RSCS

ACTIVITY RECORD FOR BILLING

VIH-00206015 IP-00060418
Mrs IP-00034
18-07-1992 33 Y (F)
Dr. SRILATA PATNAIK

Name: --

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

Date of Admission : --20/6/26 Time : 9:20AM-- Date of Discharge : ---------------- Time: -----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
20/6/26	12:05PM	MICU	O.T	[signature]
20/6/26	1:20pm	OT	MICU	[signature]
20/6/26		MICU	Room(106)	[signature]

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
20/6/26	CBP, HIV Test (card method),	41260209[illegible]	[illegible]
20/6/26	HBSAg, CT, BT		
crossed checked by [illegible]		20/6/26 at 5:40pm	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
20/6/26	Cardiac monitor	12:05PM	6:30Pm	3092519	Teju
20/6/26	Infusion pump	10:00PM	6:30Pm	3092519	
crossed checked by Teju 20/6/26 at 6:30PM?					

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
20/6/26	I.V Placement	1	3092519	[illegible]
20/6/26	PAC	1	3092520	[illegible]
20/6/26	Catheterisation	1	3092521	[illegible]
Crossed	Checked by [illegible]	20/6/26 at	5:30PM	

ANY OTHER INFORMATION

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
	[illegible] 21/6 @ 10AM		

Name	Mrs IP-00034	UHID	VIH-00206015
Father/Guardian	Mr SUKANTA BHOLA	Age/Gender	33 Y /Female
Address	g p colony, nagaram ,keesara, Nagaram, Hyderabad, Telangana, INDIA, 500083		
IP No	IP-00060418	Admission Date	20-06-2026
Ref Doctor	SELF	Discharge Date	21-06-2026

DISCHARGE SUMMARY

Consultants : Dr. SRILATA PATNAIK, CONSULTANT OBSTETRICIAN & GYNECOLOGIST

Diagnosis: G3P2L2 with 7+2 weeks with Previous LSCS for Dilatation & Curettage with Laparoscopic Bilateral Tubectomy.

History: Presenting complaint: Booked to RCH at 6 weeks. Viability scan done at 6 weeks showed SLIUF, CRL-3.3mm. Patient and husband want termination of pregnancy & Tubectomy. Admitted at 7+2 weeks with Previous LSCS for Dilatation & Curettage with Laparoscopic Bilateral Tubectomy.

History:
LMP: 30.04.2026
Obstetric formula: G3P2L2
EDD: 4.02.2027
Gestation at admission: 7+2 weeks

Obstetric History:
G1 - Male/ FTNVD/ 10 years/ 3.1kg / Sparsh Hospital, Buvaneshwar/ Uneventful/ A&H/ BFx1 month.

G2 - Male/ FTLSCS/ 1.5years/ 3.8kg/ Floating head/ Malpresentation/ Janani hospital, hyderabad/ Uneventful/ A&H/ BFx8months.
G3 - Present pregnancy Spontaneous conception.

Medical History: Nil
Family History: Father - DM
Surgical History: Previous LSCS in 2025
Allergies: Nil

Investigations: Enclosed.
Blood Group - **'B' POSITIVE**

Surgery Notes:
Operation performed: Dilatation and Curettage with Laparoscopic Bilateral Tubectomy done under GA.

Operative findings:
- Under strict aseptic conditions, under GA, patient placed in lithotomy position, parts painted and draped.
- Bladder catheterised, anterior and posterior vaginal walls retracted using Sims speculum.
- Anterior lip of cervix held with vulsellum.
- Serial cervical dilatation done with Hegar's dilators.
- Karmann's cannula no.6 was placed and products were suctioned.
- Gentle curettage was done and products obtained.
- Check curettage done.

Laparoscopy findings :
- One 5mm supraumbilical and two 5mm lateral ports inserted.
- Pneumoperitoneum created.
- Bilateral tubes and ovaries appear normal.
- Omental adhesions present and released.

- Bilateral Tubectomy done with cauterisation.
- Hemostasis secured.
- Procedure uneventful.

Post-Operative Notes: Postoperative period: - Uneventful.

Advice:

1. Tab. Cefuroxime 500mg twice daily till 26.06.2026 (9am - 9pm) after food.
2. Tab. Calpol 500mg (2tabs) thrice daily till 26.06.2026 (7am-3pm-10pm) after food.
4. Tab. Pantoprazole 40 mg once daily till 26.06.2026 (7am) before food.
5. Tab. Voveran 50 mg thrice daily till 26.06.2026 (10am-4pm-10pm) after food.
6. * **Wound care:** Remove the bandages next day after the bath and put small Johnson's bandage over the suture sites for 3 days.

Review after one week on 26.06.2026 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).

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	Mrs IP-00034	UHID	VIH-00206015

Name :

Signature :

Relationship with patient :

This summary has been explained by :

Summary prepared by: Dr.

Registrar/Resident/C.M.O

Dr. SRILATA PATNAIK
MBBS MD
CONSULTANT OBSTETRICIAN
& GYNECOLOGIST

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. 040-42462200, Ext 2000,2001,2002,

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

PatientName	: Mrs IP-00034		**Inpatient No.**	: IP-00060418
Age/Gender	: 33 Y / Female		**Admit Date**	: 20-06-2026
Ward/Bed	: N 2F-LABOUR WARD/ LW 219		**Discharge Date**	:

Investigation	Result	Unit		Biological Reference Interval
BLEEDING TIME/CLOTTING TIME (Specimen : BLOOD)				TEST RESULT STATUS : REPORT AUTHORISED Order Date :20-06-2026 10:07
BLEEDING TIME	2 min : 14 sec	min.		1 - 5
CLOTTING TIME	4 min : 40 sec			3 - 7

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit		Biological Reference Interval
COMPLETE BLOOD PICTURE (Specimen : BLOOD)				TEST RESULT STATUS : REPORT AUTHORISED Order Date :20-06-2026 10:07
HEMOGLOBIN (Colorimetry)	**10.1**	**g/dL**	L	12 - 16
RBC COUNT (DC detection method)	**3.65**	**10^12/L**	L	4 - 5.2
PCV/HCT (Calculated)	**29.2**	**VOL%**	L	33 - 51
MCV (Calculated)	**79.8**	**fL**	L	80 - 100
MCH (Calculated)	27.7	pg/cells		26 - 34
MCHC (Calculated)	34.7	g/dL		32 - 36
RDW-CV (Calculated)	**15.8**	**%**	H	11.5 - 13.1
PLATELET COUNT (DC Detection Method)	231	10^9/L		150 - 450
MPV (Calculated)	9.0	fL		6.5 - 10
WBC COUNT (DC Detection Method)	10.58	10^9/L		4.5 - 11
Differential Count				
NEUTROPHILS (Microscopy, Leishman stain)	**74**	**%**	H	35 - 66
LYMPHOCYTES (Microscopy, Leishman stain)	**18**	**%**	L	24 - 44
MONOCYTES (Microscopy, Leishman stain)	04	%		4 - 10
EOSINOPHILS (Microscopy, Leishman stain)	04	%		1 - 4
PERIPHERAL SMEAR (Microscopy, Leishman stain)	**RBC : NORMOCYTIC / HYPOCHROMIC WBC : MORPHOLOGY NORMAL PLATELETS : ADEQUATE**			

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit		Biological Reference Interval
HIV TEST (CARD METHOD) (Specimen : SERUM)				TEST RESULT STATUS : REPORT AUTHORISED Order Date :20-06-2026 10:07

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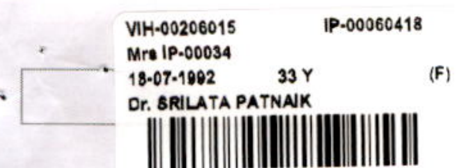
040-42462200, Ext 2000,2001,2002,

PatientName	: Mrs IP-00034	**Inpatient No.**	: IP-00060418
Age/Gender	: 33 Y / Female	**Admit Date**	: 20-06-2026
Ward/Bed	: N 2F-LABOUR WARD/ LW 219	**Discharge Date**	:

Investigation	Result	Unit	Biological Reference Interval
HIV TEST (CARD METHOD)	Non-reactive		

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356



SURGERY DETAILS

Date : 20/6/26

Patient Name: Mrs. IP - 00034 Date of Birth: 18/7/1992 Age: 33y

Gender: F Ward : OT UHID No.: 206015

Date of Surgery: 20/6/26 ☑ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : DILATATION & CURETTAGE WITH LAPAROSCOPIC BILATERAL TUBECTOMY ↓ GA

Time in : 12:16 PM Time Out : 1:15 PM

	NAME	AMOUNT
1. Surgeon	Dr. Srilata Patnaik / Dr. Swathi	OT charges
2. Anaesthetist	Dr. Vineetha	
3. Assistant Surgeon	Dr. Greeshma.	Laparoscopic charges:-
4. OT Technician	Tech. Rakesh	3092581
5. Circulating Nurse	Sr. Mary / Sr. Bhavani	12:25pm - 1pm
6. Assistant Nurse	Br. Ratan / Sr. Ruby. P	

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: 3092578 / 3092579 / 580 Order by: Ruby P

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

DEFICIENCY CHECK LIST OF MEDICAL CASE SHEET

VIH-00206015 IP-00060418
Mrs IP-00034
18-07-1992 33 Y (F)
Dr. SRILATA PATNAIK

Patient Name IP.No:

Ward: DOA:

Sl.No	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission Sheet	1	—	—	
2	Discharge Summary	3	—	—	
3	Nursing Initial assessment form	1	—	—	
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	2	—	—	
10	Conset for Surgery	1	—	—	
11	Consent for Blood Transfusion				
12	Consent forChemotherapy				
13	Consent for High Risk	1			
14	Consent for Restraint	1			
15	DAMA Consent				
16	Consent for Special Procedure	1	—	—	
17	Consent for Radiological Investigations			—	
18	Consent for HIV Test	1	—		
19	Anaesthesia consent form	1			
20	Anaesthesia notes(Pre Anaesthesia & Post)	2			
21	Pre Operative checklist	1			
22	Surgical safety Checklist	1			
23	Operation Theatre notes				
24	Nurses Clinical Presentation				
25	TPR & BP chart	2	—	—	
26	Intake and Output chart (fluid Chart)	2	—	—	
27	Drug Chart (Regular prescription)	4	—	—	
28	Daily Investigation sheet				
29	Investigation Values (Result Sheet)	1	—	—	
30	Nebulization Chart				
31	Diabetic chart				
32	Nutritional Review chart	1	—	—	
33	MLC form (in case of MLC)				
34	Patient Education Form				
	Pain Assessment	1	—	—	Noted by Baronika 21/7 @11am
	Thrombophlebitis	1	—	—	
	Braden Sore	1	—	—	
	Others	13			
	Total No. of Pages	52			

Signature and Date :

ERROR LOG

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

ICD CODE :-

OBSERVATION: -

DATE :

MRD EXECUTIVE

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WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP-00060418 **Admit Date** : 20-Jun-2026 **Admit Time** : 09:20 AM **UHID** : VIH-00206015

Patient Details :

Patient Name	: Mrs IP-00034	**Age**	: 33 Y
Guardian	: Mr SUKANTA BHOLA	**DOB**	: 18-07-1992
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: g p colony, nagaram ,keesara Nagaram Hyderabad Telangana INDIA 500083	**Phone No**	: 9182493153/ 9989585443
		E-mail	: na@GMAIL.com

Admission Details :

Bed Type : MICU **Bed No** : MICU 228 **Ward Name** : N 2F-MICU

Room No : MICU 228 **Admission Type** : First Visit

Contact Details :

Name	: Mr SUKANTA BHOLA	**Relationship**	: W/O
Contact Address	: g p colony, nagaram ,keesara Nagaram Hyderabad Telangana INDIA 500083	**Phone No**	: 9182493153

Signature

Doctor Details :

Doctor Name	: Dr. SRILATA PATNAIK	**Specialisation**	: OBSTETRICS AND GYNECOLOGY
Referral Doctor	: SELF	**Phone No**	:
Co-Consultant	:		

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash **Payor Name** : ELECTRONIC CORPORATION OF INDIA

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TEL NO :040-42462200, Ext 2000,2001,2002
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP-00060418 **Admit Date** : 20-Jun-2026 **Admit Time** : 09:20 AM **UHID** : VIH-00206015

Patient Details :

Patient Name : Mrs PRAGYAN PARAMITA PRADHAN
Age : 33 Y
Guardian : Mr SUKANTA BHOLA
DOB : 18-07-1992
Gender : Female
Religion :
Occupation :
Martial Status :
Address (H) : g p colony, nagaram ,keesara Nagaram Hyderabad Telangana INDIA 500083
Phone No : 9182493153/ 9989585443
E-mail : na@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 SUKANTA BHOLA
Relationship : W/O
Contact Address : g p colony, nagaram ,keesara Nagaram Hyderabad Telangana INDIA 500083
Phone No : 9182493153

Signature

Doctor Details :

Doctor Name : Dr. SRILATA PATNAIK
Specialisation : OBSTETRICS AND GYNECOLOGY
Referral Doctor : SELF
Phone No :
Co-Consultant :

Payment Details :

Deposit Amount : 0.00
Payment Mode : Cash
Payor Name : ELECTRONIC CORPORATION OF INDIA

IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

LMP: 30/4/2026 EDD:

Corrected EDD: GA: 7+2 wks

Obstetric Formula: $G_3P_2L_2$

ML- 12 years NCM

Obstetric Hostory:

I- Male | FTNVD | 10 yr | 3.1 kg | A&H | Sparsh Hospital bubneshwar | uneventful | BF x 1 month

II- Male | FTLSCS | 1.5 yr | 3.8 kg | Floating head / Malpresentation | Janani Hosp, Hyderabad | A&H | uneventful | BF x 8 month

III- PP, spontaneous conception

Present Pregnancy Record: Booked to RCH at 6 weeks
Viability (early) pregnancy scan was at 6 wks showed SLIUF, CRL-3.3 mm
Patient & husband want termination of pregnancy & tubectomy

RISK FACTORS:

previous LSCS

Height: 154 cm

Weight: 90 kg

Allergies: Nil

Breast: ☑ Normal ☐ Abnormal

General Examination:

Consciousness: C/C/C	Pallor: ⊖
Icterus: ⊖	Edema: ⊖
Temp: Afebrile	PR: 100 bpm
BP: 105/84 mmHg	DTR: ⊕
CVS: S_1S_2 ⊕	RS BAE ⊕
Liver/Spleen: Normal	Urine Output: Adequate

Menstrual History: Regular : ☑ Yes ☐ No

Obstetric Examination

Fundal Height: 7 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

$G_3P_2L_2$ with 7+2 weeks with previous LSCS with

for Dilatation & curettage with Laparoscopic Bilateral Tubectomy

VIH-00206015 IP-00060418
Mrs IP-00034
18-07-1992 33 Y (F)
Dr. SRILATA PATNAIK

Family History:	Surgical History:
Father - DM	Previos LSCS in 2025
Medical History:	**Medication History:**
Nil	Nil
Plan of Care: C/I to DR. SRILATA P Mam - Admission - NBM - consent - PAC - Monitor vitals - Part preparation - Foley's catheterization - Tab Misoprostol 400mcg PV stat - send CBP, BT, CT, HIV, HBSAg card method - Follow drug chart - Inform SOS Noted by Shubhashini 20/6/26 @ 10 AM	**Investigations:** BG - 'B' POSITIVE 20/6/26 HIV } NR HBsAg } 20/6/26 CBP - 10.1 / 10.58 / 2.31L BT - 2.14 sec CT - 4.40 sec 16/6/2026 Early pregnancy Scan 6 weeks single intrauterine Gsac c̄ fetal Pole Noted. CRL - 3.3 mm CL - 34 mm FHR - Not seen. Yolk sac - 2.6mm No E/o subchorionic / retroplacental bleed noted.

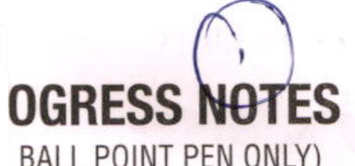
Doctor Name: Dr. Yogeshwari
Signature: [signature]
Date & Time: 20/6/2026 10 AM

Consultant Name: DR. SRilata Patnaik
Signature:
Date & Time: 20/6/2026

VIH-00206015 IP-00060418
Mrs IP-00034
18-07-1992 33 Y (F)
Dr. SRILATA PATNAIK

Rainbow Children's Hospital

PROGRESS NOTES



(BALL POINT PEN ONLY)

VIH-00206015 IP-00060418
Mrs IP-00034
18-07-1992 33 Y (F)
Dr. SRILATA PATNAIK

DATE	TIME	(SIGN ALL ENTRIES, DATE & TIME OF EACH ENTRY IS COMPULSORY)
		POD-0 (D&C + B/L Lap Tubectomy)
20/6/26		O/E Pt is c/c/c
1:30PM		GC-fair — Adv
		Afebrile — NBM x 4hrs
		BP- 94/57mmHg — Allow sips of oral
U/O - 200ml,		PR- 64bpm — fluids after 5pm
Adequate, clear		S/E-NAD — followed by soft diet
		P/A - Soft, NT — at 6pm
		BS ⊕ — Remove Foley's after
		L/E-NAB — 2 hours
Noted by Kamal		— W/F Bleeding PV
	20/6/26	— Monitor vitals
	@1:30PM	— Follow drug chart
		— Inform SOS
		Dr. [signature]
20/6/26		POD-0
5:30pm.		O/E- pt is c/c/c — Adv:
		GC-Fair — oral fluids f/b
		Afebrile. soft diet at 6pm.
U/O clear, adequate		BP - 115/70 mmHg — W/F bleeding PV
Foley's removal done		PR- 86 bpm. — monitor vitals
		S/E - NAD. — Follow drug chart
		P/A - Soft, NT. — Inform SOS
		BS ⊕
Noted by		L/E - NAB. Dr. Nikita
Kamal		@ 5:30PM

20/6/26

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

20/6/2026
6PM

POD - 0

O/E - pt is c/c/c
G/C - Fair
Vitals stable
P/A - Soft, NT
BS (+)

urine passed
pt. can be shifted to room

Adv:
- Soft diet
- W/F bleeding
- monitor vitals
- Follow drug chart
- Inform SOS.

Dr. Nikhita

noted by [illegible] 20/6/26 @

20/6/2026
9pm.

POD - 0 (Lap. tubectomy + D&C)

O/E - pt is c/c/c
G/C - Fair.
Afebrile
BP - 112/72 mmHg.
PR - 83 bpm.
S/E - NAD.
P/A - NT, soft.
L/E - NAB.

urine passed
motion not passed

Adv:
- Soft diet
- W/F bleeding PV
- Adeq. Hydration.
- monitor vitals
- Follow drug chart
- Inform SOS.

Dr. Nikhita

21/6/2026
8AM.

POD - 1 (Lap. tubectomy + D&C)

O/E - pt is c/c/c
G/C - Fair
Afebrile
BP - 110/78 mmHg
PR - 80 bpm.
S/E - NAD.
P/A - Soft, NT.
L/E - NAB.

urine passed
motion not passed
Aseptic dressing done
pt. can be discharged

Adv:
- Soft diet
- Adeq. Hydration
- Ambulation
- W/F bleeding PV
- monitor vitals
- Follow drug chart
- Inform SOS.

Dr. Nikhita

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21.6.26 10:30AM	1st POD	S/B Dr. Sindala
	GC fair	
	hit [illegible] table	
for discharge	P/A Soft	① Normal diet
	NAD	② Cont. all
	BS+	
		[signature]

VIH-00206006 IP-00060385
Master ATHIRALA .SAI SATHVIK
04-04-2009 17 Y 2 M 16 D (M)
Dr. PREETHAM KUMAR

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

PATIENT TRANSFER FORM

Patient Name & UHID No	Date & Time of Admission	Date & Time of Transfer Order
VIH-00206015 IP-00060418 Mrs IP-00034 18-07-1992 33 Y (F) Dr. SRILATA PATNAIK	20/6/26 @ 9:20 Am	20/6/26 @ 1:20 pm
	Transfer Ordered by Dr. Vineetha	**Reason for Transfer** Post Op Care.
From Unit OT	**To Unit** MICU	**Information to Attendant** Yes ☑ No ☐
Number of Sheets in Clinical File 38	**Number of Imaging Films** NIL	**Personal belongings including clinical documents. If any handed over to attendant** Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Dr. Greeshma.

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Nurse :- Maria	Doctor :- Vineetha.

Patient & Clinical Records Received by : [signature] 20/6/26 . 2:10 PM

Date & Time of Patient Received :

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

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

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

PATIENT TRANSFER FORM

VIH-00206015 IP-00060418
Mrs IP-00034
18-07-1992 33 Y (F)
Dr. SRILATA PATNAIK

	Date & Time of Admission	Date & Time of Transfer Order
	20/6/26 @ 9:20AM	20/6/26 @ 12:05PM

Treating Consultant Name	Transfer Ordered by	Reason for Transfer
	Dr. Nikith	O.T

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.	Nil	
3.		
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sis. Kamal	Dr. Nikith

Patient & Clinical Records Received by : Sr. Maria

Date & Time of Patient Received : 20/6/26 @ 12:06PM

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

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

PATIENT TRANSFER FORM

VIH-00206015 IP-00060418 Mrs IP-00034 18-07-1992 33 Y (F) Dr. SRILATA PATNAIK	Date & Time of Admission 20/6/26 @ 9:20am	Date & Time of Transfer Order 20/6/26 @ 7:35pm
Treating Consultant Name	Transfer Ordered by Dr. Nikitha	Reason for Transfer observation
From Unit MICU	To Unit Room (106)	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 38	Number of Imaging Films –	Personal belongings including clinical documents. If any handed over to attendant Yes ☑ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	Tab:- pantoprazole	15
2.	Tab:- Paracetamol 1gm	13
3.	Tab:- Diclofenac	10
4.	Tab:- Tramadol	10
5.	under pad	1

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sis. Kamal	Dr. Nikitha

Patient & Clinical Records Received by : Sr Anitha

Date & Time of Patient Received : @ 7.40pm

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

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

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

VIH-00206015 IP-00060418
Mrs IP-00034
18-07-1992 33 Y (F)
Dr. SRILATA PATNAIK

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: G3P2L2 with 7+2 wks with previous LSCS ₹ for Dilatation & curettage with laparoscopic Bilateral tubectomy			Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:			
	Surgery / Procedure:			Post OP Day:			
BACKGROUND	Date / Shift	20/6/26 M	20/6/26 E	20/6/26 E	20/6/26 N	21/6 M	
	Medical Condition (Any special condition to be noted):	-	—	-	—	Nil	
	Diet:	NBM	NBM	S diet	S-diet	S.diet	
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	RA	RA	RA	RA	RA	
	Tubes/Drains/Catheter:	☑ Yes ☒ No	☑ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.1F	98.6F	98.1F	98.4°F	98.5°F	
	Res:	17b/mt	19 b/mt	17b/mt	20b/m	19b/m	
	SpO_2:	99%	99%	98%	99%	99%	
	Pulse:	86b/mt	86b/mt	86b/mt	87b/m	80b/m	
	BP:	120/70 mmHg	125/75mmHg	123/76mmHg	103/77	110/62	
	LOC:	conscious	conscious	conscious	conscious	conscious	
	Fall Risk Score:	0	0	0	0	0	
	Pain Score:	0	0	0	0	0	
	Skin Integrity	Intact	Intact	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	NBM	S diet	S-diet	S.diet	
	Critical Lab Test / Values:	—	—	—	—	Nil	
	Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	Dependent	Dependent	Dependent	Dependent	dependent	
Post Operative Procedure Special Orders:		-	—	ω	Nil	Nil	
Handed Over By Name :		Kamal	Vanitha	Kamal	Manisha	Benonika	
Signature / ID :		020573	607506	020573	9000115	018727	
Date:		20/6/26	20/6/26	20/6/26	21/6/26	21/6	
Time:		@12:05pm	@2:10pm	@7:35pm	@8AM	@11am	
Taken Over By Name :		Vania	Kamal	manisha	Benonika		
Signature / ID :		[illegible]	[illegible]	9050115	018727		
Date:		20/6/26	20/6/26	20/6/26	21/6/26		
Time:		@12:05pm	@2:10pm	@8pm	@8am		

Noted by Benonika 21/6 @11am

Patient Sticker

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:							

VIH-00206015 IP-00060418
Mrs IP-00034 (F)
18-07-1992 33 Y
Dr. SRILATA PATNAIK

NURSING CARE RECORD

Date: 20/6/26

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	9:30 Am	Ensure safety	9:30 AM	To provied side rails.	To prevent fall	Patient is Good	[signature] 20/6/26 @2PM
	12:30PM	Maintain fluid balance	12:30 Pm	Maintaing RL load 1hr	To prevent de-hydration	Patient is Good	
Afternoon	2 PM	Ensure safety	2 PM	To provied side rails	To prevent fall	Patient is safe	[signature] 20/6/26 @7:30PM
Night	9pm	-Ensure Safety		-side rail kept up	- prevent from fall risk.	-patient is stable	manisha 21/6/26 @8AM

VIH-00206015 IP-00060418
Mrs IP-00034
18-07-1992 33 Y (F)
Dr. SRILATA PATNAIK

NURSING CARE RECORD

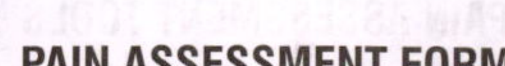
Date: 21/6/26

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				Discharge Note Doctor came for rounds and advice for discharge.			
Afternoon					Noted by Benarika 21/6 @11am		
Night							

VIH-00206015 IP-00060418
Mrs IP-00034
18-07-1992 33 Y (F)
Dr. SRILATA PATNAIK



PAIN ASSESSMENT FORM

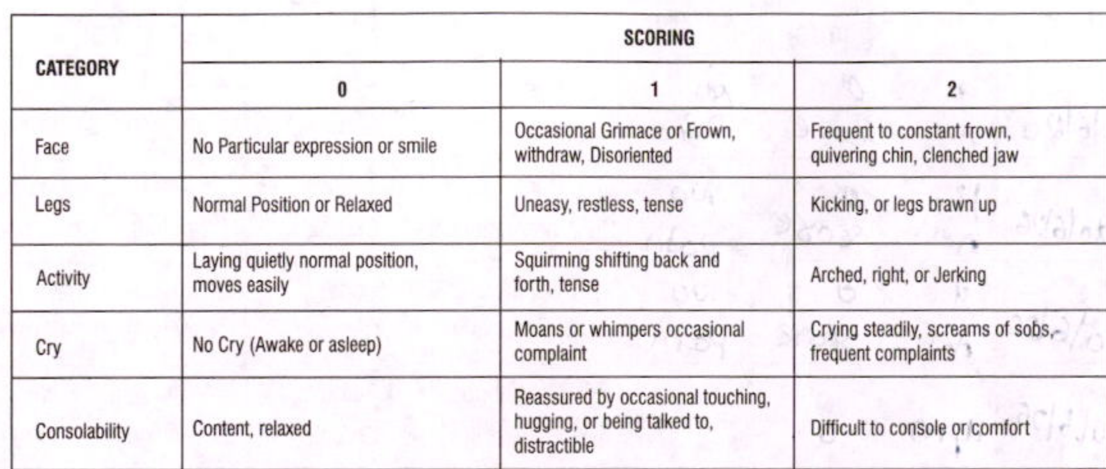
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
20/6/26	9 AM	0 score	No Pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Comfortable Position.	[illegible]
20/6/26	12 AM	0 score	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Comfortable Position	[illegible]
20/6/26	4 AM	0 score	No Pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Comfortable Position	[illegible]
20/6/26	11pm	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	manisha
21/6	11am	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Brij
				☐ 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

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)



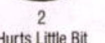
CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs brawn up
Activity	Laying quietly normal position, moves 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

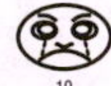
Numerical Pain Scale (Obstetric and Gynecology)

0 1 2 3 4 5 6 7 8 9 10

0 No Pain — 10 Worst Possible Pain

Wong - Baker (Pediatrics) Above 7 Years





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

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

VIH-00206015 IP-00060418
Mrs IP-00034
18-07-1992 33 Y (F)
Dr. SRILATA PATNAIK

BRADEN 'Q' SCALE

				Date :	20/6/26	20/6/2026		21/6
				Time :	9Am	4Pm	4pm	11am
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	2	2	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	3	3	4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	3	3	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	3	3	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
				TOTAL SCORE	28	23	23	27
				Evaluator's Name	[illegible]	[illegible]	Ng	[illegible]

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

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

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

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	20/6/26 DAY-1			21/6 DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	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	[signature]	[signature]	[signature]	[signature]						

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

Signature of Shift In Charge :

Signature : [signature] Name : Teja

Signature of Ward In Charge :

Signature : [signature] Name : Dhanalakshmi

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

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 IP-00034**	**Age :**	**33 Y**
IP No:	**IP-00060418**	**Sex:**	**Female**
Consultant:	**Dr. SRILATA PATNAIK**	**Ward/Bed No:**	**N 2F-MICU/MICU 228**

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 o 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.
 have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill arance. 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: Time:

Wittness Name:

Wittness Signature:

Patient Address:
g p colony, nagaram ,keesara
Nagaram Hyderabad Telangana INDIA
500083

Rainbow Children's Hospital
BirthRight by Rainbow

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 PRAGYAN PARAMITA PRADHAN**	**Age :**	**33 Y**
IP No:	**IP-00060418**	**Sex:**	**Female**
Consultant:	**Dr. SRILATA PATNAIK**	**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: Sukanto Bhola

Relationship: Husband

Date: 20-06-2026

Time:

Wittness Name:

Wittness Signature:

Patient Address:
g p colony, nagaram ,keesara
Nagaram Hyderabad Telangana INDIA
500083

OPERATION NOTES

Surgeon : Dr. Srilata Patnaik	Asst. Surgeon : Dr. Greeshma.

Pre-Operative Diagnosis: G3P2L2 with 7+2 weeks with Previous LSCS

Surgical Procedure : DILATATION & CURETTAGE WITH LAPAROSCOPIC BILATERAL TUBECTOMY U GA

Indications for Surgery :

Date : 20/6/26	Start Time : 12:16 PM	End Time : 1:15 PM

Post Operative Diagnosis:

Peri-Operative Complications:

Amount of Blood Loss: ~ 15 ml	Blood Transfused (in ML) –

Name and Number of Surgical Specimen sent for examination:

–

Operation Notes: Under strict aseptic conditions, Under GA, patient placed in lithotomy position, Parts painted and draped.
- Bladder catheterised, anterior and posterior vaginal wall retracted with sims speculum.
- Anterior lip of cervix held with Vulsellum.

- Serial cervical dilatation done with Hegar's dilators.
- Karmann's cannula no. 6 was placed and products were suctioned.
- Gentle curettage was done and products obtained.
- Check curettage done.

Laparoscopy findings:

- ~~2 x 5mm~~ One 5mm supraumbilical and 2 x 5mm lateral ports inserted.
- Pneumoperitoneum created
- Bilateral Tubes & Ovaries appear normal
- Omental adhesions present and released
- Bilateral Tubectomy done with cauterisation
- Hemostasis secured.
- Procedure uneventful

Adv

- NBM for 4 hours.
- Foley's catheter for 2 hours
- Allow Oral sips after 5pm followed by soft diet after 6pm
- WIF Bleeding PV
- Monitor vitals
- Follow drug chart
- Inform SOS
- Inj. Cefotaxime 1g IV 12th hly

Dr. Geeta [signature]

Name of the Surgeon: Dr. SRILATA PATNAIK

Signature of the Surgeon: ....

Date & Time: 20/6/26, 1:20 PM

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Srilata / Dr. Swathi
Asst. Surgeon : Dr. Greeshma.
Anaesthetist : Dr. Vineetha.
Scrub Nurse : Sr. Ruby P / Ratan

Patient Name : VIH-00206015 Mrs IP-00034 IP-00060418 (F)
18-07-1992 33 Y
Dr. SRILATA PATNAIK
UHID No.
Date 20/6/26
Gender :

Before Induction of Anaesthesia ➢ ➢

SIGN IN Time: 12:10 Pm

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 : [signature]
Name : Dr. Vineetha.

Before Skin Incision ➢ ➢

TIME OUT Time: 12:16 PM

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

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm

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

Anticipated Critical Events

Surgeon Reviews:

What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? Mild bleeding, Post Op distension, 2hr, minimal.	☑ Yes ☐ No ☐ NA

Anaesthesia Team Reviews:

Are There Any Patient-specific Concerns? High BMI.	☑ 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 : [signature]
Name : Mania

Before Patient Leaves Operating Room

SIGN OUT Time: 1:15 PM

Nurse Verbally Confirms with the Team:

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

To Surgeon, Anaesthetist and Nurse:

What are the key concerns for recovery and management of this patient?	☐ Yes ☑ No

Signature : [signature]
Name : Dr. Greeshma.

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

Patient Name : MRS PRAGYAN PARAMITA PRADHAN Gender: ☐ Male ☑ Female Age : 33 YEARS

UHID No : VIH-00206015 Date : 20/6/2026

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)

DILATATION AND CURETTAGE WITH LAPAROSCOPIC BILATERAL TUBECTOMY upon MRS. PRAGYAN PARAMITA PRADHAN
(Name of the Patient)

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

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

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

BLEEDING, BOWEL AND BLADDER INJURY, URETERIC INJURY
BLOOD AND BLOOD PRODUCTS TRANSFUSION AND ITS ASSOCIATED REACTIONS
INFECTION, UTERINE PERFORATION, PERMANENT AND IRREVERSIBLE METHOD
<1% CHANCE OF FAILURE RATE, RISK OF ECTOPIC PREGNANCY

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. SRILATA PATNAIK

Consentee :

Signature : Pragyan Paramita Pradhan

Name : PRAGYAN PARAMITA PRADHAN

Date & Time : 20/6/2026 10 AM

Witness : (NA)

Signature :

Name :

Date & Time :

Patient Attendant :

Signature : [signature]

Name : SUKANTA KUMAR BHOLA

Relationship with Patient: HUSBAND

Date & Time : 20-06-2026, 10:00 AM

Doctor (who is taking the consent) :

Signature : [signature]

Name : DR. YOGESHWARI

Date & Time : 20/6/2026 10 AM

CONSENT FOR SPECIAL PROCEDURES

Patient Name : MRS. PRAGYAN PARAMITA PRADHAN Gender: ☐ Male ☑ Female

UHID No : VIH-00206015 Department : OBGY Date : 20/6/2026

I MRS. PRAGYAN PARAMITA PRADHAN S/D/W/O SUKANTA KUMAR BHOLA

Here by give consent for procedure of : DILATATION AND CURETTAGE

For my patient, Named : MRS. PRAGYAN PARAMITA PRADHAN

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

BLEEDING, INFECTION, UTERINE PERFORATION

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

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. SRILATA PATNAIK.

Patient Attendant :

Signature : Pragyan Paramita Pradhan

Name : PRAGYAN P

Relationship with Patient: SELF

Date & Time : 20/6/2026 10 AM

Witness :

Signature : [signature]

Name : SUKANTA KUMAR BHOLA

Date & Time : 20.06.2026, 10:00 AM

Doctor (who is taking the consent) :

Signature : [signature]

Name : DR. YOGESHWARI

Date & Time : 20/6/2026 10 AM

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 రోగికి, 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 ....

సాక్షి

సంతకము ....

పేరు ....

తేదీ మరియు సమయము ....

Docu. No. : RCH/FRM / CLINICAL / 019

FORM I
REGISTERED MEDICAL PRACTITIONER (RMP) OPINION FORM
(For gestation age upto twenty weeks)

Patient Name: MRS PRAGYAN PARAMITA PRADHAN UHID no: VIH-00206015 Date: 20/6/2026

I DR. SRILATA PATNAIK
(Name and qualification of the Registered Medical Practitioner in block letter)

RAINBOW HOSPITAL KARKHANA
(Full address of the Registered Medical Practitioner)

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

MRS. PRAGYAN PARAMITA PRADHAN
(Full name of the Patient in block letter)

Resident of G.P COLONY NAGARAM KEESARA NAGARAM HYDERABAD TELANGANA
(Full address of the Patient in block letter)

For the reason given below*

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

in the admission register of the hospital / approved place.

Place: SECUNDERABAD

Date: 20/6/2026

Registered Medical Practitioner: Signature: .... Name: ....

*of the reasons specified items (a) to (e) Tick the one which is appropriate:

- ☐ a. In order to save the life of the pregnant woman.
- ☐ b. In order to prevent grave injury to the physical and mental health of the pregnant woman.
- ☐ c. In view of the substantial risk that if the child born it would suffer from such physical or mental abnormalities as to be seriously handicapped.
- ☐ d. As the pregnancy is alleged by pregnant woman to have been caused by rape.
- ☐ e. As the pregnancy has occurred as a result of failure of any contraceptive device or methods used by a woman or her partner for the purpose of limiting the number of children or preventing pregnancy.

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.

Place: ....

Date: ....

Registered Medical Practitioner: Signature: .... Name: ....

(FORM – C)
CONSENT FOR MEDICAL TERMINATION OF PREGNANCY (MTP)

Patient Name: MRS. PRAGYAN PARAMITA PRADHAN UHID no: VJH-00206015 Date: 20/6/2026

I MRS. PRAGYAN PARAMITA PRADHAN Daughter / wife of SUKANTA KUMAR BHOLA

aged about 33 YEARS Years of G. P. COLONY NAGARAM KEESARA NAGARAM HYDERABAD TELANGANA (here state the permanent address).

At present residing at .... do herby 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: Pragyan Paramita Pradhan

Name: PRAGYAN PARAMITA PRADHAN

Date & Time: 20/6/26 10 AM

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 herby 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: ....

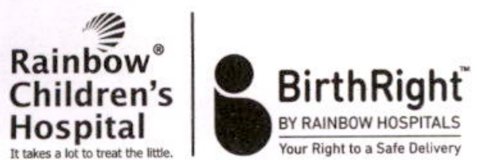
Date & Time: ....

Doctor: (who is taking the consent)

Signature: ....

Name: ....

Date & Time: ....



CONSENT FORM FOR HIV

Patient Name : MRS PRAGYAN PARAMITA PRADHAN Age : 33 YEARS

Gender : M ☐ F ☑ IP No : .... Marital Status : MARRIED

Ward / Bed No. : MICU IP/OP No. : .... Date : 20/6/2026

I have to say that I have been counseled about the test and the reason for undergoing the test has been clearly explained to me. I have also been explained about the implications of the test result-positive, negative or indeterminate All the details pertaining to HIV, its transmission, testing procedure Its limitations and interpretation of the results have been explained to me in language that I can understand.

I, hereby give my willful consent for the HIV test to be conducted on me in order to ascertain my HIV sero status. The status of my HIV test will be confidential

Patient Attendant :

Signature : Pragyan Paramita Pradhan

Name : PRAGYAN PARAMITA PRADHAN

Relationship with Patient: SELF

Date & Time : 20/6/2026 9:30AM

Parent (when patient is minor) :

Signature : ....

Name : ....

Relation : ....

Date & Time : ....

OR (Next to kin in case of unconscious patient) :

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

Relation : .... Date & Time : ....

I, certify that the Consent form for the HIV test has been signed in my presence and patient has been given pre-test counseling and post-test counseling is ensured by me and my team.

Doctor :

Signature : [signature]

Name : DR YOGESHWARI

Date & Time : 20/6/2026 10AM.

హెచ్.ఐ.వి. పరీక్ష అంగీకార పత్రం

రోగిపేరు .... వయస్సు .... లింగం........ పు ☐ స్త్రీ ☐

వివాహస్థితి .... వార్డు / బెడ్ నెంబర్ ....

హెచ్.ఐ.వి టెస్ట్ గురించి నాకు అవగాహన కల్పించటమైనదనియు మరియు పరీక్ష చేయించుకోవలసిన కారణము నాకు స్పష్టముగా వివరించటమైనది అవ నేను చెప్పుచున్నాను. ఈ టెస్ట్ ఫలితం యొక్క పర్యవసానాలకు పాజిటివ్, నెగిటివ్ లేక నిర్ధారణ విధానము, దాని పరిమితులు మరియు ఫలితాల వివరణకు నాకు అర్థమయ్యే భాషలో వివరించారు.

నా హెచ్.ఐ.వి. రోగిస్థితి అంచనా వేయటానికి నాపై జరుపబడే టెస్ట్‌కు నేను ఇష్టపూర్వకంగా అంగీకారం తెలుపుతున్నాను. నా హెచ్.ఐ.వి. పరీక్ష ఫలితం రహస్యంగా వుంచాలి.

రోగి :	సాక్షి
సంతకము :	సంతకము : ....
పేరు :	పేరు : ....
బంధము :	బంధము : ....
తేది మరియు సంతకం :	తేది మరియు సమయము : ....

(రోగి అపస్మారక స్థితిలో వున్నచో అతని దగ్గరి రక్త బంధువు)

పేరు :	సంతకము : ....
సంబంధము :	తేది మరియు సమయము : ....

హెచ్.ఐ.వి. టెస్ట్ అంగీకార పత్రంపై నా సమక్షంలో సంతకం చేయబడిన దనియు, టెస్ట్‌కు ముందు ఇవ్వవలసిన సలహా ఇవ్వబడిన దనియు మరియు టెస్ట్ తర్వాత ఇవ్వవలసిన అవగాహన ఖచ్చితంగా ఇవ్వ గలమని నేను నా బృంధం ధృవీకరిస్తున్నాము.

డాక్టర్ :

సంతకము : ....

పేరు : ....

తేది మరియు సమయము : ....

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

Patient Name : Mrs. Pragyan Parawita Pradhan Age : 33y Gender : Male ☐ Female ☑

UHID NO: VIH-00206015 Surgeon Name: Dr Srilata Patnaik

Anaesthesiologist : Dr. Sunidhara

Operative procedure planned : Dilatation & Curettage + Laproscopic Tubectomy

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 : Desaturation, Laryngospasm

Comments :

- Doctor to document in medical record also if necessary (Cross-out if not applicable)

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient Mrs. Pragyan Parawita Pradhan the above mentioned operation / Diagnostic / Therapeutic procedures Dilatation & Curettage + Laproscopic Tubectomy

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 : Pragyan Paramita Pradhan

Name : Pragyan Paramita Pradhan

Relationship with Patient: ~~Spouse~~ Self

Date & Time : 18/6, 11:30AM

Witness :

Signature : [signature]

Name : Sukanta Kumar Bhola (Husband)

Date & Time : 18/6, 11:30 am

Doctor (who is taking the consent) :

Signature : [signature]

Name : Dr. Brunda

Date & Time : 18/6/26, 11:30AM

BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date: 20|6|26

To Be Filled In By Assigned Nurse:

Department: L|W Duration of Procedure : 1hour 15min

Name of Surgeon: Dr: Srilata Patnaik Date of Admission : 20|6|26

Bundle Care Criteria: (Tick (√) if done)

		Staff Signature
1.	Antibiotic given prior to surgery? ☑ Yes ☐ No ☑ Single Dose Antibiotic Or ☐ Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision? ☐ Yes ☐ No Name of the Antibiotic:	[signature]
2.	Hair Removal ☑ Yes ☐ No If Yes: ☐ Surgical Clipper Department where Hair Removed: ☑ Ward ☐ Operating Room ☐ Other: .... Skin preparation done (cleanse surgical area with antiseptic agent)? ☑ Yes ☐ No	[signature]
3.	Patient's body temperature immediately post operation (Recovery Room) 37 °C ☐ Oral Or ☑ Axilla (Goal: 36-37°C)	[signature]
4.	Name of doctor or staff administering the antibiotic: Dr: Nikith Date & Time of antibiotic administration: 20|6|26 @ 11:05 Am Date & Time procedure started: 20|6|26 @ 12:16 pm	[signature]

- Ensure form is filled in completely by assigned staff whenever patient had surgery
- If any bundle care criteria has not been observed or unmet, assigned staff must inform infection control nurse for management
- All forms (Bundle care and when required SSI form) are completed properly
- Forms must always be kept in Infection Control folder in respective department

VIH-00206015 IP-00060418
Mrs IP-00034
18-07-1992 33 Y (F)
Dr. SRILATA PATNAIK

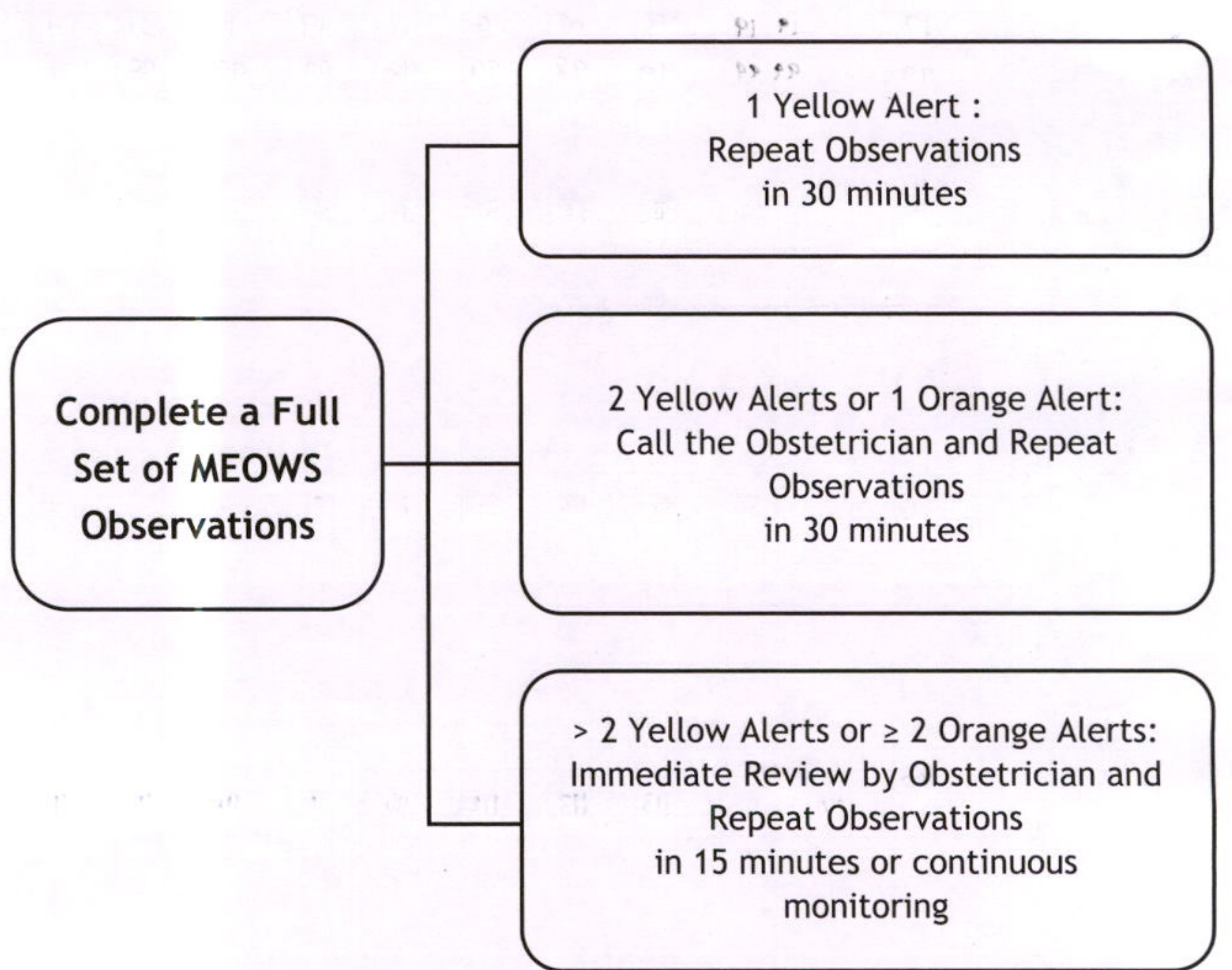
(1)

Early Warning Observation Score Chart - Obstetrics

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

20/6/26	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			19	19		19		18		19		18		19		19		20		19		19
	0 - 10																								
Saturations	94 - 100 %		99			99	99		99		98		99		98		99		99		98		99		98
	< 94 %																								
Administered O_2 (L/min.)																									
Temp °c	40																								
	39																								
	38																								
	37		37°C			37°C	37°C		37°C		37°C		37°C		37°C		36°C		37°C		37°C		37°C		37°C
	36																								
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80		86			88	86		80		86		83		89		88		86		88		89		89
	70																								
	60																								
	50																								
	40																								
Systolic Blood Pressure ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120		120			125																			
	110				110		115		113		113		112		110		103		114		113		112		110
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80		80																						
	70				70	75	70		76		73		72		70		72		70		75		76		78
	60																								
	50																								
	40																								
NEURO RESPONSE [✓]	Alert		✓		✓	✓	✓		✓		✓		✓		✓		✓		✓		✓		✓		✓
	Voice																								
	Pain																								
	Unresponsive																								
URINE mls / hour	> 30		✓		✓	✓	✓		✓		✓		✓		✓		✓		✓		✓		✓		✓
	< 30																								
Proteinuria	Protein + +																								
	Protein > + +																								
Lochia	Normal		NA		NA	NA	NA		NA		NA		NA		N		N		N		N		N		N
	Heavy / Foul																								
Liquor	Clear / Pink		NA		NA	NA	NA		NA		NA		NA		N		N		N		N		N		N
	Green																								
TOTAL YELLOW SCORES			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
Nurse Initial			[illegible]		[illegible]	[illegible]	[illegible]		[illegible]		[illegible]		[illegible]		M		M		M		M		M		[illegible]

Obstetrics and Gynaecology Early Warning Signs



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

Ref. No. : F / HW / GYNIC / EWOS / 18

Early Warning Observation Score Chart - Obstetrics

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

VIH-00206015 IP-00060418
Mrs IP-00034
18-07-1992 33 Y (F)
Dr. SRILATA PATNAIK

Name : .... Date of Birth : ....

UHID No. : ....

21/6/26	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																								
	36		36°C																						
	35																								
	<35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70		77																						
	60																								
	50																								
	40																								
Systolic Blood Pressure	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110		110																						
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
Diastolic Blood Pressure	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70		70																						
	60																								
	50																								
	40																								
NEURO RESPONSE [✓]	Alert		✓																						
	Voice																								
	Pain																								
	Unresponsive																								
URINE mls / hour	>30		✓																						
	<30																								
Proteinuria	Protein ++		·																						
	Protein>++																								
Lochia	Normal		✓																						
	Heavy / Foul																								
Liquor	Clear / Pink		✓																						
	Green																								
TOTAL YELLOW SCORE			0																						
TOTAL ORANGE SCORE			0																						

Noted by [illegible] 21/6 @11am

VIH-00206015 IP-00060418
Mrs IP-00034
18-07-1992 33 Y (F)
Dr. SRILATA PATNAIK

FLUID CHART

Sheet No. : 1 20/6

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

Date	Time	Nature of Fluid	Route: Mouth	Route: I.V	Route: N.G	NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombophlebitis Score	Sign. Nurse
20/6/26	08:00 am											
	09:00 am	NBM + RL F/F								✓	0	
	10:00 am	NBM + RL F/F								.	0	Kaul
	11:00 am	NBM + RL F/F								50ml	0	20/6/26
	12:00 pm	NBM+RL [illegible] ml/hr								50ml	0	[illegible]
	01:00 pm	NBM + RL 500ml/hr								50ml	0	[illegible]
Total Intake :		1000ml				Total Output :				150ml		
20/6	02:00 pm	NBM + RL 100ml/hr								100ml	0	
	03:00 pm	NBM + RL 100ml/hr								50ml	0	Kaul
	04:00 pm	NBM + RL 100ml/hr								100ml	0	
	05:00 pm	H2O + RL 100ml/hr								100ml	0	20/6/26
	06:00 pm	H2O + RL 100ml/hr									0	@7PM
	07:00 pm	H2O + RL 100ml/hr								Passed	0	
Total Intake :		600ml				Total Output :				350ml Passed		
20/6	08:00 pm		Idly									
	09:00 pm		water									
	10:00 pm									✓		
	11:00 pm										0	manisha
	12:00 am											
	01:00 am									200ml		
Total Intake :						Total Output :						
21/6	02:00 am		water									
	03:00 am									✓		
	04:00 am											manisha
	05:00 am		ORS								0	21/6/26
	06:00 am									✓		@8AM
	07:00 am											
Total Intake :						Total Output :						

Total 24 hrs. Intake		Total 24 hrs. Output	

VIH-00206015 IP-00060418
Mrs IP-00034
18-07-1992 33 Y (F)
Dr. SRILATA PATNAIK

FLUID CHART

Sheet No. : 21/6

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

Date	Time	Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
21/6/25	08:00 am											
	09:00 am		Idly water							✓		Beenika 21/6 @11am
	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 :						

Noted by Beenika 21/6 @11am

Total 24 hrs. Intake		Total 24 hrs. Output	

Patient Sticker

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											
	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	

VIH-00206015 IP-00060418
Mrs IP-00034
18-07-1992 33 Y (F)
Dr. SRILATA PATNAIK

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: MICU 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						☐C ☐DC
2						☐C ☐DC
3						☐C ☐DC
4						☐C ☐DC
5		NIL				☐C ☐DC
6						☐C ☐DC
7						☐C ☐DC
8						☐C ☐DC
9						☐C ☐DC
10						☐C ☐DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Y DR YOGESHWARI

Date & Time : 20/6/2026 10 AM

Nurse Name & Signature: Shrehoshini [signature]

Date & Time : 20/6/26 @10AM

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

VIH-00206015 IP-00060418
Mrs IP-00034
18-07-1992 33 Y (F)
Dr. SRILATA PATNAIK

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: MICU Shifted to: ROOM ( )

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	1 GM	IV	12 TH HOURLY		☑ C ☐ DC
2	TAB - PANTOPRAZOLE	40 MG	PO	ONCE DAILY		☑ C ☐ DC
3	TAB - PARACETAMOL	1 GM	PO	6 TH HOURLY		☑ C ☐ DC
4	TAB - DICLOFENAC	50 MG	PO	8 TH HOURLY		☑ C ☐ DC
5	TAB - TRAMADOL	100 MG	PO	8 TH HOURLY		☑ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : [signature] DR - NIKHITA

Date & Time : 20/6/2026 6:30 PM

Nurse Name & Signature: [signature]

Date & Time : 20/6/26 6:30 PM

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

Rainbow Children's Hospital

VIH-00206015 IP-00060418
Mrs IP-00034
18-07-1992 33 Y (F)
Dr. SRILATA PATNAIK

Ref. No. : F / HW / DC / RP / INPR / 05.a

Patient		I.P. No.	Sheet No.	Wards	Weight (kg)

REGULAR PRESCRIPTIONS

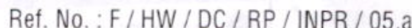
Chkd 20/6/26

DRUG: T. PANTOPRAZOLE				Date ➤ / Time	21/6/26
Dose	Route	Frequency	Start Dt.		6AM
40MG	PO	ONCE DAILY	20/6		
Name & Signature of the Doctor starting the Drugs: Dr. Geeeshma.					
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.				



Ref. No. : F / HW / DC / RP / INPR / 05.a

Patient Name :	I.P. No.	Sheet No.	Wards	Weight (kg)

REGULAR PRESCRIPTIONS

DRUG :

Dose	Route	Frequency	Start Dt.

Date ➤ / Time ▼

Name & Signature of the Doctor starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

DRUG :

Dose	Route	Frequency	Start Dt.

Date ➤ / Time ▼

Name & Signature of the Doctor starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

DRUG :

Dose	Route	Frequency	Start Dt.

Date ➤ / Time ▼

Name & Signature of the Doctor starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

DRUG :

Dose	Route	Frequency	Start Dt.

Date ➤ / Time ▼

Name & Signature of the Doctor starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

DRUG CHART

Date of Admission: 20/6/2026 Drug Allergies: NIL ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).

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

NURSES - Nurses must follow strictly the FIVE RIGHTS before administration of medication.

1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time

- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

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

VIH-00206015 IP-00060418
Mrs IP-00034
18-07-1992 33 Y (F)
Dr. SRILATA PATNAIK

I.V. FLUIDS CHART

Weight. 9.0 kg Ward. 2 W

		Composition of I.V. Fluid (...ntion ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
20/6/26	10:29 am	RINGER LACTATE	IV	FF	[signature]	[signature]	20/6	[signature]	[signature]
20/6/26	10:55 AM	RINGER LACTATE	IV	100ml/HR	[signature]		20/6	[signature]	Rakesh [signature]
20/07	12:20Pm	RINGER LACTATE	IV	900ml/hr	[signature]	Rakesh [signature]	20/06	[signature]	Rakesh [signature]
20/06	1:10 Pm	RINGER LACTATE	IV	500ml/hr	[signature]	Rakesh [signature]	20/6	[signature]	[signature]
20/6	4:45 pm	RINGER LACTATE	IV	100ML/HR	[signature]	[signature]	20/6	[signature]	[signature]

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

VIH-00206015 IP-00060418
Mrs IP-00034
18-07-1992 33 Y (F)
Dr. SRILATA PATNAIK

Weight. 90kg Ward. L/W

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
20/6/26	10 AM	T. MISOPROSTOL	400 MCG	PV	[signature]	[signature]
20/6/26	11:05 AM	INJ CEFOTAXIME (AFTER TEST DOSE)	1 GM	IV	[signature]	[signature]
20/6/26	10:55 AM	INJ PANTOPRAZOLE	40 MG	IV	[signature]	[signature]
20/6/26	10:55 AM	INJ METOCLOPRAMIDE	10 MG	IV	[signature]	[signature]
20/06	1:10 PM	T. MISOPROSTOL	400 mcg	PV	[signature]	Rakesh
20/06	12.25 Pm	INJ. MORPHINE	6 mg	IV	[signature]	Rakesh
20/06	1.00 Pm	INJ. PARACETAMOL	1 gm	IV	[signature]	Rakesh
20/06	1.15 Pm	SUPP. DICLOFENAC	100 mg	PR	[signature]	Rakesh
20/06	1.15 Pm	SUPP. TRAMADOL	100 mg	PR	[signature]	Rakesh

Chitt 20/6/26

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

Mrs IP-00034
18-07-1992 33 Y (F)
Dr. SRILATA PATNAIK

REGULAR PRESCRIPTIONS

Weight. 90kg Ward. L/W

DRUG : INJ. CEFOTAXIME				Date ▸ / Time ▾	20/6/26
Dose	Route	Frequency	Start Date		
1 GM	IV	12th hrly	20/6	11AM	✓
Name & Signature of the Doctor Starting the Drugs: Dr. Gaeethma				11PM	[signature]
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

Chitt 20/6/26

DRUG : TAB. PARACETAMOL				Date ▸ / Time ▾	20/6/26	21/6
Dose	Route	Frequency	Start Date			
1gm	PO	6HRLY	20/06	12AM	✓	[signature]
Name & Signature of the Doctor Starting the Drugs: DR. M. VINEETHA				6AM	✓	[signature]
				12PM	✓	
Additional Instructions:				6PM	[signature]	
Daily Doctor's Endorsement by a Sign						

Chitt 20/6/26

DRUG : TAB. TRAMADOL				Date ▸ / Time ▾	20/6/26	21/6
Dose	Route	Frequency	Start Date			
100 mg	PO	8HRLY	20/06	7AM	✓	[signature]
Name & Signature of the Doctor Starting the Drugs: DR. M. VINEETHA				3PM	✓	
				11PM	[signature]	
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						

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DRUG : TAB. DICLOFENAC				Date ▸ / Time ▾	20/6/26	21/6
Dose	Route	Frequency	Start Date			
50 mg	PO	8HRLY	20/06	6AM	✓	[signature]
Name & Signature of the Doctor Starting the Drugs: DR. M. VINEETHA				2PM	✓	
				10PM	[signature]	
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						

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