


ACTIV VIH-00205975 IP-00060368 **ING**
Mrs IP-00033
28-09-1994 31 Y 8 M 20 D (F)
Dr. KOPPULA SIRISHA REDDY

Name:  -----

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

Date of Admission: 17/6/26 Time: 1:07 AM Date of Discharge: ----- Time: -----

Room / Bed No: 222 Ward: 4/w Suggested Billable bed type: -----


WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
<u>17/6/26</u>	<u>10:35pm</u>	<u>MW</u>	<u>Room (104)</u>	<u>A</u>

Cross Consultation Visit

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
12/6/26	SI placement	①	3091056	
<hr/>				
	Clean checked	100	G. Shaver	12/6/26 G. Shaver

ANY OTHER INFORMATION

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
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Name	Mrs IP-00033	UHID	VIH-00205975
Father/Guardian	Mr MADHUSUDHAN REDDY PALA	Age/Gender	31 Y 8 M 20 D/Female
Address	ADITHYA PEARL APARTMENT FLAT NO G1 VENKATARAMANA COLONY, STREET NO 8 MALLAPUR HYDERABAD, Mallapur, Hyderabad, Telangana, INDIA, 500076		
IP No	IP-00060368	Admission Date	17-06-2026
Ref Doctor	SELF	Discharge Date	18-06-2026

DISCHARGE SUMMARY

Consultant: Dr. KOPPULA SIRISHA REDDY,

Diagnosis: G2P1L1 with 20+4weeks with Previous Lower segment caesarean section with Fetal anomalies for Termination of Pregnancy

History:

Menstrual History: regular
L.M.P: 17.1 .2026

Obstetric History:

G1 - female/ 5.8years/ FTLSCS/ NPOL/ BW- Padmavathi hospital/ A&H / BF 1.8year

G2 - Pregnancy: spontaneous conception

Medical History: Nil

Family History: Mother- DM, Father- HTN

Surgical History: Previous LSCS

Allergies: Nil

Antenatal Details: Mrs IP-00033 was booked to Rainbow hospital at 20+2weeks of gestation. Previous ANC's done at Padmavathi Hospital. She had regular antenatal checkups and investigations as advised. was diagnosed with Hypothyroidism since conception managed with Tab Thyroxine 12.5mcg. TIFFA scan done on 15.6.2026 showed Thorsic , lumbar spine scoliosis , kyphosis ,

Name	Mrs IP-00033	UHID	VIH-00205975
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hemivertebrae in lower thoracic and lumbar vertebrae . Patient and attenders explained regarding anomalies and option for termination given and they opted for it. Patient took Tab Mifepristone 200mg OD on 15.6.2026 after informed consent. She was admitted at 20+4 weeks with Previous Lower segment caesarean section with Fetal anomalies for Termination of Pregnancy

Investigations:

Blood group- O POSITIVE

Management: Course in Hospital:

She was admitted for TOP. MERPC done with PGE1. Patient expelled a dead ,Male fetus weighing 342gms at 4:10Pm and placenta of 343 gms at 4:22pm on 17.6.2026 .Patient and attenders explained regarding need for whole Exome Microarray and DNA storage and risk of anomalies in next pregnancy explained but they denied . Lactation supression was given with Tab. Cabergolin . She was stable at the time of discharge.

Advice:

- 1.Tab. Taxim O 200mg twice daily till 23.6.2026 (9am-9pm) after food
- 2.Tab. Emanzen D as and required if abdominal pain
- 3.Tab. Pan 40mg once daily (before food) till 23.6.2026
4. Tab Metronidazole 200mg thrice daily till 23.6.2026 (9am-2Pm- 9pm) after food
5. Tab. Livogen (Elemental Iron - 50mg, folic acid 1.5mg) once daily (7am) for one months before breakfast.
6. Tab. Shelcal (Elemental Calcium 500mg, Vitamin D3 250 IU) once daily (2pm) for 1month
7. Tab Cabergolin 0.5 mg (2 tabs) at 8 pm on 18.06.2026 after food.

Review on 23.6.2026 in Gynaec OPD with prior appointment for rescan (This consultation will be charged).

To take appointment for OPD consultation at Rainbow Children's Hospital, just dial one number 1800-2122 (between 8 a.m. to 8 p.m.)

Name	Mrs IP-00033	UHID
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(or) log on to www.rainbowhospitals.in

In case of emergency kindly contact 040-42462200. Extension 2155, 2177 (Rainbow Hospital, Karkhana).

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 doctorin the language that I understand and I have understood the same.

Name :

Signature :

Relationship with patient :

This summary has been explained by :

Summary prepared by: Dr.

Dr. KOPPULA SIRISHA REDDY
MBBS,DNB
58977

Registrar/Resident/C.M.O



PatientName : Mrs IP-00033
Age/Gender : 31 Y 8 M 20 D/ Female
Ward/Bed : N 2F-LABOUR WARD/ LW 222

Inpatient No. : IP-00060368
Admit Date : 17-06-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)			TEST RESULT STATUS : REPORT ENTERED
			Order Date :17-06-2026 19:24
RANDOM BLOOD GLUCOSE (GOD/POD)	106	mg/dl	70 - 140

Interim Report

DEFICIENCY CHECK

CASE SHEET



VIH-00205975
 Mrs IP-00033
 28-09-1994
 31 Y 8 M 20 D (F)
 Dr. KOPPULA SIRISHA REDDY

IP-00060368

Patient Name :

IP.No:

Ward:

DOA:



Sl.No	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission Sheet	01	-	-	
2	Discharge Summary	02	-	-	
3	Nursing Initial assessment form	01	-	-	
4	Patient Transfer Forms	01	-	-	
5	In-patient Medical Record	03	-	-	
6	Doctors Progress Sheets	02	-	-	
7	Nurses Progress notes	02	-	-	
8	Consultation Sheets				
9	General Consent for Treatment	01			
10	Consent for Surgery				
11	Consent for Blood Transfusion				
12	Consent for Chemotherapy				
13	Consent for High Risk				
14	Consent for Restraint				
15	DAMA Consent				
16	Consent for Special Procedure	01			
17	Consent for Radiological Investigations				
18	Consent for HIV Test				
19	Anaesthesia consent form				
20	Anaesthesia notes (Pre Anaesthesia & Post)				
21	Pre Operative checklist				
22	Surgical safety Checklist				
23	Operation Theatre notes				
24	Nurses Clinical Presentation				
25	TPR & BP chart	02			
26	Intake and Output chart (fluid Chart)	02			
27	Drug Chart (Regular prescription)	03			
28	Daily Investigation sheet				
29	Investigation Values (Result Sheet)	01			
30	Nebulization Chart				
31	Diabetic chart				
32	Nutritional Review chart	01			
33	MLC form (in case of MLC)				
34	Patient Education Form				
	pain Assessment	01			
	Thrombosis	01			
	Radiation	01			
	others	04			
	Billing	01			
	Total No. of Pages	34			

Noted by *[Signature]*
 18/10/20

Signature and Date :

ERROR LOG

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

ICD CODE :-

OBSERVATION: -

DATE :

MRD EXECUTIVE

ADMISSION SHEET

Registration Details :



Admission No : IP-00060368

Admit Date : 17-Jun-2026

Admit Time : 07:07 AM **UHID** : VIH-00205975

Patient Details :

Patient Name : Mrs IP-00033

Age : 31 Y 8 M 20 D

Guardian : Mr MADHUSUDHAN REDDY PALA

DOB : 28-09-1994

Gender : Female

Religion :

Occupation :

Martial Status :

Address (H) : ADITHYA PEARL APARTMENT FLAT NO G1
VENKATARAMANA COLONY, STREET NO 8
MALLAPUR HYDERABAD Mallapur Hyderabad
Telangana INDIA 500076

Phone No : 9963433423/ 8978575546

E-mail : NA@GMAIL.COM

Admission Details :

Bed Type : MICU

Bed No : LW 222

Ward Name : N 2F-LABOUR WARD

Room No : LW 222

Admission Type : First Visit

Contact Details :

Name : Mr MADHUSUDHAN REDDY PALA

Relationship : W/O

Contact Address : ADITHYA PEARL APARTMENT FLAT NO G1
VENKATARAMANA COLONY, STREET NO 8
MALLAPUR HYDERABAD Mallapur Hyderabad
Telangana INDIA 500076

Phone No : 9963433423


Signature

Doctor Details :

Doctor Name : Dr. KOPPULA SIRISHA REDDY

Specialisation : OBSTETRICS AND GYNECOLOGY

Referral Doctor : SELF

Phone No :

Co-Consultant :

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : MEDI ASSIST INSURANCE TPA PVT LTD

OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 17/6/26 Time of Arrival: 6 pm Time Seen by Nurse: 6:15 Pm

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:

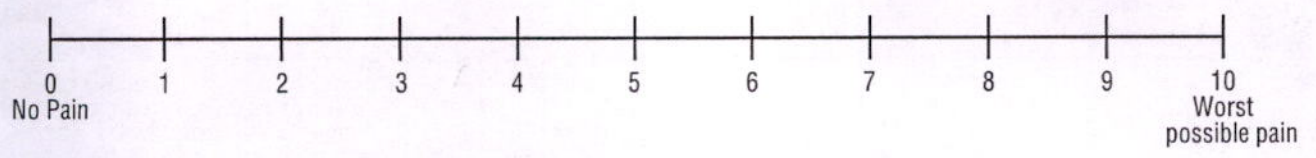
3) Vital Signs: Temperature: 98.6 Pulse: 86 RR: 18 SpO₂: 99% BP: 110/70 Weight: 72 kg

4) Gestational Criteria:

Gravida:	G <u>2</u>	P <u>1</u>	L <u>1</u>	A <u>—</u>
LMP:	<u>12/1/26</u>	EDD:	<u>—</u>	Gestational Age: <u>20+9 wks</u>

Uterine Contraction	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> NA	Onset	Time	Frequency:
Membrane Rupture	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> NA	Onset	Time	Fluid Color:
Vaginal bleeding	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> NA	Onset	Time	Amount:
Pre Eclampsia Symptoms	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> NA	If Yes specify: Headache / Visual Symptoms / Pain Abdomen / Vomiting		
Good fetal Movement	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> 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: Pre- LSCS
- b) Medical:



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	<ul style="list-style-type: none"> • Acute onsite severe abdominal pain • Altered level of consciousness • Cord prolapse • Severe respiratory distress • Suspected sepsis 	<ul style="list-style-type: none"> • Major trauma • Shortness of breath • Unplanned and unattended birth 	<ul style="list-style-type: none"> • Abdominal/back pain greater than expected in pregnancy • Flank pain / hematuria • Nausea /vomiting and /or diarrhea with suspected dehydration 	<ul style="list-style-type: none"> • 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) 	<ul style="list-style-type: none"> • 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: 7 AM

Nurse Name : Rani Nurse Signature: [Signature]

Date: 12/1/20 Time: 7 AM

OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 12/11/26

Baseline Information:

Admission From: ER OPD Admission Desk Others, specify ED

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: Ab. ALI @ 26 + 4 wgt
TOP Doctor Notified on Admission: Yes No
 Name of the Doctor: Dr. Manikya
 Time Notified: _____

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

Past Medical History	Past Surgical History	Previous Hospital Admission
—	prev-LSCS	— Nil

Gynecology Assessment: <input checked="" 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>12/11/26</u>	Caesarean Section: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Cervical Cerclage: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Ectopic Pregnancy: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Myomectomy: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Others: _____	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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes Infertility: <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes Type: <input type="checkbox"/> Primary <input type="checkbox"/> Secondary

Obstetric History: G 2 P 1 L 1 A _____

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, father - HTN

Vital Signs / Measurements: Temp: 98.6 HR: 85 RR: 18
 BP: 110/70 Weight: _____ 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 0 (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore: Yes No Score 28 (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. IP-00033

Name of Person Orientation was given to: Mrs. IP-00033

Orientation not given Reason:

Nurse Signature: Dani

Nurse Name: Dani

Date & Time: 12/6/26 @ 7:45 AM

PATIENT TRANSFER FORM

VIH-00205975 IP-00060368
Mrs IP-00033
28-09-1994 31 Y 8 M 20 D (F)
Dr. KOPPULA SIRISHA REDDY



Date & Time of Admission 17/6/26 @ 7:7am		Date & Time of Transfer Order 17/6/26 @ 10:40pm
Treating Consultant Name	Transfer Ordered by Dr. Aswini	Reason for Transfer Observation
From Unit Mater L/W	To Unit Room (104)	Information to Attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Number of Sheets in Clinical File - 36 -	Number of Imaging Films - Nil -	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.		
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes No

Name & Signature of Person who is Transferring Sr. Parthivhar	Name of Person Ordered Transfer Dr. A Swini
--	--

Patient & Clinical Records Received by : Subbar

Date & Time of Patient Received : 10:40 pm

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

AH-00205975 IP-00060368
 Vra IP-00033
 18-09-1994 31 Y 8 M 20 D (F)
 Dr. KOPPULA SIRISHA REDDY



IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

Obstetric Formula: G2 P1 U
m1-94rs 1.4cm

Obstetric History: G1 - ♀ | 5.8 yrs | FTLWC | PPOL / AGH
Radmanathya Hospital

G2-PP, Spontaneous Conception

Present Pregnancy Record:
Over ANC At Radmanathya Hospital
Hypothyroid: Conception on T-Thyromom
12.5mcg

RISK FACTORS: TOOCT mife on 15/6/26
(200mcg)

- Hypothyroid
 - Prev LWS

Height: 154 cm
 Weight: 72 kg
 Allergies: NIL
 Breast: Normal Abnormal
 General Examination: PTISCC, ureteris
 Consciousness: (+) Pallor: -
 Icterus: - Edema: -
 Temp: Afebrile PR: 89 bpm
 BP: 110/80 mmHg DTR: (+)
 CVS: S1S2 (+) RS: BAF (+)
 Liver/Spleen: NAD Urine Output: Adequate

LMP: 17-1-2026 EDD:
 Corrected EDD: 31-10-26 GA: 20+4 weeks

Menstrual History: Regular: Yes No

Obstetric Examination

Fundal Height: at - 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

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

G2 P1 U 20+4 weeks GA - Abnormal Fetal Anomaly (PRULSES
(Hemivertebrae) for Termination of pregnancy.



<p>Family History:</p> <p>mother - DM Father - HTH</p>	<p>Surgical History:</p> <p>Prex WCs</p>
<p>Medical History:</p> <p>-</p>	<p>Medication History:</p> <p>T-FERONOD T-CALCIUMOD</p>
<p>Plan of Care:</p> <ul style="list-style-type: none"> - Admission - Consent - Post pre preparation - Trace CBP, (Ue, TSH, T6g, PT, INR) - T-miso 200mg with hourly - Follow on chest - monitor vitals - Inform sos. <p><u>Noted by Rami 17/6/26 @ 8 AM</u></p>	<p>Investigations: BCU: 0 POSITIVE</p> <p>HIV HBSAG HCV VDRL } NR.</p> <p>15/6/26 Anomally scan SLT/F, low talarus Thoracic spine Lumbar spine: scoliosis, } abnormal Kyphosis, sacral spine - Hemivertebrae in lower thoracic & lumbar vertebrae Kypho-scoliosis.</p>

Doctor Name: Dr. Pramanik

Signature: Dr. Pramanik

Date & Time: 17/6/26, 7:00 AM

Consultant Name: Dr. K. Sirisha Reddy

Signature: _____

Date & Time: _____

PROGRESS NOTES
(USE BALL POINT PEN ONLY)



DATE	TIME	(SIGN ALL ENTRIES, DATE & TIME OF EACH ENTRY IS COMPULSORY)	
17/6/26	8:15 AM	O/E	
		Atisco, uteris	
		Afebrile	ADY
		BP - 110/70 mmHg	Ⓢ Diet
		PR - 86 bpm	W/F spontaneous
		S/E - NAD	Expulsion
		PIA - uteris relaxed	Follow on chart
		Uterus - long	monitor vitals
		OS - closed	Inform SOS
			Out primary.
Noted by G. Sharma 17/6/26 2 AM			
17/6/26	12:15 PM	O/E -	
		pt is c/c/c	Adv:
		Gc - Fair	- Ⓢ diet
		Afebrile	- w/f spontaneous
		BP - 112/76 mmHg	expulsion.
		PR - 82 bpm	- Follow drug
		S/E - NAD	chart
		PIA - uteris relaxed	- monitor vitals
			- Inform SOS
Noted by G. Sharma 17/6/26 12:15 PM			
			Ⓢ
			DS - Nikhita

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

17/06/26

4:10 PM

Expulsion Notes

Patient expelled a Male fetus of weight 342gms at 4:10 PM on 17/06/26 and placenta of weight 342gm expelled at 4:22 PM on 17/06/26.

[Signature]
Dr. Gredhna

17/06/26

4:45 PM

OPD to Dr. Srinisha Reddy Manna

OPD RT ic clc

Vitals stable

HA - DFW WIR

Soft NT


Adv

- Ij: Cefotaxime 2g IV 12mly x 5 days
- Ij: Metronidazole 500mg IV x 5 days
- Ij: Pantoprazole 40mg IV ^{orally}
- Whole Exome
- Microarray
- DNA storage
- Monitor vitals
- Follow drug chart
- Inform ses

noted by
S. Sharma
17/06/26
4:45 PM

[Signature]
Dr. Gredhna

PROGRESS NOTES
(USE BALL POINT PEN ONLY)

+00205975 IP-00060368
Patient IP-00033
-09-1994 31 Y 8 M 20 D (F)
Age KOPPULA SIRISHA REDDY
I.P. 

DATE	TIME	(SIGN ALL ENTRIES, DATE & TIME OF EACH ENTRY IS COMPULSORY)
17/6/26	5:20 PM	<p>Patient and attenders have been explained regarding the need for whole Exome, Microarray and DNA storage and risks of anomalies in next pregnancy but they denied for the tests.</p> <p>noted by G. Shanu 17/6/26 5 pm</p> <p>by patient (Patient) (Husband) by Dr. Geethamma.</p>
17/6/26	5:30 PM	<p>C/S/B Dr. Sirisha Reddy, Marm</p> <p>OK - Pt is c/c</p> <p>Vitals stable.</p> <p>PIA - Uterus w/ck</p> <p>follo NT</p> <p>LIE - NAB</p> <p>Adv</p> <ul style="list-style-type: none"> - T. Cabergoline 0.5mg 2 tabs stat x 2 days - T. SPON x 1 month - OD - T. CALCIUM x 1 month - OD - Shift to room <p>noted by G. Shanu 17/6/26 5 pm</p>

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

7/16/26
9pm

Oleptado

Adv

u gair
afbrile

- soft diet
- wif bleeding
pu

BP - 110/72 mmg

PR - 85 bpm

- monitor
vitals

SEENAD

PIA soft

- follow drug
chart

NT

PIUNAB

- inform sos

OP

Dr Ashuni

Noted by Madhula @ 9pm

7/16/26

7/16/26
7am

PAD-1

Oleptado

Adv

u gair
afbrile

- soft diet
- wif bleeding
pu

BP - 100/72 mmg

PR - 92 bpm

- monitor
vitals

SEENAD

PIA soft

- follow drug
chart

NT

PIUNAB

- inform sos

OP
me

nt can be
discharged

Per vaginal examination
no active bleeding

Dr Ashuni

Noted by Rich
9pm
7/16/26

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <u>h2 put 20th wky r.</u> <u>Abnormal fetal anomaly (Hernia)</u>	Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known						
	Surgery / Procedure: <u>(TOP)</u>	Post OP Day:						
BACKGROUND	Date	Shift	17/6/26 mom	17/6/26 Emergency	18/6/26 N	17/6/26 Night	18/6/26 m	
	Medical Condition (Any special condition to be noted):							
	Diet:							
ASSESSMENT	Allergy:	<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 checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):		RA	RA	RA	RA	RA	
	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 checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	98.2°f	98.6°f	98.2°f	98.6°f	98.4°f	98.4°f
		Res:	18 b/m	20 b/m	19 b/m	19 b/m	20 b/m	20 b/m
		SpO ₂ :	99%	100%	96%	96%	98%	98%
		Pulse:	86 b/m	82 b/m	80 b/m	85 b/m	88 b/m	88 b/m
		BP:	110/70	118/70	109/69	111/67	110/70	110/70
		LOC:	conscious	conscious	conscious	conscious	conscious	conscious
		Fall Risk Score:	0	0	0	0	0	0
Pain Score:	0	0	0	0	0	0		
Skin Integrity	Intact	Intact	Intact	Intact	Intact	Intact		
Recommendations	Safety Needs:	<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 checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Physiotherapy:		nil	nil	nil	nil	nil	
	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 checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Diet:	N-diet	N-diet	N-diet	N-diet	N-diet	N-diet	
	Critical Lab Test / Values:		nil		nil	nil	nil	
	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 checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Recommendations	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 checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" 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 checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	ADL (Dependent / Non Dependent):	dependent	dependent	dependent	dependent	dependent	dependent	
	Post Operative Procedure Special Orders:	nil	nil	nil	nil	nil	nil	
Handed Over By Name :	C. Shams	C. Shams	Prathysa	Subha	Pradu			
Signature / ID :			020533	12444	88888			
Date:	17/6/26	17/6/26	17/6/26	18/6/26	18/6/26			
Time:	2pm	8pm	@ 10pm	@ 8AM	9AM			
Taken Over By Name :	C. Shams	Prathysa	Subha	Pradu				
Signature / ID :		020533	12444	88888				
Date:	17/6/26	17/6/26	17/6/26	18/6/26				
Time:	2pm	@ 8pm	@ 10PM	@ 8AM				

Noted by Pradu
 29 AM
 18/6

VIH-00205875
 Mrs IP-00033
 28-09-1994
 IP-00060368
 31 Y 8 M 20 D
 Dr. KOPPULA SIRISHA REDDY (F)



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:						
	Surgery / Procedure:	Post OP Day:						
BACKGROUND	Date							
	Shift							
	Medical Condition (Any special condition to be noted):							
	Diet:							
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):							
	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 ₂ :						
		Pulse:						
		BP:						
		LOC:						
		Fall Risk Score:						
Pain Score:								
Skin Integrity								
Recommendations	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:								



NURSING CARE RECORD

Date: 17/6/26

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 AM	→ maintain fluid balance.	8 AM	→ provided orally of oral fluids	→ maintain fluid balance	→ Re-Assess maintained fluid balance patient is safe	Ravi 17/6/26
	12 PM	Ensure safety	1 PM	provided side rails	to prevent fall		Sn
Afternoon	2 PM	Maintain fluid balance	2 PM	Encourage to take oral fluids	to prevent dehydration	patient hydrated well	
	4 PM	Top at 4 PM Patient not with for DNA Storage	4 PM	Patient p/v to bed in room	patient is comfortable	patient is safe	Uthman 17/6/26 7 PM
Night	10 PM	no vitals	10 PM	vitals are normal Checked vitals	vitals are normal	patient was stable	pradip 17/6/26
	11 PM	→ maintain good nutritional		→ provided normal diet	→ oral intake is good	→ No fresh complaints	Subhan 18/6/26 @ 8 AM

VIH-00205975

IP-00060368

Mrs IP-00033

31 Y 8 M 20 D (F)

28-09-1994

Dr. KOPPULA SIRISHA REDDY



NURSING CARE RECORD



Date: 18/10/28

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		discharge notes, - or care for hands for discharge.			patient is stable advice		
Afternoon	Noted by [Signature] 18/10/28						
Night	Noted by [Signature] 18/10/28						

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
12/6/26	8AM	10 ⁺ Score	NO Pain	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comfortable Pain	B
12/6/26	10AM	10 ⁺ Score	NO Pain	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comfortable Pain	B
12/6/26	12 PM	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comfortable	R
12/6/26	2 PM	0 ⁺	Abd Pain	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input checked="" type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input checked="" type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Comfortable	R
17/6/26	upn	2 ⁺	Abd Pain	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input checked="" type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input checked="" type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Comfortable	R
12/6/26	5pm	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comfortable	R
12/6	10pm	0 score	NO Pain	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comfortable	B
18/6	2AM	0	NI ⁺	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nil	Subhan
18/6	9AM	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	nil	Indu.
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Re-assessment Frequency:

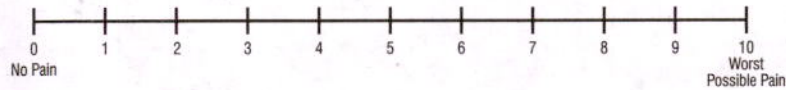
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1		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, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



VIH-00205975 IP-00060368
 Mrs IP-00033
 28-09-1994 31 Y 8 M 20 D (F)
 Dr. KOPPULA SIRISHA REDDY



①

CHECKLIST FOR THROMBOPHLEBITIS

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 17/6			DAY-2 18/6			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0		0	0	0						
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 cord pyrexia	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 : Shamini

Signature of Ward In Charge :
 Signature : _____ Name : Dhanalakeshan

VIH-00205975
Mrs IP-00033
28-09-1994

IP-00060368

31 Y 8 M 20 D (F)

Dr. KOPPULA SIRISHA REDDY



(1)

BRADEN 'Q' SCALE



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

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

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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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

GENERAL CONSENT FOR TREATMENT

Patient Name: Mrs IP-00033 Age : 31 Y 8 M 20 D
IP No: IP-00060368 Sex: Female
Consultant: Dr. KOPPULA SIRISHA REDDY Ward/Bed No: N 2F-LABOUR WARD/LW 222

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 life 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.

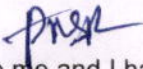
I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal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

Relationship: 

Date: 17-06-2006

Time:

Witness Name: 

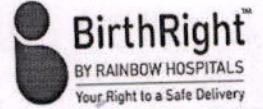
Witness Signature: 

Patient Address:

ADITHYA PEARL APARTMENT FLAT NO
G1 VENKATARAMANA COLONY,
STREET NO 8 MALLAPUR HYDERABAD
Mallapur Hyderabad Telangana INDIA
500076

(FORM - C)

CONSENT FOR MEDICAL TERMINATION OF PREGNANCY (MTP)



Patient Name: MRS SANDHYA UHID no: NIH-00205928 Date: 15/6/2026

I MRS SANDHYA Daughter / wife of MADHUSUDHAN REDDY PALA

aged about 31 YEARS Years of ADITHYA PEARL APARTMENT, FLAT NO. G1

At present residing at VENKATARAMANA COLONY, STREET NO. 8, MALLAPUR HYDERABAD do hereby give my consent to be

Termination of my Pregnancy at RAINBOW HOSPITAL KARKHANA
(State the name of place where the pregnancy is to be terminated).

Place: SECUNDERABAD

Patient:

Signature: [Handwritten Signature]

Name: Sandhya

Date & Time: 15/6/2026 8:15 PM

Doctor: (who is taking the consent)

Signature:

Name:

Date & Time:

(To be filled in by guardian where the women is a lunatic or minor)

I son / daughter / wife of

aged about Years of (here state the permanent address).

At present residing at do hereby give my consent to the

Termination of Pregnancy of my ward who is minor / lunatic at (Place of termination of pregnancy).

Place:

Patient Guardian:

Signature:

Name:

Relationship with patient:

Date & Time:

Doctor: (who is taking the consent)

Signature: [Handwritten Signature]

Name:

Date & Time:

FORM E
REGISTERED MEDICAL PRACTITIONER (RMP) OPINION FORM
(For gestation age beyond twenty weeks till twenty-four weeks)



Patient Name: MRS. SANDHYA UHID no: VIH-00205928 Date: 15/6/26

I DR. KOPPULA SIRISHA REDDY,
(Name and qualification of the Registered Medical Practitioner - I in block letter)

BIRTHRIGHT BY RAINBOW HOSPITAL
(Full address of the Registered Medical Practitioner - I)

I
(Name and qualification of the Registered Medical Practitioner - II in block letter)

.....
(Full address of the Registered Medical Practitioner - II)

Hereby certify that we are of opinion, formed in good faith, that it is necessary to terminate the pregnancy of

MRS. SANDHYA
(Full name of the Patient in block letter)

Resident of ADITHYA PEARL APARTMENT, FLAT NO.61 VENKATARAMANA COLONY, STREET NO.8, MALLAPUR, HYDERABAD
(Full address of the Patient in block letter)

Which is beyond twenty weeks but till twenty-four weeks under special circumstances as given below*

*Specify the circumstance (s) from (a) to (g) appropriate for termination of pregnancy beyond twenty weeks till twenty-four weeks

- a. Survivors of sexual assault or rape or incest.
- b. Minors
- c. Change of marital status during the ongoing pregnancy (widowhood and divorce)
- d. Women with physical disabilities [major disability as per criteria laid down under the Rights of Persons with Disabilities Act, 2016 (49 of 2016)]
- e. Mentally ill women including women with intellectual disability.
- f. The fetal malformation that has sustained risks of being incomplete with life or if the child is born it may suffer from such Physical or mental abnormalities to be seriously handicapped.
- g. Women with pregnancy in humanitarian settings or disaster or emergency situations as declared by Government

We hereby give intimation that we terminated the pregnancy of the woman referred to above who bears the serial no:

in the admission register of the hospital / approved place.

Registered Medical Practitioner - I: Signature: Name: [Signature]

Registered Medical Practitioner - II: Signature: Name:

Place: SECUNDERABAD

Date: 15/6/26

Note: Account may be taken of the pregnant woman's actual or reasonably foreseeable environment in determining whether the continuance of her pregnancy would involve a grave injury to her physical or mental health.

CONSENT FOR SPECIAL PROCEDURES

Patient Name : MRS SANDHYA Gender: Male Female
UHID No : VIH-00205928 Department : OBGY Date : 15/6/2026

I MRS SANDHYA S/D/W/O MADHUSUDHAN REDDY PALA

Here by give consent for procedure of : MEDICAL TERMINATION OF PREGNANCY

For my patient, Named : MRS SANDHYA

The doctors have clearly explained to me that the procedure has following possible complications:

BLEEDING, INFECTION

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :

HYSTEROTOMY

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure: DR. KOPPULA SIRISHA REDDY

Patient Attendant

Signature : [Signature]

Name : Sandhya

Relationship with Patient: SELF

Date & Time : 15/6/26 ; 8:15 PM

Witness :

Signature :

Name :

Date & Time :

Doctor (who is taking the consent) :

Signature : [Signature]

Name : DR. NAUSHEEN

Date & Time : 15/6/26 ; 8:15 PM

ప్రత్యేక విధానాలకు సమ్మతి



రోగి పేరు లింగం పురుషుడు స్త్రీ

యు.హెచ్.ఐ.డి విభాగం తేదీ

నేను S/D/W/O

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా

నా గోగికి, పేరు :

ఈ ప్రక్రియ కోసం ప్రత్యామ్నాయాలు, నష్టాలు మరియు ప్రయోజనాలు గురించి డాక్టర్ నాకు తెలిసిన భాషలో వివరించా

.....

.....

.....

నాకు తెలిసిన భాషలో పైన పేర్కొన్న విషయాన్ని నేను అర్థం చేసుకున్నాను మరియు ప్రక్రియకు సమ్మతిని తెలియజేస్తున్నాను.

ప్రక్రియ చేస్తున్న వైద్యుని పేరు :

సహాయకుడు (అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

స్వామి

సంతకము

పేరు

తేదీ మరియు సమయము

VH-00205975
 Mrs IP-00033
 28-09-1994
 31 Y 8 M 20 D (F)
 Dr. KOPPULA SIRISHA REDDY

IP-00060368

①

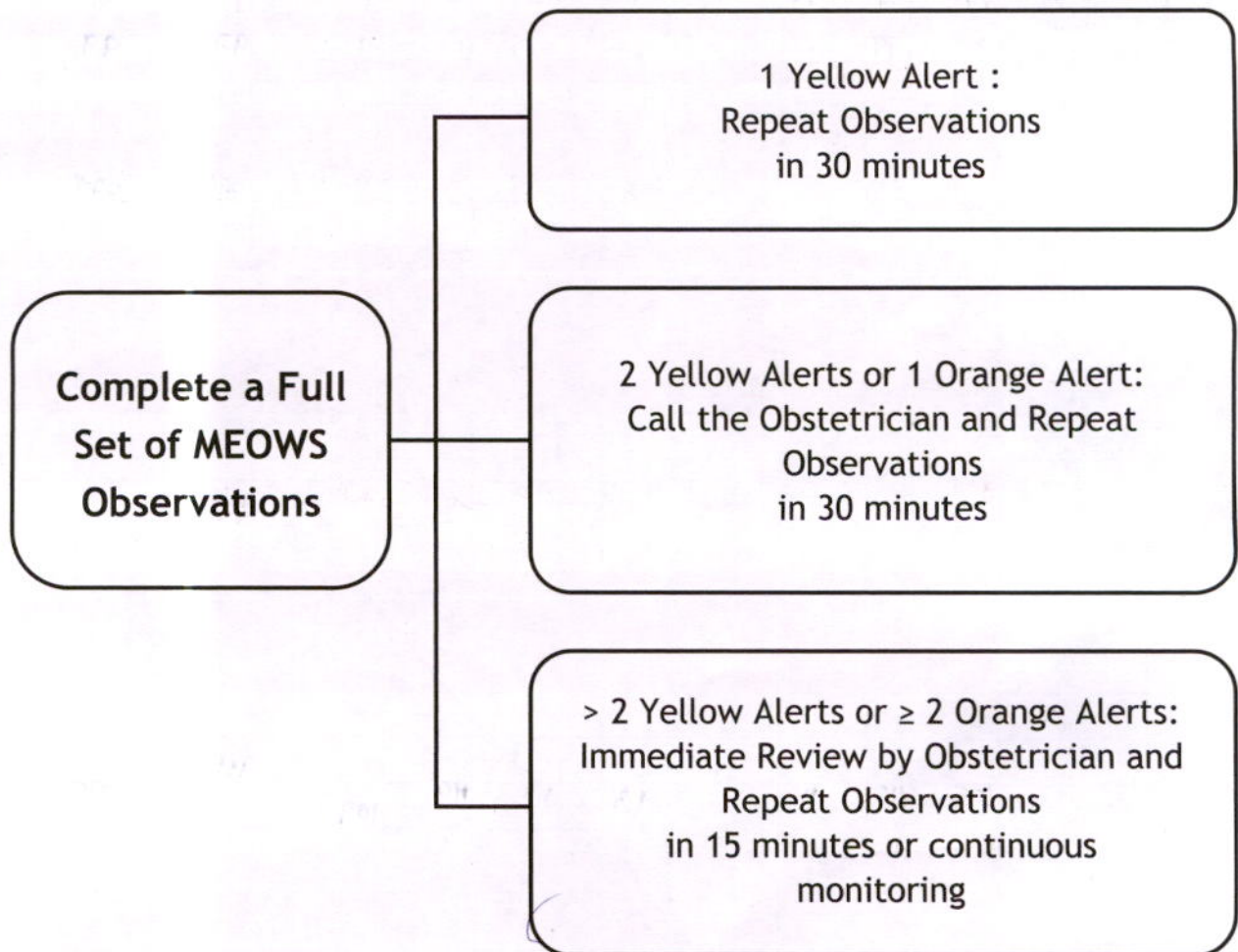


Early warning Observation Score Chart - Obstetrics

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

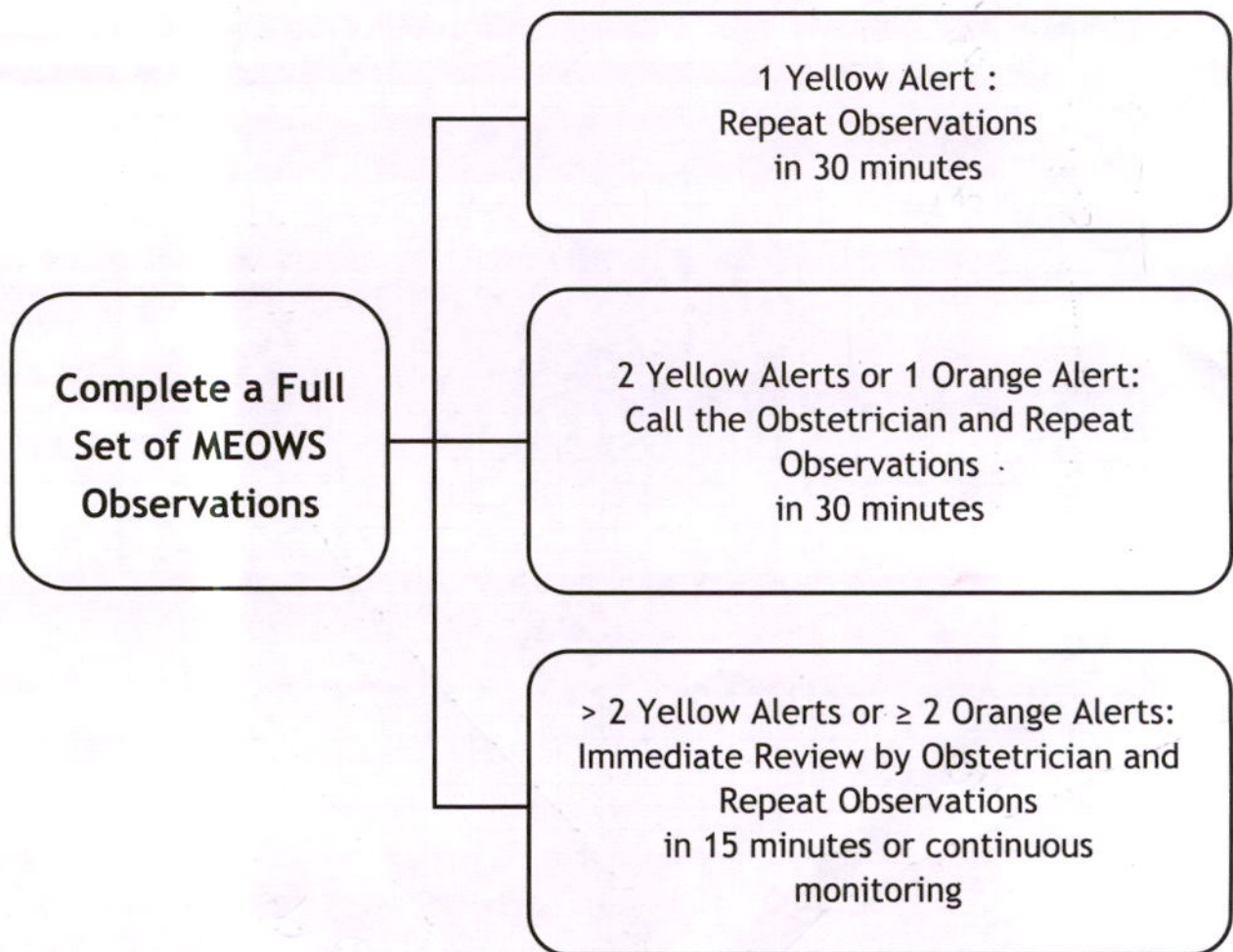
Date		Time																							
17/6/26		8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																								
	21 - 30																								
	11 - 20	19	19	19		18	19	19	19	19	19	19	19	19	19	19	19	19	19	19	19	19	19	19	19
	0 - 10																								
Saturations	94 - 100 %	98	99	99		99	100	99	100	99	100	99	99	99	99	99	99	99	99	99	99	99	99	99	99
	< 94 %																								
Administered O ₂ (L/min.)																									
Temp °C	40																								
	39																								
	38																								
	37																								
	36	36.2	36.2	36.2	36.2	36.2	36.2	36.2	36.2	36.2	36.2	36.2	36.2	36.2	36.2	36.2	36.2	36.2	36.2	36.2	36.2	36.2	36.2	36.2	36.2
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80	80	88	84		76	74	72	76	80	76	85	91												
	70																								
60																									
50																									
40																									
↑ Systolic Blood Pressure	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110	105	110	116		120	118	112	110	109	111	120	102												
	100																								
	90																								
80																									
70																									
60																									
50																									
↓ Diastolic Blood Pressure	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70	73	70	74		74	76	70	72	69	76	81	72												
60																									
50																									
40																									
NEURO RESPONSE [✓]	Alert	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	Voice																								
	Pain																								
	Unresponsive																								
URINE mls / 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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
TOTAL ORANGE SCORES		0	0	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Nurse Initial		SK	SK	SK		SK	SK	SK	SK	SK	SK	SK	SK	SK	SK	SK	SK	SK	SK	SK	SK	SK	SK		

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

FLUID CHART

Sheet No. : 1

- 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	Intake				Output					IV Site Thrombophlebitis Score	Sign. Nurse
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
12/6	08:00 am	H ₂ O 100 ml								✓		Joshi 12/6/12
	09:00 am	H ₂ O 100 ml										
	10:00 am	H ₂ O 100 ml										
	11:00 am	H ₂ O 100 ml								✓		
	12:00 pm	H ₂ O 100 ml										
	01:00 pm	H ₂ O 100 ml										
Total Intake :		500 ml				Total Output :						
	02:00 pm	H ₂ O 100 ml									0	Joshi 12/6/12
	03:00 pm	H ₂ O 50 ml M 100 ml								✓	0	
	04:00 pm	H ₂ O 100 ml M 100 ml									0	
	05:00 pm	M 300 ml FF									0	
	06:00 pm	H ₂ O 100 ml									0	
	07:00 pm	H ₂ O 100 ml								7:30	0	
Total Intake :		950 ml				Total Output :						
	08:00 pm	H ₂ O 100 ml									0	Joshi 12/6/12
	09:00 pm	H ₂ O 100 ml									0	
	10:00 pm	H ₂ O 100 ml									0	
	11:00 pm										0	
	12:00 am										0	
	01:00 am										0	
Total Intake :						Total Output :						
18/6	02:00 am											Subbar 18/6 @ 7 AM
	03:00 am		water									
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output

FLUID CHART

Sheet No. : 2

18/6/26

- 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
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
18/6	08:00 am										✓	<div style="font-size: 2em;">}</div>
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output

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: ICU Shifted to: OT

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	INJ CEFOTAXIME	1GM	IV	BD	17/6	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
2	INJ METRONIDAZOLE	500mcg	IV	TID	17/6	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
3	INJ PANTOPRAZOLE	40mcg	PO	TID	17/6	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
4	T. IRON	1TAB	PO	OD	17/6	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
5	T. CALCIUM	500mcg	PO	OD	17/6	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : H. Dr. Achini

Date & Time : 17/6/26 5:30pm

Nurse Name & Signature: Prathisha

Date & Time : 17/6/26 5:30pm



Patient Name :		I.P. No.	Sheet No.	Wards 16	Weight (kg) 22kg
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REGULAR PRESCRIPTIONS

DRUG : T. CALCIUM				Date 18/6																			
Dose 1TAB	Route PO	Frequency ONCE DAILY	Start Dt. 18/6																				
Name & Signature of the Doctor starting the Drugs: <i>Dr. G. Suresh</i>																							
Additional Instructions: T. Shelcal																							
Daily Doctor's Endorsement by a Sign.																							

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

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

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

Dr. G. Suresh
 17/6/2018
 17/6/2018

KOPPULA SIRISHA REDDY

Patient Name :



I.P. No.

Sheet No.

Wards

Weight (kg)


REGULAR PRESCRIPTIONS

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

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

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

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

VH-00205975 IP-00060358
 Mrs IP-00033
 28-09-1994 31 Y 8 M 20 D (F)
 Dr. KOPPULA SIRISHA REDDY




DRUG CHART

Date of Admission: 17/6/26 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	Date Time																
Doctor's Signature		Valid Period	Pharm.																	
Additional Instructions:																				

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

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

VERIFIED BY : Name Signature

Weight. Ward.



		Date Time	Nurse Sig.	Nurse Sig.	Nurse Sig.	Nurse Sig.
DRUG :		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.

VARIABLE DOSE		Date Time	Nurse Sig.	Nurse Sig.	Nurse Sig.	Nurse Sig.
DRUG :		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
17/6/26	8:15 AM	TAB MISOPROSTOL	200mcg	PV	ay.	[Signature]
17/6/26	12:15 PM	T. MISOPROSTOL	300 mcg	PV	gn	[Signature]
17/6/26	3:30 pm	T. CABERGOLIN	0.5 mg (2 TABS)	PO	g	[Signature]
18/6/26	11 AM	T. CABER 40LIV	0.5 MG (2 TAB)	PO	H	[Signature]

82
 17/6/26
 12:15 pm
 18/6
 11 am

VERIFIED BY: Name Signature

REGULAR PRESCRIPTIONS

Weight 72 kg Ward 40

Dr. D. J. Shanka
 C. Shanka
 17/6/26 @ 7pm
 Dr. D. J. Shanka
 C. Shanka
 17/6/26 @ 7pm
 Dr. D. J. Shanka
 C. Shanka
 17/6/26 @ 7pm
 Dr. D. J. Shanka
 C. Shanka
 17/6/26 @ 7pm

DRUG : ENI CEFOTAXIME				Date Time	17/6 12/6																	
Dose	Route	Frequency	Start Date	1	AM																	
1GM	IV	12M daily	17/6																			
Name & Signature of the Doctor Starting the Drugs:																						
Additional Instructions:																						
Daily Doctor's Endorsement by a Sign																						
DRUG : ENI METRONIDAZOLE				Date Time	17/6 12/6																	
Dose	Route	Frequency	Start Date	6	AM																	
500MG	IV	8M daily	17/6																			
Name & Signature of the Doctor Starting the Drugs:																						
Additional Instructions:																						
Daily Doctor's Endorsement by a Sign																						
DRUG : ENI PANTOPRAZOLE				Date Time	17/6 12/6																	
Dose	Route	Frequency	Start Date	6	AM																	
40MG	IV	ONCE DAILY	17/6																			
Name & Signature of the Doctor Starting the Drugs:																						
Additional Instructions:																						
Daily Doctor's Endorsement by a Sign																						
DRUG : T-LIDON				Date Time	17/6 12/6																	
Dose	Route	Frequency	Start Date	2	PM																	
1TAB	PO	ONCE DAILY	17/6																			
Name & Signature of the Doctor Starting the Drugs:																						
Additional Instructions:																						
Daily Doctor's Endorsement by a Sign																						