAUZE 7.5X7.5 12 PLY 5 NOS	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
8	POVINANZ SOLUTION 10% 100 ML		1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
9	NITRILE EXAMINATION GLOVES P F- MEDIUM	NITRILE GLOVES M	10 Nos	/ Once Daily	1 Days		10 Nos	Dispensed

SWATHI H V
OBSTETRICS AND GYNECOLOGY
Reg No : TSMC/FMR/15501

* 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.**

Printed Date/Time : 05/06/2026 19:09 Printed By : GUVVALA VIJAYA SUSHEELA

Rainbow Childrens Hospital-Himayatnagar

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040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	HNH-00015766	Name	Mrs SWATHI INNANI
Age / Sex	: 40 Y 5 M 27 O / Female	Doctor	: SWATHI H V
Adm/Reg Date/Time	: 05/06/2026 07:18	Payor	: MEDI ASSIST INSURANCE TPA PVT LTD
Order Date	: 05/06/2026 18:12	Ordernumber	: 26-0000204521
Visit ID	: IP26-00006507	Ward/Bed No	: 4F -OT / LDR-415
Patient Address	: HNO:3-4-423/424,F-106,SYMPHONY ROYAL APARTMENTS, Narayanguda, Hyderabad, Telangana, INDIA, 500029		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	BIOXAMIC 500 MG INJ		1 Nos	/ Once Daily	3 Days		3 Ample	Dispensed
2	LEGGINGS DISPOSABLE (PROTECTCARE) BIG		1 Nos	/ 12th Hourly	1 Days		1 Nos	Dispensed
3	JUSTIN SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
4	MAJOR PACK	MAJOR PACK	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
5	D WATER 10 ML AMPULE	DISTIL WATER10ML	1 Bottle	External / Once Daily	1 Days		2 Bottle	Dispensed
6	MCT-ROF 100MG 10ML		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
7	FOLEYS CATHETER 16-UROCATH		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
8	HIGH PRESSUR EXTENTION 200 CM PRYMAX		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
9	OxygenMask With Tubing - Adult ROMSONS-FC		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
10	MOPS 30X30 8PLY SS X-RAY	MOPS 30X308 PLYDATT	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
11	ARTIFLEX 15 CM X 3M (SOFTROLL)	CAST PADING 15X3	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
12	VICRYL 1-0 VP 2346	VICRYL 1-0 VP 2346	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
13	ENCORE MICROPTIC GLOVES-8 PF		1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
14	MYOPYROLATE-INJ-5ML		1 Nos	/ Once Daily	1 Days		1 Ample	Dispensed
15	COTTON BALLS 2 GM 5 NOS	COTTON BALLS 2G- 5 NOS	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
16	ASTHALIN 100 MCG INHALER		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
17	OSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
18	UROBAG (ADULT) - URODYNE		1 Nos	External / 1-2 TIMES A DAY	1 Days		1 Nos	Dispensed
19	LOX-LIDOCAIN-5PER PATCH 2S		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
20	PROXIMATE PLUS MD 3500 STAPLER(PMW35)	PROXIMATE PLUS MD 3500 STAPLERPMW35	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
21	SURGICAL BLADE 22	SURGICAL BLADE 22	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
22	NS 1000 ML CLOSED EUROFLEX	NORMALSALINE 1000ML CLOSED	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
23	ADULT DIAPERS-XXL		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
24	IRRIGATTO(T.U.R SET)	IRRIGATTO(T.U.R SET)	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
25	TEGADERM WITH PAD 5X7CMS (3582)(8582)	TEGADERM 8582	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
26	VACCUME SUCTION SET	VACCUME SUCTION SET	1 Nos	/ Once Daily	3 Days		3 Nos	Dispensed
27	E.C.G ELECTRODES (ADULT)	ELECTRODES ADULT	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
28	ET TUBE 7.0 CUFFED RUSCH		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
29	NS 500ML CLOSED BOTTLE	NORMALSALINE 500ML CLOSED	1 Bottle	External / Once Daily	1 Days		1 Bottle	Dispensed
30	OSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
31	KIPINEX FORTE INJ 1.5 GM		1 Vial	External / Once Daily	1 Days		1 Vial	Dispensed
32	PREGELLED SURGICAL PLATES(ADULT)	PREGELLED PLATED ADULT	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
33	NELTON CATHETER-10 POLYMED		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
34	SUPRIDOL SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
35	CAUTERY PENCIL (ADVANCE)	CAUTERY PENCIL (ADVANCE)	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
36	ABGEL SURGI PAD (BIG) (GELSPON)	ABGEL	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
37	NASOPHARYNGEAL TUBES 26	NASOPHARYNGEAL TUBE26	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
38	ONDOKIND INJ 4 MG 2 ML	ONDANSETRON 4MG 2ML INJ	1 Nos	/ Once Daily	1 Days		1 Vial	Dispensed

SWATHI H V
OBSTETRICS AND GYNECOLOGY
Reg No : TSMC/FMR/15501

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Name	Mrs SWATHI INNANI	**UHID**	HNH-00015766
Father/Guardian	Mr DEEPAK INNANI	**Age/Gender**	40 Y 5 M 27 D/ Female
Address	HNO:3-4-423/424,F-106,SYMPHONY ROYAL APARTMENTS, Narayanguda, Hyderabad, Telangana, INDIA, 500029		
IP No	IP26-00006507	**Admission Date**	05-06-2026
Ref Doctor	Self.		
Discharge Date	08.06.2026		

DISCHARGE SUMMARY

Consultants :
Dr. Swathi H V
MBBS/MS
TSMC/FMR/15501

Diagnosis: P1L2E1 WITH PERVIOUS LSCS WITH LEFT COMPLEX OVARIAN CYST AND RIGHT ENDOMETRIOTIC CYST

TOTAL LAPAROSCOPIC HYSTERECTOMY + BILATERAL SALPINGO-OOPHERECTOMY + ADHESIOLYSIS DONE ON 05.06.2026

History: She came with complaints of lower abdominal discomfort since 6 months USG (12.05.2026) right ovarian cyst-complex 2.9x2.3x2.7cm, left ovarian cyst -10x6.3cmx9.2cm. left hydrosalpinx. MRI- Pelvis done for further evaluation,- showed 55x88x90mm left ovarian complex cyst Diffuse widening of Junctional zone in the posterior myometrium with loss of Endo-myometrial interface, the myometrium shows heterogenous T2 hypointense signal with multiple T1 hyper intense, T2 hyperintense cystic areas (blood degradation products). feature are suggestive of uterine adenomyosis. Right ovary is seen adherent to right posterolateral wall- suggestive of endometriotic adhesions with well defined cyst in right ovary sixe 34x26x36mm- shows mild diffusin restriction and corresponding drop on ADC- likely endomteriotic cyst, Few (3-4) similar morphology smaller endomteriotic cyst noted in right ovary largest size 12x11mm. A well defined cyst size 20x22mm is nited in right ovary likely follicular cyst. A well defined complex cyst lesion in left adnexa with its morphology an dextension size 50x88x90mm ?left ovarian neoplastic etiology. Cervix is displaced in left adenxa with few nabothian cysts, largest size 9.2cm.

Name	Mrs SWATHI INNANI	UHID	HNH-00015766
IP No	IP26-00006507	Admission Date	05-06-2026

Tumor marker done and traced- CA-125 : 51.2 / CEA :1.37. She was admitted for TLH with BSO.

Menstrual History:-
LMP- 22.05.2026
Previous cycles: Regular

Obstetric History: P1L2E1, LSCS, LCB-2016

Medical History: K/CO hypothyroidism since 2021 on Tab. Thyronorm 100mcg OD **Surgical History:** LSCS-2016, laparoscopic right salpingectomy done in 2012
2 endometriotic cystectomy - 2011, 2019
Allergies: Nil
Family History: Mother-HTN

Investigations: Enclosed.
Blood group: "B" Positive

Surgery Notes:
Operation performed: **TOTAL LAPAROSCOPIC HYSTERECTOMY + BILATERAL SALPINGECTOMY ADHESIOLYSIS DONE UNDER GENERAL ANAESTHESIA**

Indication: Left ovarian complex cyst + endometriosis grade III

Operative findings:

- Uterus normal in size.
- Intraperitoneal inclusion cyst of 8x8cm noted in left lateral pelvic wall.
- Left ovary and tube adhesion to left lateral pelvic wall and sigmoid colon densely.
- Right ovarian endometriotic cysts + 2x2cm, 3x3cm adherent to posterior surface of uterus and uterosacral ligament.
- Right tube absent .
- POD obliterated.
- Adhesiolysis done. Peritoneal collection drained out ,clear fluid noted.
- Left tube and ovary dissected out, and adhesions with sigmoid colon released.
- Proceeded with TLH+BSO.
- Specimen retrieved vaginally.
- Rectovaginal nodule dissected out and retreived.

Name	Mrs SWATHI INNANI	**UHID**	HNH-00015766
IP No	IP26-00006507	**Admission Date**	05-06-2026

- Vault closed with vicryl no.1. Hemostasis secured .
- Thorough irrigation and suction done , drain placed insitu.
- Bilateral ureteric peristalsis noted at the end of procedure
- procedure uneventful.

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. CEFTUM 500mg (Cefixime 200mg) twice daily till 13.06.2026 (9am - 9pm) after food.
2. Tab.HIFINAC - P Thrice daily (8am-3pm-10pm) FOR 7 DAYS
3. Tab.Pantodac 40 mg (Pantoprazole 40mg) once daily (7am) before food till 11.06.2026
4. Tab. Zincovit once daily (2pm) for 1 month after food.
5. Collect HPE reports.
6. SYP Duphalac SOS.

Review consultation with **Dr. Swathi H V,** on **12.06.2026** in Gynec OPD with HPE report in Rainbow Children's Hospital (**Review consultation will be charged**).

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

Patient/ Attender

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

Registrar/Resident/C.M.O

Name	Mrs SWATHI INNANI	**UHID**	HNH-00015766
IP No	IP26-00006507	**Admission Date**	05-06-2026

Consultants :
Dr. Swathi H V
MBBS/MS
TSMC/FMR/15501

PATIENT TRANSFER FORM

Rainbow® Children's Hospital
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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00015766 IP26-00006507 Mrs SWATHI INNANI 09-12-1985 40 Y 5 M 27 D (F) Dr. SWATHI H V	5/6/26 @ 7:18AM	6/6/26 @
	Transfer Ordered by Dr. Dua	Reason for Transfer Observation
From Unit Pre & Post	To Unit Floor	Information to Attendant Yes ☐ No ☐
Number of Sheets in Clinical File 30	Number of Imaging Films -	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
[signature] 6/6/26 @	Dr. Dua.

Patient & Clinical Records Received by : [signature] 6/6/26 @ 10AM

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

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
IP26-00006507 HNH-00015766 Mrs SWATHI INNANI 40 Y 5 M 27 D (F) 09-12-1985 Dr. SWATHI H V	5/6/26 @ 7:20 Am	5/6/26 @ 8:20 Am
	Transfer Ordered by Dr. Naveena.	Reason for Transfer TLH
From Unit MICU	To Unit OT	Information to Attendant Yes ☐ No ☐
Number of Sheets in Clinical File 35	Number of Imaging Films -	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	RL — 100ml	1
2.		
3.		
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sis. Monika.	Dr. Jwalki

Patient & Clinical Records Received by : Puja

Date & Time of Patient Received : 5/6/26 @ 8:20 Am

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

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

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

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006507 **Admit Date** : 05-Jun-2026 **Admit Time** : 07:18 AM **UHID** : HNH-00015766

Patient Details :

Patient Name	: Mrs SWATHI INNANI	**Age**	: 40 Y 5 M 27 D
Guardian	: Mr DEEPAK INNANI	**DOB**	: 09-12-1985
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: HNO:3-4-423/424,F-106,SYMPHONY ROYAL APARTMENTS Narayanguda Hyderabad Telangana INDIA 500029	**Phone No**	: 9739724748/
		E-mail	: deepakinnani@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 DEEPAK INNANI **Relationship** : Husband

Contact Address : HNO:3-4-423/424,F-106,SYMPHONY ROYAL APARTMENTS Narayanguda Hyderabad Telangana INDIA 500029 **Phone No** : 9739724748

Signature

Doctor Details :

Doctor Name : Dr. SWATHI H V **Specialisation** : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self. **Phone No** :

Co-Consultant :

Payment Details :

Payment Mode : Cash **Deposit Amount** : 10000.00

Payor Name : MEDI ASSIST INSURANCE TPA PVT LTD

HNH-00015766 IP26-00006507
Mrs SWATHI INNANI
09-12-1985 40 Y 5 M 27 D (F)
Dr. SWATHI H V

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ACTIVITY RECORD FOR BILLING

Name :_____

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

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
5/6/26	8:20AM	MICU	OT	Monika /
5/6	11AM	OT	MICU	/
6/6/26	10AM	Pre&Post	FLOOR	Akhila /

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
6/6/26	CBP	9427	Dri
5/6/26	Biopsy medium	9364	
5/6/26	Biopsy Large	9362	
	Cross checked by R	7/6/26	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
			6/6/26		
5/6	cardiac monitor	11Am	8:20Am	204400	
5/6	Infusion Pump	11Am	8:40Pm	204400	
5/6	oxygen	11Am	1Am	204400	

Cross check done by Akwila.

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
5/6	IV placement	1	4401	[illegible]
5/6	PAC	1	4402	[illegible]
5/6	Catheterization	1	4399	[illegible]
6/6/26	NHA	1	4962	

Cross check done 5/1 [illegible]

Cross check by [illegible] 7/6/26 @ 9 Am

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00015766 IP26-00006507
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I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 5/6/2026 Time of Admission : .....

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

PRESENTING COMPLAINTS :

clo lower abdominal discomfort ∴ 6months.

USGC 3- Rt. ovarian cyst- complex 2.9x2.3x2.7cm

lt. ovarian cyst - 10x6.3cm x9.2cm.

lt. hydrosalpinx.

MRI - pelvis - slo 55x88x90mm left ovarian complex cyst -

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : 2007	Parity : P1L2E1
Previous Periods : Regular	Mode of Delivery : LSCS - 2016.
LMP : 22/5/2026	Last Child Birth : 2016
Contraception : Nil	

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
K/c/o hypothyroidism ∴ 2021 on T. thyronorm 100mcg PO	LSCS - 2016 Lap. Right Salpingectomy 2012

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mother - HTN.	**MEDICATION HISTORY:** T. Thyronorm. 100mcg.

INITIAL ASSESSMENT :

Date 5/6/2026	Breasts	Local/Speculum Examination
Ht. ____ Wt. ____	normal.	not done
BMI ____		
B.P 110/70mmHg		Bimanual Pelvic Examination
Pallor No		
CVR S_1S_2 (+) nomurmur	Abdominal Examination	not done.
Respiratory System BL NVBS (+)	Soft, NT.	
Thyroid normal.		

PROVISIONAL DIAGNOSIS : $P_1L_2E_1$ with previous LSCS with complex lt. Cyst & Rt. Endometrioma c/c Cyst

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT
CBP (4/6/2026) BGT-B' positive.	- Admission
@ Hb - 12.9	- Parts preparation.
TLC - 9400	- Inform. Consent
plt - 2.97	- drugs as charted
PCV - 36.9.	- 1 @ PRBC. Reserve
USG.	- monitor Vitals
	- Inform SOS

Name of the Doctor : D. Swathi HV
Date & Time : 5/6/2026 @ 8:20am

Signature of Doctor

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/6/26 11:30pm	c/s/B Dr. Veena / Dr Swathi HV	
	POD-0 / P	
	Pt is stable, No c/o	Adv
	O/E GC fair	- NBM x 24 hours
	BP - 110/60 mmHg	- IV Fluids / Analgesics &
	PR - 68 bpm	Thromboprophylaxis as per Axon
	SpO_2 - 100% on $4L O_2$	- IV Antibiotics (Att discharge).
	P/A - Soft, NT	- Vital monitoring
	Drain - minimal	- I/O charting
	L/E - NAD	- Drain care
		- Inform SOS
		- Drugs as charted.
		- w/f fever, tachycardia, guarding & rigidity.
		- Ted stockings
	S/B Dr SWATHI HV	
5/6/2026 1:30pm	- POD-0 / TLH + BSO + Adhenolysis.	
	- pt stable, no complaints	Advice:
	O/E: P = 80 bpm	- NBM x 24 - 36 hrs
U/O	BP - 100/60 mmHg	{Till further orders}
~100 ml/hr	no pallor	- Strict I/O charting
	PA: NO/T	- vitals @
drain: minimal	LE: NAD	w/f pain / bleed / fever / guarding rigidity - drain loss

Docu. No. : RCH /FRM / CLINICAL / 088 (P.T.O)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/6/26 @ 9PM	C/S/B Dr. Durg POD-0 (S/P TLH+BSO)	
	P° GC fair Afebrile BP: 109/77 mmHg PR: 76/min SpO2: 99% on RA P/A soft BS+ D/O- Minimal Urine - 100ml clear	Adv. - NBM for 24 hours - IV fluids - Drugs as charted - TED stockings - Vital Monitoring - I/O charting - Drain care - Informed
6/6/26 @ 6AM	C/S/B Dr. Durg POD-1 (S/D TLH+BSO)	
Pt can be shifted to room	P° GC fair, Afebrile BP: 110/70 mmHg PR: 67 bpm SpO2: 99% on RA P/A soft BS+ U/O - Adequate 100ml/hr. D/O - 60ml.	Adv. - NBM for 24hrs. - IV fluids - Drugs as charted - TED stockings - Vital Monitoring - I/O charting - Drain care Informed

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/6/2026 12:00pm		c/s/by Dr. Naveena
	O/E GC-fair	Adv
	Afebrile	NBM
	Vitals-stable	IVF and drugs as charted
	PA: soft, NT	TED STOCKINGS
	Dressing: dry & clean	Urine I/O charting
	L/E: no PV bleeding	Monitor Vitals
		Inform SOS
	Bladder: U/O: adequate clear	Noted by Divya 6/6/26 @ 12:PM
	D/T- minimal	
		Dr Naveena
	c/m Dr SWATHI HV	
6/6/2026 2:10pm	- day 0 of TLH + BSO + Adhesiolysis	
	- pt recovering well.	Advice
	→ O/E: P- 82,	→ start sips of water
	BP - 116/82 mmHg	
	PA: soft BS +/+	→ Ambulation
	L/E: NAD	→ Send CBC
P/O ↓ reviewed		→ To review 2 hrs / dos.
	Dr Swathi HV. Noted by Divya 6/6/26 @ 12:PM	→ soft mound / vomiting, → distension

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/6/2026	C/s/b Dr. Mamatha	
7:30pm		
	GC fair Afebrile	Adv
	Vitals stable	Liquid diet today
	P/A soft	(If tolerates → soft diet fo[ll]ow 7/m)
	BS⊕	Drugs as charted
	L/E NAD	Ambulation
F✓	U/O Adeq	Inform SOS
	D/o ~ 50cc	Ⓐ Foley's removal @ 6Am C/m
		T/o monitoring
		Inform SOS
		Noted Divya 6/6/26 7:30Pm
		by Dr. Mamatha
7/6/26 12pm	c/s/b Dr. Veena - c/D/w Dr. Swathi	
	POD-2 / TLH + BSO + Adhesiolysis	
	Pt is stable. No c/o	
	o/E GC fair, Afebrile	Adv
U✓	Vitals - stable	Soft diet
F✓	~~P/A - U well retracted~~	Drugs as charted
S✗.	~~BS(+)~~	Ambulation
Can be discharged	~~L/E - NAD~~	Adequate hydration
	P/A - Soft, BS(+)	Vital monitoring
	L/E - NAD.	Inform SOS
Send file for processing	DT - 50cc	Noted by Divya 7/6/26 @ 12pm

Docu. No. : RCH /FRM / CLINICAL / 088

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00015766 IP26-00006507
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DRUG CHART

Date of Admission: 5/6/26 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 .....

Docu. No. : RCH /FRM / CLINICAL / 118

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09-12-1985 40 Y 5 M 27 D (F)
Dr. SWATHI H V

I.V. FLUIDS CHART

Weight. 66kgs Ward. .....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
5/6	8AM	RINGER LACTATE	IV	100ml/hr			5/6		
5/6	9:20AM	RINGER LACTATE	IV	FF			5/6		
5/6	10:10AM	RINGER LACTATE	IV	FF			5/6.		
5/6	4PM	DNS DEXTROSE NORMAL SALINE		100ml/hr.			6/6		
6/6.	12 AM.	RL RINGER LACTATE	IV	100ml/hr.			6/6		
6/6	5 AM	DNS DEXTROSE NORMAL SALINE	IV	100ml/hr					
6/6/26	1PM	RL	IV	100ml/hr					
6/6/26	8PM	DNS	IV	100ml/hr.					
7/6/26	2AM	RL							

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RESULT SHEET

Date	6/6/26					
Time						
Hb	11.0					
PCV	30.4					
RBC	3.91					
WBC	11.15					
N/L	84/11					
Platelets	272					
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						
1 ⓒ PRBC	Reserve in surya blood bank					
HIV HBSAg } NR HCV						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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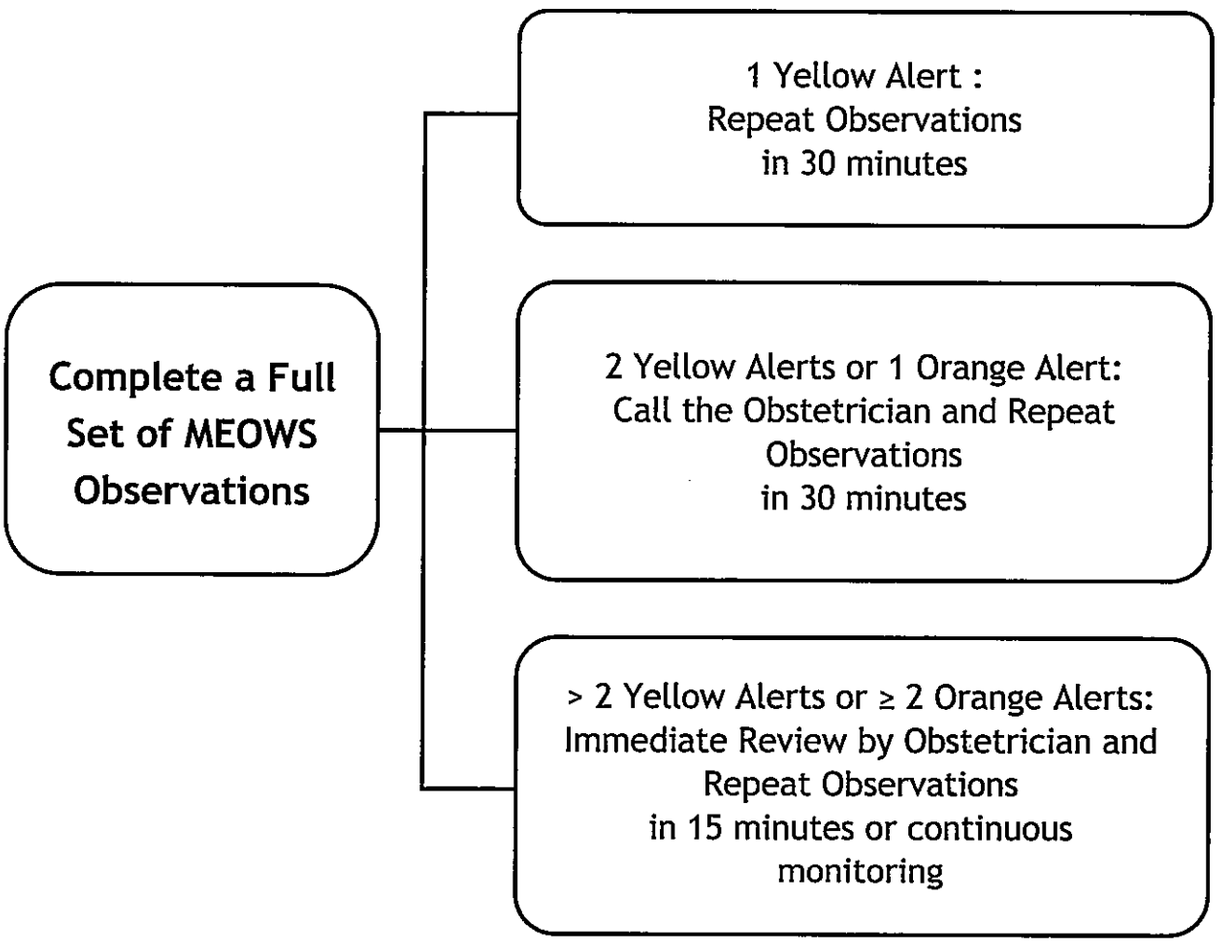
Early Warning Observation Score Chart - Obstetrics

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

		Date																							
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20																								20	
	0 - 10																									
Saturations	94 - 100 %																								99	
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37																									
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	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																										

Obstetrics and Gynaecology Early Warning Signs



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

HNH-00015786 IP26-00006507
Mrs SWATHI INNANI
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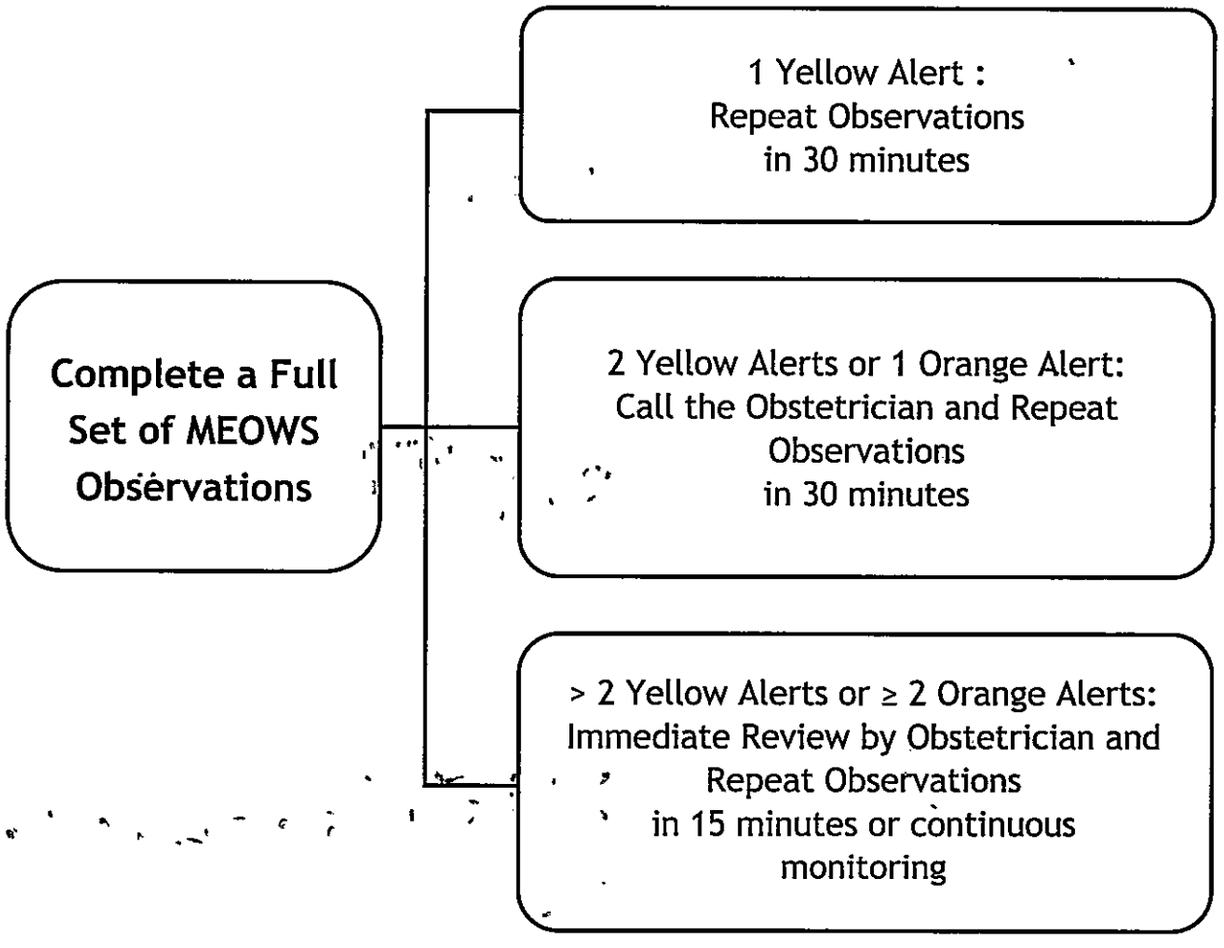
Early Warning Observation Score Chart - Obstetrics

5/6

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

		Date																						
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20	20																								
	0 - 10																									
Saturations	94 - 100 %	99%																								
	< 94 %																									
Administered O_2 (L/min.)		9																								
Temp°c	40																									
	39																									
	38																									
	37	-																								
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80	75																								
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110	110																								
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70	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																								
TOTAL ORANGE SCORES		0																								
Nurse Initial		@																								

Obstetrics and Gynaecology Early Warning Signs



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

HNH-00015766 IP26-00006507
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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

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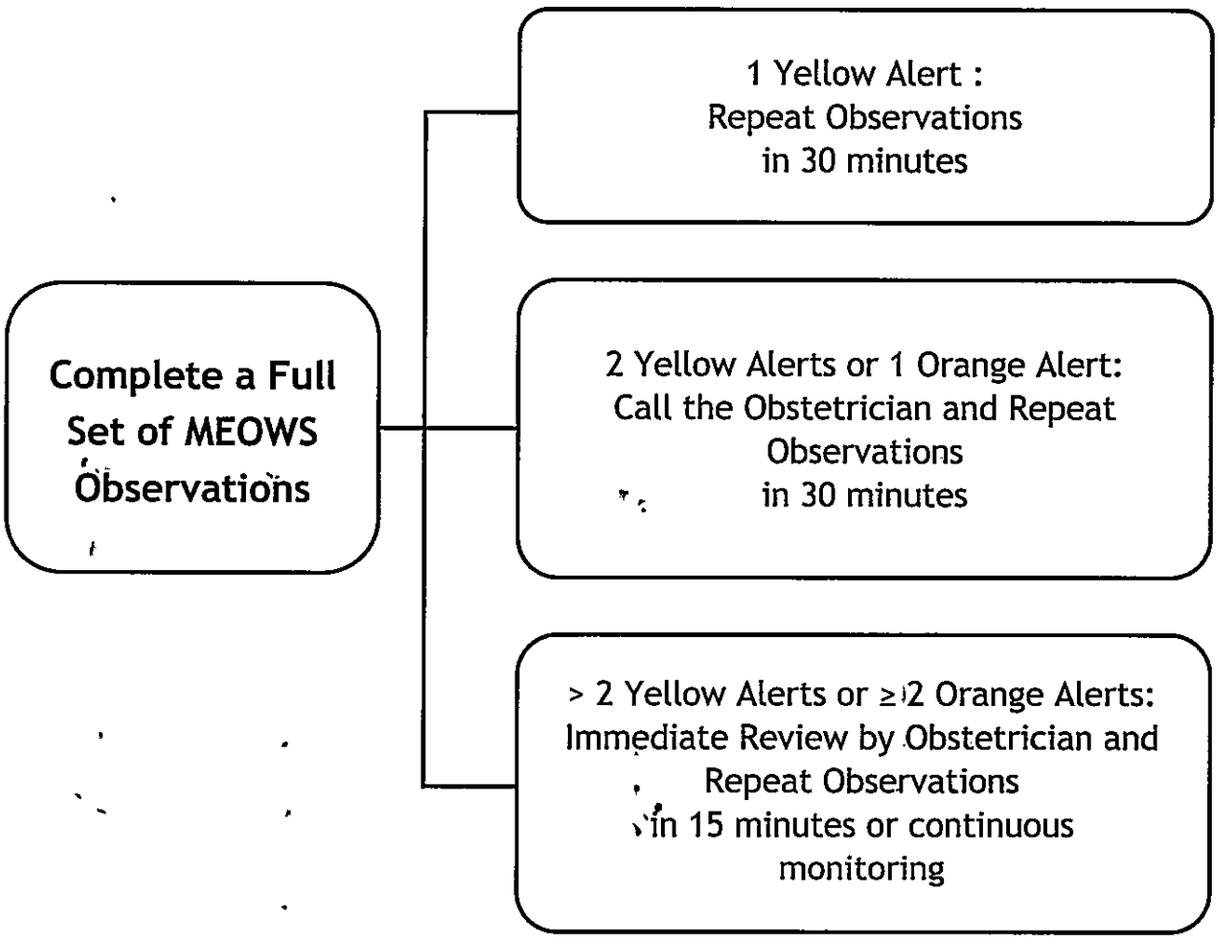
		Date																						
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20	20		20					20				20				20				20				20	
	0 - 10																									
Saturations	94 - 100 %	99%		100%					99%				99%				100%				99%				99%	
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37	36°		36.1°					99°F				98.1°F				97.8F				98.2F				96.	
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80	75		73					82				76bpm				86				78				75	
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110				150				116				110				117				111				110	
	100	95																								
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70				72				76				65				82				72				70	
	60	69																								
	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				1				0				0	
TOTAL ORANGE SCORES		0		0					0				0				0				0				0	
Nurse Initial																										

Obstetrics and Gynaecology Early Warning Signs



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

HNH-00015766 IP26-00006507
Mrs SWATHI INNANI
09-12-1985 40 Y 5 M 27 D (F)
Dr. SWATHI H V

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FLUID CHART

Sheet No. : 0

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am	RL	NBM	100ml			NBM				0	
	06:00 am	RL	NBM	100ml							0	
	07:00 am	RL	NBM	100ml							0	
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

J

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FLUID CHART

Sheet No. : ..... ②

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
5/6	08:00 am	RL	D	100ml						✓	0	
	09:00 am	RL		100ml				—				
	10:00 am	RL	M	100ml			NA				0	
	11:00 am	RL		100ml		—				150ml		
	12:00 pm	RL	D	100ml								
	01:00 pm	RL	M	100ml								
Total Intake :						**Total Output :** passed						
	02:00 pm	RL	M	100								
	03:00 pm	RL		100						300ml	1	Empty
	04:00 pm	RL	B	100							0	Bottle
	05:00 pm	RL		100								
	06:00 pm	RL	M	100						200ml	1	Empty
	07:00 pm	DNS		100								
Total Intake : Taken 600ml.						**Total Output :** passed 500ml						
5/6/26	08:00 pm	RL		100ml							1	
	09:00 pm	RL	M	100ml								
	10:00 pm	RL		100ml							0	
	11:00 pm	RL	B	100ml			NA			500ml		Empty
	12:00 am	RL	M	100ml								
	01:00 am	RL		100ml								
Total Intake : 600ml						**Total Output :** 500ml						
6/6/26	02:00 am	DNS		100ml								
	03:00 am	RL	M	100ml						200ml		
	04:00 am	RL	B	100ml							0	
	05:00 am	DNS	M	100ml			NA					
	06:00 am	DNS		100ml		—				100ml		Empty
	07:00 am	DNS		100ml								
Total Intake : 600ml						**Total Output :** 600ml						

Total 24 hrs. Intake	1800ml	Total 24 hrs. Output	2140ml

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FLUID CHART

Sheet No. : 3

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

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
6/6/26	08:00 am	DNS	10	100ml								
	09:00 am	DNS		100ml								
	10:00 am	DNS	13	100ml						300ml		Emptied
	11:00 am	DNS	30	100ml								
	12:00 pm	RL	no	100ml								
	01:00 pm	RL	30	100ml								
Total Intake :						**Total Output :**						
6/6/26	02:00 pm	RL		100ml						800ml		Empty
	03:00 pm	RL	stopped	100ml								
	04:00 pm	RL	ORS water	100ml								
	05:00 pm	RL		100ml						200ml		5 pm
	06:00 pm	RL		100ml								
	07:00 pm	RL		100ml								
Total Intake :						**Total Output :**						
7/6/26	08:00 pm		H2O	100 ml						800ml		Empty
	09:00 pm			100 ml								
	10:00 pm	DNS		100 ml								
	11:00 pm			100ml								
	12:00 am			100 ml								
	01:00 am			100 ml								
Total Intake :						**Total Output :**						
7/6/26	02:00 am			100 ml						800ml		Empty
	03:00 am			100 ml								
	04:00 am	DNS		100 ml								
	05:00 am			100 ml								
	06:00 am			100 ml						300ml		Empty @6:30
	07:00 am			100ml								today's urine
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

Patient Sticker

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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
7/6/20	08:00 am											
	09:00 am											
	10:00 am	0	Jdly								0	
	11:00 am		+		NA			NA				
	12:00 pm		H_2O									
	01:00 pm											
Total Intake :						**Total Output :**						
7/6/20	02:00 pm											
	03:00 pm											
	04:00 pm		kidrid									
	05:00 pm	0	+		NA			NA			0	
	06:00 pm		H_2O									
	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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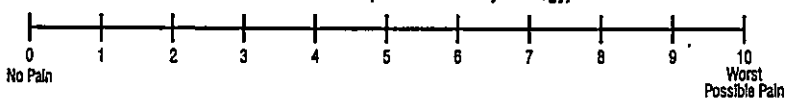
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
5/6	6Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NP	
5/6	12Pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
5/6	8Pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NP	
5/6	4Pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
5/6	10Pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
6/6/26	8Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
6/6/26	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
6/6/26	8pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
7/6/26	2Pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
7/6/26	8Pm	0/10	NP	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

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

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PAIN ASSESSMENT FORM

Date	Time	(0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
7/6/26	8pm	0/10	NA	☐ 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		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

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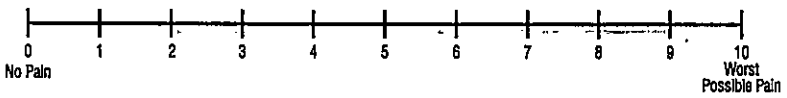

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BRADEN 'Q' SCALE

				Date :	4/8	5/6	5/6	5/6
				Time :	N1	E46	E2	R4
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	4	4	4
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
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	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 mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
				TOTAL SCORE	28	28	28	28
				Evaluator's Name	[illegible]	[illegible]	[illegible]	[illegible]

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

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

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

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BRADEN 'Q' SCALE

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					Date : 6/6/26	8/6/26	7/6/26	
					Time : MB	MI	MS	
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	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	
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	
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 oply requires changing every 24 hours.	4	4	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	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 mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	3	
				TOTAL SCORE	28	28	27	
				Evaluator's Name				

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

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

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09-12-1985 40 Y 5 M 27 D (F)
Dr. SWATHI H V

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	4/5/26	5/6/26	5/6/26	Fall Risk Grading		
		Score		MB	EB			
History of Falling (immediately or w/in 3 months)	Yes	25				Risk Level	Morse Fall Score (MFS)	Action
	No	0						
Secondary Diagnosis (more than one diagnosis)	Yes	15						
	No	0	0	0	0	Low Risk	0 - 24	Standard Fall Precaution
Ambulatory Aid	Furniture	30						
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0					
IV / Heparin Lock or Saline	Yes	20	20	20	20	Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20						
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0	0	0	0	High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
Mental Status	Forgets limitations	15						
	Oriented to own ability	0						
Total Morse Fall Scale Score:			20	20	20			
		Signature	MB					

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	6/6/26	6/6/26	7/6/26
		Score	MG	MG	MG
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0	0	0	0
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0			
IV / Heparin Lock or Saline	Yes	20	20	20	20
	No	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			
Total Morse Fall Scale Score:			20	20	20
		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)

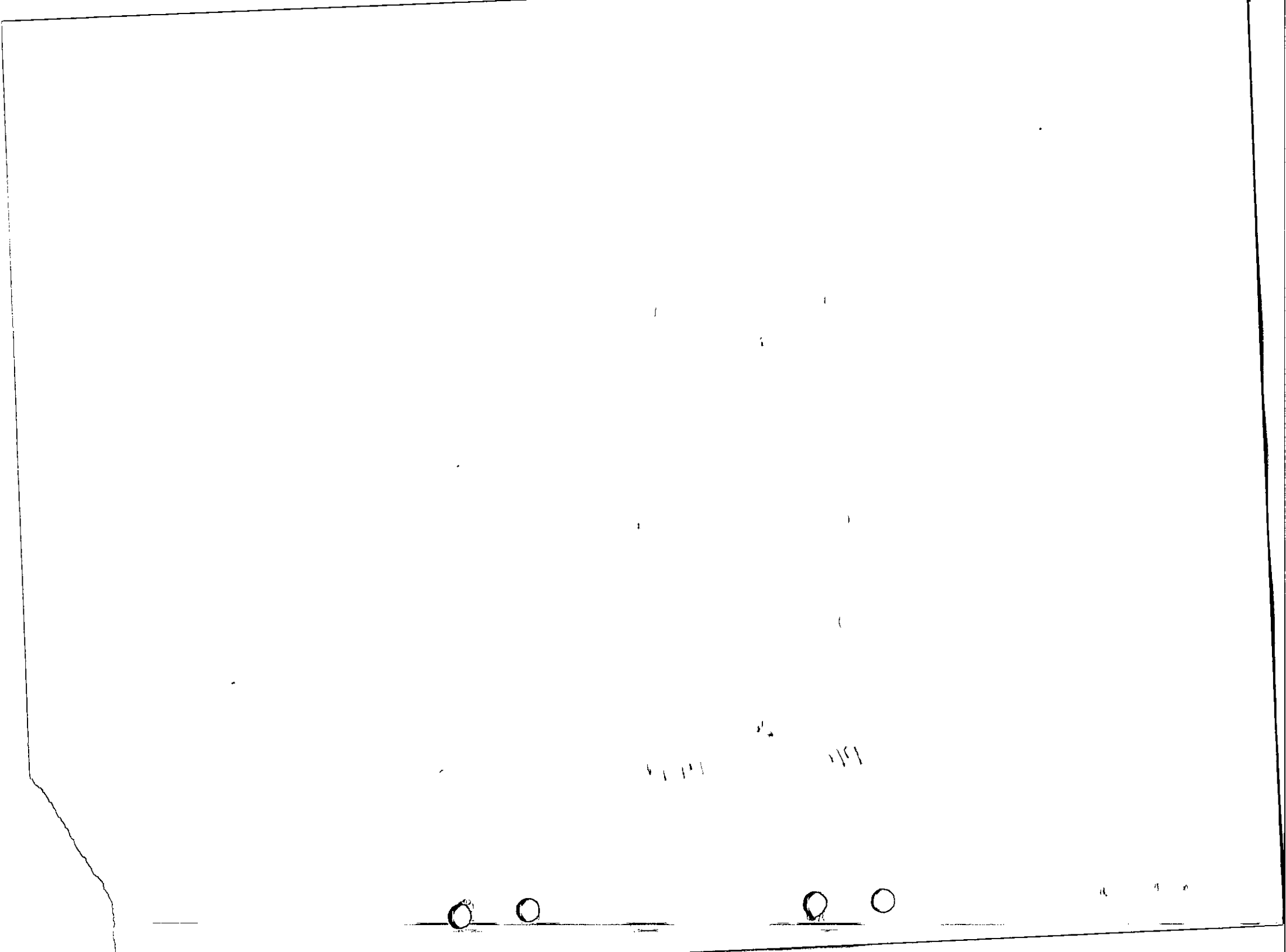
- ☐ Ensure patients use their prescribed eye glasses if any, in the hospital
- ☐ Use chairs with arm rests
- ☐ Use safety straps on stretchers and wheelchairs while transporting patients

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



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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0	0	0	0	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			ND	-	-	-	-	ND	ND	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			ND	-	-	-	-	ND	ND	
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			ND	-	-	-	-	ND	ND	
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			ND	-	-	-	-	ND	ND	
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			ND	-	-	-	-	ND	ND	
		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

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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	7/6/24 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	0									
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	0									
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	0									
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	0									
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	0									
			Signature of the Nurse	DS									

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

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NURSING CARE RECORD

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Date: 3/5/26

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 ↓ 8PM	→ Assess the pt condition → monitor vital → maintain I/O chart	8AM ↓ 8PM	→ Assessed the pt condition → monitored vitals → maintained I/O	Now pt is stable	Re-check vital	Meeri
Afternoon	2PM ↓ 8PM	→ Assess the pt condition → check the vital's → I/O chart Maintain → patient having urine bag & Ted stalking → Plan for Medication	2PM ↓ 8PM	→ Assessed pt condition → checked vitals & Recorded → Maintained I/O chart → Medication given as per doctor's order	patient is stable	vital's is normal	Anusha
Night	8PM ↓ 8AM	→ Assess the pt condition → monitor vitals → maintain I/O chart	8PM ↓ 8AM	→ Assessed the pt condition → monitor vital → Maintained I/O chart	Now pt is stable	Re-check vital	Meeri

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NURSING CARE RECORD

Date: 8/6/26

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 | 2pm	→ Assess the pt condition → monitor the vitals & record → Pt is NBM till further order → Administration of medication → maintain Drochost & drain	8Am | 2pm	→ Assessed the pt condition → monitored the vitals & recorded → Pt is NBM → Administered medication as per doctor order → maintained Drachost & drain	Pt is stable	monitor the vitals & recorded.	AK [signature]
Afternoon				DDY			
Night	8pm to 8Am	→ Assess the patient Condition. → Monitering vitals Checked and Recorded	8pm to 8pm	→ Assess the pt General Condition → Administration medication as for drug Chart.	patient is Stable.	monitering vitals Checked and Recorded.	[signature]

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NURSING CARE RECORD

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Date: 7/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM	→ Assess the pt condition. → Monitor the vitals. → Maintain I/O chart. → drugs give as per drug chart.	8AM	→ Assessed the pt condition. → monitored the vitals. → maintained I/O chart. → drugs given as per drug chart.	→ pt is stable now	→ Re assessed the vitals	(D)
	8pm		8pm				
Afternoon	Day						
Night							

Patient Sticker

NURSING CARE RECORD

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Date: .....

Goals

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

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

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NURSING SHIFT HAND OVER FORM

SITUATION

Diagnosis: TLH.

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

Surgery / Procedure:

Post OP Day:

	Date / Shift	5/6 M	5/6 E	5/6 N	6/6 M	6/6 N	6/7/26 M
BACKGROUND	Medical Condition (Any special condition to be noted):	—	—	—	—	—	—
	Diet:	—	NBM	NBM	NBM	—	Soft diet
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	—	—	—	—	—	—
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98	98.2	98.6	98.1	98.6°F	98.1°F
	Res:	26	20	20	20 bpm	20 b/m	20 b/m.
	SpO_2:	98%	98%	98%	98%	98%	99%
	Pulse:	110/20	110/26	110/20	110/32	110/28	109/69
	BP:	—	—	—	—	—	—
	LOC:	—	—	—	—	—	—
	Fall Risk Score:	—	—	—	0	—	—
	Pain Score:	—	Good	Good	0	—	0
	Skin Integrity	Good	Good	Good	Good	—	Good
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	—	—	—	—	—	—
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	—	NBM	—	—	—	—
	Critical Lab Test / Values:	—	—	—	—	—	—
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	dependent		dependent	—	Dependent	Dependent
Post Operative Procedure Special Orders:		NA	NA	NA	—	—	NA
Handed Over By Name :		Akila	Anusha	Akila	Akila	Priyanka	Divya
Signature / ID :							
Date:		5/6	5/6	6/6/26	6/6/26	6/6/26	7/6/26
Time:		8 AM	8 PM	8 AM	2 PM	8 PM	8 PM
Taken Over By Name :		Akila	Akila	Akila	Priyanka	Divya	
Signature / ID :							
Date:		5/6/26		6/6/26	6/6/26	7/6/26	
Time:		2 PM		8 AM	8 PM	8 AM	

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URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 5/6 Date of Removal: 7/6/26 @ 6:30 Am

Parameters / Date / Shift Time	5/6 AM	6/6/26 AM	6/6/26					
Need for the Catheter	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hand Hygiene	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Usage of Sterile Equipment	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the Collection bag below the level of bladder	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Check the Tube for Obstruction (Free of Kinking)	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Catheter dated as policy	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Collecting bag is been emptied regularly?	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Maintenance of closed system for the catheter	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing clean and dry?	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the line removed as Policy?	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Performance of Perineal Care	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Onset of New Fever	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Asses for the leakage at the site of insertion	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Nurse	Madhu	Akila	Renuka					
Signature of the Nurse	@	@	@					

removed

Docu. No. : RCH /FRM / CLINICAL / 114

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Mrs SWATHI INNANI
09-12-1985 40 Y 5 M 27 D (F)
Dr. SWATHI H V

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...EDICATION RECONCILIATION FORM

Drug Allergies: ..... ☐ Not known any Drug Allergies

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

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

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T Thyronom	100mcg	PO	OD	5/6	☑ 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 Manohar

Date & Time : 5/6/2026 @ 8Am

Nurse Name & Signature: Madhumitha @ Madhu

Date & Time : 5/6/26 @ 8Am

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

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NUTRITIONAL ASSESSMENT FOR GYNEC PATIENTS

Date: 6/6/26 Time: 12:10 pm

Origin: Indian Height: 152 cm Weight: 66 Kg BMI: 28 Kg/m²

Food Allergies: No f A

Diagnosis: TLH + BSO

Medical History: Hypothyroidism

Surgical History: —

☑ Vegetarian ☐ Non-Vegetarian ☐ Vegan

Diet Advised: NPO till further order.

Patient's / Attendant's

Signature: Kumar

Name: Swathi Innani

Date & Time: 6/6/26; 12:10 pm

Dietician's

Signature: Sabiya

Name: Syeda Sabiya Zaheer

Date & Time: 6/6/26; 12:10 pm

7/6/26
12pm Can start with liquid diet as advised.

Sabhwitha S
Dietitian

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OPERATION THEATER NOTES

HNH-00015766 IP26-00006507
Mrs SWATHI INNANI
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Dr. SWATHI H V

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

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

Surgeon : Dr. NAGESHWAR RAO.	Asst. Surgeon : Dr. Swathi HV
Anesthetist : - Dr SAMIR.	OT Nurse : S/N prantha.

Surgical Procedure : →
- TLH + BSO + Adhesiolysis.

Indications for Surgery :
↓ Ⓑ ovarian complex cyst + Endometriosis Grade III.

Date : - 5/05/2026.	Start Time :	End Time :

PRE-OPERATIVE PREPARATION :

OPERATION NOTES: - Patient in low lithotomy position 24A.

→ Intraop findings:

- uterus Ⓝ size
→ Retroperitoneal collection of 8x8cm noted
- Left ovary & tube adherent to left lateral pelvic wall & sigmoid colon densely.
→ Right ovarian endometriotic cysts ⊕ 2x2cm, 3x3cm adherent to posterior surface of uterus & uterosacral ligament.

→ Adhesiolysis done - Retroperitoneal collection drained out, clear fluid noted.

→ Left tube & ov - dissected out, adhesions c̄ sigmoid colon released.

→ proceeded with TLH + BSO ~~done~~.

→ Specimen retrieved vaginally

→ Rectovaginal nodule dissected out & retrieved.

→ Vault closed c vicryl (NO.1). Haemostasis secured
- Thorough irrigation & suction done. Drain placed insitu.
→ B/L ureteric peristalsis noted @ end of procedure
- procedure uneventful.

POST - OPERATIVE ORDERS :–

- NBM - 24 hrs.
- IV fluid → 1 RL / 1 DNS } @ 100ml/hr
- Inj Magnex forte 1.5g iv BD × 48hrs
- Inj PANTOP 40mg OD.
- Inj PCM 1g iv TID
- Inj DICLOFENAC 50mg iv. BD.
- Check vitals @
- I/O charting
→ TEDS stockings.
- Inform SOS.
- Inj ~~[illegible]~~ EMSET 4mg iv BD

DEEPWATHI.H.V.
Consultant Surgeon's Name

Consultant Surgeon's Signature

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

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Swathi H V
Asst. Surgeon :
Anaesthetist : Dr. Samir
Scrub Nurse : Sr. Archana Prabavathi

Patient Name :
UHID No. :
Date : 05/6/26

HNH-00015766 IP2[illegible]0006507
Mrs SWATHI INNANI
09-12-1985 40 Y 5 M 27 D (F)
Dr. SWATHI H V

... Gender : F

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 8:07am

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

Site Marked ☐ Yes ☐ No ☑ NA

Anaesthesia Safety Check Completed ☑ Yes ☐ No

Pulse Oximeter on Patient & Functioning ☑ Yes ☐ No

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

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

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

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

Signature : Dr SRIMA
Name : Dr SRIMA

Before Skin Incision ➤➤

TIME OUT Time: 8:50am

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, 1hr 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 : Rija.
Name :

Before Patient Leaves Operating Room

SIGN OUT Time:

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

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

Signature :
Name :

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00015766 IP26-00006507 Mrs SWATHI INNANI 09-12-1985 40 Y 5 M 27 D (F) Dr. SWATHI H V		05/06/26 @ 10:55am
	Transfer Ordered by Dr. Samir	Reason for Transfer Observation
From Unit OT-	To Unit Pre-Post	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File —	Number of Imaging Films —	Personal belongings including clinical documents. If any handed over to attendant Yes ☑ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
SPS. Puja	Dr. Sreeja

Patient & Clinical Records Received by : Madhu

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

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

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : Swathi. I Age : 40Y Gender : Male ☐ Female ☑

UHID NO: ..... Surgeon Name: .....

Anaesthesiologist : Dr. Srijan Atmireddy

Operative procedure planned : Left oophorectomy / TLH + BSO.

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 : Hypotension, Bradycardia/Tachycardia, Bronchospasm, Laryngospasm, Requirement of Blood & Blood products.

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 Swathi. I ..... the above mentioned operation / Diagnostic / Therapeutic procedures .....

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

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

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

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

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

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

- Pregnant : ☐ Yes ☐ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

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

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

Patient / Patient Attendant :

Signature : .....

Name : Swathi

Relationship with Patient: .....

Date & Time : 5/6/26.

Witness :

Signature : .....

Name : Deepak Annavi

Date & Time : 5/6/26.

Doctor (who is taking the consent) :

Signature : Dr. SRIJAA

Name : Dr. SRIJAA

Date & Time : 5/6/26.

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : MRS · SWATHI INNANI Gender: ☐ Male ☑ Female Age : 40 YRS

UHID No : HNH – 00015766 Date : 5/6/2026

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)

TOTAL LAPROSCOPIC HYSTERECTOMY WITH BILATERAL SALPINGOOOPHERECTOMY WITH ADHESIOLYSIS upon

MRS. SWATHI INNANI (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.

Haemolysis, Adhesiolysis, Injury to adjacent organs, Need for Blood and Blood products transfusion RIO Conversion to laprotomy

My signature on this form indicates that

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

Name of the Doctor who is performing the Surgery / Procedure: Dr· SWATHI HV·

Consentee :

Signature : Deepak

Name : Swathi Innani

Date & Time : 5/6/26@7:30am

Patient Attendant :

Signature : Deepak

Name : Deepak Innani

Relationship with Patient: Husband

Date & Time : 5/6/2026 @ 7:30am

Witness :

Signature : Madhu

Name : Madhumitha

Date & Time :

Doctor (who is taking the consent) :

Signature :

Name : Dr· Naveena.

Date & Time : 5/6/2026@7:30am

IntraOp Consent

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : Mrs Swathi Innani Gender: ☐ Male ☑ Female Age : 40

UHID No : HNH-0015766 Date : 5/6/2024

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)

TOTAL LAPAROSCOPIC HYSTERECTOMY WITH BILATERAL SALPINGO-OOPHORECTOMY upon

(Name of the Patient) Mrs Swathi Innani

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.

Bleeding, Infection, Injury to Bowel, Bladder, Blood vessel, chances of Blood transfusion, chances of Conversion to Laparotomy

My signature on this form indicates that

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

Name of the Doctor who is performing the Surgery / Procedure: Dr Swathi HV

Consentee :

Signature :

Name : Swathi Innani

Date & Time : 5/6/24 @ 9AM

Witness :

Signature : Madhu

Name : Madhumita

Date & Time : 5/6/24 @ 9AM

Patient Attendant :

Signature : Deepak

Name : Deepak Innani

Relationship with Patient: Husband

Date & Time : 5/6/2024 @ 9pm

Doctor (who is taking the consent) :

Signature :

Name : Dr Mamta

Date & Time : 5/6/2024 @ 9AM

Ref. No. : F / HW / CON / HR / 05

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INFORMED CONSENT FOR HIGH RISK

Patient Name : MRS. SWATHI INNANI Age : 40YRS

Gender : ☐ M ☐ F - IP No. : HNH - 0001576 6

Ward / Bed No. : ..... Date : 5/6/2026

I/We MRS. SWATHI INNANI have been explained by Dr. SWATHI HV

about the medical condition and the proposed procedure.

I/We have been told that our patient MRS. SWATHI INNANI. has the

Following Medical Condition / Diagnosis

P1L2E1 with pre. ISCS with.
Bilat complex ovarian Cyst and Right Endometriotic Cyst - Adherent to Postero lateral wall.

Proposed treatment / Procedure / Operation:

Total laproscopy hysterectomy + BSO + Adhesiolysis.

I / (We the relative / legal guardian) have been explained in the language understood by me / us,

about the medical condition mentioned above and that our patient has following risks involved

Haemorrhage, Injury to adjacent organs, Need/risk of Conversion to laprotomy

I / We have been explained that our patient carrier a higher risk than usual and there reason for the I / We have been informed that the ongoing treatment in the ICU involves the risk of unsuccessful result, complication, temporary or permanent injury or disability and even fatality from known or unforeseen causes and no guarantee or promises have been made to me / us concerning the results I / We have understood the consequences of not undergoing the proceed treatment. I / We hereby give (my / our) full consent for the above –mentioned treatment.

Name of the Doctor performing the procedure : Dr. SWATHI HV | Dr. NAGESHWAR RAO

Patient Attendant :

Signature : Deepak

Name : Deepak Innani

Relationship with Patient: Husband

Date & Time : 5/6/2026 @ 7:30am

Witness :

Signature : Deepak

Name : Deepak Innani

Date & Time : .....

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. Naveena

Date & Time : 5/6/2026 @7:30am

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: Mrs. Swathi Irrani Age: 40 Sex: female UHID.No : HNH-15766

Date: 3/6 Time: 1pm Proposed Operation: Ⓛ oophorectomy / +/- TLH +BS

Diagnosis: Endometriotic cyst Ⓒ.

B.P / CRT: 100/61 H.R: ..... Weight: 66 ASA Physical Status: ☑1 ☐2 ☐3 ☐4 ☐5

Laboratory Data:

Hgb: 12.9	Glucose: 97	Protein: 8.4	HIV: NR	X-Ray: WNL
PCV: 36.9	Urea:	Alb: 4.1	HBS Ag: NR	ECG: NSR - VR - 55
WBC: 9400	Creat: 0.6	Total Bill: 0.4	HCV: NR	2D Echo: EF-65%. (N) VALVE
Plate: 2.97	Na:	Dir. Bill: 0.1	Blood group: B pos.	Stress/Anglo: NO RWMA
PT: 13.2	K:	LDH:	T3	Other: Good LV/RV func
PTT: 26.5	Ca++:	Alk phos: 88	F T4 1.23	
INR: 0.89	Mg++:	Amylase:	TSH 1.65	
eGFR - 117.7 HbA1c - 5.0	Cl -:	SGOT/SGPT: 32/30		

27/5

Allergies: NKDA.

Medical History: CVS : NO CAD°/PALPITATIONS°/HTN°/SYNCOPE°

RESP : NO BA°/TB°/PNEUMO°/COVID° Diabetes : NON-DIABETIC

CNS : NO SEIZURES°/CVA°/TIA°/

Renal : NO URINARY SYMPTOMS.

Hepatic / GE : NO RECENT JAUNDICE Physical Activity: NYHA - I, METS >10

Others : hypothyroid (2019) - compliant c medication

Past Anaesthetic History: lap ov. cyst. x 2 + GA / IVF + TIVA / LSCS (2016) + SAB (PDPH)

Physical Exam: CONSCIOUS / COHERENT ectopic (R) + GA. / Lap. torsion (?) (L) + GA.

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

Lungs : / clear

Heart:

CNS:

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	100 MCG.
a	

Pre-Operative Instructions: fasting explained

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours; Others 6 Hours
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☑ Discussed with Patient
5. Other Instructions:
   - THYRONORM TO CONTINUE
   - (D) PROC to be resumed.

Signature: Name: Dr Samira Nayak.

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

HNH-00015766 IP26-00006507
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09-12-1985 40 Y 5 M 27 D (F)
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ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No	Fasting Status: 7 hrs	
Physical Status: ☑ Patient Identified	☑ Consent Present	☑ Chart Reviewed

H.R: 70bpm | B.P / CRT: 107/78 | SpO_2: 100% RA | R.R: 14/mnt | Last Feed: 4/4/26

Pre-OP Diagnosis: ..... Operation: TLH Date: 5/6/26

Surgeon: ..... Anaesthesiologist: Dr. Samir / Dr. SA Technician: Saraswathi

TIME	8:30	9				10			11
N_2O/AIR/O_2 LPM	1L/mn								
HALO/SO/SEVO	1MAC								
Drugs:									
MIDA 2mg/ml	2mg/IV								
FEN-TANYL	100mcg/IV								
PROPOFOL	130mg/IV								
ROCURONIUM	40mg/IV		110mg			40mg/IV			
MYORELAX	5ml/IV								
FIO_2 / SaO_2		100	100	100	100	100	100	100	100
$ETCO_2$		32	34	35	36	38	40	40	41	40
ECG		SR	SR	SR	SR	SR	SR	SR	SR	SR
Temperature			33.7			36.3				
Urine Output										
RL		11	11	11	11	11	11	11	11	1
Fluids / Blood										

Antibiotic

Suppository

Blood Loss

NOTES

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

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

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

LAB Values: ABG | GRBS | Others

☑ Equipment Checked and Functional
☑ BP
☑ Cuff Site: Lt UL
☐ Art Site: .....
☑ EKG Lead
☑ Temp Site skin
☑ FIO_2 Monitor
☑ Agent Monitor
☑ Pulse Oximeter
☑ Capnograph
☑ Ventilator
☐ Nerve Stimulator

Position: supine
☐ 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: 8:30Am
OP Start: 8:50Am
OP End: 10:30Am
Leave OR: 10:45Am

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP: .....
☐ ART: .....
☑ IV: 18G - RtUL
☐ IV: .....
☐ IV: .....

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

☐ Mask ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
ETT# 7 at 19½ cm
☐ Oral ☐ Nasal ☑ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug: ROCURONIUM.

☐ Awake ☐ Direct Vision
☑ Video Laryngoscopy ☑ Stylette / Bougie
☐ Fiberoptic
Blade# 3 Attempts: 1
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 R/R
☐ PACU ☐ ICU ☐ Other
Relaxant Reversed ☑ Yes ☐ No ☐ NA
Name of the Doctor : Dr. SRIMAA
Signature of the Doctor : Dr. SRIMAA

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Dr. SWATHI H V

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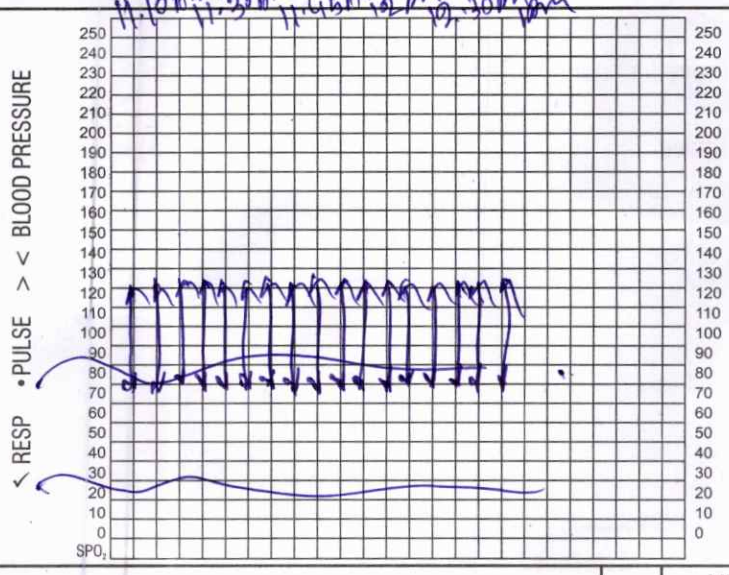
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Madhu Time Received : 11 AM Time Discharged : .....

11.10 am 11.30 am 11.45 am 12 pm 12.30 pm



IV Cannula Site : Right

- ☐ O_2 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: NIL

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
5/6	11Am	0	Normal	
5/6	12Pm	0	Normal	
5/6	3Pm	0	Normal	
6/6	6Am	0/10	NA	

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

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

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

PACU Nurse Name : Akhila
PACU Nurse Signature: .....
Date & Time: 6/6/26

Transferred to Unit by (PACU): (306)
Date & Time: 6/6/26

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : .....

Any other issues :

a) .....

b) .....

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level Left Right	Maternal		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 : .....

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NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name: Mrs Swathi Innani		Age: 40 Y	Gender: Female
UHID No: HNH-RD0157[illegible]	IP No: 26-00006507	Date: 5/6/26	Time: 7.36
Diagnosis: TLH (LSCT)			

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml		
2.	Morphine Sulphate Inj. 15mg/Ml	15mg	01 Amp
3.	Remifentanil Hydrochloride Inj. 2MG		
4.	Remifentanil Hydrochloride inj. 1MG		

Doctor Name: Dr SAIRAM V Doctor Registration No: APMC 75177

Signature: SAIRAM V

NARCOTIC DISPENSING FORM
APPENDIX 4 – FORM NO. 3E
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: 26-00006507 **Date:** 5/6/26

Aadhaar No. of the Patient (Optional): .....

1.	**Name :** Mrs Swathi Innani	**Remarks**
2.	Complete postal address (with contact number, if any)	Royal Apartment Narsapur
3.	Brief description of the illness	TLH
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	NO
5.	Details of essential Narcotic drug dispensed	INJ. Morphine

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
5/6	INJ. Morphine	01		

Dispensed by (Name & ID No.): Sania Signature: .....

Received by (Name & ID No.): M Arvind Kumar (021257) Signature: Arv

Time: .....

Docu. No: RCH / FRM / CLINICAL / 133

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NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name: Mrs Swathi Innani		Age: 40Y		Gender: Female	
UHID No: HNH-00015766	IP No: 26-00006507	Date: 5/6/26		Time: 7:41Am	
Diagnosis: TLH (W: OT)					

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	50 mcg	01 Amp
2.	Morphine Sulphate Inj. 15mg/Ml	—	—
3.	Remifentanil Hydrochloride Inj. 2MG	—	—
4.	Remifentanil Hydrochloride inj. 1MG	—	—

Doctor Name: Dr SAIRAJ V — Doctor Registration No: APMC 75177

Signature: [signature]

NARCOTIC DISPENSING FORM
APPENDIX 4 – FORM NO. 3E
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: 26-00006507 **Date:** 5/6/26

Aadhaar No. of the Patient (Optional): ......

		Remarks
1.	**Name :** Mrs Swathi Innani	
2.	Complete postal address (with contact number, if any)	Roy al Apartment Narayanguda
3.	Brief description of the illness	TLH
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	NO
5.	Details of essential Narcotic drug dispensed	Fentanyl

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
5/6	INJ : Fentanyl	01	[signature]	

Dispensed by (Name & ID No.): sania Signature: ......

Received by (Name & ID No.): M. Arvind kumar (021257) Signature: [signature]

Time: ......

Docu. No: RCH / FRM / CLINICAL / 133