Pati
MAH-00374774 IP-00060497
Mrs AILENI SREEJA
06-01-1998 28 Y 5 M 21 D (F)
Dr. BHAVANA K

Rainbow® Children's Hospital
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SURGERY DETAILS

Date : 27/6/28

Patient Name: Mrs. A Sreeja Date of Birth: 6/01/1998. Age: 28

Gender: Female Ward : OT UHID No.: 374774

Date of Surgery: 27/6/28 ☑ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : cervical cerclage. + SA

Time in : 8:15AM Time Out : 8:45AM.

	NAME	AMOUNT
1. Surgeon	: Dr. Bhavana	OT Charges
2. Anaesthetist	: Dr. madhav	
3. Assistant Surgeon	: Dr. farnaaz.	
4. OT Technician	: Br. Rakesh	
5. Circulating Nurse	: Sr. Vanita	
6. Assistant Nurse	: Sr. Jyothi	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 309572/309573 Order by:

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ACT[illegible] RECORD FOR BILLING

Nam[illegible] ----------

UHI ---------- Consultant : ---------- Dept : ----------

Date of Admission : 27/6/26 Time : 7:02AM Date of Discharge : ---------- Time: ----------

Room / Bed No : 219 Ward : ICU Suggested Billable bed type : ----------

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
27/6/26	8:05AM	MICU	O.T	
27/6/26	8:50AM	OT	MICU	

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
27/6/26	GRBS 6:50 AM 102 mg/dl.	V126021669	
27/6/26	CBP	V126021666	
CROSS	Chesteley Rhenup	27/06/26 at 4 Am	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
27/6/26	Cardiac Monitor	8:50 Am	11.30Am	3095114.	
~~27/6/26~~	Infusion Pump ~~Infusion pump~~	8.50 Am ~~8:50 Am~~	11.30Am	3095040	
	Cross Checked by Dr Mp			27/6/2026 at 11.30Am	

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
27/6/26	I.V Placment	1	3095042	
27/6/26	PAC	1	3095041	
Cross Checked by Dharma		27/06/2026 at	11Am	

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

DEFICIENCY CHECK LIST OF MEDICAL CASE SHEET

MAH-00374774 IP-00060497
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Patient Name :

IP.No: 60497

Ward: 4W

DOA: 27/6/26

Sl.No	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission Sheet	1			
2	Discharge Summary	2			
3	Nursing Initial assessment form	2			
4	Patient Trasfer Forms	2			
5	In-patient Medical Record	1			
6	Doctors Progress Sheets	1			
7	Nurses Progress notes	2			
8	Consultation Sheets	-			
9	General Consent for Treatment	1			
10	Conset for Surgery	1			
11	Consent for Blood Transfusion	-			
12	Consent forChemotherapy	-			
13	Consent for High Risk	-			
14	Consent for Restraint	-			
15	DAMA Consent	-			
16	Consent for Special Procedure	-			
17	Consent for Radiological Investigations	-			
18	Consent for HIV Test	-			
19	Anaesthesia consent form	1			
20	Anaesthesia notes(Pre Anaesthesia & Post)	1			
21	Pre Operative checklist	1			
22	Surgical safety Checklist	1			
23	Operation Theatre notes	1			
24	Nurses Clinical Presentation	-			
25	TPR & BP chart	2			
26	Intake and Output chart (fluid Chart)	2			
27	Drug Chart (Regular prescription)	1			
28	Daily Investigation sheet	-			
29	Investigation Values (Result Sheet)	1			
30	Nebulization Chart	-			
31	Diabetic chart	-			
32	Nutritional Review chart				
33	MLC form (in case of MLC)	-			
34	~~Patient Education Form~~ Triage	1			
35.	Morse fall risk Assessment	1			
36.	Braden Q	1			
37.	Checklist for Thrombophlebitis	1			
38.	pain Assessment form	1			
39.	Medication Reconciliation form	1			
40.	Billing policy	5			
	Total No. of Pages	35			

Signature and Date : 27/6/26

ERROR LOG

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

ICD CODE :-

OBSERVATION: -

DATE :

MRD EXECUTIVE

Rainbow Children's Hospital - Secunderabad

H.No.3-7-222/223,Sy.No.51 to 54,Opp.Karkhana P S,Karkhana Main Road,Kakaguda, Karkhana ,Hyderabad ,Telangana, INDIA ,500009.
TEL NO :040-42462200, Ext 2000,2001,2002
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP-00060497 **Admit Date** : 27-Jun-2026 **Admit Time** : 07:02 AM **UHID** : MAH-00374774

Patient Details :

Patient Name	: Mrs AILENI SREEJA	**Age**	: 28 Y 5 M 21 D
Guardian	: Mr p.manikanta	**DOB**	: 06-01-1998
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: alwal hills road no 4 laxmi niayam ts Haig Lines Hyderabad Telangana INDIA 500010	**Phone No**	: 8520038488
		E-mail	: sreejaaleni0378@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 p.manikanta **Relationship** : W/O

Contact Address : alwal hills road no 4 laxmi niayam ts Haig Lines Hyderabad Telangana INDIA 500010 **Phone No** : 8520038488 / 7013841897

Signature

Doctor Details :

Doctor Name : Dr. BHAVANA K **Specialisation** : OBSTETRICS AND GYNECOLOGY

Referral Doctor : SELF **Phone No** :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash **Payor Name** : SELFPAY

Name	Mrs AILENI SREEJA	**UHID**	MAH-00374774
Father/Guardian	Mr p.manikanta	**Age/Gender**	28 Y 5 M 21 D/Female
Address	alwal hills road no 4 laxmi niayam ts, Haig Lines, Hyderabad, Telangana, INDIA, 500010		
IP No	IP-00060497	**Admission Date**	27-06-2026
Ref Doctor	SELF	**Discharge Date**	

DISCHARGE SUMMARY

Consultants : Dr. BHAVANA K, CONSULTANT GYNECOLOGIST & OBSTETRICIAN

Diagnosis: G2A1 with 21 weeks with hypothyroidism with Pre Gestational Diabetes Mellitus (insulin) with short cervix for cervical cerclage.

CERVICAL CERCLAGE DONE UNDER SPINAL ANAESTHESIA ON 27.06.2026

History:
LMP: 21.01.2026
Obstetric formula: G2A1
EDD: 07.11.2026
Gestation at admission: 21 weeks

Obstetric History:
G1 -7 weeks/ Missed miscarriage/ MERPC/ D&C/ lifespring hopsital/ 2024
Present pregnancy
G2- PP- Spontaneous conception.

Medical History: H/O Hypothyroidism since 10 yrs on tab thyroxine 125 mcg

Name	Mrs AILENI SREEJA	UHID	MAH-00374774

once daily.

H/o PCOD since 8 yrs took tablet
Family History: Both parents- Hypothyroidism, HTN
Surgical History: D &C in view of RPOC in dec 2024
Allergies: Nil

Antenatal Details: Mrs AILENI SREEJA was booked to Rainbow hospital at 7 weeks of gestation. She had regular antenatal checkups and investigations as advised. Diagnosed with Pre gestational diabetes mellitus at 17+6 weeks managed with insulin glargine 20 IU OD. On Tab Ecosprin 150 mg since conception. TIFFA scan done on 24.06.2026 showed SLIUF, 20+4 weeks, placenta- posterior high, CL- 28.3 mm, unilateral choroid plexus cyst 11.2 x 7.8 mm, no anomalies. She was admitted at 21 weeks with hypothyroidism with Pre Gestational Diabetes Mellitus (insulin) with short cervix for cervical cerclage.

Investigations: Enclosed.
Blood group: A POSITIVE

Surgery Notes:
Operation performed: Cervical cerclage under spinal anaesthesia
Indication: Short cervix (28.3 mm)

Operative procedure:
- Under strict aseptic condition, under spinal anaesthesia
-Parts painted and draped, bladder drained
-Anterior and posterior vaginal wall retracted with sims speculum.
-Anterior lip of cervix help with babcocks forcep

Intra op findings:
- Short cervix noted
-A small 0.3 x 0.3 cm ulcer noted on anterior lip of cervix.
-cervical cerclage done by Mc Donalds stitch

Name	Mrs AILENI SREEJA	UHID	MAH-0037477

- Knot placed anteriorly
-Hemostasis secured
-No active bleeding noted.

Post-Operative Notes: Postoperative period: - Uneventful. Patient comfortable and FHR good at the time of discharge

Advice:

1. Complete bed rest
2. TEDD stockings
3. Tab. Taxim-O 200mg twice daily till 04.07.2026 (9am - 9pm) after food.
4. Tab. Calpol 500mg (2tabs)thrice daily till 04.07.2026 (7am-3pm-10pm) after food.
4. Tab. Pantoprazole 40 mg once daily till04.07.2026 (7am) before food.
5. Tab Thyroxine 125 mcg once daily on mepty stomach till further orders.
6. Tab Ecosprin 150 mg once daily from 28.06.2027 onwards till further orders.
7. Continue Iron, calcium and folic acid as prescribed.
8. Continue Inj Insulin Glargine 20 IU once daily after dinner.
9. Clingen forte pessary per vaginally once daily at bed time till 12.07.2026
10. Review in emergency if PV bleeding, leaking, pain in abdomen.
11. Fetal ECHO at 23 weeks on 11/07/2026.

Review after 15 days on 13.07.2026 in Gynec OP (This consultation will be charged).

For OPD appointment contact 040-43404340 (between 8 a.m. to 8 p.m.) (or) log on to www.rainbowhospitals.in (or) contact our Toll Free number 1800-2122

In case of emergency like bleeding, fever - kindly contact 040-42462200. Extension 2220 (Rainbow Hospital, Karkhana).

Name	Mrs AILENI SREEJA	**UHID**	MAH-00374774

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

Name : A. Sreeja Signature : A. Sreeja

Relationship with patient : self

This summary has been explained by :

Summary prepared by: Dr.

Registrar/Resident/C.M.O

Dr. BHAVANA K
MBBS, DNB, FMAS, PGDMLE (NLSIU), MRCOG (UK),
CONSULTANT GYNECOLOGIST & OBSTETRICIAN
54774

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(1)

OBSTETRICS / GYNECOLOGY
NURSING INITIAL ASSESSMENT FORM

Date of Admission: 27/6/26

Baseline Information:

Admission From: ☐ ER ☐ OPD ☑ Admission Desk ☐ Others, specify L/W

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: Cervical cerclage. Doctor Notified on Admission: ☑ Yes ☐ No

Name of the Doctor: Dr. Nikitha

Time Notified: @ 7Am

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Hypothyroidism since 10yrs PCOS:- 8yers	D&C in Dec 2024	NO

Gynecology Assessment: ☐ Not Applicable

Menstrual History: –

Onset of Menarche: .....

Menstrual Cycle: ☑ Regular ☐ Irregular

Last Menstrual Period: 21/1/2026

Gynecology Surgical History:

Caesarean Section: ☑ No ☐ Yes

Cervical Cerclage: ☑ No ☐ Yes

Ectopic Pregnancy: ☑ No ☐ Yes

Myomectomy: ☑ No ☐ Yes

Others: –

Gynecological History:

Contraceptives: ☑ No ☐ Yes

Vaginal Discharge: ☑ No ☐ Yes

Post-Coital Bleeding: ☑ No ☐ Yes

Infertility: ☐ No ☐ Yes

If Yes Type: ☐ Primary ☐ Secondary

Obstetric History: G 2 P – L – A 1

Previous LSCS: NO

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 Both Parents: Hypothyroid HTN

Vital Signs / Measurements: Temp: 98.1°F HR: 86bl/mt RR: 18bl/mt

BP: 110/70mmHg Weight: 74.6kg Height: 153 BMI: .....

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

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Dr. BHAVANA K

PHYSICAL ASSESSMENT

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

Fall Assessment: ☑ Yes ☐ No Score ..... (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore: ☑ Yes ☐ No Score ..... (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. sreeja .....

Name of Person Orientation was given to: ..... mrs. sreeja .....

Orientation not given Reason: ..... mrs. sreeja .....

Nurse Signature: .....

Nurse Name: ..... Kamala .....

Date & Time: ..... 27/6/26 7:10Am.

PATIENT TRANSFER FORM

(1)

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Dr. BHAVANA K

	Date & Time of Admission	Date & Time of Transfer Order
	27/6/26 @7:02am	27/6/26 @8:05AM
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
	D. & Nithith	~~Post Operative Surgery~~ Surgery
From Unit	**To Unit**	**Information to Attendant**
MICU	O.T	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
38	—	Yes ☑ No ☐
		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 ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
sis.	DR. Nithith.

Patient & Clinical Records Received by : Sr. Ruby. P

Date & Time of Patient Received : 27/6/26 @8:05 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

PATIENT TRANSFER FORM

(2)

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
MAH-00374774 IP-00060497 Mrs AILENI SREEJA 08-01-1998 28 Y 5 M 21 D (F) Dr. BHAVANA K	27/26/26 @ 7.20 am	27/6/26 @ 9.50 am
	Transfer Ordered by	**Reason for Transfer**
	Dr. Madhav	Post op care
From Unit	**To Unit**	**Information to Attendant**
O-T	micu	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
(10)	nil	Yes ☐ No ☑ 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 ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
SP Jyothi	Dr. Madhav

Patient & Clinical Records Received by : Meghana

Date & Time of Patient Received : 27/6/26 @ 9:20AM

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

MAH-00374774 IP-00060497
Mrs AILENI SREEJA
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Dr. BHAVANA K

(1)

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IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

LMP: 21/01/2026 EDD:

Corrected EDD: 7/11/2026. GA: 21 weeks.

Obstetric Formula: G2A1

ML - 4 yrs. NCM.

Obstetric History:
G1 - missed miscarriage / SERPC / lifespring hosp / 2024 / 7 wks.

G2 - Present pregnancy / Sp. conception

Present Pregnancy Record: Booked. to RCH at 7 weeks.
- Diagnosed c PGDM at 17+6 wks. managed on insulin glargine 20IU OD.
- on Tab. Ecospirin 150mg since conception.

RISK FACTORS:
- short cervix.
- GDM (I)
- Hypothyroidism (125)

Height: 153 cm

Weight: 74.40 kg

Allergies: Nil.

Breast: ☑ Normal ☐ Abnormal

General Examination: pt is c/c/c

Consciousness: ⊕ Pallor: ⊖

Icterus: ⊖ Edema: ⊖

Temp: Afeb. PR: 101 bpm.

BP: 106/63 mmHg. DTR: ⊕

CVS: S_1S_2 ⊕ RS BAE ⊕

Liver/Spleen: NAD. Urine Output: Adeq.

Menstrual History: Regular : ☐ Yes ☑ No

Obstetric Examination

Fundal Height: ~ 20 wks.

Ut. Activity: ☑ Relaxed ☐ Mild ☐ Mod ☐ Severe

Liquor: ☑ Adequate ☐ Oligo ☐ Poly

PP: ☐ Cephalic ☐ Breech Others _____

Head Fifths Palpable: _____

FHS: ☑ Normal ☐ Tachy ☐ Brady ☐ Absent

Per Speculum Examination Not done

Draining: ☐ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination Not done

Cervix: ☐ Long ☐ Partially effaced ☐ Effaced

Os: Closed _____ Dilated _____

Membranes: ☐ Present ☐ Absent

Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Presenting Part: ☐ Vertex ☐ Breech ☐ Others

Sutton: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Pelvis: ☐ Adequate ☐ Doubtful

DIAGNOSIS

G2A1 with 21 weeks with hypothyroidism (125) with pre-gestational diabetes mellitus (I) with short cervix for cervical cerclage.

MAH-00374774 IP-00060497
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Family History:

Both parents - Hypothyroid, HTN.

Surgical History:

D & C in Dec. 2024. for RPOC.

Medical History:

Hypothyroidism since 10 yrs.
PCOS :- 8 yrs.

Medication History:

- Tab. Ecospirin 150 mg OD.
- Tab. Thyroxine 125 mcg OD
- Insulin glargine 20 IU ONCE DAILY.

Plan of Care:

GTRBS - 102 mg/dl

C/I to Dr. Bhavana mam

- Admission
- Consent
- NBM
- PAC
- past preparation
- FHR monitoring
- monitor vitals
- Send CBP.
- Follow drug chart
- Inform SOS.

Noted by Kavala 27/6/26 @7AM

Investigations:

BG: 'A' POSITIVE

HIV, HBSAg, HCV, VDRL } NR. 27/6/26

LBP - 10.9 / 12.37 / 3.32 L

- NT Scan -
  2/5/2026
  SLIUF
  12+2 wks.
  NT - 1 mm.
  CL - 33.8 mm.
  Screen positive for Preeclampsia.

- TIFFA scan
  24/6/2026.
  SLIUF
  20+4 wks.
  PL - post. high.
  CL - 28.3 mm.
  - U/L choroid plexus cyst 11.2 mm x 7.8 mm.
  - No anomalies

FTS - low risk

Doctor Name: Dr. Nikhita

Signature:

Date & Time: 27/6/2026 7 AM.

Consultant Name: Dr. Bhavana k.

Signature:

Date & Time: 27/6/2026

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/6/26 8:45 pm	POD-0 Pt cs c/c/c GC fair Afebrile BP - 108/67mmHg PR - 84 bpm S/E - NAD P/A - Ut ~ 20 weeks FHR (+) 148 bpm V/E - NO active bleeding Noted by Meghana 27/6/26 @ 8:45 AM	Adv - NBM x 2 hours - Rest - W/F PV bleeding - follow drug chart - monitor vitals - Inform SOS Dr. Yogeshwaran.
27/6/26 10:45 AM.	POD-0 (Cerclage) Pt is c/c/c GC fair Afebrile BP - 121/73 mmHg PR - 96 bpm S/E - NAD P/A - Ut ~ 20 wks FHR (+) 146 bpm V/E - NO Active Bleeding Pt can be discharged Noted by Meghana 27/6/26 @ 10:45 AM	Adv - Sips of water ffb clear liquid / ffb soft diet - Rest - W/F bleeding PV - Monitor vitals - Monitor FHR - Follow drug chart - Inform SOS Dr Yogeshwaran.

Patient Sticke

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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06-01-1998 28 Y 5 M 21 D (F)
Patient Dr. BHAVANA K

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: G2A1 E21wks EHypothyroidism (125) Type gestational diabetes mellitus (T) with short cervix for cervical cerclage				Any Infection: ☐ Yes ☑ No ☐ Not Known If Yes Specify:		
	Surgery / Procedure: cervical cerclage				Post OP Day:		
BACKGROUND	Date / Shift	27/6/26 N	27/6/26 M	27/6/26 M			
	Medical Condition (Any special condition to be noted):	HYPO	Hypothyroid	Hypothyroid			
	Diet:	NBM	NBM	Soft diet			
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	RA	RA	RA			
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.1°F	98.6°F	98.6°F			
	Res:	18bl/mt	19bpm	19br/mt			
	SpO_2:	100%	100%	100%			
	Pulse:	86bl/mt	82bpm	93bl/mt			
	BP:	113/72 mmHg	110 atomary	121/73 mmHg			
	LOC:	Conscious	conscious	Conscious			
	Fall Risk Score:	15	15	15			
	Pain Score:	0	0	0			
	Skin Integrity	Intact	Intact	Intact			
Recommendations	Safety Needs:	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	—	—	Nil			
	Others Specify:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	NBM	—	Soft diet			
	Critical Lab Test / Values:	—	—	—			
	Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	Dependent	dependent	Dependent			
Post Operative Procedure Special Orders:			NBM				
Handed Over By Name :		Kamal	Sr. Ruby p	Meghana			
Signature / ID :		020573	018135	M020232			
Date:		27/6/26	27/6/26	27/6/26			
Time:		@6:15AM	@9:20Pm	@			
Taken Over By Name :		Ruby	Meghana				
Signature / ID :		018135	M020232				
Date:		27/6/26	27/6/26				
Time:		8:05PM	@9:20Pm				

MA[illegible] IP-00060497
M[illegible]
08-01-[illegible] [illegible] (F)
Dr. BHAVANA K

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
	Surgery / Procedure:				Post OP Day:		
BACKGROUND	Date / Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	LOC:						
	Fall Risk Score:						
	Pain Score:						
	Skin Integrity						
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:						
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							

MAH-00374774 IP-00060497
Mrs AILENI SREEJA
06-01-1998 28 Y 5 M 21 D (F)
Dr. BHAVANA K

NURSING CARE RECORD

(1)

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Date: 27/6/26

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							
Afternoon							
Night	7 AM	Ensure safety	7 AM	To provied side rails	To prevent fall	Patient is Good	Vani 27/6/26 8AM

MAH-00374774 IP-00060497
Mrs AILENI SREEJA
06-01-1998 28 Y 5 M 21 D (F)
Dr. BHAVANA K

NURSING CARE RECORD

Rainbow® Children's Hospital
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Date: 27/6/26

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	8:50 am	Ensure safety	8:50 am	provided side rails	TO prevent falls	patient is safe	Meghana 27/6/26
	11 am	Maintain fluid Balance	11 am	Encourage to take oral fluids/& IV fluids administered	TO prevent dehydration	patient is well hydrated	
		Maintain Good Nutritional Status		Soft diet given	TO maintain good Nutritional status	patient took soft diet	
Afternoon							
Night							

Rainbow Children's Hospital - Secunderabad
H.No.3-7-222/223,Sy.No.51 to 54,Opp.Karkhana P S,Karkhana Main Road,Kakaguda, Karkhana ,Hyderabad ,Telangana, INDIA ,500009.
TEL NO :040-42462200, Ext 2000,2001,2002
WEB : https://rainbowhospitals.in

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Mrs AILENI SREEJA**	**Age :**	**28 Y 5 M 21 D**
IP No:	**IP-00060497**	**Sex:**	**Female**
Consultant:	**Dr. BHAVANA K**	**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: Manikanta.
Relationship: Father
Date: 27/6/2026 Time: 7:04 Am
Witness Name:
Witness Signature:

Patient Address:
alwal hills road no 4 laxmi niayam ts
Haig Lines Hyderabad Telangana
INDIA 500010

(1)

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : MRS. AILENI SREEJA Gender: ☐ Male ☑ Female Age : 28 Y

UHID No : MAH - 00374774 Date : 27/6/2026

Instruction:

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

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

CERVICAL CERCLAGE

upon MRS. AILENI SREEJA.

(Name of the Patient)

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

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

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

BLEEDING, INFECTION, CHANCES OF RUPTURE OF MEMBRANES, CHANCES OF SPONTANEOUS MISCARRIAGE, CHANCES OF PRETERM LABOUR.

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. BHAVANA K.

Consentee :

Signature : A. Sreeja

Name : MRS. AILENI SREEJA.

Date & Time : 27/6/2026 7:13 AM

Patient Attendant :

Signature : Pavi

Name : Mani Kanta

Relationship with Patient: Husband

Date & Time : 27/6/2026 7:13 AM

Witness :

Signature : .....

Name : .....

Date & Time : .....

Doctor (who is taking the consent) :

Signature : Ekhar

Name : DR FARNAZ

Date & Time : 27/6/2026

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : AILENI SREEJA Age : 28yr Gender : Male ☐ Female ☐

UHID NO: MAH00374774 Surgeon Name: Dr. Bhavana

Anaesthesiologist : Dr. Madhav

Operative procedure planned : Cervical cerclage

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 : .....

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 AILENI SREEJA. the above mentioned operation / Diagnostic / Therapeutic procedures Cervical Cerclage

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 : A. Sreeja

Name : Mrs. Sreeja.

Relationship with Patient: patient

Date & Time : 27/6/2026 7:13 AM

Witness :

Signature : .....

Name : Manikanta

Date & Time : 27/6/26. 7:13 AM.

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. Madhav.

Date & Time : 27/06/26.

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Bhavana K
Asst. Surgeon : Dr. Farnaaz.
Anaesthetist : Dr. madhav
Scrub Nurse : Sr. Jyothi

MAH-00374774 IP-00060497
Mrs AILENI SREEJA
06-01-1998 28 Y 5 M 21 D (F)
Dr. BHAVANA K

Age : 28 Gender : F
Name : Sreeja Cerclage

Date : ① In-time : 8:15am Out-time : 8:45am

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 8:40am

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

Site Marked ☐ Yes ☐ No ☐ NA

Anaesthesia Safety Check Completed ☑ Yes ☐ No

Pulse Oximeter on Patient & Functioning ☑ Yes ☐ No

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

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

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

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

Signature : Dr Bhavana Bandaru
Name : Dr Bhavana Bandaru

Before Skin Incision ➤➤

TIME OUT Time: 8:45am

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

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm → Mrs. A Sreeja
- Correct Patient (Check ID Band) ☑ Yes ☐ No
- Correct Site Cervical ☑ Yes ☐ No
- Correct Procedure → Cerclage ☑ Yes ☐ No

Anticipated Critical Events

Surgeon Reviews: - bleeding
- What are the Critical or Unexpected Steps, Operative Duration, 15 min Anticipated Blood Loss? - None ☑ Yes ☐ No ☐ NA

Anaesthesia Team Reviews:
- Are There Any Patient-specific Concerns? ☐ Yes ☑ No ☐ NA

Nursing Team Reviews:
- Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☑ Yes ☐ No ☐ NA
- **Is Essential Imaging Displayed?** ☐ Yes ☐ No ☐ NA
- Power Supply, Earthing, Power Backup and functioning of equipment checked. ☐ Yes ☐ No

Signature : Jyothi
Name : Jyothi

Before Patient Leaves Operating Room

SIGN OUT Time: 8:45am

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 : Dr Farnaz
Name :

MAH-00374774 IP-00060497
Mrs AILENI SREEJA
06-01-1998 28 Y 5 M 21 D (F)
Dr. BHAVANA K

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OPERATION NOTES

Surgeon : Dr Bhavana Kasu	Asst. Surgeon : Dr Farnaz

Pre-Operative Diagnosis: G_2A_1 with 21 weeks ⊂ Hypothyroidism ⊂ PGDM (I) ⊂ short cervix for cervical cerclage

Surgical Procedure : cervical cerclage.

Indications for Surgery : short cervix (28.3mm)

Date : 27/6/26	Start Time : 8:50 am	End Time : 8:55 am

Post Operative Diagnosis:

Peri-Operative Complications:

Amount of Blood Loss: minimal	Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

Operation Notes:

- under strict aseptic condition, under SA,
- parts painted & draped, bladder drained.
- Anterior & posterior vaginal wall retracted with sim's speculum.

(P.T.O.)

- Anterior Intra op findings :-
  (1) Short cervix noted
  (2) A small 0.3 x 0.3 cm ulcer noted on Anterior lip of cervix.

- Anterior lip of cervix held with babcocks forcep.
- cervical cerclage done by Mcdonald's stitch
- knot placed anteriorly.
- Hemostasis secured.
- NO active bleeding.

Post op - uneventful.

Post op instructions - NBM x 2 hours, Rest, w/f PV bleeding, follow drug chart, monitor vitals, Inform SOS.

Name of the Surgeon: Dr. Sharon Joseph

Signature of the Surgeon: .....

Date & Time: 27/6/26 8:45 AM.

MAH-00374774 IP-0006049?
Mrs AILENI SREEJA
08-01-1998 28 Y 5 M 21 D (F)
Dr. BHAVANA K

Patient Stic

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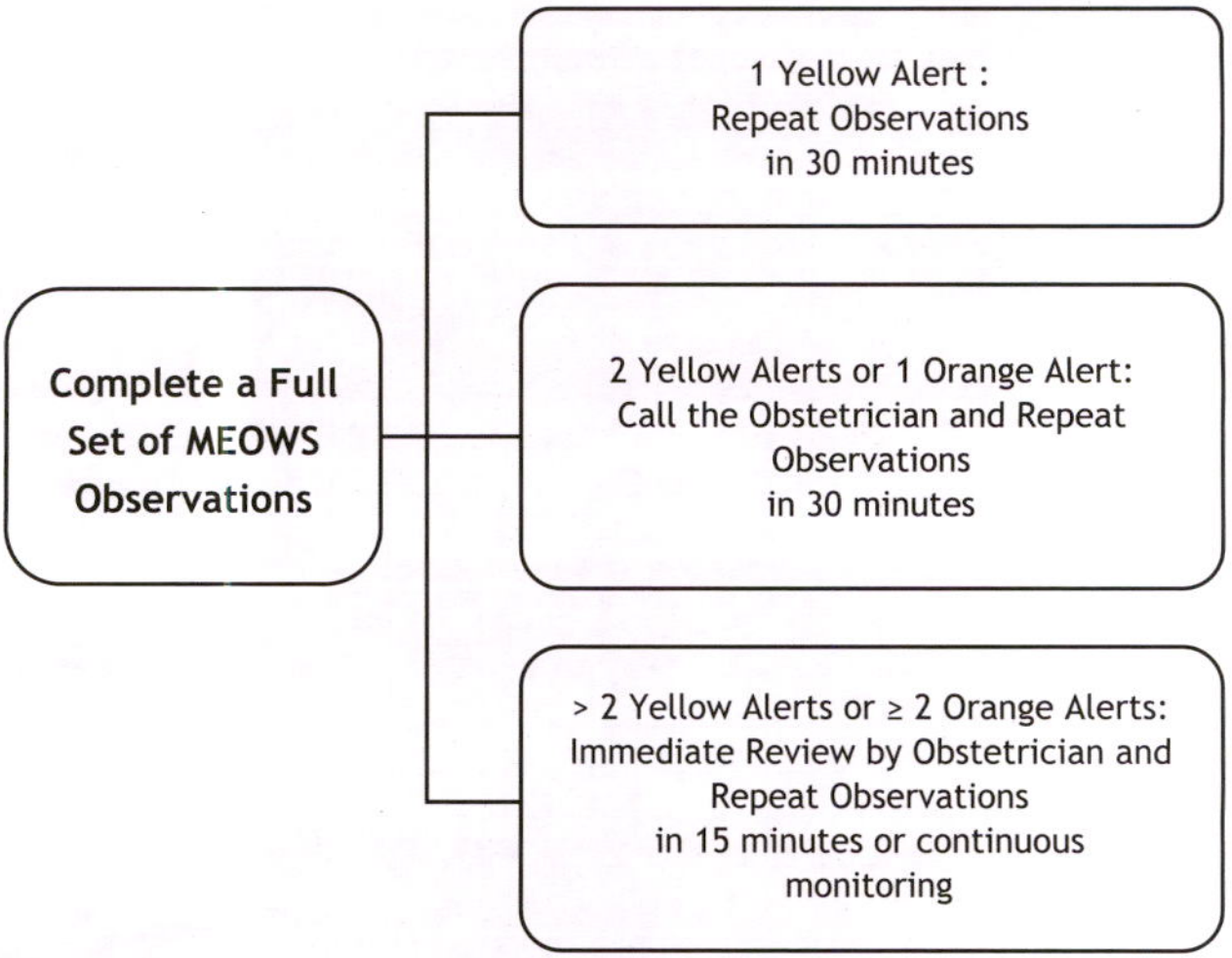
Early Warning Observation Score Chart - Obstetrics

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

27/6/26	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
	0 - 10																								
Saturations	94 - 100 %																								99
	< 94 %																								
Administered O_2 (L/min.)																									
Temp°c	40																								
	39																								
	38																								
	37																								37C
	36																								
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80																								86
	70																								
	60																								
	50																								
	40																								
↑ Systolic Blood Pressue	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								113
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
↓ Diastolic Blood Pressure	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70																								70
	60																								
	50																								
	40																								
NEURO RESPONSE [✓]	Alert																								✓
	Voice																								
	Pain																								
	Unresponsive																								
URINE mls / hour	> 30																								✓
	< 30																								
Proteinuria	Protein + +																								
	Protein > + +																								
Lochia	Normal																								NA
	Heavy / Foul																								
Liquor	Clear / Pink																								NA
	Green																								
TOTAL YELLOW SCORES																									0
TOTAL ORANGE SCORES																									0
Nurse Initial																									

Obstetrics and Gynaecology Early Warning Signs



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

MAH-00374774 IP-00060497
Mrs AILENI SREEJA
06-01-1998 28 Y 5 M 21 D (F)
Dr. BHAVANA K

Patient S

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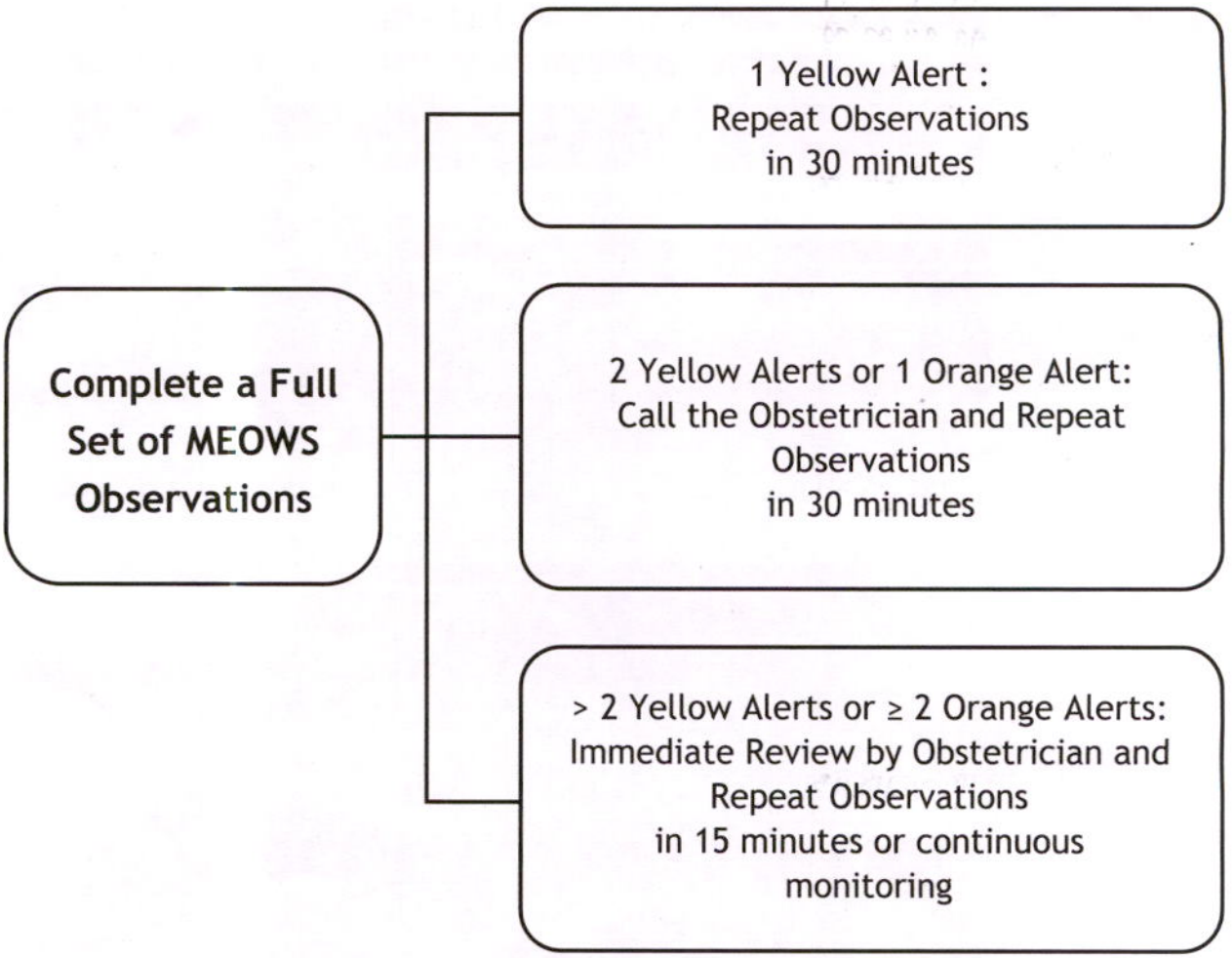
Early Warning Obser.vation Score Chart - Obstetrics

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

		Date																								
27/6/26		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		19	19	19	19																				
	0 - 10																									
Saturations	94 - 100 %		99	99	99	99																				
	< 94 %																									
Administered O_2 (L/min.)																										
Temp °c	40																									
	39																									
	38																									
	37		37	37	37	37																				
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80		85	82	86	84																				
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110		110	110	108	113																				
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70		74	75	72	86																				
	60																									
	50																									
	40																									
NEURO RESPONSE [✓]	Alert		✓	✓	✓	✓																				
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30		✓	✓	✓	✓																				
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal		NP	NP	NP	NP																				
	Heavy / Foul																									
Liquor	Clear / Pink		NP	NP	NP	NP																				
	Green																									
TOTAL YELLOW SCORES			0	0	0	0																				
TOTAL ORANGE SCORES			0	0	0	0																				
Nurse Initial																										

Obstetrics and Gynaecology Early Warning Signs



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

Patier

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Mrs AILENI SREEJA
08-01-1998 28 Y 5 M 21 D (F)
Dr. BHAVANA K

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FLUID CHART

Sheet No. : 1

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
27/6	06:00 am	NBM	+ RL F/F 500ml							✓	○ Skaul	
	07:00 am	NBM	+ RL F/F 500ml								○ 27/6/26 @8AM	
Total Intake :		1000ml				**Total Output :**				passed		

Total 24 hrs. Intake	1000ml	Total 24 hrs. Output	passed

Patient Sticker

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FLUID CHART

Sheet No. : .....

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

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

Total 24 hrs. Intake		**Total 24 hrs. Output**	

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FLUID CHART

(2)

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
27/6/26	08:00 am	NBM + RL 100ml/hr									0	Sreeja 27/6/26 @ 11 AM
	09:00 am	" NBM 100ml each									0	
	10:00 am	NBM + RL 100ml/hr									0	
	11:00 am	H2O 50ml									0	
	12:00 pm	H2O 100ml										
	01:00 pm											
Total Intake :		450ml				**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	

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DRUG CHART

Date of Admission: 27/6/2026 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 *I* through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

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

SOS / PRN (As required Medication)

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

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

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

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

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I.V. FLUIDS CHART

Weight. 74.60 Ward. 4(W)

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
27/6	6:45 AM	RINGER LACTATE	IV	FR	R		27/6		
27/6	7:40 AM	RINGER LACTATE	IV	100 ml/HOUR	R		27/6		
27/6	8:40 AM	RINGER LACTATE	IV	100ml/hr			27/		

Signature .....

VERIFIED BY : Name .....

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Weight. 74.60 Ward. U/CW

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.

Signature

VERIFIED BY Name

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
27/6	6:50 AM	INJ. PANTOPRAZOLE	40 MG	IV		
27/6	6:55 AM	INJ. METOCLOPRAMIDE	10 MG	IV		
27/6	7:50 AM	INJ. CEFOTAXIME [AFTER TEST DOSE]	1 GM	IV		
27/6						
27/6		INJ. HYDROXY PROGESTERONE CAPROATE	500 MG	IM		HOLD

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REGULAR PRESCRIPTIONS Weight. 74.60 Ward. L/W

9 mcg/kg/min @ 2.5 ml/hr

DRUG : TAB. THYROXINE

Dose	Route	Frequency	Start Date
125 MCG	PO	ONCE DAILY	27/6

Name & Signature of the Doctor Starting the Drugs: DR. NIKHITA.

Additional Instructions:

Date/Time: 29/6 — 6 AM — Patient refused

Daily Doctor's Endorsement by a Sign

DRUG : INJ CEFOTAXIME

Dose	Route	Frequency	Start Date
1 GM	IV	12TH HOURLY	27/6

Name & Signature of the Doctor Starting the Drugs: Dr Farheen

Additional Instructions:

Date/Time: 24/6 — 7 AM — 7 PM

Daily Doctor's Endorsement by a Sign

D Diclofenac

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Date/Time:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Date/Time:

Daily Doctor's Endorsement by a Sign

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(1)

RESULT SHEET

Date	27/6/26					
Time						
Hb	10.9%					
PCV	~~10.1~~					
RBC	~~12.2~~					
WBC	12.37					
N/L						
Platelets	3.32					
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 Grouping	: A^+ Positive					
HIV	N.R					
HbsAg						
HCV						
VDRL						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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(1)

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OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 27/6/26 Time of Arrival: 6:30 Am Time Seen by Nurse: 6:35 AM

1) **Level of Consciousness:** ☑ Conscious ☐ Semi-Conscious ☐ UnConscious

2) **Chief Complaint (Reason for Visit):** (Circle the item as appropriate)

- ☐ Severe Pain / Moderate Pain
- ☐ Bleeding PV: Slight / Heavy
- ☐ Decreased Fetal Movement
- ☐ No Fetal Movement
- ☐ Preterm rupture of Membranes / Leaking Water PV
- ☐ Preterm Labor/ Labor
- ☐ Spontaneous Rupture of Membrane / Leaking Water PV
- ☑ Other Reason: cervical cerclage

3) **Vital Signs:** Temperature: 98.1F Pulse 87 b/mt RR: 17 b/mt SpO_2: 99% BP: 110/70 mmHg Weight: 74.60 kg

4) **Gestational Criteria:**

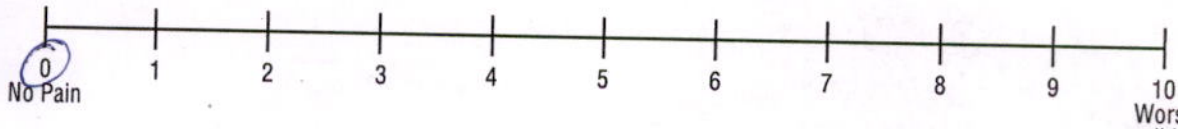
Gravida:	G 2	P –	L –	A 1

LMP: 21/1/2026 EDD: 7/11/26 Gestational Age: 21 wks

Uterine Contraction	☐ Yes	☑ No	☐ NA	Onset	Time	Frequency:
Membrane Rupture	☐ Yes	☑ No	☐ NA	Onset	Time	Fluid Color:
Vaginal bleeding	☐ Yes	☑ No	☐ NA	Onset	Time	Amount:
Pre Eclampsia Symptoms	☐ Yes	☑ No	☐ NA	If Yes specify: Headache / Visual Symptoms / Pain Abdomen / Vomiting		
Good fetal Movement	☑ Yes	☐ No	☐ NA	If No specify:		

5) **Pain Screening:**

Numerical Pain Scale (NPS)



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

6) **Past History:**

a) Surgeries: D&C in Dec 2024

b) Medical: Hypothyroidism since 10 yrs PCOS :- 8 yrs

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08-01-1998 28 Y 5 M 21 D (F)
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7) **Allergy:** ☐ Yes ☑ No, If Yes : .....

8) **Current Medications:** ☐ Prenatal Vitamin ☑ None ☐ Others: .....

9) **Prenatal Medical History:**

☑ None
☐ Chronic Hypertension
☐ Gestational Hypertension
☐ Diabetes
☐ Gestational Diabetes
☐ Low placenta
☐ Others if yes, specify .....

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

☐ **Category I:** Resuscitative (Time to Physician: Immediate & Reassessment: Continuous nursing care)
☑ **Category II:** Emergent (Time to Physician: ≤ 15 minutes & Reassessment: Every 15 minutes)
☐ **Category III:** Urgent (Time to Physician: ≤ 30 minutes & Reassessment: Every 15 minutes)
☐ **Category IV:** Less Urgent (Time to Physician: ≤ 60 minutes & Reassessment: Every 30 minutes)
☐ **Category V:** Non Urgent (Time to Physician: ≤ 120 minutes & Reassessment: Every 60 minutes)

OBCU Obstetrical Triage Acuity Scale (OTAS)

OTAS	Level 1 (Resuscitative)	Level 2 (Emergent)	Level 3 (Urgent)	Level 4 (Less Urgent)	Level 5 (Non Urgent)
Level 1 (Resuscitative)	Immediate	≤ 15 minutes	≤ 30 minutes	≤ 60 minutes	≤ 120 minutes (2 Hours)
Re-Assessment	Continuous Nursing Care	Every 15 Minutes	Every 15 Minutes	Every 30 Minutes	Every 60 Minutes
Labour / Fluid	Imminent Birth	Suspected Pre-term Labour / PPROM < 37 Weeks	Signs of Active Labour > 37 weeks	Signs of Early Labour/ SROM > 37 weeks	Discomforts of Pregnancy
Bleeding	Active Vaginal bleeding with/ without abdominal pain	Bleeding associated with cramping (<spotting) <37 weeks	Bleeding associated with cramping (>spotting) >37 weeks	Spotting	
Hypertension	Seizure activity	Hypertension > 160/110 and / or headache, visual disturbance, RUQ pain	Mild hypertension >140/90 with/without associated signs and symptoms		
Fetal Assessment	Abnormal FHR tracing Non-Fetal Movement	Atypical FHR tracing, abnormal dopplers Diseased fetal movement			
Others	• Acute onsite severe abdominal pain • Altered level of consciousness • Cord prolapse • Severe respiratory distress • Suspected sepsis	• Major trauma • Shortness of breath • Unplanned and unattended birth	• Abdominal/back pain greater than expected in pregnancy • Flank pain / hematuria • Nausea /vomiting and /or diarrhea with suspected dehydration	• Ongoing assessment from out patient clinic (for hypertension, blood work) • Minor trauma (minor MVC/fall) • Nausea/Vomiting and /or diarrhea • Signs of infection (ie dysuria ,cough, fever, chills)	• Anything that does not seem to pose threat to mother or fetus • Cervical ripening • Out patient placenta previa protocols • Pre-booked visits (ie Rh and progesterone injections, NST • Assessment for version • Rashes

Time seen by Doctor: 7AM

Nurse Name : Manola Nurse Signature: .....

Date: 27/6/26 Time: 7:05AM

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(1)

Morse Fall risk Assessment tool for Adults

Parameter	Interpretation	Tick	Score
1.HISTORY OF FALLING (immediately or w/in 3 months)	Yes	X	25
	No	0	0
2. OLDER THAN 60	Yes	X	15
	No	0	0
3. SECONDARY DIAGNOSIS (more than one diagnosis)	Yes	15	15
	No	0	0
4.AMBULATORY AID	Furniture	X	30
	Crutches, Cane(S), Walker	X	15
	None/Bed Rest/Nurse Assist	0	0
5. IV / HEPARIN LOCK OR SALINE	Yes	X	20
	No	0	0
6.GAIT / TRANSFERRING	Impaired	X	20
	Weak (uses touch for balance)	X	10
	Normal/On Bed Rest/Immobile	0	0
7.MENTAL STATUS	Impaired Vision/ Hearing	X	20
	Forgets limitations / Dizziness	X	15
	Oriented to own ability	0	0
8.MEDICATION USE	Anti-hypertensives/ diuretics/ antianxiety/within 2 hours post anesthesia/ sedation	X	25
	None	0	0
Total Score		15	
Signature of the Nurse		[signature]	
Action Plan	Good Basic Nursing Care		

Risk Level	MFS Score	Action
No Risk	0 - 24	Good Basic Nursing Care
Low Risk	25 - 50	Implement Standard Fall
High Risk	≥ 51	Implement High Risk Fall

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BRADEN 'Q' SCALE

(1)

					Date : 27/6/26	28/6/26		
					Time : 7AM	9AM		
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	2		
"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	1		
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		
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		
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	2		
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	1		
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		
				TOTAL SCORE	28	23		
				Evaluator's Name		NS		

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

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

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CHECKLIST FOR THROMBOPHLEBITIS

(1)

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 27/6/26			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0						
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 : Dhanalakshmi

MAH-00374774 IP-00060497
Mrs AILENI SREEJA
06-01-1998 28 Y 5 M 21 D (F)
Dr. BHAVANA K

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①

PAIN ASSESSMENT FORM

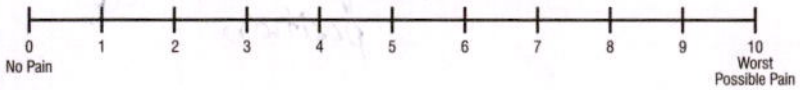
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
27/6/26	7 AM	0 score	No Pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Comfortable Position	[signature]
27/6/26	9AM	'0'	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Comfortable position	[signature]
27/6/26	11AM	'0'	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Comfortable position	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

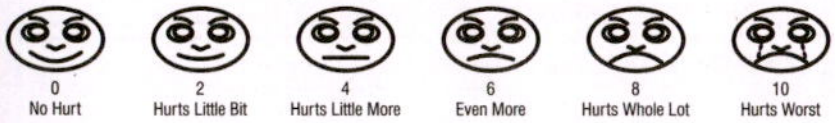
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
   a) At least every 2 hours for the first 24 hours
   b) Then every 4 hours.
   c) Prior to pain pain-relieving intervention.
   d) Within 30 – 60 minutes after pain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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years



FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

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

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(1)

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: L/W Shifted to: O.T

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. IRON	1 TAB	PO	ONCE DAILY	26/6	☐ C ☑ DC
2	TAB. CALCIUM	1 TAB	PO	ONCE DAILY	26/6	☐ C ☑ DC
3	TAB. FOLIC ACID	1 TAB	PO	ONCE DAILY	26/6	☐ C ☑ DC
4	TAB. ECOSPRIN	150 MG	PO	ONCE DAILY	26/6	☐ C ☑ DC
5	TAB. THYROXINE	125 MCG	PO	ONCE DAILY	27/6	☑ C ☐ DC
6	INSULIN GLARGINE	20 IU	SC	ONCE DAILY	26/6.	☐ C ☑ DC
7	INJ. HYDROXY PROGESTERONE	500 MG	IM.	ONCE WEEKLY	17/6	☑ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : DR. NIKHITA.

Date & Time : 27/6/2026. 7AM.

Nurse Name & Signature:

Date & Time : 27/6/26 @ 7AM

6

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BILLING POLICY

- Billing Cycle: - Bed charges will be calculated based on 12PM to 12PM checkout. Settlement post 12PM, room rent will be charged for half day extra & post 6PM, it will be charged for full day. Less than 24 hours stay will be considered as one day.
- Room Rent inclusive of Bed, Nursing, Consultation Charges and all other charges, like Diet, Investigations, IP or OP Procedures, Equipment, Cross Consultations, Blood/ Blood Products, Implants, Ward Consumables, Infection Preventive Measure Charges, Pharmacy and Consumables will be charged extra.
- 5% GST Charges applicable on more than INR 5,000/- Bed Charges which was effective from 18.07.2022 as per the GST Council.
- As per the G.O.I. guidelines, we can collect Rs 1,99,999/- only in cash mode, balance patient can pay through Credit Card / Debit Card / NEFT / RTGS / Demand Draft and Online Payment.
- In the event of TPA/ Cashless denial or approval not received due to any reason then hospital tariff will be applicable and any discount or special rates given to TPA's / Corporate won't be applicable.
- If the Surgery / Procedures performed in emergency hours (8PM-6AM), Public Holiday and on Sunday will be charged 30% extra.
- Asst. Surgeon and Anesthetist Charges will be charged 30% on the Surgeon Charges.
- Admission will be done according to the ward category chosen by the patient; charges will be applicable as per the ward category. All charges vary as per Room category, except Pharmacy and consumables.
- Patient / Guardian Self Attested Government ID proof is mandatory to submit at the admission.
- TPA/Insurance Processing Fee applicable for all Insurance Cases.
- In our hospital there is "No Discounts Policy". Kindly co-operate.
- No Duplicate / Second copy of OP or IP bill will be issued.
- In case the patient is shifted from lower category to higher category, all the charges like consultant visits, investigations, operations and procedures etc. from the date of admission will be charged according to the higher category.
- If the patient is shifted to the ICU, the attendant should vacate the room. If the attender occupies the room, it will be charged as per dual occupancy.
- Room eligibility is purely subject to TPA approval. Proportionate difference of the bill amount is applicable in case the patient opts for higher category higher than the TPA approved, which has to 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 (Depends on the TPA/Insurance Co. T&C).
- It takes time for cash discharge is a minimum 3-4hrs. and in the case of insurance, it will take a minimum 6-7hrs.
- 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.
- Two attendants are permitted with patients in Deluxe, Private Rooms and only one is permitted in the rest of the categories of rooms. No attendant is permitted in ICU's.
- All the refunds more than Rs.5,000/- will be refunded through NEFT within 7 Bank working days.
- Patient attendant can collect for Interim/provisional bill of the patient from the billing section on daily basis. Interim Bill shall be based on the acknowledged services in HIS. Final Bill of the patient may vary from the Interim bill based on actual update taken on the day of discharge. It is requested that patients/attendants enquire daily about the bill amount from billing section and pay the outstanding as on that day. You are requested to clear your outstanding amount on daily basis before 12 PM. **Patient bill outstanding should not be increase more than 10,000/-**

DECLARATION

I have attended the Financial Counselling desk & understood the expected costs & other conditions applicable. In this 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 as per Hospital Cash Tariff.

Patient Name : A. Sreeja	UHID Number : 374774
Self/Attendant Name : Manikanta	Relation : Husband.
Self / Attendant Signature : Phone Number :	Name & Signature of Financial Counselor Venkat

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Date & Time: 27/6/26; 7:02 Am

ATTENDANT INFORMATION SHEET

I, Mr/Mrs Manikanta. s/o _____ hereby state that my child/Wife Sreeja. UHID No: 374 774 has been admitted in MICU. I understand that hospital is taking utmost precautions by standards set by Ministry of health, India.

The Treating Team has requested us to follow the following instructions.

We are requested to follow below instructions strictly.

1. **Always wear MASK**
2. **Follow strict hand hygiene with Alcohol hand rub frequently**
3. **Avoid any movement in the hospital (Once admitted will move out only after discharge).**
4. **Only one attendant is allowed per patient and no visitors are allowed in the hospital.**

Name & signature of Legal Guardian and relationship with patient:

Name and signature of Executive taking the consent

Shirisha.

Name and signature of Witness:

भारत सरकार

आधार

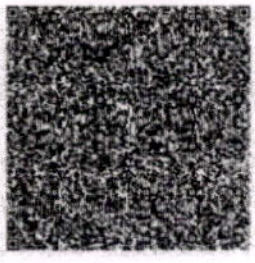
భారత ప్రభుత్వం
Government of India

భారత విశిష్ట గుర్తింపు ప్రాధికార సంస్థ
Unique Identification Authority of India

రిజిస్ట్రేషన్/ Enrolment No.: 2081/30089/64392

To
బిలేని శ్రీజ
Aileni Sreeja
D/O: Aileni Kamalakar Rao,
1-4/4,
Machareddy Mandal,
VTC: Yellapgonda,
PO: Yelpagonda,
Sub District: Machareddy,
District: Nizamabad,
State: Telangana,
PIN Code: 503111,
Mobile: 8520038488

Signature Not Verified



మీ ఆధార్ సంఖ్య / Your Aadhaar No. :

8485 7335 2839

VID : 9155 1912 8904 6159

నా ఆధార్, నా గుర్తింపు

Government of India

AADHAAR

సమాచారము / INFORMATION

- ఆధార్ అనేది గుర్తింపు రుజువు, పౌరసత్వం లేదా పుట్టిన తేదీ కి కాదు. పుట్టిన తేదీ అనేది ఆధార్ నంబర్ హోల్డర్ సమర్పించిన నిబంధనలలో పేర్కొన్న పుట్టిన తేదీ పత్రం యొక్క రుజువు ఆధారం ద్వారా ఇచ్చే సమాచారంపై ఆధారపడి ఉంటుంది.
- ఈ ఆధార్ లేఖను UIDAI నియమించిన ప్రమాణీకరణ ఏజెన్సీ ద్వారా ఆన్‌లైన్ ప్రమాణీకరణ ద్వారా లేదా యాప్ స్టోర్‌లలో అందుబాటులో ఉన్న mAadhaar లేదా ఆధార్ QR స్కానర్ యాప్‌ని ఉపయోగించి లేదా www.uidai.gov.inలో అందుబాటులో ఉన్న సురక్షిత QR కోడ్ రీడర్ యాప్‌ని ఉపయోగించి QR కోడ్ స్కానింగ్ ద్వారా ధృవీకరించాలి.
- ఆధార్ ప్రత్యేకమైనది మరియు సురక్షితమైనది.
- ఆధార్ నమోదు చేసిన తేదీ నుండి ప్రతి 10 సంవత్సరాల తర్వాత గుర్తింపు మరియు చిరునామాకు సంబంధించిన పత్రాలతో ఆధార్ ను నవీకరించాలి.
- వివిధ ప్రభుత్వ మరియు ప్రభుత్వేతర ప్రయోజనాలు/సేవలను పొందడంలో ఆధార్ మీకు సహాయపడుతుంది.
- మీ మొబైల్ నంబర్ మరియు ఈ-మెయిల్ ఐడిని ఆధార్ లో అప్‌డేట్ చేసుకోండి.
- ఆధార్ సేవలను పొందేందుకు mAadhaar యాప్‌ను డౌన్‌లోడ్ చేసుకోండి.
- ఆధార్/బయోమెట్రిక్‌లను ఉపయోగించనప్పుడు భద్రతను నిర్ధారించడానికి లాక్/అన్‌లాక్ ఆధార్/బయోమెట్రిక్స్ ఫీచర్‌ని ఉపయోగించండి.
- ఆధార్‌ను కోరే సంస్థలు తప్పనిసరిగా సమ్మతి పొందవలసి ఉంటుంది

- Aadhaar is proof of identity, not of citizenship or date of birth (DOB). DOB is based on information supported by proof of DOB document specified in regulations, submitted by Aadhaar number holder.
- This Aadhaar letter should be verified through either online authentication by UIDAI-appointed authentication agency or QR code scanning using mAadhaar or Aadhaar QR Scanner app available in app stores or using secure QR code reader app available on www.uidai.gov.in.
- Aadhaar is unique and secure.
- Documents to support identity and address should be updated in Aadhaar after every 10 years from date of enrolment for Aadhaar.
- Aadhaar helps you avail of various Government and Non-Government benefits/services.
- Keep your mobile number and email id updated in Aadhaar.
- Download mAadhaar app to avail of Aadhaar services.
- Use the feature of Lock/Unlock Aadhaar/biometrics to ensure security when not using Aadhaar/biometrics.
- Entities seeking Aadhaar are obligated to seek consent.

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Government of India

Aadhaar no. Issued: 13/07/2013

బిలేని శ్రీజ
Aileni Sreeja
పుట్టిన తేదీ/DOB: 06/01/1998
స్త్రీ/ FEMALE

ఆధార్ అనేది గుర్తింపు రుజువు మాత్రమే, పౌరసత్వం లేదా పుట్టిన తేదీ కి కాదు. ఇది ధృవీకరణతో మాత్రమే ఉపయోగించాలి (ఆన్‌లైన్ ప్రమాణీకరణ లేదా QR కోడ్ / ఆఫ్‌లైన్ XML యొక్క స్కానింగ్).

Aadhaar is proof of identity, not of citizenship or date of birth. It should be used with verification (online authentication, or scanning of QR code / offline XML).

8485 7335 2839

నా ఆధార్, నా గుర్తింపు

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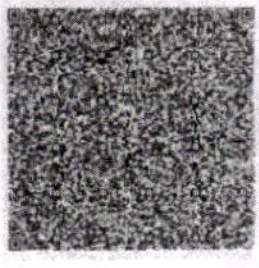
Unique Identification Authority of India

Details as on: 29/12/2023

చిరునామా:
D/O: బిలేని కమలాకర్ రావ్, 1-4/4, మాచారెడ్డి మండల్, ఎల్లపొండ, ఎల్లగొండ, పిఓ:మాబాద్, తెలంగాణ - 503111

Address:
D/O: Aileni Kamalakar Rao, 1-4/4, Machareddy Mandal, Yellapgonda, PO: Yelpagonda, DIST: Nizamabad, Telangana - 503111



8485 7335 2839

VID : 9155 1912 8904 6159

1947 | help@uidai.gov.in | www.uidai.gov.in

ESTIMATION SLIP

Rainbow® Children's Hospital — It takes a lot to treat the little.
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Date: 24/6/26 UHID/IP No.: MAH-0037 4774 Sl. No.: 29107

Name of Patient: Mrs. A. Sheela Age: 28y Gender: f

Father's / Husband's Name: Mr. Manikanta Corporate/Occupation: pvt

Address: Alwal Phone: 7013841897 Email:

Procedure/Plan: Cerclage DOS:

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

TARIFF INFORMATION : DR. Bhavana. K

ROOM CATEGORY	GW	SW	TSW	PR	DLX	NICU	PICU	MICU	DAY CARE
Room Rent & Nursing Charges (Per Day)								8hrs	/
Doctor's Fee									
Tax									4800

PARTICULARS			AMOUNT (₹)
Surgeon's / Anesthetist's Fee / O.T Charges			36000/-
O.T Consumables			3000/- Subject to approval by TPA/Insurance Company
Instrument Charges			Not Covered by TPA/Insurance Company
Pharmacy, Consumables & Investigations			5K DAC As per actual – Not Included In Estimation
Equipment Charges	Monitor :	Oxygen:	Infusion Pump/Syringe Pump:
	Ventilator	*Conventional:*	*HFO-SLE 5000:* / *HFO-Sensormedix:*
	Phototherapy	*Single Surface:*	*Double Surface:* / *Triple Surface:*
Blood / Blood Products / Implants / IP or OP Procedures / Cross Consultations, etc.			As per actual – Not Included In Estimation
Package			
Others	MRD-2K; MRD-2800, RR-2K, Consultant-2200(PD)		
Initial Minimum Deposit			

REMARKS : 40K

1. The estimated amount may change according to duration of stay, medical condition, investigations, pharmacy and any other procedure.
2. **The estimated surgical charges may vary subject to Surgeon's decisions / Complications / Patient's requirements / Modes of Procedure (like Laparoscopic, Thorocoscopic, etc) / Unilateral to Bilateral Procedure.**
3. 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.
4. Room eligibility is purely subject to TPA approval and the Package/Room tariff starts from the time of admission.
5. 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.
6. **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.**
7. 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.
8. 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.
9. 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.
10. Tariffs are subject to revision.
11. Kindly check your billing status on day to day basis at IP Billing Department .

DECLARATION

I Manikanta 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 | Spouse | Signatory Relationship | Signature of the Financial Counselor