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**ACTIVI** VIH-00095750 IP-00060439  
Mrs BHAGYA LAKSHMI N.  
07-12-1979 46 Y 6 M 15 D (F)  
Dr. KAPPAGANTULA APARNA

**IG**

Name: ---  -----

UHID No : ----- Consultant : *Dr. Kappaganthile Aparna* Dept : -----

Date of Admission : *22/6/20* Time : *09:16am* Date of Discharge : ----- Time: -----

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

**WARD TRANSFERS**

Date	Time	From	To	Signature of Nurse
<i>22/6/20</i>	<i>10:31Am</i>	<i>MICU</i>	<i>OT</i>	<i>[Signature]</i>
<i>22/6/20</i>	<i>11:32am</i>	<i>OT</i>	<i>MICU</i>	<i>[Signature]</i>

**Cross Consultation Visit**

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





**PROCEEDURE**

Date	Proceedure	Quantity	Order No.	Signature
22/6/26	IV placement	1	3093137	[Signature]
22/6/26	PAC	1	3093136	[Signature]
<del>rewritten Checked by Tusa 22/6/26 at: 12:16PM.</del>				

**ANY OTHER INFORMATION**

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Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
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VIH-00095750 IP-00060439  
 Mrs BHAGYA LAKSHMI N.  
 07-12-1979 46 Y 6 M 15 D (F)  
 Dr. KAPPAGANTULA APARNA



## SURGERY DETAILS

Date : 22/6/26

Patient Name: MRS. Bhagya lakshmi Date of Birth: 07-12-1979 Age: 46/19

Gender: Female Ward : OT UHID No.: 0095750

Date of Surgery: 22/6/26  OT-1  OT-2  OT-3  OT-4  OBG OT-1  OBG OT-2

Name of the Surgery : dilatation & curettage under spinal anaesthesia

Time in : 10:45 AM

Time Out : 11:05 AM

	<u>NAME</u>	<u>AMOUNT</u>
1. Surgeon	: <u>DR. APARNA</u>	: <u>OT-Charges</u>
2. Anaesthetist	: <u>DR. Nikitha</u>	:
3. Assistant Surgeon	: <u>DR. Nikitha</u>	:
4. OT Technician	: <u>BR. Rakesh / SR. Vaishnavi</u>	:
5. Circulating Nurse	: <u>SR. Maria</u>	:
6. Assistant Nurse	: <u>SR. prasanna</u>	:

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

Dr. Nikitha

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 3093162

Order by: SR Jyothi



## **ERROR LOG**

LOCATION: - NICU / PICU / HDU / OT / GENERAL WARD

ICD CODE :-

OBSERVATION: -

DATE :

MRD EXECUTIVE

## ADMISSION SHEET



### Registration Details :

Admission No : IP-00060439

Admit Date : 22-Jun-2026

Admit Time : 09:16 AM UHID : VIH-00095750

### Patient Details :

Patient Name : Mrs BHAGYA LAKSHMI N.

Age : 46 Y 6 M 15 D

Guardian : Mr MR. Y. JANARDHAN

DOB : 07-12-1979

Gender : Female

Religion :

Occupation :

Martial Status : Married

Address (H) : HNO. 27-16/27/38/1/1, LB NAGAR,  
SAFILGUDA, NEREDMET. Neredmet  
Hyderabad Telangana INDIA 500056

Phone No : 8074860120

E-mail : na123@gmail.com

### Admission Details :

Bed Type : MICU

Bed No : LW 219

Ward Name : N 2F-LABOUR WARD

Room No : LW 219

Admission Type : First Visit

### Contact Details :

Name : Mr MR. Y. JANARDHAN

Relationship : W/O

Contact Address : HNO. 27-16/27/38/1/1, LB NAGAR,  
SAFILGUDA, NEREDMET. Neredmet Hyderabad  
Telangana INDIA 500056

Phone No : 8074860120 / 9959357559



Signature

### Doctor Details :

Doctor Name : Dr. KAPPAGANTULA APARNA

Specialisation : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant :

### Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY

VIH-00085750 IP-00060439  
 Mrs BHAGYA LAKSHMI N.  
 07-12-1979 46 Y 6 M 15 D (F)  
 Dr. KAPPAGANTULA APARNA



## OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 22/6/26

**Baseline Information:**

Admission From:  ER  OPD  Admission Desk  Others, specify .....

Primary Language:  Telugu  English  Hindi  Others, specify .....

Do you require an interpreter?  Yes  No if Yes specify .....

Source of Information:  Patient  Family  Others, specify .....

**Allergies:**  Yes  No  Medications  Blood Transfusion  Food  Other: .....

If yes, identify .....

**Chief Complaints:** ..... Doctor Notified on Admission:  Yes  No  
Dilation & Curettage ..... Name of the Doctor: Dr. Greshma  
 ..... Time Notified: 9:30 am

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>Migraine ∴ 16 years not on medication</u>	<u>2 previous LSCS</u>	<u>Yes</u>

Gynecology Assessment: <input type="checkbox"/> Not Applicable	Gynecology Surgical History:	Gynecological History:
Menstrual History: ..... Onset of Menarche: ..... Menstrual Cycle: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular Last Menstrual Period: <u>21/6/26</u>	Caesarean Section: <input type="checkbox"/> No <input type="checkbox"/> Yes Cervical Cerclage: <input type="checkbox"/> No <input type="checkbox"/> Yes Ectopic Pregnancy: <input type="checkbox"/> No <input type="checkbox"/> Yes Myomectomy: <input type="checkbox"/> No <input type="checkbox"/> Yes Others: <u>Dilation &amp; Curettage</u>	Contraceptives: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Vaginal Discharge: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Post-Coital Bleeding: <input type="checkbox"/> No <input type="checkbox"/> Yes <b>Infertility:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If Yes Type: <input type="checkbox"/> Primary <input type="checkbox"/> Secondary

**Obstetric History:** G - P 3 L 2 A D -1

**Previous LSCS:** Yes

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

**Family History:**  No Abnormalities Detected

Heart Disease  Hypertension  Diabetes  Stroke  Seizures  Kidney disease  
 Liver disease  Other: Mother - DM, HPTN

**Vital Signs / Measurements:** Temp: 96.2°F HR: 80/beat RR: 20/min  
 BP: 110/70 mmHg Weight: 82.5 kg Height: ..... BMI: .....

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



**PHYSICAL ASSESSMENT**

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

Fall Assessment:  Yes  No Score 15 (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore:  Yes  No Score 0 (complete the Braden Q Sheet)

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

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

Inform consultant for positive criteria

**NUTRITIONAL SCREENING:**  No Abnormality Detected

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

Inform consultant for positive criteria

**PSYCHOLOGICAL SCREENING:**

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

Inform consultant for positive criteria

**SOCIAL SCREENING:**

1. Marital Status:  Single  Married  Divorced  Widow

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

Social History: Lives With Family

**Orientation has been given regarding the following aspects:**

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

Above information given to Mrs. Bhagya Lakshmi N.

Name of Person Orientation was given to: Mrs. Bhagya Lakshmi N.

Orientation not given Reason: .....


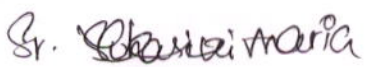
Nurse Signature: [Signature]

Nurse Name: Pradhyesh

Date & Time: 22/6/16 @ 8:30 AM

# PATIENT TRANSFER FORM



Patient Name & UHID No. VIH-00095750 IP-00060439 Mrs BHAGYA LAKSHMI N. 07-12-1979 46 Y 6 M 15 D (F) Dr. KAPPAGANTULA APARNA 		Date & Time of Admission 22/6/26 9:16Am	Date & Time of Transfer Order 22/6/26 @ 10:30Am
		Transfer Ordered by DR. Vineetha	Reason for Transfer Post-op-care
From Unit OT	To Unit MICU	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File —	Number of Imaging Films —	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	N/A		
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/> Dr. Vineetha			
Name & Signature of Person who is Transferring Sr. 		Name of Person Ordered Transfer Dr. Vineetha	
Patient & Clinical Records Received by : Prathyusha			
Date & Time of Patient Received : 22/6/26 @ 10:30Am			

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

- Unavailable Bed
  Nurse not Available
  Available Bed not ready

# PATIENT TRANSFER FORM

VIH-00095750 IP-00060439  
Mrs BHAGYA LAKSHMI N.  
07-12-1979 46 Y 6 M 15 D (F)  
Dr. KAPPAGANTULA APARNA



Date & Time of Admission 22/6/26 at 9:06 am	Date & Time of Transfer Order 22/6/26 10:03 AM	
Treating Consultant Name	Transfer Ordered by Dr. Nikhita	Reason for Transfer O/C
From Unit NICU	To Unit OT	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File 35	Number of Imaging Films nil	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

Shifting Summary / Notes Written by Doctor : Yes  No

Dr. Nikhita

Name & Signature of Person who is Transferring S.S. K. Subbarao	Name of Person Ordered Transfer Dr. Nikhita
--	--

Patient & Clinical Records Received by : Manj 22/6/26 @ 10:30 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

T. MEPERATE ALLERGY

VIH-00095750 IP-00060439  
Mrs BHAGYA LAKSHMI N.  
07-12-1979 46 Y 6 M 15 D (F)  
Dr. KAPPAGANTULA APARNA

Ref. No.: F/GYNIC/18

I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission: 22/6/26

Time of Admission: 9 AM

PERSONAL DETAILS

Name: Mrs. BHAGYA LAKSHMI. N Age 46 Y 6 M Date of Birth 7/12/1979

UHID No. VIH-00095750 IP No.:

Department: OBGY Consultant: Dr. K. APARNA

PRESENTING COMPLAINTS

P3L2D1 with Previous LSCS with Non Tubectomised with Migraine with Abnormal Uterine Bleeding

She has c/o Prolonged Menstrual Bleeding since Oct 2025 associated w heavy flow, Clots. 5 days 13-14 pads/day fully soaked / Clots (+) Dysmenorrhoea (-). She took T. DUOLUTON 42days in November 2025. Feb H/O Amenorrhoea for 1 month in May 2026. She had Prolonged Bleeding since 7/6/26 till now. u is on T-TRAPIC 500mg TID. TVS scan done on 16/6/26 showed increased Endometrial thickness. she was planned for Dilatation & Curettage.

TVS (16/6/26)

Ut ~ Retroverted

ET - 17mm

Small multiple cystic spaces, largest ~ 5.1 x 3.5mm

Left Ovary 37x23 mm w Follicular cyst ~ 30x21 mm without any septations or solid elements.

16/6/26

CBP - 11.5 / 6890 / 2.5 GL

16/6/26

HIV } NR  
HbA1c }  
HCV }

LFT - (N)

ECG - (N)

S.Na - 141

S.K+ - 4.5

S.Cl - 103

16/6/26

CBP - 11 / 5900 / 2.6 GL

BLOOD GROUP - O POSITIVE

PT - 10.7 s Creat - 0.7

APTT - 25.6 TSH - 2.84

INR - 0.95

CT - 6 mm

UE - Eci 0.8

PRC - 1.52

Renals: 103

MENSTRUAL HISTORY

Year of Marriage: 25 Y

Previous Periods: Regular, 5 days, 28-30 days, 3-5 day flow, Clots (+), Dysmen

LMP: 7/6/26 till date

Contraception: Non tubectomised  
Husband - Vasectomised

OBSTETRIC HISTORY

Parity: P3L2D1 (3-25 Y, 2-16 Y)

Mode of Delivery: 1 MVD, 2 LSCS

Last Child Birth: 16 Y



HISTORY	SURGICAL HISTORY
Migraine since 16 years not on Medication	2 Previous LSCs
FAMILY HISTORY	NOTES / ALLERGIES
Mother - DM, HTN	- T-MEPERATE Allergy

INITIAL ASSESSMENT

Date: 22/6/20 Ht. _____ Wt. 82.7kg BMI _____ B.P. 114/77mmHg Pallor (+) CVS S1C2 (+) Respiratory System RAE (+) Thyroid Normal PR - 81 bpm	Breasts Normal, No lumps  Abdominal Examination Soft, NT	Local / Speculum Examination Not done  Bimanual Pelvic Examination Not done
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PROVISIONAL DIAGNOSIS: P<sub>3</sub>L<sub>2</sub>D<sub>1</sub> ± Previous LSCs ± Non Tubectomised ± Migraine ± Abnormal Uterine Bleeding for Dilatation & Curettage

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT	PRESCRIPTION
	- Admission - NBSM - Consent - PAC - Pains Preparation - Monitor vitals - Follow up chart - Discharge	Tab. Misoprostol 200mcg Pu.

Name of the Doctor: Dr. K. APARNA

Date: 22/6/20 Time: 9:30 Am.

Signature of Doctor

VIH-00095750 IP-00060439  
 Mrs BHAGYA LAKSHMI N.  
 07-12-1979 46 Y 6 M 15 D (F)  
 Dr. KAPPAGANTULA APARNA



1

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

BirthRight™  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/6/2026	POD-0 (D&C)	Adv:
11:30 Am.	O/E - pt is c/c/c	- NBM x 2 hours.
	Gc - Fair.	- w/f bleeding PV
	Afebrile	- monitor vitals
	BP - 116/80 mmHg	- Follow drug chart
	PR - 71 bpm	- Jufosm sos.
	S/E - NAD.	
	PIA - Soft, NT	
	BS $\frac{+}{-}$	
	L/E - NAB.	
	Noted by Prathyesha @ 11:30 Am	
22/6/2026	POD-0 (D&C)	Adv:
12:30 pm.	O/E - pt is c/c/c	- NBM till 1:30 pm.
	Gc - Fair.	- w/f bleeding PV
	Afebrile.	- monitor vitals
	BP - 120/78 mmHg.	- Follow drug chart
	PR - 74 bpm.	- Jufosm sos.
	S/E - NAD.	
	PIA - Soft, NT.	
	BS $\frac{+}{-}$	
	L/E - NAB.	Dr - Nikhita
	Noted by Prathyesha @ 12:30 pm	



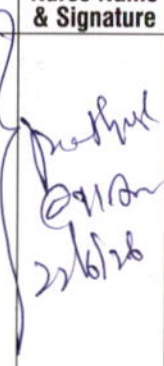


# NURSING CARE RECORD



Date: 22/6/20

- 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	Ensure safety	8am	provided side rails	Pt prevent from fall	patient is safe	 Anitha 22/6/20
	11am	Maintain fluids	11am	provide IV fluids	provided IV fluids	patient was dehydrated	
Afternoon							
Night							

VIH-00095750 IP-00060439  
 Mrs BHAGYA LAKSHMI N.  
 07-12-1979 46 Y 6 M 15 D (F)  
 Dr. KAPPAGANTULA APARNA



# NURSING CARE RECORD



Date: .....

**Goals**

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

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

### GENERAL CONSENT FOR TREATMENT

Patient Name: Mrs BHAGYA LAKSHMI N. Age : 46 Y 6 M 15 D  
IP No: IP-00060439 Sex: Female  
Consultant: Dr. KAPPAGANTULA APARNA Ward/Bed No: N 2F-LABOUR WARD/LW 219

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

Patient, be deemed advisable or necessary.

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


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

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


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

Note:

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

Receivers Signature:.....

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

Signature of Patient/Relative: 

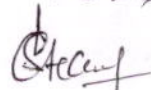
Name: Janardhan

Relationship: Father Husband.

Date: 22/6/2026

Time: 9:16 Am.

Witness Name:

Witness Signature: 

Patient Address:

HNO. 27-16/27/38/1/1, LB NAGAR,  
SAFILGUDA, NEREDMET. Neredmet  
Hyderabad Telangana INDIA 500056

# INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE



Patient Name : Mrs. BHAGYA LAKSHMI . N. Gender:  Male  Female Age : 46 years

UHID No : VH-00095750 Date : 22/6/26

**Instruction:**

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

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

DILATATION & CURETTAGE

upon

(Name of the Patient) Mrs. BHAGYA LAKSHMI . N.

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

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

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

BLEEDING, INFECTIONS, NEED FOR TRANSFUSION OF BLOOD AND BLOOD PRODUCTS AND ITS ASSOCIATED REACTIONS, UTERINE PERFORATION

**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. K. APARNA

**Consentee :**

**Patient Attendant :**

Signature : [Signature]

Signature : [Signature]

Name : Mrs. BHAGYA LAKSHMI

Name : Y. Jayadev

Date & Time : 22/06/2026 9:30 AM

Relationship with Patient: Husband

Date & Time : 22/6/26, 9:20 AM

**Witness :**

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

Signature : .....

Signature : [Signature]

Name : .....

Name : Dr. Quechuma

Date & Time : .....

Date & Time : 22/6/26, 9:20 AM

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



Patient Name : Mrs. Bhagya Lakshmi Age : 46 yr. Gender : Male  Female

UHID NO: VH-00015750 Surgeon Name: Dr. C. Aparna

Anaesthesiologist : Dr. Vineetha

Operative procedure planned : Dilatation & Curettage

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

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

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

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 Mrs. Bhagya Lakshmi the above mentioned operation / Diagnostic / Therapeutic procedures Dilatation & Curettage.

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

- Pregnant :  Yes  No

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

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

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

**Patient / Patient Attendant :**

Signature : [Signature]  
Name : N. Bhagya Lakshmi  
Relationship with Patient: Self  
Date & Time : 22/6/26.

**Witness :**

Signature : [Signature]  
Name : Y. Jayalakshmi (Husband)  
Date & Time : 22/6/26.

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

Signature : [Signature]  
Name : DR. M. VINETHA  
Date & Time : 22/07/26.

# SURGICAL SAFETY CHECKLIST

Surgeon : DR. APARNA  
 Asst. Surgeon : DR. NIKITHA  
 Anaesthetist : DR. VINEETHA  
 Scrub Nurse : SR. PRASOONA

Patient Name : .....  
 UHID No. : .....  
 Date : ..... In-  
 VIH-00095750 IP-00060439  
 Mrs BHAGYA LAKSHMI N.  
 07-12-1979 46 Y 6 M 15 D (F)  
 Dr. KAPPAGANTULA APARNA



## Before Induction of Anaesthesia > 40

SIGN IN		Time: <u>10 am</u>
<b>Patient Has Confirmed</b>		
Identity	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Site	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Procedure	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Consent	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Site Marked	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA	
Anaesthesia Safety Check Completed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Pulse Oximeter on Patient & Functioning	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Does Patient have a:</b>		
Known Allergy?	<u>NO PATE Allergy</u> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Difficult Airway / Aspiration Risk?</b>		
Yes, & Equipment / Assistance Available	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Risk of &gt; 500ml Blood Loss (7ml/kg In Children)?</b>		
Yes, and Adequate Intravenous Access and Fluids Planned	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA	
Blood Units Reserved	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA	
Has Antibiotic Prophylaxis been given within the last 60 minutes?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Signature : <u>[Signature]</u>		
Name : <u>Dr. Vineetha</u>		

## Before Skin Incision > 45

TIME OUT		Time: <u>10 pm</u>
<b>Confirm all team members have introduced themselves by Name and Role</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Surgeon, Anaesthesia Professional and Nurse Verbally Confirm</b>		
Correct Patient (Check ID Band)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Correct Site	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Correct Procedure	<u>DRC</u> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Anticipated Critical Events</b>		
<b>Surgeon Reviews:</b>		
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? <u>Bleeding 1/2 hours some</u> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA		
<b>Anaesthesia Team Reviews:</b>		
Are There Any Patient-specific Concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA		
<b>Nursing Team Reviews:</b>		
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA		
<b>Is Essential Imaging Displayed?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA		
Power Supply, Earthing, Power Backup and functioning of equipment checked. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
Signature : <u>[Signature]</u>		
Name : <u>Sweetha</u>		

## Before Patient Leaves Operating Room 5

SIGN OUT		Time: <u>11 am</u>
<b>Nurse Verbally Confirms with the Team:</b>		
The Name of the Procedure Recorded	<input type="checkbox"/> Yes <input type="checkbox"/> No	
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
The Specimen is Labelled (including patient name)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA	
Whether there are any Equipment Problems to be addressed	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA	
<b>To Surgeon, Anaesthetist and Nurse:</b>		
What are the key concerns for recovery and management of this patient? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
Signature : <u>[Signature]</u>		
Name : <u>Dr. Nikitha</u>		



Sims Speculum.

- A uterus cervical lip held with vulsellum.
- Gentle curettage done.

Intraoperative findings :-

- uterus retroverted.
  - UCCL ~ 3 inches.
  - Plenty of curetting obtained.
  - uterine cavity regular.
- 
- Above intraop findings noted.
  - plenty of curettings obtained.
  - Curettings sent for HPE.
  - Hemostasis secured.
  - Instruments & sponge counts tallied.

• post-op - NBM for 2 hours.

Rest

w/F bleeding PV

monitor vitals

Follow drug chart

Tubasm SOS.



Dr. Nikhita

Name of the Surgeon: ..... Dr. Aparna K. ....

Signature of the Surgeon: .....

Date & Time: ..... 22/6/2026 .....

VIH-00095750 IP-00060439  
 Mrs BHAGYA LAKSHMI N.  
 07-12-1979 46 Y 6 M 15 D (F)  
 Dr. KAPPAGANTULA APARNA

Pat



SHIFT HAND OVER FORM

SITUATION	Diagnosis: <i>P3/2 PE mer kes ren dylectomy &amp; mupine abnormal alpine bleedin for delena + eczema</i>			Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known				
	Surgery / Procedure:			If Yes Specify: _____ Post OP Day:				
BACKGROUND	Date	<i>22/6/26</i>	<i>22/6/26</i>	<i>22/6/26</i>				
	Shift	<i>M</i>	<i>M</i>	<i>M</i>				
	Medical Condition (Any special condition to be noted):	<i>-</i>	<i>-</i>	<i>-</i>				
Diet:	<i>NBM</i>	<i>NBM</i>	<i>NBM</i>					
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	<i>RA</i>	<i>RA</i>	<i>RA</i>				
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:	<i>98°F</i>	<i>98°F</i>	<i>98.2°F</i>			
		Res:	<i>18 blm</i>	<i>18 blm</i>	<i>19 blm</i>			
		SpO <sub>2</sub> :	<i>99%</i>	<i>99%</i>	<i>98.1%</i>			
		Pulse:	<i>82 bpm</i>	<i>85 bpm</i>	<i>80 bpm</i>			
		BP:	<i>112/82 mmHg</i>	<i>110/88 mmHg</i>	<i>112/82 mmHg</i>			
		LOC:	<i>conscious</i>	<i>conscious</i>	<i>conscious</i>			
		Fall Risk Score:	<i>0</i>	<i>0</i>	<i>0</i>			
Pain Score:	<i>0</i>	<i>0</i>	<i>0</i>					
Skin Integrity	<i>Intact</i>	<i>Intact</i>	<i>Intact</i>					
Recommendations	Safety Needs:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>				
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Special Diet:	<i>NBM</i>	<i>NBM</i>	<i>NBM</i>				
	Critical Lab Test / Values:	<i>-</i>	<i>-</i>	<i>-</i>				
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
ADL (Dependent / Non Dependent):	<i>dependent</i>	<i>dependent</i>	<i>dependent</i>					
Post Operative Procedure Special Orders:								
Handed Over By Name :		<i>Bhasini</i>	<i>Mani</i>	<i>Madhyshe</i>				
Signature / ID :		<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>				
Date:		<i>22/6/26</i>	<i>22/6/26</i>	<i>22/6/26</i>				
Time:		<i>10:00 am</i>	<i>11:20 am</i>	<i>12:00 pm</i>				
Taken Over By Name :		<i>Madhyshe</i>	<i>Mani</i>	<i>Bhasini</i>				
Signature / ID :		<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>				
Date:		<i>22/6/26</i>	<i>22/6/26</i>	<i>22/6/26</i>				
Time:		<i>10:00 am</i>	<i>11:20 am</i>	<i>12:00 pm</i>				

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 Dr. KAPPAGANTULA APARNA



## NURSING SHIFT HAND OVER FORM

<b>SITUATION</b>	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: .....						
	Surgery / Procedure:	Post OP Day:						
<b>BACKGROUND</b>	Date							
	Shift							
	Medical Condition (Any special condition to be noted):							
	Diet:							
<b>ASSESSMENT</b>	Allergy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):							
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:						
		Res:						
		SpO <sub>2</sub> :						
		Pulse:						
		BP:						
		LOC:						
	Fall Risk Score:							
Pain Score:								
Skin Integrity								
<b>Recommendations</b>	Safety Needs:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:							
	Others Specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Special Diet:							
	Critical Lab Test / Values:							
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
DVT Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
ADL (Dependent / Non Dependent):								
Post Operative Procedure Special Orders:								
Handed Over By Name :								
Signature / ID :								
Date:								
Time:								
Taken Over By Name :								
Signature / ID :								
Date:								
Time:								

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

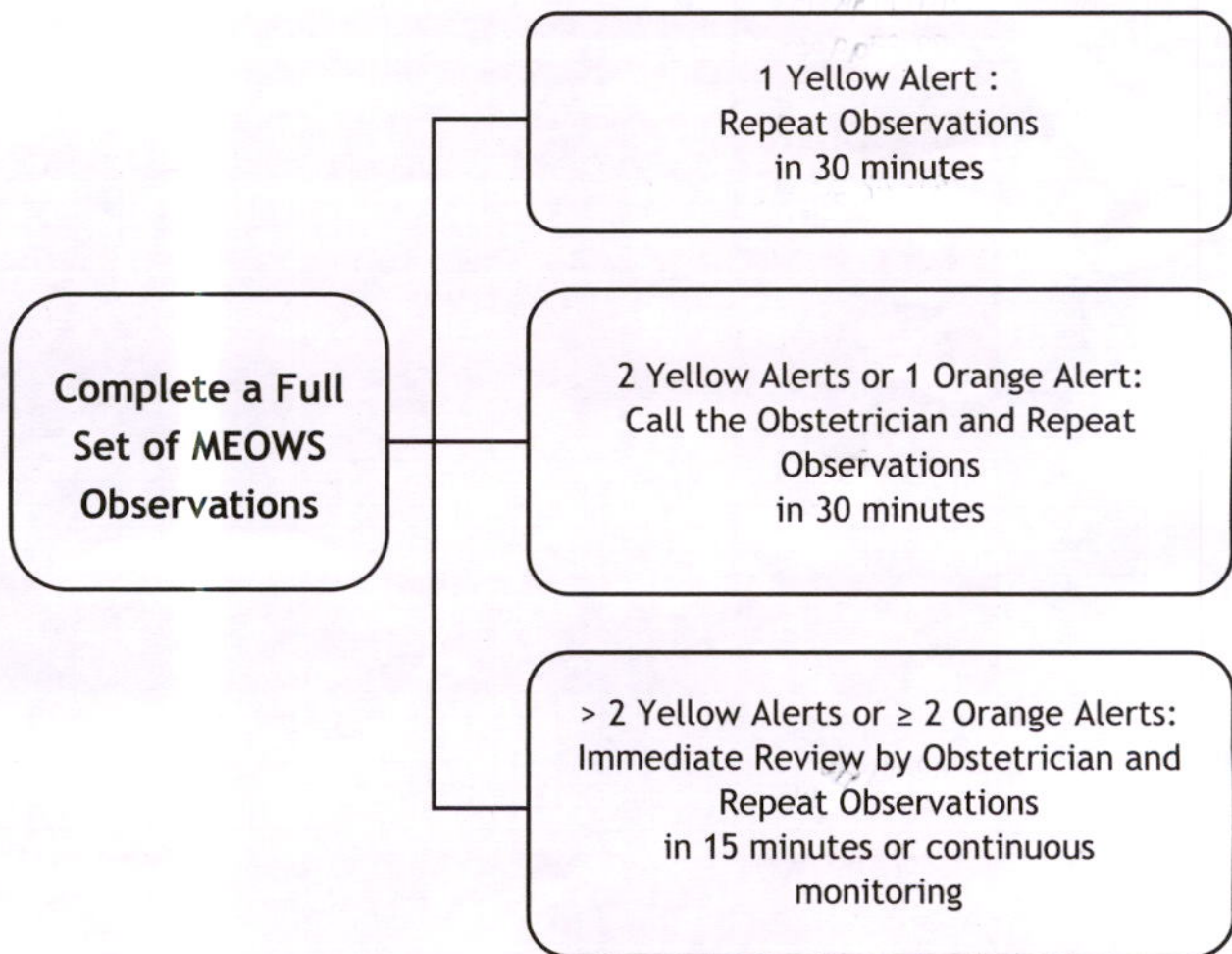
BirthRight™  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

## Early Warning Observation Score Chart - Obstetrics

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

		Date																										
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7		
RESP (write rate in corresp. box)	> 30																											
	21 - 30																											
	11 - 20			19	19	19	19																					
	0 - 10																											
Saturations	94 - 100 %			99	99	99	99																					
	< 94 %																											
Administered O <sub>2</sub> (L/min.)																												
Temp °C	40																											
	39																											
	38																											
	37			37	37	37	37																					
	36																											
	< 35																											
Heart Rate	170																											
	160																											
	150																											
	140																											
	130																											
	120																											
	110																											
	100																											
	90			82	84	85																						
	80																											
	70																											
60																												
50																												
40																												
Systolic Blood Pressure ↑	190																											
	180																											
	170																											
	160																											
	150																											
	140																											
	130																											
	120			112	114	116																						
	110																											
	100																											
	90																											
80																												
70																												
60																												
50																												
Diastolic Blood Pressure ↓	130																											
	120																											
	110																											
	100																											
	90																											
	80			82	84	88																						
70																												
60																												
50																												
40																												
NEURO RESPONSE [✓]	Alert			✓	✓	✓	✓																					
	Voice																											
	Pain																											
	Unresponsive																											
URINE mis / hour	> 30			✓	✓	✓	✓																					
	< 30																											
Proteinuria	Protein ++																											
	Protein > ++																											
Lochia	Normal			NA	NA	NA	NA																					
	Heavy / Foul																											
Liquor	Clear / Pink			NA	NA	NA	NA																					
	Green																											
TOTAL YELLOW SCORES				0	0	0	0																					
TOTAL ORANGE SCORES				0	0	0	0																					
Nurse Initial				80	80	80	80																					

## Obstetrics and Gynaecology Early Warning Signs



\* The Modified Early Warning Score (MEOWS)

VIH-00095750 IP-00060439  
 Mrs BHAGYA LAKSHMI N.  
 07-12-1979 46 Y 6 M 15 D (F)  
 Dr. KAPPAGANTULA APARNA



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# FLUID CHART

Sheet No. : .....

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am	RLT 100ml								✓	0	
	10:00 am	RLT 100ml								0		
	11:00 am	RLT 100ml								0		
	12:00 pm	RL 100ml								0		
	01:00 pm	RL 100ml								0		
<b>Total Intake :</b>			900ml			<b>Total Output :</b>					Balmed	
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
<b>Total Intake :</b>						<b>Total Output :</b>						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
<b>Total Intake :</b>						<b>Total Output :</b>						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
<b>Total Intake :</b>						<b>Total Output :</b>						

**Total 24 hrs. Intake**

**Total 24 hrs. Output**

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Mrs BHAGYA LAKSHMI N.

07-12-1979 46 Y 6 M 15 D (F)

Dr. KAPPAGANTULA APARNA



# FLUID CHART

Sheet No. : .....

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

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

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

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







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

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

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

**STAT / ONCE ONLY DRUGS**

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
22/6/26	9:25 AM	T-MISOPROSTOL	200 mg	PR	[Signature]	[Initials]
22/6/26	10 AM	TRICERTAXIME (AFTER TEST POS)	14 mg	IV	[Signature]	[Initials]
22/6/26	10 AM	IVR PANDOPRAZOLE	40 mg	IV	[Signature]	[Initials]
22/6/26	10 AM	IVR METDOPRAMIDE	10 mg	IV	[Signature]	[Initials]
22/6/26	11:05 AM	IVR TRAMADOL	100 mg	PR	[Signature]	[Initials]
22/6/26	11:05 AM	IVR DICLOFENAC	100 mg	PR	[Signature]	[Initials]

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

VIH-00095750

Mrs BHAGYA LAKSHMI N.

07-12-1979 46 Y 6 M 15 D (F)

Dr. KAPPAGANTULA APARNA



REGULAR PRESCRIPTIONS

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

<b>DRUG :</b> TAB. PARACETAMOL				Date																
				Time																
Dose	Route	Frequency	Start Date																	
1gr	PO	6 HRly	22/02																	
Name & Signature of the Doctor Starting the Drugs:																				
DR. M. VINKETHA																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

<b>DRUG :</b> TAB. TRAMADOL				Date																
				Time																
Dose	Route	Frequency	Start Date																	
100 mg	PO	8 HRly	22/02																	
Name & Signature of the Doctor Starting the Drugs:																				
DR. M. VINKETHA																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

<b>DRUG :</b> TAB. MICLOFENAC				Date																
				Time																
Dose	Route	Frequency	Start Date																	
100 mg	PO	8 HRly	22/02																	
Name & Signature of the Doctor Starting the Drugs:																				
DR. M. VINKETHA																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

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



# ESTIMATION SLIP



Date: 22/6/26 UHID/IP No.: \_\_\_\_\_ Sl. No.: 28900  
 Name of Patient: Mrs. Bhagya Lakshmi Age: 27 Gender: Female  
 Father's / Husband's Name: Mr. Janardhan Corporate/Occupation: Govt  
 Address: Safilguda Phone: 9959357559 Email: \_\_\_\_\_  
 Procedure/Plan: DALC DOS: \_\_\_\_\_

MODE OF PAYMENT:  SELF  TPA: cash  GIPSA: \_\_\_\_\_  OTHER

TARIFF INFORMATION: Dr. Aparna K

ROOM CATEGORY	GW	SW	TSW	PR	DLX	NICU	PICU	MICU	DAY CARE
Room Rent & Nursing Charges							CP to		
Doctor's Fee							8 HRS		
L. Tax									1800

PARTICULARS		AMOUNT ( ₹ )	
Surgeon's / Anesthetist's Fee / O.T Charges		38,000/-	
O.T Consumables		4,000/- Subject to approval by TPA/Insurance Company	
Instrument Charges		Not Covered by TPA/Insurance Company	
Pharmacy, Consumables & Investigations		As per actual - Not Included In Estimation	
Equipment Charges	Monitor: <u>1350 (P.D)</u>	Oxygen: <u>4800 (P.D)</u>	Infusion Pump/Syringe Pump <u>650 (650 (P.D))</u>
	Ventilator	Conventional:	HFO-SLE 5000:
	Phototherapy	Single Surface:	Double Surface:
			HFO-Sensormedix:
Blood / Blood Products / Implants / IP or OP Procedures / Cross Consultations, etc.		As per actual - Not Included In Estimation	
Package			
Others <u>MD 2500/-</u>		<u>S/A D.A</u>	
Initial Minimum Deposit <u>5000</u>			

### REMARKS:

- The estimated amount may change according to duration of stay, medical condition, investigations, pharmacy and any other procedure.
- The estimated surgical charges may vary subject to Surgeon's decisions / Complications / Patient's requirements / Modes of Procedure (like Laparoscopic, Thoroscopic, etc) / Unilateral to Bilateral Procedure.
- In case the patient is shifted from lower category to higher category, all charges for the consultant visit, investigations, operations and/or procedures from the date of admission will be according to the higher category.
- Room eligibility is purely subject to TPA approval and the Package/Room tariff starts from the time of admission.
- Proportionate difference of bill amount is applicable in case the patient opts for a category higher than the TPA approved, which has to be paid by the patient and may not be reimbursed by the TPA / Insurance Company at later stage.
- For Non - Medicals, Disposables, Consumables, Infusion Pump, Taxes, Implants, HIV/HbsAg, Medical Records, Insurance Processing Fee, Double Occupancy and Registration Charges, etc, credit cannot be extended. These items are not payable to us as per Insurance Company norms.
- During Non-working hours of O.T (8:00PM to 6:00AM), Sundays & Public Holidays, 30% extra charges are applicable on surgical cost, and this is not covered by TPA / Insurance Company. In case the length of stay is beyond the package permitted, additional payment is applicable, for which kindly contact the Financial Counseling desk between 9 am to 6 pm.
- Difference, if any between the final bill amount and amount permitted / approved by the TPA or total bill amount in case of denial from TPA has to be paid by the patient. In case of denial, cash tariff would be applicable.
- Two attendants are permitted with patients in SDLX, DLX and PVT Rooms and only one is permitted in the rest of the categories of rooms. And no attendant is permitted in ICUs.
- Tariffs are subject to revision.
- Kindly check your billing status on day to day basis at IP Billing Department.

### DECLARATION

I Y. Janardhan have attended the Financial Counseling desk and understood the expected costs and other conditions applicable. In case the TPA/Insurance Company rejects the claim for whatsoever reasons at any point of time after discharge, I promise to settle the claim with the hospital.

Signature of the Client: Y. Janardhan  
 Signatory Relationship: wife  
 Signature of the Financial Counselor: [Signature]