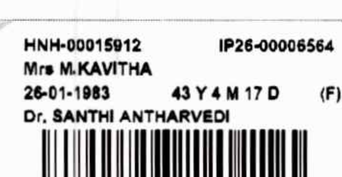
HNH-00015912 IP26-00006564
Mrs M.KAVITHA
26-01-1983 43 Y 4 M 17 D (F)
Dr. SANTHI ANTHARVEDI

SURGERY DETAILS

Date : 12/6/26

Patient Name: Mrs. Kavitha Date of Birth: 26-01-1983 Age: 43Yrs

Gender: female Ward : OT-II UHID No.: HNH-00015912 IP26-00006564

Date of Surgery: 12/6/26 ☐ OT -1 ☑ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Total Laparoscopic Hysterectomy + B/L salpingectomy + Adhesiolysis + Rt ovarian cystectomy.

Time in : 8:30 Am Time Out : 10:55 Am

		NAME	AMOUNT
1.	Surgeon	Dr. Santhi, Dr. Swathi	
2.	Anaesthetist	Dr. Ayusha	Mrs M.KAVITHA (43 Y 4 M 17 D/ F) UTERS NINV00213 HN26009703UTERS
3.	Assistant Surgeon	–	
4.	OT Technician	Br. Arvind	
5.	Circulating Nurse	Sr. Karuna	
6.	Assistant Nurse	Sr. Sandya	

Special Equipment:
☑ Laparascopy (26-000020618S) ☐ Broncoscope ☑ Harmonic (26-000020618 4) vesselsealing ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others vesselsealer

Signature of the Surgeon Signature of Circulating Nurse Karuna.

Order No: 26-000020 6184/185 Order by: Sushela 12/6/26 @ 11:41 Am

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

HNH-00015912 IP26-00006564
Mrs M.KAVITHA
26-01-1983 43 Y 4 M 17 D (F)
Dr. SANTHI ANTHARVEDI

TLH + B/L Salpingectomy
Ovarian Cystectomy

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

CONSUMABLES OF OT

Circulating staff : Sr. Sandhya Technician : Br. Aravind Date : 12/6/26 Time :

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube 6.5 cuffed		01	Major Pack		01	Inj Vit.K		
LMA			Sutures Stratafix 407		01	Cord Clamp		
ECG leads : A / P / N		03	5062		01	Suction Catheter		
HME filter : A / P / N		02				Feeding Tube		
Syringes : 10 cc		04				Vaccum Suction Set		
05 cc		04	Gloves S: G 6½	4		Surgical Gloves		
02 cc		04	Encore 6, 6½, 7	1+1+1		Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / P / N		01	Surgical blade 11	01		Surgical Blade # 20		
IV set		01	NG tube			Koochies (S)		
RL		03	Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml		01+02	Koochies			TURP set		01
Minispike (V)		01	Ointments			Tegaderm 8582		4
PCM		01	Suction Catheter					
Fentanyl		01	Cap, Mask	40 + 40		Proximate plus		01
Morphine		01	Gauze Pack 7.5 (m)		02			
Ketamine			Mop Pack		01			
Propofol		02	Steristrip					
Rocuronium		03	Underpad		2			
Glycopyrolate		01	Draw sheet					
Myopyrolate		01	Abgel					
Ondansetron		01	Foleys catheter 16		01			
Pencan 25g/ Spinal Needle 22			Urobag		02			
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
O2 mask [A]		01	Tegaderm					
Suppositories			~~Ioban~~ Leggings Big	4				
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg		01	Vaccum Suction set		02			
Justin : 12.5 mg / 25mg / 100mg		01	Plastic ~~Bed Sheet~~ Disposable		2			
Tab. Misoprost : 200mg			Betadine Solution		02			
PMoline 200cm		01	Microshield		02			
Dexamethazone		01	Cotton Balls		01			
Nasal airway 26		01	Latex Gloves		20			
Ryles Tube 16		01	Ramdione Scrub					
Tranexa		02	Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 26-0000206212 / 211 Ordered by :

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-00015912	Name	: Mrs M.KAVITHA
Age / Sex	: 43 Y 4 M 17 D / Female	Doctor	: SANTHI ANTHARVEDI
Adm/Reg Date/Time	: 12/06/2026 06:10	Payor	: STAR HEALTH AND ALLIED INSURANCE CO LTD
Order Date	: 12/06/2026 12:42	Ordernumber	: 26-0000206211
Visit	: IP26-00006564	Ward/Bed No	: 4F -OT / PPO-417
Patient Address	: mig-2nd block no:08, flat no-11, baghlingampally, hyd, Bagh Lingampally, Hyderabad, Telangana, INDIA, 500044		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	BCV-INTRAFIX SAFESET		1 Nos	/ Once Daily	1 Days		1 Nos	Ordered
2	THEMIPYRRNOM 0.2MG INJ		1 Nos	Injection / 10 AM	1 Days		1 Nos	Ordered
3	MYOPYROLATE-INJ-5ML		1 Nos	/ Once Daily	1 Days		1 Ampule	Ordered
4	PROXIMATE PLUS MD 3500 STAPLER(PMW35)	PROXIMATE PLUS MD 3500 STAPLERPMW35	1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
5	UNDERPADS 60X90 BUTTERFLY		1 Nos	External / 10 AM	1 Days		2 Nos	Ordered
6	POVINANZ SOLUTION 10% 100 ML		1 Nos	External / Once Daily	1 Days		2 Nos	Ordered
7	SURGEON CAP(FEMALE)	FEMALE CAP	1 Cap	External / Once Daily	1 Days		10 Cap	Ordered
8	FACE MASK 3 LAYER - ELASTIC	FACE MASK 3 LAYER	1 Nos	External / Once Daily	1 Days		10 Nos	Ordered
9	NITRILE EXAMINATION GLOVES P F- MEDIUM	NITRILE GLOVES M	1 Nos	External / Once Daily	1 Days		20 Nos	Ordered
10	NS 100ML ACCULIFE - EH		1 mL	External / 10 AM	1 Days		1 mL	Ordered

SANTHI ANTHARVEDI

Reg No : 49827

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Note

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

*** Do not refill medicines.**

Rainbow Childrons 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-00015912	Name	: Mrs M.KAVITHA
Age / Sex	43 Y 4 M 17 D / Female	Doctor	SANTHI ANTHARVEDI
Adm/Reg Date/Time	12/06/2026 06:10	Payor	STAR HEALTH AND ALLIED INSURANCE CO LTD
Order Date	: 12/06/2026 12:42	Ordernumber	26-0000206212
Visit ID	: IP26-00006564	Ward/Bed No	4F -OT / PPO-417

Patient Address : mig-2nd block no:08, flat no-11, baghlingampally, hyd, Bagh Lingampally, Hyderabad, Telangana, INDIA, 500044

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	TEGADERM WITH PAD 5X7CMS (3582)(8582)	TEGADERM 8582	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
2	LEGGINGS DISPOSABLE (PROTECTCARE) BIG		1 Nos	/ 10 AM	1 Days		1 Nos	Dispensed
3	COTTON BALLS 2 GM 5 NOS	COTTON BALLS 2G- 5 NOS	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
4	VACCUME SUCTION SET	VACCUME SUCTION SET	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
5	BIOXAMIC 500 MG INJ		1 Nos	/ Once Daily	2 Days		2 Ampule	Dispensed
6	JUSTIN SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
7	Encore Microptic gloves-6.5		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
8	OxygenMask With Tubing - Adult ROMSONS-FC		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
9	NS 1000 ML CLOSED EUROFLEX	NORMALSALINE 1000ML CLOSED	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
10	PREGELLED SURGICAL PLATES(ADULT)	PREGELLED PLATED ADULT	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
11	E.C.G ELECTRODES (ADULT)	ELECTRODES ADULT	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
12	ENCORE MICROPTIC GLOVES-7 PF		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
13	ET TUBE - 6.5 MM CUFFED (WELCO LIFE)		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
14	MERSILK 1-0 NW 5062	MERSILK 5062	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
15	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
16	SURGICAL BLADE 11	SURGICAL BLADE 11	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
17	ENCORE MICROPTIC GLOVES-6 PF		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
18	ONDOKIND INJ 4 MG 2 ML	ONDANSETRON 4MG 2ML INJ	1 Nos	/ Once Daily	1 Days		1 Vial	Dispensed
19	IRRIGATTO(T.U.R SET)	IRRIGATTO(T.U.R SET)	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
20	MAJOR PACK	MAJOR PACK	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
21	NASOPHARYNGEAL TUBES 26	NASOPHARYNGEAL TUBE26	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
22	ROCUNIUM INJ 50 MG 5 ML		1 Nos	/ Once Daily	3 Days		3 Vial	Dispensed
23	DEXAMETHASONE INJ 2 ML		1 Vial	External / Once Daily	1 Days		1 Vial	Dispensed
24	MOPS 30X30 8PLY 5S X-RAY	MOPS 30X308 PLYDATT	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
25	H.M.E FILTER (ADULT)-1641-POLYMED		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
26	SUPRIDOL SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
27	RELIPARA(PARACETAMOL) 1000MG 100ML BOTTLE		1 Nos	Injection / Once Daily	1 Days		1 Nos	Dispensed
28	MINISPIKE-V	MINISPIKE-V	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
29	UROBAG (ADULT) - URODYNE		1 Nos	External / 10 AM	1 Days		2 Nos	Dispensed
30	FOLEYS CATHETER 16-UROCATH		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
31	RL 500 ML CLOSED SYSTEM	RINGER LACTATE 500ML CLOSED	1 Bottle	/ Once Daily	3 Days		3 Bottle	Dispensed
32	DISPOSABLE APRONS STERILE XL	DISPOSABLE APPRON STERILE XL	1 Nos	/ Once Daily	2 Days		2 Nos	Dispensed
33	DSYRINGE 5ML(NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
34	GAUZE 7.5X7.5 12 PLY (5 NOS)	GAUZE 7.5X7.5 12 PLY 5 NOS	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
35	RYLES TUBE 16 POLYMED		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
36	DSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
37	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
38	HIGH PRESSUR EXTENTION 200 CM PRYMAX		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
39	STRATAFIX SPIRAL PDO (SXPD2B407)	STRATAFIXSPIRALPDO (SXPD2B407)	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
40	MCT-ROF 100MG 10ML		1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
41	BACTOPREP SOLUTIONS 100 ML	CHLORHEXIDINE GLUCONATE2% &ALCOHOL80% 500	1 mL	/ Once Daily	2 Days		2 Nos	Dispensed

SANTHI ANTHARVEDI

Reg No : 49827

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Note

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

* **Do not refill medicines.**

210.

Name	Mrs M.KAVITHA	UHID	HNH-00015912
Father/Guardian	Mr K.GANGADHAR	Age/Gender	43 Y 4 M 17 D/ Female
Address	mig-2nd block no:08, flat no-11, baghlingampally, hyd, Bagh Lingampally, Hyderabad, Telangana, INDIA, 500044		
IP No	IP26-00006564	Admission Date	12-06-2026
Ref Doctor	Self.		
Discharge Date	14.06.2026		

DISCHARGE SUMMARY

Consultant:
Dr. SANTHI ANTHARVEDI
MBBS, M.S (OBGYN)
49827

Diagnosis: P2L2 WITH ABNORMAL UTERINE BLEEDING-ADENOMYOSIS AND LEIOMYOMA

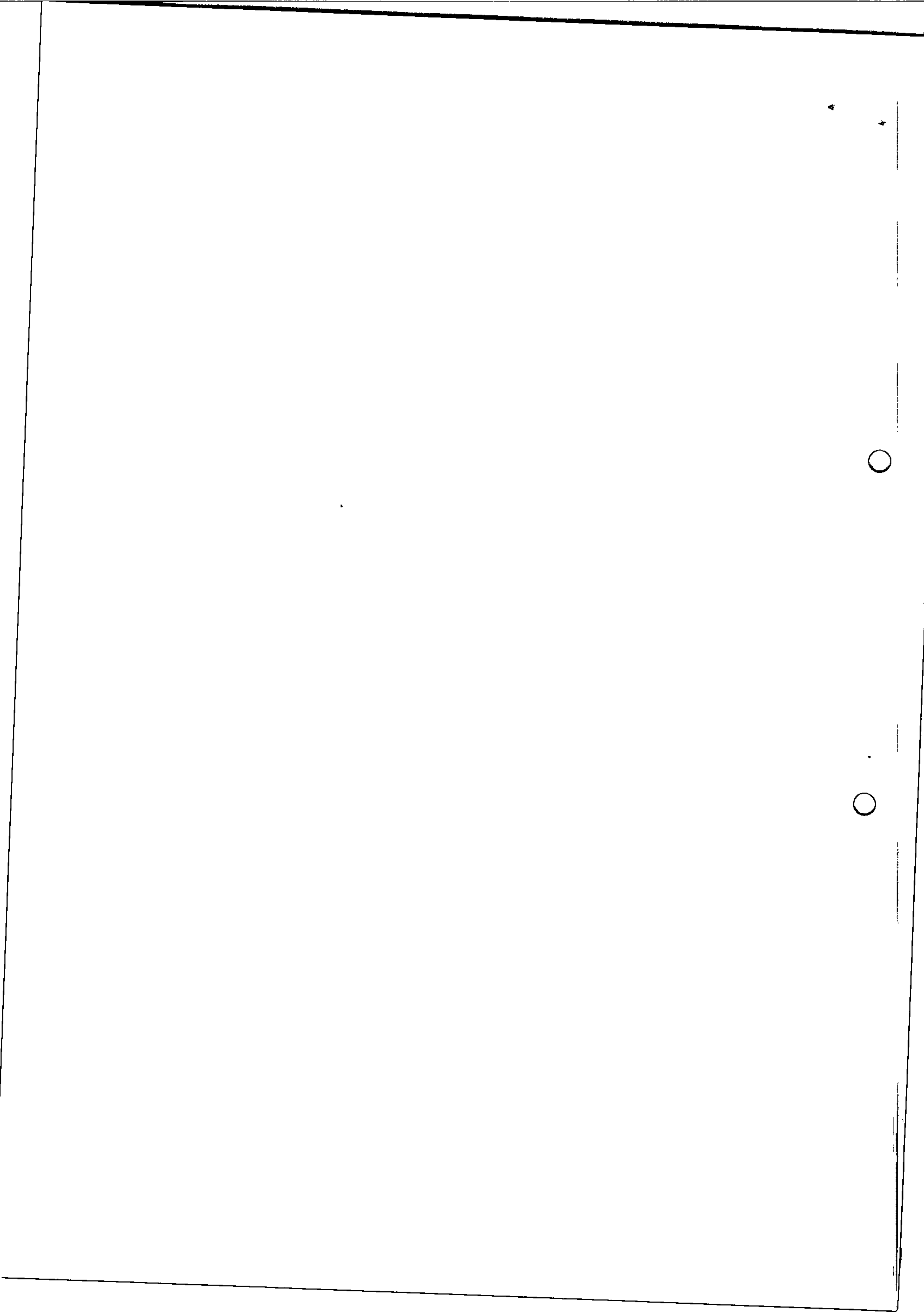
TOTAL LAPAROSCOPIC HYSTERECTOMY + BILATERAL SALPINGECTOMY + ADHESIOLYSIS + BILATERAL OVARIAN CYSTECTOMY DONE ON 12.06.2026

History: She came with complaints of heavy mensural bleeding, associated with passage of clots and dysmenorrhea since 3 months. USG scan done on 21.05.2026 uterus bulky (89*44*50mm), Posterior subserosal fibroid (12*9mm), and Anterior myometrial fibroid(10*7mm), ET:6mm, bilateral ovaries visualised and normal. She was admitted for Total laparoscopic hysterectomy and bilateral salpingectomy.

Menstrual History:-
LMP- 21.05.2026
Previous cycles: Regular

Obstetric History: P2L2, 1NVD, 1LSCS, LCB-14 years ago.

Medical History: K/C/O hypothyroidism on Tab. Thyronorm 75mcg
Surgical History: 1 LSCS, Laparoscopic Tubectomy



Name	Mrs M.KAVITHA	UHID	HNH-00015912
IP No	IP26-00006564	Admission Date	12-06-2026

Allergies: Nil
Family History: Mother-hypothyroidism

Investigations: Enclosed.
Blood group: "A" Positive

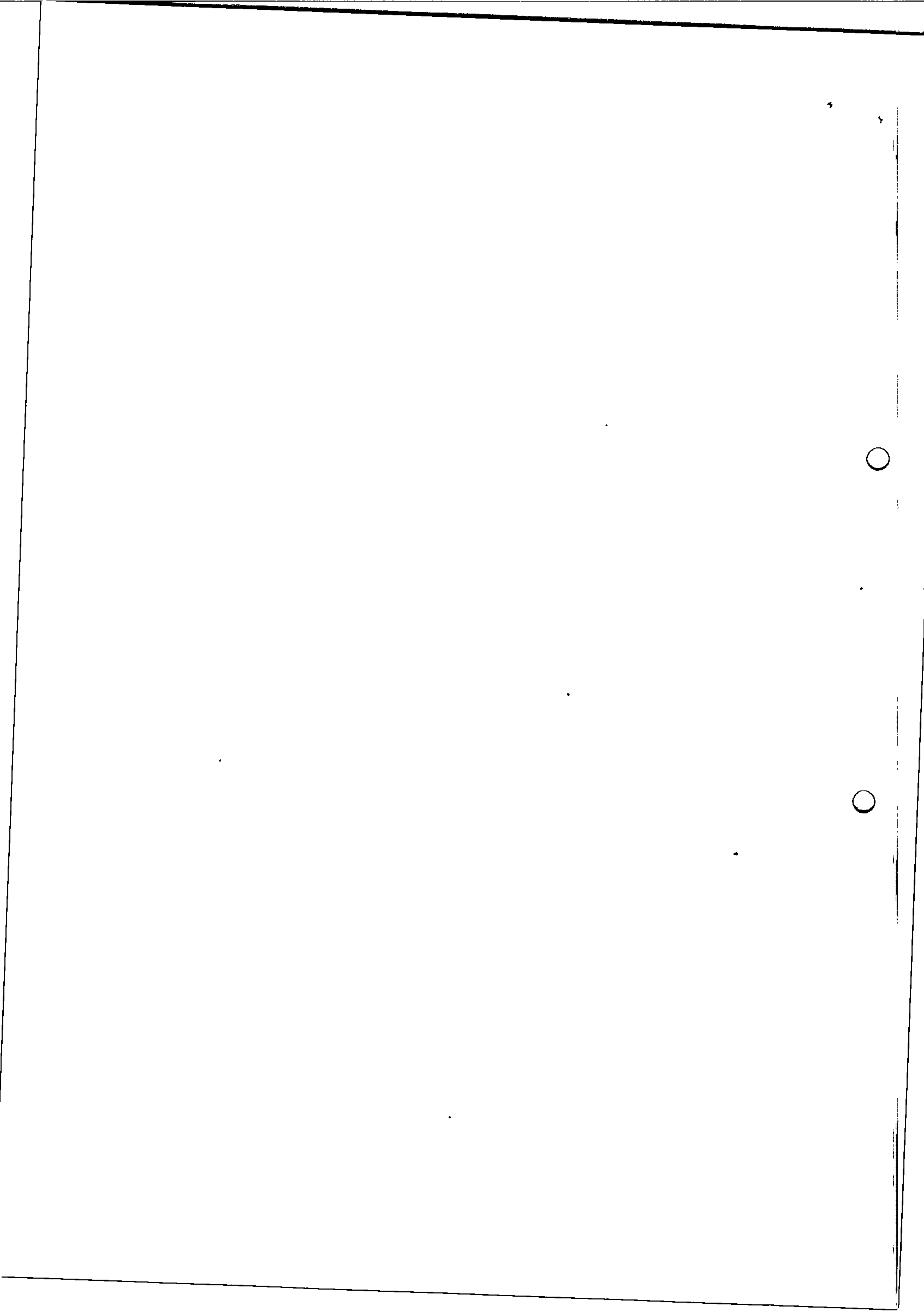
Surgery Notes:
Operation performed: **TOTAL LAPAROSCOPIC HYSTERECTOMY + BILATERAL SALPINGECTOMY + ADHESIOLYSIS+ Right OVARIAN CYSYSTECTOMY.**

Indication: AUB-L+A

Operative findings:
- Uterus 8 weeks size.
- Bilateral ovaries cystic, right ovary-2*2cm cyst and left ovary - 2*1 cm cyst noted.
- Bilateral tubes normal.
- Omental adhesions noted to Anterior Abdominal wall - Adhesiolysis done.
- Proceeded with TLH+BS done, followed by right ovarian cystectomy.
- Specimen retrieved vaginally.
- Vault closed by stratafix no.2-0
- Procedure was uneventful.
- Hemostasis secured.
- Thorough irrigation and suction done.
- Urine clear at the end of procedure.

Post-Operative Notes: She was closely monitored in the postoperative period. Her vital signs remained stable. CBP repeated on Post operative day 1 and found to be normal. She was shifted to room. She was encouraged to ambulate and void spontaneously. Her general condition was satisfactory and she was found to be fit for discharge. Wound care and medications were explained to the patient supplemented by written information.

Advice:
1. Tab. Ceftum 500mg (Cefuroxime Axetil 500mg) twice daily till 20.06.2026 (9am - 9pm) after food.
2. Tab. Aceclo-Plus(Aceclofenac + Paracetamol) Thrice daily (8am-3pm-10pm) till 18.06.2026
3. Tab. Pantodac 40 mg (Pantoprazole 40mg) once daily (7am) before food till 18.06.2026.
4. Collect HPE reports.



Name	Mrs M.KAVITHA	UHID	HNH-00015912
IP No	IP26-00006564	Admission Date	12-06-2026

5. Syp.Cremaffin 15ml at bed time SOS.
6. Tab. Livogen (Elemental Iron - 50mg, folic acid 1.5mg) Twice daily for 1 month. before breakfast.
7. Tab. Zincovit once daily (2pm) for 1 month after food.
8. Inj.Clexane(Enoxaparin) 40mg sucutaneously over thigh once daily till 14.06.2026 (10pm)

Review consultation with Dr. SANTHI ANTHARVEDI, after **1week** on **19.06.2026** with HPE reports in Gynec OPD (**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**

Veena

Registrar/Resident/C.M.O

Consultant:
Dr. SANTHI ANTHARVEDI
MBBS, M.S (OBS&GYN)
49827

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 : IP26-00006564 **Admit Date** : 12-Jun-2026 **Admit Time** : 06:10 AM **UHID** : HNH-00015912

Patient Details :

Patient Name	: Mrs M.KAVITHA	**Age**	: 43 Y 4 M 17 D
Guardian	: Mr K.GANGADHAR	**DOB**	: 26-01-1983
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: mig-2nd block no:08, flat no-11, baghlingampally, hyd Bagh Lingampally Hyderabad Telangana INDIA 500044	**Phone No**	: 9908850597/ 9866417925
		E-mail	: na@gmail.com

Admission Details :

Bed Type	: TWIN SHARING	**Bed No**	: PPO-417	**Ward Name**	: 4F -OT
Room No	: PPO-417	**Admission Type**	: First Visit		

Contact Details :

Name	: Mr K.GANGADHAR	**Relationship**	: Husband
Contact Address	: mig-2nd block no:08, flat no-11, baghlingampally, hyd Bagh Lingampally Hyderabad Telangana INDIA 500044	**Phone No**	: 9908850597

Signature

Doctor Details :

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

Payment Details :

Payment Mode	: DC/CC Card	**Deposit Amount**	: 10000.00
		Payor Name	: STAR HEALTH AND ALLIED INSURANCE CO LTD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PATIENT TRANSFER FORM

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00015912 IP26-00006564 Mrs M.KAVITHA 26-01-1983 43 Y 4 M 17 D (F) Dr. SANTHI ANTHARVEDI	12/6/26 @ 6:10AM	12/6/26 @ 8:31 Am
	Transfer Ordered by	**Reason for Transfer**
	Dr. Santhi	TLH + BSO
From Unit	**To Unit**	**Information to Attendant**
pre post	OT	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
35	Nil	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. Archana	Dr. Santhi

Patient & Clinical Records Received by : Karuna

Date & Time of Patient Received : 12/6/26

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

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

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

TLH+BSO

ACTIVITY RECORD FOR BILLING

HNH-00015912 IP26-00006564
Mrs M.KAVITHA
26-01-1983 43 Y 4 M 17 D (F)
Dr. SANTHI ANTHARVEDI

Name: --

UHID No : ----------- Consultant : ------------------------ Dept : -----------------

Date of Admission : ------ Date of Discharge : ---------------- Time: -----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
12/6/26	8:31 Am	pre post	OT	Mounika / Karuna
12/6/26	10:40 Am	OT	pre - post	Karuna / [signature]
13/6/26	10 Am	pre-post	210	Sujatha /

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
12/6	4RBS (117 mg/dL) 11:30 Am	9704 ✓	[illegible]
13/6/26	CBP	9738 ✓	[illegible]
		Coors charted done by [illegible]	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
12/6/26	Cardiac Monitor	11Am	13/6/2026 10AM	206189	[illegible]
12/6/26	Infusion pump	11Am	13/6/2026 10AM	206189	[illegible]
12/6	oxygen	11Am	12/6/2026 2pm	206189	[illegible]

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
12/6/26	IV Placement	1	206132	[illegible]
12/6/26	catheterization	1	61909	[illegible]
	PAC (OP)	1	12335	[illegible]
13/6/26 (11am)	NHA	1	6441	[illegible]
			Cross checked done by Anglia	

ANY OTHER INFORMATION

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00015912 IP26-00006564
Mrs M.KAVITHA
26-01-1983 43 Y 4 M 17 D (F)
Dr. SANTHI ANTHARVEDI

I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 12/06/2026 Time of Admission : ....

Allergies: nil. ☑ Not know any drug allergies

PRESENTING COMPLAINTS :

- c/o. heavy menstrual bleeding : 3 months.
- 5-6d/25-30. c̄ passage of clots.

Scan done:
- Uterus bulky 9 x 4 x 6 cm.
- 2 x 1 cm, 1 x 3 cm : fibroid ⊕ over posterior myometrium
- ET = 6 mm, B/L ov ⓝ, R OV: 3 x 1.6 cm cyst ⊕

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : -	Parity : - P2L2
Previous Periods : LMP → 21/5/2026	Mode of Delivery : 1NVD / 1LSCS.
LMP :	Last Child Birth : 16 yrs back
Contraception : - nil	

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
K/c/o hypothyroidism on TAB. Thyronorm 75 mcg	- LSCS - Lap Resection(?)

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

HNH-00015912 IP26-00006564
Mrs M.KAVITHA
26-01-1983 43 Y 4 M 17 D (F)
Dr. SANTHI ANTHARVEDI

FAMILY HISTORY:	**MEDICATION HISTORY:**
- Mother hypothyroidism	TAB Thyronorm 75 mcg

INITIAL ASSESSMENT :

	Breasts	Local/Speculum Examination
Date 12/06/2026 Ht. ____ Wt. 52kg BMI ____ B.P 110/70. Pallor nil. CVR ____ Respiratory System ____ Thyroid ____	(N) Abdominal Examination (N) p/scar (+)	- Bimanual Pelvic Examination -

PROVISIONAL DIAGNOSIS : - AUB - A + h

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT
(21/05) - HB = 11gr. BGT → A+ve - plt - 2.16. HCV / HBsAg / HCV - NR RBS - 86.	- Admission - Informed consent - pre op Ab + meds do as per drug chart → IV fluid @ 100ml/hr. → shave & prepare parts - shift to OT on call → Reserve 1 PRBC.

Name of the Doctor : Dr. Swathi, HV

Signature of Doctor: [signature]

Date & Time : 12/06/2026.

HNH-00015912 IP26-00006564
Mrs M.KAVITHA
26-01-1983 43 Y 4 M 17 D (F)
Dr. SANTHI ANTHARVEDI

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	c/s/b/y. Dr. Naveena	
12/06/2026 11:30am		
	O/E GC-fair	Adv
	Afebrile	- NBM for 6hrs
	PR: 56bpm	- foley's T/M
	BP: 70/40mmHg —inf→ 96/56mmHg	@12pm
	CVS/RS: NAD	- CBP-T/M 6am.
	PA: soft, NT	- drugs as charted
	Dressing: dry & clean	- w/f PV bleeding.
	ILE: ~~[?]~~ NAD.	- Soft diet T/M.
	U/O: 200ml clear	- Monitor Vitals
	emptied in OT	- Urine I/O charting
		- Inform SOS
		Dr. Naveena.
12/6/26 3:30 pm	c/s/B Dr. Veena	
	POD-0 / TLH+BS	
	Pt is stable, No c/o	Adv
	O/E GC fair - Afebrile	- NBM for 6hours
	BP- 90/68bpm	- Oral sips after 5pm, Liquid diet today
	PR- 72 mmHg	- CBP c/m @ 6am
	SpO_2 - 100% on RA	- Drugs as charted
	P/A - Soft, NT, BS(+)	- Vital monitoring
	Ue - NAD	- I/O charting.
	U/O - 100ml/hr, clear	- Inform SOS

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/6/2026	C/s/b Dr Manshe	
7pm	POD 0	
		Adv
	CC for Afebrile	
	BP 90/50	- Allow sips ~~→ 9:30pm~~ if tolerates → liq diet
	PR 84	- Soft Diet c/m
	PA Soft	⊕ Repeat CBP C/M 6AM →
	L/E NAD	Inform Report
	U/O ~50ml/hr (clear)	- Foley's removal @ 12pm T/m
		- Monitor Vitals
		- I/O monitoring
		- Inform SOS
		sd/- Dr manshe
12/6/2026	C/s/b Dr Manshe	
10:30pm		
	CC for Afebrile	Adv
	BP 84/70 → 86/53	- Axn Review
	PR - 76	- Repeat CBP C/M @ 6AM
	P/A soft	- Foley's Removal @ 12pm T/M
	L/E NAD	- Monitor vitals
	U/o 100ml/hr (clear	- I/O monitoring
		- Drugs as chart
		- Inform SOS
		sd/- Dr manshe

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

HNH-00015912 IP26-00006564
Mrs M.KAVITHA
28-01-1983 43 Y 4 M 17 D (F)
Dr. SANTHI ANTHARVEDI

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/6/2026	C/s/b Dr Mansha	
3Am		
	C/o Afebrile	Adv:-
	BP- 90/75	- Soft Diet c mumy
	PR - 80	- Ambulation
	P/A - Soft	- Drugs as charted
	L/E NAD	- CBP @ 6Am
	U/o Adeq	- Inform s/o
		My
		Drmansha
13/6/2026	C/s/b Dr Mansha	
7Am		
	C/c - Far Afebrile	Adv
	BP - 92/50	- Soft Diet /Adeq hydration
	PR 77	- Drugs as charted
	P/A soft ;	- Ambulation
	L/E NAD	- I/O monitoring
	U/o. N80 cal/u	- Foley's removed @ 12pm T/m
		- Inform s/o
	CBP - 10.2/8.55/194	My
		Drmansha

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Dr. SANTHI ANTHARVEDI

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/06/2026 9:00am.	c/s by Dr Naveena	
	O/E GC-fair	Adv
	Afebrile, SpO_2 98% on RA	- Soft diet
	PR: 88bpm.	- Adequate hydration
	BP: 100/60mmHg	
	CVS/RS: NAD	- drugs as charted
	PA: soft, NT.	- W/F PV bleeding
	Dressing: dry & clean	- Urine I/O charting
	UE. NAD.	
	U/O: adequate, clear.	- foley's removal @ 12pm.
	Kindly shift the patient to room	- Monitor Vitals
		- Inform SOS
	Dr Naveena.	
		Noted by Srinitha 13/6/26 @ 10AM
13/6/26	c/s by [illegible]	
	Cefai	Rx
	Treo	(i) Soft diet, [illegible]
@ 10.	bus	
placed urine. [illegible]	BP 110/[illegible]	(ii) Inj [illegible]
[illegible]	P/A soft	(iii) T. Aceclofenac [illegible]

(iv) T. Aceclofenac [illegible] (v) T. Pantop 40 [illegible]

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Mrs M.KAVITHA
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Dr. SANTHI ANTHARVEDI

RESULT SHEET

Date	2/5	13/6/26				
Time		6AM				
Hb	M	10.2				
PCV		29.5				
RBC		4.51				
WBC		8.55				
N/L		83.8				
Platelets	2.10	194				
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		A+ve				
HIV		1 Ⓤ	PRBC	Reserve	done.	
Hbsag	NR					
HCV						

Culture and Sensitivities : ....

....

....

....

Radiology : USG : ....

X-Ray : ....

ECHO : ....

CT : ....

MRI ....

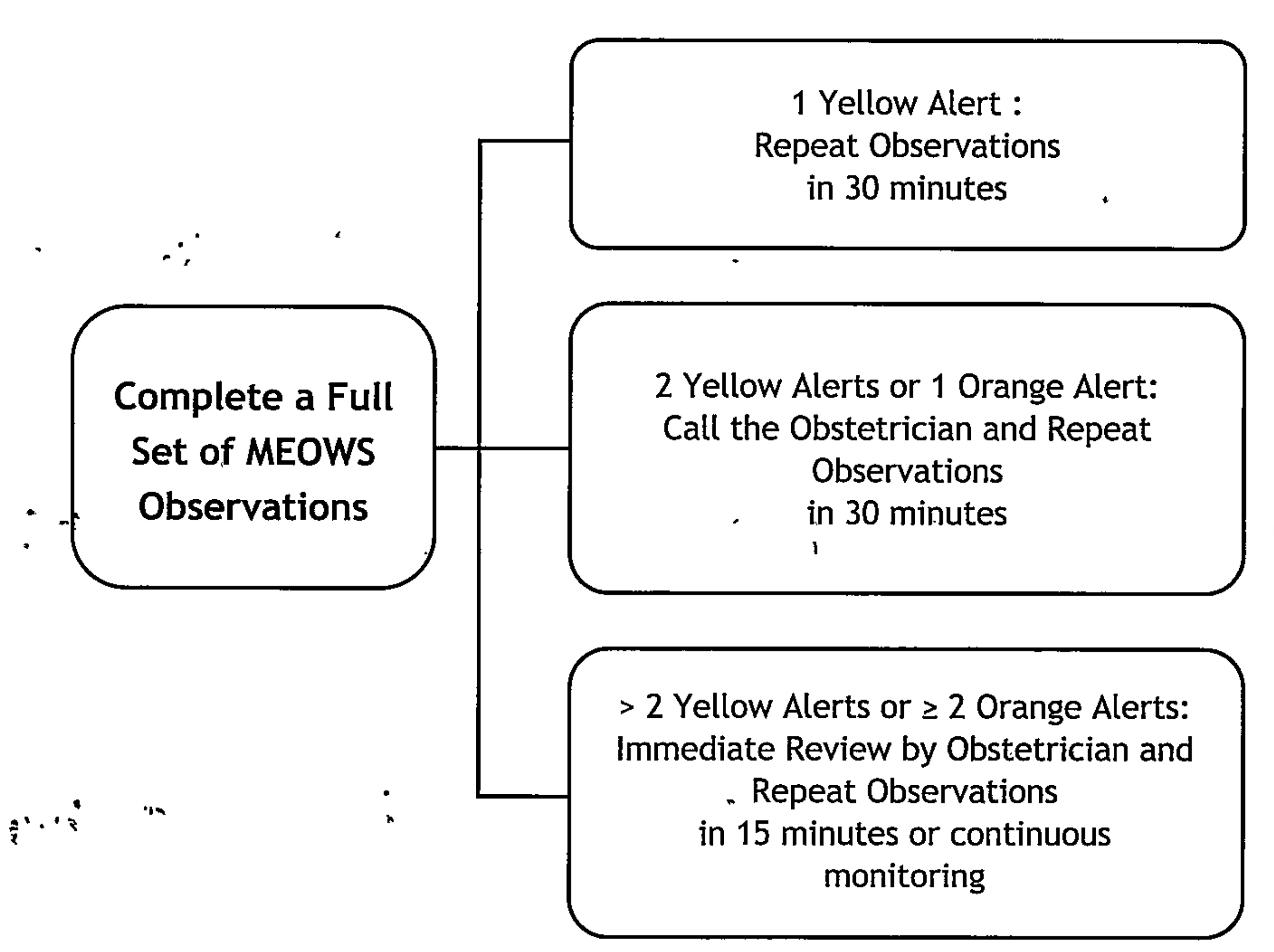
Others (ECG, Contrast Studies etc.,) : ....

HNH-00015912 IP26-00006564
Mrs M.KAVITHA
28-01-1983 43 Y 4 M 17 D (F)
Dr. SANTHI ANTHARVEDI

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	12/6/26																							
	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	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20
	0 - 10																								
Saturations	94 - 100 %	99			99	98	20	20							95	100	99	99	99	95	99	96	96	96	95
	< 94 %																								
Administered O_2 (L/min.)					[illegible]	[illegible]	[illegible]	[illegible]	–	–	–	–	–	–											
Temp°c	40																								
	39																								
	38																								
	37																	98							
	36	36			36	36		2r		36		36		36											
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80	81			84	81																			
	70						79	72	73	79	82	84	86	84	64	94	66	66	76	66	70	80	75	66	77
	60																								
	50																								
	40																								
↑ Systolic Blood Pressure	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110	116			100	99	90	89	98	97	98	97	98	98	85	90	98	83	92	80	82	92	90	85	82
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
↓ Diastolic Blood Pressure	130																								
	120																								
	110																								
	100																								
	90																								
	80	81																							
	70																						72		
	60				59	60	57		40	58	56	51	50	51	54	54	54	55	52	54	52	60		54	50
	50																								
	40																								
NEURO RESPONSE [✓]	Alert	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓											
	Voice																								
	Pain																								
	Unresponsive																								
URINE mls / hour	> 30														✓	✓	✓		✓						
	< 30																								
Proteinuria	Protein + +																								
	Protein > + +																								
Lochia	Normal														✓	✓	✓	✓	✓						
	Heavy / Foul																								
Liquor	Clear / Pink														✓	✓	✓	✓	✓						
	Green																								
TOTAL YELLOW SCORES		0			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL ORANGE SCORES		0			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Nurse Initial																									



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

HNH-00015912 IP26-00006564
Mrs M.KAVITHA
26-01-1983 43 Y 4 M 17 D (F)
Dr. SANTHI ANTHARVEDI

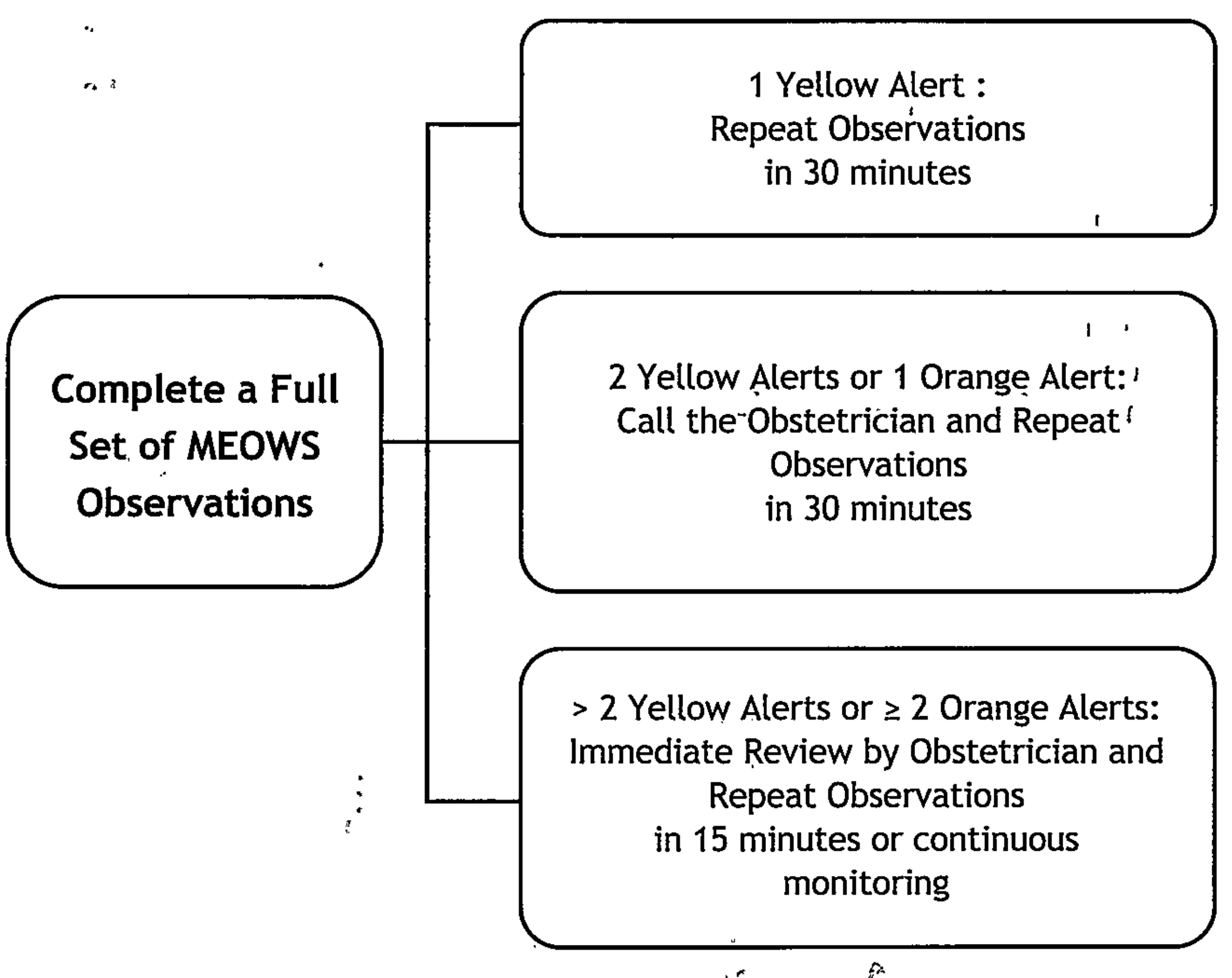
Early Warning Observation Score Chart - Obstetrics

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

Date: 13/6/26

Parameter	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																	
	0 - 10																								
Saturations	94 - 100 %	99%	99	99%	99%			99%																	
	< 94 %																								
Administered O_2 (L/min.)																									
Temp°c	40																								
	39																								
	38																								
	37																								
	36	97°F		98F	36°C			36°C																	
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80							85																	
	70	76		80	71																				
	60																								
	50																								
	40																								
↑ Systolic Blood Pressure	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100	98		99	97			101																	
	90																								
	80																								
	70																								
	60																								
	50																								
↓ Diastolic Blood Pressure	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70				65																				
	60	65		67				61																	
	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																	
TOTAL ORANGE SCORES		0		0	0			0																	
Nurse Initial		[illegible]		[illegible]	[illegible]			[illegible]																	

Obstetrics and Gynaecology Early Warning Signs



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

HNH-00015912 IP26-00006564
Mrs M.KAVITHA
28-01-1983 43 Y 4 M 17 D (F)
Dr. SANTHI ANTHARVEDI

FLUID CHART

Sheet No. : 1

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

Date	Time	Intake: Nature of Fluid	Route: Mouth	Route: I.V	Route: N.G	Output: NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
12/6	08:00 am	RL	N	100ml								
	09:00 am	RL		100ml							0	
	10:00 am	RL	B	100ml								
	11:00 am	RL		100ml			NA			900ml		Empty
	12:00 pm	RL	N	100ml								
	01:00 pm	RL		100ml								
Total Intake :		600ml				**Total Output :**				Passed		
12/6	02:00 pm	RL	N	100ml								
	03:00 pm	RL		100ml								Empty
	04:00 pm	RL	B	100ml						100ml		4pm
	05:00 pm	RL		100ml			NA				0	0
	06:00 pm	RL	D	100ml								
	07:00 pm	RL	SN	100ml						500ml		Empty 7:20 pm
Total Intake :			sips	600ml		**Total Output :**				600		
12/6	08:00 pm	RL	sips	100ml								
	09:00 pm	RL	sips	100ml								
	10:00 pm	RL		100ml								
	11:00 pm	RL	sips	100ml		NA					0	
	12:00 am	RL		100ml						800ml		Empty
	01:00 am	RL		100ml								
Total Intake :				600ml		**Total Output :**				800		
12/6	02:00 am	RL		100ml								
	03:00 am	RL	sips	100								
	04:00 am	RL		100								
	05:00 am	RL		100		NA					0	CB
	06:00 am	RL	H2O	100								
	07:00 am	RL	Idly	100						400ml		Em
Total Intake :				500ml		**Total Output :**				400		

Total 24 hrs. Intake	2400ml	Total 24 hrs. Output	1800ml.

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

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.

13/6/26		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	RL	idly	100ml								
	09:00 am	RL	H2O	100ml								
	10:00 am	RL		100ml						100ml	0	Empty
	11:00 am	RL		100ml								
	12:00 pm	RL					✓	✓		200ml		
	01:00 pm	RL										
Total Intake :		[illegible]				Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						

Total 24 hrs. Intake	

Total 24 hrs. Output	

HNH-00015912 IP26-00006564
Mrs M.KAVITHA
28-01-1983 43 Y 4 M 17 D (F)
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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	12/6 DAY-1			13/6 DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	6	0	0						
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	–	–	NA	NA						
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	–	–	NA	NA						
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	–	–	NA	NA						
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	–	–	NA	NA						
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	–	–	NA	NA						
			Signature of the Nurse	[signature]	[signature]	[signature]	[signature]						

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

Signature of Shift In Charge :

Signature : [signature] Name : Mounika

Signature of Ward In Charge :

Signature : [signature] Name : Kasthuri

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

Patient Sticker

CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

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

HNH-00015912 IP26-00006564
Mrs M.KAVITHA
28-01-1983 43 Y 4 M 17 D (F)
Dr. SANTHI ANTHARVEDI

Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	12/6/26	12/6/26	12/6/26
		Score	M6	E2	N1
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0			
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0	0	0	
IV / Heparin Lock or Saline	Yes	20			
	No	0	0		
GAIT / Transferring	Impaired	20	20	20	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	[signature]	[signature]	[signature]

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

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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

HNH-00015912 IP26-00006564
Mrs M.KAVITHA
26-01-1983 43 Y 4 M 17 D (F)
Dr. SANTHI ANTHARVEDI

Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	13/6		
		Score	8AM		
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0			
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0	0		
IV / Heparin Lock or Saline	Yes	20	20		
	No	0			
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		
		Signature	[signature]		

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

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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

HNH-00015912 IP26-00006564
Mrs M.KAVITHA
26-01-1983 43 Y 4 M 17 D (F)
Dr. SANTHI ANTHARVEDI

BRADEN 'Q' SCALE

				Date :	12/6	12/6	12/6	13/6
				Time :	M6	E2	N1	8AM
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	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	[signature]	[signature]	[signature]	[signature]

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

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

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

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Mrs M.KAVITHA 43 Y 4 M 17 D (F)
28-01-1983
Dr. SANTHI ANTHARVEDI

PAIN ASSESSMENT FORM

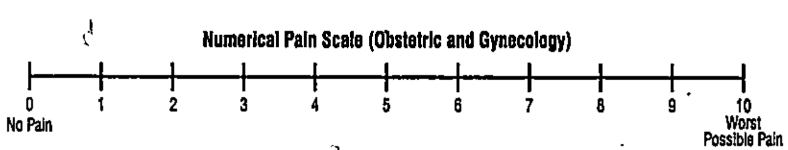
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
12/6	10Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
12/6	3PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
12/6	4Pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
12/6	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
13/6	12Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
13/6	4Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
13/6	6Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
13/6	8Am	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		

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

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

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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Dr. SANTHI ANTHARVEDI

NURSING CARE RECORD

Date: 12/6/26

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 to 2pm	→ Assess the pt condition → monitor vitals → Maintain I/O chart → Administer medication as for Doctor order	8Am to 2pm	→ Assessed the pt condition → Admission done. → Vitals Normal → IV placement done.	Now pt is stable	Re-check vitals	Mouni [signature]
Afternoon	2Pm to 8Pm	→ Assess the pt condition → monitor the vitals & record → [illegible] → Administration of medication → maintain	2Pm to 8Pm	→ Assessed the pt condition → monitored the vitals & recorded → Administered medication as per doctor → maintained I/O chart [illegible]	pt is stable	maintain I/O chart [illegible]	Akhila [signature]
Night	8pm to 8Am	⇒ Assess the patient condition ⇒ plan for vital ⇒ plan for I/O chart	8pm to 8Am	⇒ Assessed the patient condition ⇒ maintain all vitals & Record ⇒ maintain I/O chart	patient is stable	vital is Normal	[signature]

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Dr. SANTHI ANTHARVEDI

NURSING CARE RECORD

Date: 13/6/20

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM To 2PM	→ Assess the pt condition → plan for vitals → plan for I/o chart → plan for medication	8AM To 2PM	→ Assessed the pt condition → vital are checked & recorded → I/o chart maintained	I/o chart maintained	patient is stable	[signature] Sujatha
Afternoon							
Night							

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+LH + BSO.

NURSING SHIFT HAND OVER FORM - WARD

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

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

	Area / Shift Time	12/6/26 MG	12/6/26 Ev	12/6 Nt	13/6 8AM		
BACKGROUND	Medical Condition (Any special condition to be noted):	NA	—	—	NA		
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	97.6	98.1°F	97°F	98°F		
	Res:	16	20 bmt	16	16		
	SpO_2:	99%	98%	99%	99%		
	Pulse:	82	87 bmt	69	72		
	BP:	110/70	110/70	80/50	90/62		
	Fall Risk Score:	—	—				
	Pain Score:	—		—	—		
Recommendations	Safety Needs:	good	[illegible]	—	—		
	Physiotherapy	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	—	—	—	NA		
	Special Diet:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	NO	—	NA	NA		
Post Operative Procedure Special Orders:		NO	—	NO	NA		
Handed Over By Name :		Mouni	Akshita	Chandu	Sirisha		
Signature :		[signature]	[signature]	[signature]	[signature]		
Date:		12/6/26	12/6/26	13/6/26	13/6/26		
Time:		2PM	8PM	8AM	2PM		
Taken Over By Name :		Akshita	Chandu	Sirisha			
Signature :		[signature]	[signature]	[signature]			
Date:		12/6/26	12/6/26	13/6/26			
Time:		2PM	8PM	8AM			

Patient Sticker

NURSING SHIFT HAND OVER FORM - WARD

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

SITUATION	Diagnosis:			Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:			
BACKGROUND	Area / Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							

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URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 12/6/26 Date of Removal: 13/6/26 @ 12 PM

Parameters	Date / Shift Time: 12/6/26 E2	12/6 N1	13/6 8AM				
Need for the Catheter	☑ 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
Usage of Sterile Equipment	☑ 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
Check the Tube for Obstruction (Free of Kinking)	☑ 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
Collecting bag is been emptied regularly?	☑ 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
Dressing clean and dry?	☑ 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
Performance of Perineal Care	☑ 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
Asses for the leakage at the site of insertion	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Nurse	Akhila	[illegible]	Priyanka				
Signature of the Nurse	[signature]	[signature]	[signature]				

Removed

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

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Mrs M.KAVITHA
26-01-1983 43 Y 4 M 17 D (F)
Dr. SANTHI ANTHARVEDI

DRUG CHART

Date of Admission: 12/6/2026 Drug Allergies: nil ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

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

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

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

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

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Dr. SANTHI ANTHARVEDI

REGULAR PRESCRIPTIONS

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

DRUG : Inj CEFOPERAZONE + SULBACTUM

Dose	Route	Frequency	Start Date
1gm	IV	BD	12/6

Date: 12/6, 13/6
Time: 7AM, 9pm

Name & Signature of the Doctor Starting the Drugs: [signature]

Additional Instructions: Inj Magnex Forte

Daily Doctor's Endorsement by a Sign

DRUG : Inj PANTOPRAZOLE

Dose	Route	Frequency	Start Date
40mg	IV	OD	12/6

Date: 12/6, 13/6
Time: 6AM, 6pm

Name & Signature of the Doctor Starting the Drugs: [signature]

Additional Instructions:

STOP 13/6/26

Daily Doctor's Endorsement by a Sign

DRUG : Inj. PARACETAMOL

Dose	Route	Frequency	Start Date
1gm	IV	TID	12/6/26

x24hrs

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

Additional Instructions: To be converted to oral after 24hrs.

WH Dr. Naveen

Daily Doctor's Endorsement by a Sign

DRUG : T. DICLOFENAC

Dose	Route	Frequency	Start Date
50mg	PO	BD	12/6/26

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

Additional Instructions:

WH Dr. Naveen

Daily Doctor's Endorsement by a Sign

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

DRUG : INJ-ENOXIPARIN				Date/Time	12/6
Dose	Route	Frequency	Start Dt.		
40MG	S/C	OD	12/6		
Name & Signature of the Doctor Starting the Drugs: Dr. Naveera				11pm	[signature]
Additional Instructions: START FROM 11pm today FOR 3days.					
Daily Doctor's Endorsement by a Sign					[signature]

DRUG : INJ PARACETAMOL				Date/Time	12/6	13/6
Dose	Route	Frequency	Start Dt.			
1GM	IV	TID	12/6	7Am	X	[signature]
Name & Signature of the Doctor Starting the Drugs: Dr. Naveera				3pm	[signature]	
Additional Instructions:				11pm	[signature]	
Daily Doctor's Endorsement by a Sign					[signature]	

STOP — Dr. Naveera

DRUG : INJ DICLOFENAC				Date/Time	12/6	13/6
Dose	Route	Frequency	Start Dt.			
50MG	IV	TID	12/6	6AM	X	[signature]
Name & Signature of the Doctor Starting the Drugs: Dr. Naveera				2pm	X	
Additional Instructions:				10pm	[signature]	
Daily Doctor's Endorsement by a Sign					[signature]	

STOP — Dr. Naveera

DRUG : T. PARACETAMOL				Date/Time	13/6
Dose	Route	Frequency	Start Dt.		
1GM	PO	TID	13/6	7Am	✓
Name & Signature of the Doctor Starting the Drugs: Dr. Naveera				3pm	
Additional Instructions: AFTER FOOD				11pm	
Daily Doctor's Endorsement by a Sign					

STOP [signature]

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

(P.T.O.)

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

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26-01-1983 43 Y 4 M 17 D (F)
Dr. SANTHI ANTHARVEDI

Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

DRUG: T-DICLOFENAC				Date/Time: 13/6
Dose	Route	Frequency	Start Dt.	
50mg	PO	BD	13/6	8Am ✓
Name & Signature of the Doctor Starting the Drugs: Dr. Naveera				STOP
Additional Instructions: AFTER FOOD				8pm
Daily Doctor's Endorsement by a Sign				

DRUG: T.ACECLOFENAC + PARACETAMOL				Date/Time
Dose	Route	Frequency	Start Dt.	
100/325mg	P/O	BD	13/6/26	
Name & Signature of the Doctor Starting the Drugs: [signature]				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG: T.PANTAPRAZOLE				Date/Time
Dose	Route	Frequency	Start Dt.	
40mg	P/O.	BD	13/6/26	
Name & Signature of the Doctor Starting the Drugs: [signature]				
Additional Instructions: Before food				
Daily Doctor's Endorsement by a Sign				

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

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

HNH-00015912 IP26-00006564
Mrs M.KAVITHA
26-01-1983 43 Y 4 M 17 D (F)
Dr. SANTHI ANTHARVEDI

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
12/06	6AM	Inj METACLOPRAMIDE	10mg	IV	[signature]	[signature]
12/6	8:50Am	Inj. PARACETAMOL	1gm	IV	[signature]	[signature]
12/6	10:45Am	DICLOFENAC Suppository	100mg	PR	[signature]	[signature]
12/6	/	TRAMADOL Suppository	100mg	PR	[signature]	
12/6	9:25Am	Inj. MORPHINE	4.5mg	IV	[signature]	[signature]

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

HNH-00015912 IP26-00006564
Mrs M.KAVITHA
26-01-1983 43 Y 4 M 17 D (F)
Dr. SANTHI ANTHARVEDI

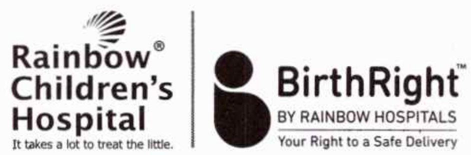
I.V. FLUIDS CHART

Weight. .... Ward. LDF

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
12/6/26	6:45AM	RINGER LACTATE		FF	[signature]	[signature]	12/6	[signature]	[signature]
12/6/26	7:30AM	RINGER LACTATE	IV	100 ml/hr	[signature]	[signature]	12/6	[signature]	[signature]
12/6/26	8:30Am	RINGER LACTATE	IV	500ml/hr	[signature]	[signature]	12/6	[signature]	[signature]
12/6/26	9:30Am	RINGER LACTATE	IV	500 ml/hr	[signature]	[signature]	12/6	[signature]	[signature]
12/6/26	11AM	RINGER LACTATE	IV	100 ml/hr	[signature]	[signature]	12/6	[signature]	[signature]
12/6	2PM	RINGER LACTATE	IV	100 ml/hr	[signature]	[signature]	12/6	[signature]	[signature]
12/6	5PM	RINGER LACTATE	IV	100 ml/hr	[signature]	[signature]	12/6	[signature]	[signature]
12/6	8:30pm	RINGER LACTATE	IV	100 ml/hr	[signature]	[signature]	13/6	[signature]	[signature]
13/6	1AM	RINGER LACTATE	IV	100 ml/hr	[signature]	[signature]	13/6	[signature]	[signature]
13/6	7AM	RINGER LACTATE	IV	100 ml/hr	[signature]	[signature]			

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

HNH-00015912 IP26-00006564
Mrs M.KAVITHA
26-01-1983 43 Y 4 M 17 D (F)
Dr. SANTHI ANTHARVEDI



MEDICATION RECONCILIATION FORM

Drug Allergies: nil. ☐ 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	TAB Thyronorm	75mcg	P/O	OD	12/6.	☑ 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 Sarathi [signature]

Date & Time : 12/06/2026 9AM

Nurse Name & Signature: Alci @ Alci

Date & Time : 12/6/26 @ 1:00 PM

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

PATIENT TRANSFER FORM

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00015912 IP26-00006564 Mrs M.KAVITHA 28-01-1983 43 Y 4 M 17 D (F) Dr. SANTHI ANTHARVEDI	12/6/26 @ 6:10 AM	13/6/26 @ 10:14 AM
	Transfer Ordered by	Reason for Transfer
	DR. Naveena	observation
From Unit	To Unit	Information to Attendant
pre - post	Room	Yes ✓ No ☐
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant
30	—	Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	RL 500 ml	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. Lalitha	DR Naveena

Patient & Clinical Records Received by : [signature] 13/6/26 @ 10:22 Am

Date & Time of Patient Received :

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

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

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

HNH-00015912 IP26-00006564
Mrs M.KAVITHA
26-01-1983 43 Y 4 M 17 D (F)
Dr. SANTHI ANTHARVEDI

210

NUTRITIONAL ASSESSMENT FOR GYNEC PATIENTS

Date: 13/6/26 Time: 10am

Origin: Indian Height: 167cm Weight: 52kg BMI: 18 Kg/m²

Food Allergies: No

Diagnosis: TLH + BS

Medical History: Hypothyroidism

Surgical History:

☑ ovo Vegetarian ☐ Non-Vegetarian ☐ Vegan

Diet Advised: Soft diet

Patient's / Attendant's

Signature: [signature]

Name: Kavitha

Date & Time: 13/6/26; 11 am

Dietician's

Signature: Sobiya

Name: Syeda Sobiya Zaheer

Date & Time: 13/6/26; 11am

OPERATION THEATER NOTES

HNH-00015912 IP26-00006564
Mrs M.KAVITHA
26-01-1983 43 Y 4 M 17 D (F)
Dr. SANTHI ANTHARVEDI

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

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

Surgeon : Dr. Swathi / Dr Shanthi	Asst. Surgeon :
Anesthetist :- 1	OT Nurse :

Surgical Procedure : Total laparoscopic hysterectomy + + B/L salpingectomy + Adhesiolysis + Rt ovarian cystectomy + left ovarian cystectomy

Indications for Surgery : → AUB - L + A.

Date : 12/6/26	Start Time : 8:35 Am	End Time : 10:35 Am

PRE-OPERATIVE PREPARATION :

–

OPERATION NOTES: - pt in low lithotomy position

→ Ports :- 10mm, 3 Accessory ports → 5mm

→ Intraop. findings:
- uterus normal size
→ B/L ov: cystic, Rt ovary - 20mm cyst present
→ B/L tubes - Normal, Lt ovary - 2x1cm cyst
2x1cm present
It was removed.
→ omental Adhesions Ⓣ to anterior Abdominal wall. Adhesiolysis done
→ Proceeded with TLH + BS done
followed by Ⓑ ovarian cystectomy
→ specimen retrieved vaginally.
→ vault closed by vicryl/polysorb No. 2-0
→ procedure uneventful.

→ Haemostasis secured
- Thorough irrigation [illegible] done
- [illegible] clear @ end of procedure

POST - OPERATIVE ORDERS :

→ NBM x 6 hrs
→ [illegible] x [illegible] ([illegible])
- Inj PCM 1g iv TID
→ Foleys [illegible]
→ Inj DICLOFENAC 50mg TID
→ Inj PANTOP 40mg OD
4·
CBP T/M @ 6am
- Inj MAGNEX FORTE 1.5g iv BD x 48hrs
- IV fluids x24 hrs
- [illegible] pain/fever/bleed pv
- Inform SOS.

[illegible] (handwritten)

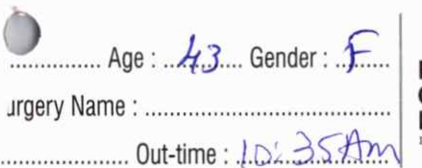
Consultant Surgeon's Name

Consultant Surgeon's Signature

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

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Santhi
Asst. Surgeon : —
Anaesthetist : Dr. Ayesha
Scrub Nurse : Sr. Sandya



Date 12/6/26

Age : 43 Gender : F
Surgery Name :
Out-time : 10:35Am

Before Induction of Anaesthesia ➤ ➤

SIGN IN Time: 8:30Am

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 : Ayesha

Name : Dr. SK Ayesha

Before Skin Incision ➤ ➤

TIME OUT Time: 9:00Am

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

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm

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

Anticipated Critical Events

Surgeon Reviews:

What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? Bleeding, 2 hours, 500ml	☑ Yes	☐ No	☐ NA

Anaesthesia Team Reviews:

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

Nursing Team Reviews:

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

Signature : [signature]

Name : Karuna @ 9:00Am

Before Patient Leaves Operating Room

SIGN OUT Time: 10:35Am

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 : [signature]

Name : Dr. Vaishnavi

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

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PATIENT TRANSFER FORM

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00015912 IP26-00006564 Mrs M.KAVITHA 26-01-1983 43 Y 4 M 17 D (F) Dr. SANTHI ANTHARVEDI	12/6/26 @ 6:10 Am	12/6/26 @ 10:40 Am
	Transfer Ordered by	**Reason for Transfer**
	Dr. Ayesha	observation
From Unit	**To Unit**	**Information to Attendant**
OT	pre-post	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
36	-	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
Karuna	Dr. Ayesha

Patient & Clinical Records Received by : Mounika

Date & Time of Patient Received : 12/6/26 @ 10:40 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

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

Patient Name : KAVITHA - M. Gender: ☐ Male ☑ Female Age : 42F

UHID No : HNH - 00015912 . Date : 11/06/2026

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 LAPAROSCOPIC HYSTERECTOMY + BILATERAL SALPINGECTOMY + RIGHT OVARIAN CYSTECTOMY + ADHESIOLYSIS upon

KAVITHA - M. (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.

Excess bleeding, inadvertent injury to bowel / bladder / ureter & other vital structures; Risk of infection, DVT thromboembolism, need of conversion to open surgery explained.

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 / Dr Shanthi A.

Consentee :

Signature : [signature]

Name : M Kavitha

Date & Time : 12/6/26 ⓐ

Witness :

Signature : Madhu

Name : Madhumathi

Date & Time : 12/6/26 ④

Patient Attendant :

Signature : K. Gangadhar

Name : K. Gangadhar

Relationship with Patient: Husband

Date & Time : 12/6/26 ⓔ

Doctor (who is taking the consent) :

Signature : [signature]

Name : Dr SWATHI HV.

Date & Time : 12/06/2026

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

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

Patient Name : KAVITHA·M .... Age : 42y ...... Gender : Male ☐ Female ☑

UHID NO: .... Surgeon Name: Dr. Shanthi ....

Anaesthesiologist : Dr. Samir | Dr. Akhila·K ....

Operative procedure planned : Total Laparoscopic Hysterectomy ....

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 : laryngospasm, bronchospasm, hypotension ....

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 M·Kavitha .... the above mentioned operation / Diagnostic / Therapeutic procedures Total Laparoscopic Hysterectomy ....

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 : [signature]

Name : M Kavitha

Relationship with Patient: Self.

Date & Time : 10/6/26 2:30pm

Witness :

Signature : K. Gangadhar

Name : K. Gangadhar

Date & Time : 10/6/26 2:30pm.

Doctor (who is taking the consent) :

Signature : [signature]

Name : Dr. AKHILA - K

Date & Time : 10/6/26 2:30pm.

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

Name: KAVITHA · M Age: 42y Sex: F UHID.No :

Date: 10/6/26 Time: 2:15pm Proposed Operation: TLH

Diagnosis: Abnormal uterine Bleeding / Fibroid uterus

B.P / CRT: 13 sec · H.R: 88 Weight: 57kgs · ASA Physical Status: ☐ 1 ☑ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 11-0	Glucose: 86	Protein: WNL	HIV: NR	X-Ray: ↑ BVM
PCV:	Urea:	Alb:	HBS Ag: NR	ECG: NSR - VR - 69
WBC: 4000	Creat:	Total Bill:	HCV: NR	2D Echo: EF 65% / RVSP - 25
Plate: 216	Na:	Dir. Bill:	Blood group: A+ve	Stress/Anglo: NORMAL
PT: 19	K:	LDH:	T3	Other:
PTT: 30	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH 0-2.	
BT - 2:00, CT - 4:00	Cl -:	SGOT/SGPT:		

Allergies: - Nil -

Medical History: CVS : Nil significant

RESP : Diabetes :- No.

CNS :

Renal :

Hepatic / GE : Physical Activity: active.

Others : Hypothyroidism - 5yrs.

Past Anaesthetic History: LSCS ↓ SA - 2009 U/E.

Physical Exam:

Airway: MP 1 ② 3 4 Mouth Opening: 3FB Mentohyoid Distance: 3FB Neck: Ⓝ Teeth: lower incisor ? loose

Lungs : BAE ⊕ clr.

Heart: S1 S2 ⊕

CNS: c/c/c.

Pregnant: ☐ Yes ☑ No ☐ NA | Venous Access Site : accessible. | Spine Exam for regional : well felt.

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

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

CURRENT MEDICATIONS	DOSAGE
T. Thyronorm	75mcg.

Pre-Operative Instructions:

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours; Others 6 Hours } To follow surgeons orders.
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☑ Discussed with Patient
5. Other Instructions: ~~ECG, 2D Echo, Sr. creat, PT, aPTT, INR.~~
   - To check for blood availability.

Signature: [signature] Name: Dr. Akhila. K.

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

HNH-00015912 IP26-00006564
Mrs M.KAVITHA
26-01-1983 43 Y 4 M 17 D (F)
Dr. SANTHI ANTHARVEDI

ANAESTHESIA CHART

Pre Induction Assessment:

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

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

H.R: 69/min | B.P / CRT: 96/67 mmHg | SpO_2: 99% on RA | R.R: 18/min | Last Feed: > 6hrs

Pre-OP Diagnosis: AUB c̄ fibroid uterus Operation: TLH+ Date: 12/6/26

Surgeon: Dr. Santhi, Dr. Swathi Anaesthesiologist: Dr. Ayesha Technician: Aravind

TIME	8:35	8:45	9:00	9:15	9:30	10:00	10:30	10:45	10:55
N_2O / AIR / O_2 LPM	////// (air, continuous) → O_2								
HALO / ISO / SEVO	MAC 0.9 →								

Drugs:
- Inj. MIDAZOLAM 2mg IV
- Inj. PROPOFOL 100mg + 20mg IV
- Inj. FENTANYL 100 mcg IV
- Inj. ROCURONIUM 30mg IV +10mg
- Inj. PARACETAMOL 1gm IV
- Inj. MORPHINE 4.5mg IV
- Inj. NEOSTIGMINE + GLYCOPYRROLATE 5ml

FIO_2 / SaO_2	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
$ETCO_2$	29	30	32	33	33	33	34	35	37	36	37	35	32	26	27	28
ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Temperature	36.3°C															
Urine Output	200ml															

Fluids / Blood: 2 RL

B.P: V Systolic, Λ Diastolic, X Mean, • Heart Rate (plotted: systolic ~90–100, heart rate ~75–85, diastolic ~60)

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

Antibiotic

Suppository: PR – DICLOFENAC 100mg, TRAMADOL 100mg

Blood Loss: 50 ml

NOTES
1. NBM till further orders.
2. Monitor vitals, inform SOS

LAB Values: ABG / GRBS / Others

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

Position: ....
☑ 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: 8:35Am
OP Start: 9:05Am
OP End: 10:40Am
Leave OR: 10:55Am

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP: ....
☐ ART: ....
☑ IV: 18G on (Rt) UL
☐ IV: ....
☐ IV: ....

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

☐ Mask ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
ETT# 6.5 at 20 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: (struck through)
Extremity Specify: ....
☐ Spinal ☐ Epidural ☐ Caudal
Others: ....
Position: ....
Site: ....
Needle Size: .... Depth: ....
Parasthesia ☐ Yes ☐ No
Catheter at skin .... cm
Drug Name & Conc: ....
Bolus: ....
Infusion: ....
Block Level: ....
Comments: ....
Transportation to
☐ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☐ NA
Name of the Doctor: ....
Signature of the Doctor: ....

HNH-00015912 IP26-00006564
Mrs M.KAVITHA
26-01-1983 43 Y 4 M 17 D (F)
Dr. SANTHI ANTHARVEDI

POST-ANAESTHESIA CARE UNIT RECORD

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

(Chart times: 11Am, 11:15Am, 11:30Am, 11:45Am, 12pm, 12:15pm, 12:30pm, 1pm)

RESP > PULSE > < BLOOD PRESSURE — chart scale 250 to 0, SPO₂

IV Cannula Site : Right

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

Vomiting : ☐ Yes ☑ No Drug: Kilpnek
NG Tube : ☐ Yes ☑ No
Drain: ☐ Yes ☑ No
Urinary Catheter: ☑ Yes ☐ No
Chest Tube: ☐ Yes ☑ No
Nil Oral ☐ Yes ☑ No
IV Fluids: RL
Oral Feeds: ....

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
12/6	11Am	0	Normal	[signature]
12/6	12Pm	0	Normal	[signature]
12/6	1Pm	0/10	NA	[signature]
12/6	2Pm	0/10	NA	[signature]

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

Anaesthesiologist Name : [signature]
Anaesthesiologist Signature: ....
Date & Time: ....

PACU Nurse Name : Sujatha
PACU Nurse Signature: [signature]
Date & Time: 13/6/26 @ 10Am

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

Transferred to Unit by (PACU): 2nd Floor 210
Date & Time: 13/6/26 @ 10Am.

Patient Sticker

Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : ....

Any other issues :

a) ....

b) ....

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

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

Catheter Removed by and Tip Inspected : ....

Patient Satisfaction : ....

Discharge /Shifting ordered by

Doctor Signature: ....

Doctor Name: ....

Date and Time : ....

26-00002 06135

NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name: MRS. KAVITHA.		Age: 43 Y	Gender: F.
UHID No: AWH-00015912	IP No: IP26-00006566	Date: 12/6/26	Time: 6:47 Am.
Diagnosis: TLH			

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	100MCG	ONE Amp
2.	Morphine Sulphate Inj. 15mg/Ml	-	-
3.	Remifentanil Hydrochloride Inj. 2MG	-	-
4.	Remifentanil Hydrochloride inj. 1MG	-	-

Doctor Name: Dr. Amir Doctor Registration No: 67529

Signature: [signature]

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

IP Registration No: IP26-00006566 **Date:** 12/6/26

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

		Remarks
1.	**Name :** MRS. KAVITHA.	
2.	Complete postal address (with contact number, if any)	MIG-7ND BLOCK. NO 05 FLAT NO:11 BACHLINGAMPALLY HYD
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
12/6/26	FENTANYL	ONE Amp	[signature]	

Dispensed by (Name & ID No.): Sowo (018442) Signature: ....

Received by (Name & ID No.): SAI CHANDU 02153 Signature: [signature]

Time: ....

26-0000

NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name: MRS. KAVITHA		Age: 63Y	Gender: F
UHID No: HWH 00015912	IP No: IP26-00006566	Date: 12/6/26	Time: 6.47 pm
Diagnosis: TLH			
PRESCRIPTION DETAILS (Tick only one of the following)			

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	100mcg	one Amp
2.	Morphine Sulphate Inj. 15mg/Ml	-	-
3.	Remifentanil Hydrochloride Inj. 2MG	-	-
4.	Remifentanil Hydrochloride inj. 1MG	-	-

Doctor Name: Dhamir

Doctor Registration No: 67529

Signature:

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

IP Registration No: IP26-00006566 **Date:** 12/6/26

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

		Remarks
1.	**Name :** MRS KAVITHA	
2.	Complete postal address (with contact number, if any)	
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	

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
12/6/26	Fentanyl	one Amp	Kavitha	

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

Received by (Name & ID No.): .... Signature: ....

Time: ....

Docu. No: RCH / FRM / CLINICAL / 133

NARCOTIC PRESCRIPTION FORM

(MEDICAL RECORD)

Patient Name		Age	Gender
OHID No.	IP No:	Date	Time
Diagnosis			

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		
3.	Remifentanil Hydrochloride Inj. 2MG		
4.	Remifentanil Hydrochloride Inj. 1MG		

Doctor Name: Doctor Registration No:

Signature:

NARCOTIC DISPENSING FORM

APPENDIX 4 – FORM NO. 3E

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

IP Registration No: .... Date: ....

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

		Remarks
1.	Name :	
2.	Complete postal address (with contact number if any)	
3.	Brief description of the illness	
4.	Whether registered with any other registered medical practitioner / recognized medical institution (If yes, details to be recorded)	
5.	Details of essential Narcotic drug dispensed	

Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb impression of the patient / Patient Attender	Remarks, if any

Dispensed [illegible] Name & ID No: Signature:

Received [illegible] Name & ID No: Signature:

Time:

Doc. No: RCH / FRM / [illegible]

26-000020636

NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name: MRS KAVITH.		Age: 43 Y	Gender: F
UHID No: HWH 00015912	IP No: IP26-00006564	Date: 12/6/26	Time: 6:50 Am.
Diagnosis: TLH			

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	15 MG	ONE Amp
3.	Remifentanil Hydrochloride Inj. 2MG	–	–
4.	Remifentanil Hydrochloride inj. 1MG	–	–

Doctor Name: Dr. SAmir   Doctor Registration No: 67929

Signature: [signature]

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

IP Registration No: IP26-00006564   **Date:** 12/6/26

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

		Remarks
1.	**Name :** MRS. KAVITHA	
2.	Complete postal address (with contact number, if any)	MIG-2 AND BLOCK NO.05 FLAT NO:11 BACHUPALLY GAMPALLY HYD.
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	MORPHINE

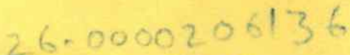
Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
12/6/26	MORPHINE.	ONE Amp	Kavitha	

Dispensed by (Name & ID No.): Sawo (018442) .... Signature: ....

Received by (Name & ID No.): SAI CHANDU 021153 .... Signature: [signature]

Time: ....

Docu. No: RCH / FRM / CLINICAL / 133



NARCOTIC PRESCRIPTION FORM

(MEDICAL RECORD)

Patient Name: MDA KAVITH.		Age: 43 Y	Gender: F
UHID No: HWH.00015112	IP No: IP26-00006564	Date: 12/6/26	Time: 6:50 Am.
Diagnosis: TLH			

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	15 MG	one Amp
3.	Remifentanil Hydrochloride Inj. 2MG	–	–
4.	Remifentanil Hydrochloride inj. 1MG	–	–

Doctor Name: Dr. Samir

Doctor Registration No: 67929

Signature: [signature]

NARCOTIC DISPENSING FORM

APPENDIX 4 – FORM NO. 3E

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

IP Registration No: IP26.00006564 **Date:** 12/6/26

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

		Remarks
1.	**Name :** MDA KAVITHA	
2.	Complete postal address (with contact number, if any)	MIG-2ND BLOCK NO.05 FLAT NO.11 BAGHLINGAMPALLY HYD
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	MORPHINE

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
12/6/26	MORPHINE	one Amp	Kavitha	

Dispensed by (Name & ID No.): Sameer (01842) .... Signature: ....

Received by (Name & ID No.): SAI CHANDU 021153 .... Signature: [signature]

Time: ....

Docu. No: RCH / FRM / CLINICAL / 133

Rainbow Children's Hospital

NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name:		Age:	Gender:
UHID No:	IP No:	Date:	Time:
Diagnosis:			
PRESCRIPTION DETAILS (Tick only one of the following)			

S.No	Drug Name	Dosage	Remarks
1	Fentanyl Citrate inj. 50mcg/ml		
2	Morphine Sulphate inj. 10mg/ml		
3	Remifentanil Hydrochloride inj. 2MG		
4	Remifentanil Hydrochloride inj. 1MG		
	Doctor Name:	Doctor Registration No:	Time:
	Signature:		

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

IP Registration No: .... **Date:** ....

Aadhaar No. of the Patient (Optional)

1	Name :	Remarks
2	Complete postal address (with contact number, if any)	
3	Brief description of the illness	
4	Whether registered with any of registered medical practitioner / recognized medical institution (if yes, details of the recorded)	
5	Details of essential Narcotic drug dispensed	

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb impression of the patient / Patient Attender	Remarks, if any

Dispensed By (Name & ID No.) .... Signature

Received by (Name & ID No.) .... Signature