Birthright | Rainbow Children's Hospital

## DISCHARGE TRACKING SHEET

GUC-00091617 IP18-00036137
Mrs DIVYA DS
03-09-1993 32 Y 9 M 20 D (F)
Dr. MATHANGI RAJAGOPALAN

UHID- FLOOR- NAME OF CONSULTANT-

| ACTIVITY | INTIME | OUT TIME | NAME & SIGNATURE | REMARKS | <To be filled by Admin> | | |
|---|---|---|---|---|---|---|---|
| Activity Sheet update by Nursing | | 24/6/2016 at 6AM | [signature] | | | | |
| Activity Sheet update by Pharmacy | | | [signature] | | | | |

GUC-00091617 IP18-00036137
Mrs DIVYA DS
03-09-1993 32 Y 9 M 19 D (F)
Dr. MATHANGI RAJAGOPALAN

# ACTIVITY RECORD FOR BI

Name: Mrs. DIVYA DS

UHID No: 91617 IP No: 36137 Consultant: Dr. Mathangi Dept: LDR

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

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

## WARD TRANSFERS

| Date | Time | From | To | Signature of Nurse |
|---|---|---|---|---|
| 22/6/26 | 11 pm | LDR | 7th floor | [illegible] 01170 |
| 23/6/2026 | 8 AM | 7th floor (705) | MICU | [illegible] 01064 |
| 23/6/26 | 9.30 AM | MICU | OT | [illegible] 015720 |
| 23/6/26 | | OT | MICU | [illegible] 01013 |
| 23/6/26 | 3.45pm | MICU | 705 | [illegible] |

## CROSS CONSULTATION VISIT

| | Doctor Name | Date | Order No. | Signature |
|---|---|---|---|---|
| 1. | PAC | 22/6/26 | 1710717 | [illegible] 01170 |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**INVESTIGATIONS**

| Date | Investigations | Order No. | Signature |
|---|---|---|---|
| 23/6/2026 | CBC | 26019829 | [illegible] |
| | | | |
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## MEDICAL EQUIPMENT ( WARD & ICU)

| Date | Name of Equipment | Connecting Time | Disconnecting Time | Order No. | Signature |
|---|---|---|---|---|---|
| 23/6/26 | Infusion Pump | 10-30 PM | 23/6/2026 at 10pm | | [signature] |
| | | | | | |
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## PROCEDURE

| Date | Procedure | Quantity | Order No. | Signature |
|---|---|---|---|---|
| 23/6/2026 | IV placement of | (1) | 1765778 | [signature] |
| 23/6/2026 | catheterization | (1) | (OT) | [signature] |
| | | | | |
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**ANY OTHER INFORMATION:**

procedure : cervical encirclage
Surgeon : DR mattangi
Assist. surgeon : DR priyadharsini /DR pavithra
Anaesthetist : DR mohan /DR priyadharsini
Time in : 9:35 Am Time out : 10:25 Am

Date: 24/6/2026 Time: 8:50 AM Prepared By:

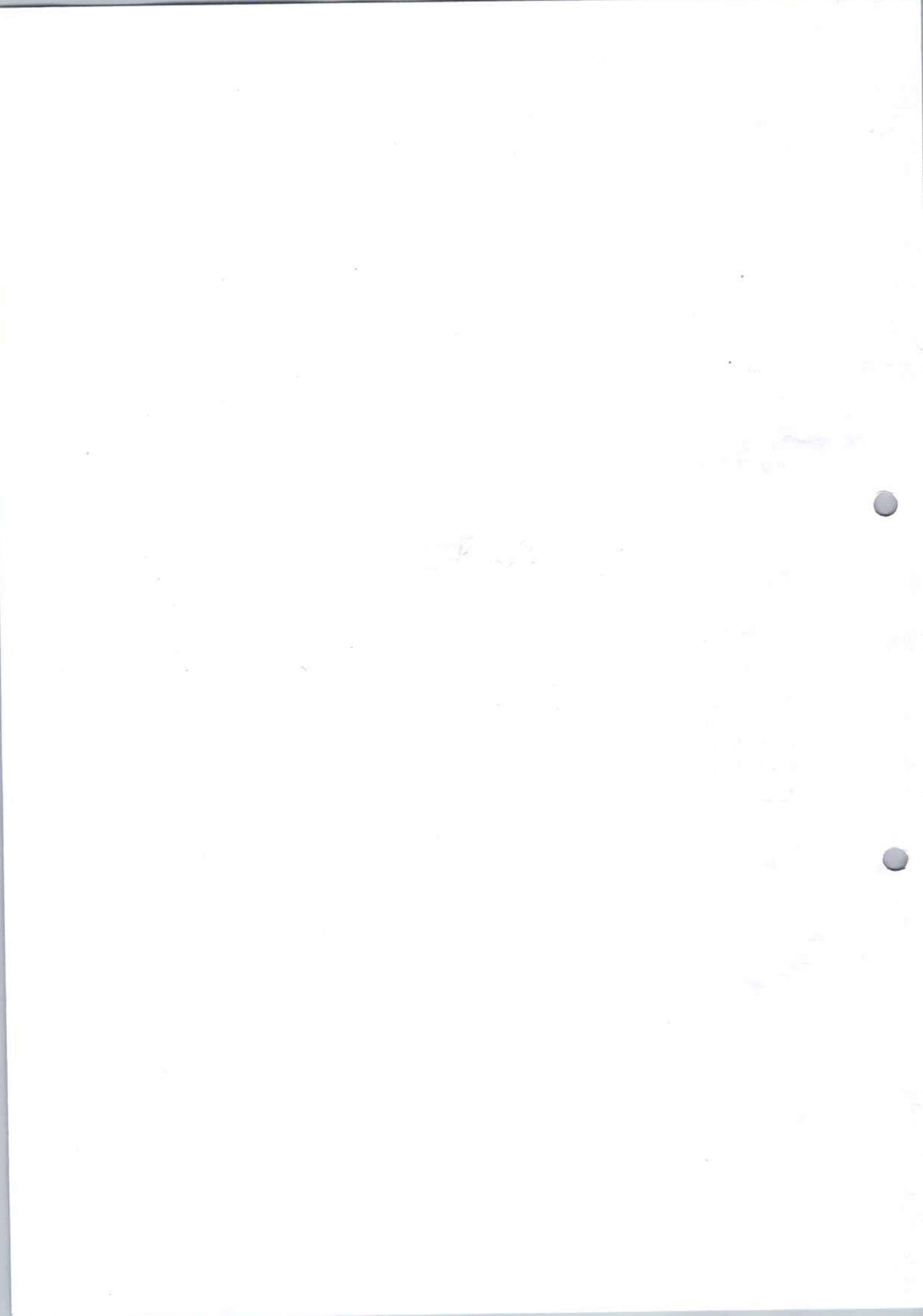
| Staff Nurse | Shift / Ward | Billing Assistant | Billing Supervisor |
|---|---|---|---|
| [signature] | | | |

## DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTA

GUC-00091617 IP18-00036137
Mrs DIVYA DS
03-09-1993 32 Y 9 M 20 D (F)
Dr. MATHANGI RAJAGOPALAN

| ACTIVITY | TIME | | NAME & SIGNATURE | REMARKS | <To be filled by Admin> |
|---|---|---|---|---|---|
| Discharge Announcement | | | | | |
| | INTIME | OUT TIME | | | |
| Arrangement of File by Nursing | | 11.10 am | [signature] | | |
| Preparation of Discharge Summary | | | | | |
| Finalization of discharge summary | | | | | |
| Transfer of file from Ward to Billing Dept | | | | | |
| Bill Processing | | | | | |
| Audit Clearance | | | | | |
| Billing Clearance | | | | | |
| Physical Clearance | | | | | |
| | | | | | |



GUC-00091617 IP18-00036137
Mrs DIVYA DS
03-09-1993 32 Y 9 M 20 D (F)
Dr. MATHANGI RAJAGOPALAN

# BED SIDE CHECK LIST FOR NURSES

| Date: | 22/6/26 | 23/6/26 | 24/6 | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Doctor's Orders | yes | yes | yes | | | | | | |
| Carried out or not | yes | yes | yes | | | | | | |
| **Bed Side** | | | | | | | | | |
| Structured Handover done | yes | yes | yes | | | | | | |
| IV Site | yes | yes | yes | | | | | | |
| Central Lines | NA | NA | NA | | | | | | |
| Arterial Lines | NA | NA | NA | | | | | | |
| Feeding Catheter | NA | NA | NA | | | | | | |
| Urinary Catheter | NA | NA | NA | | | | | | |
| Skin Care | yes | yes | yes | | | | | | |
| Eye Care | yes | yes | yes | | | | | | |
| Mouth Care | yes | yes | yes | | | | | | |
| Sterillum Bottle, Stethoscope | yes | yes | yes | | | | | | |
| Suction Bottle (Should be clean & empty) | yes | yes | yes | | | | | | |
| Intubation Tray | NA | NA | NA | | | | | | |
| Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline | NA | NA | NA | | | | | | |
| Ventilator Tubing, (Any Water, Blood) | NA | NA | NA | | | | | | |
| Humidification | NA | NA | NA | | | | | | |
| Check all Infusion (Labelling, Correct Preparation) | NA | NA | NA | | | | | | |
| Chest Physio & Neb | NA | NA | NA | | | | | | |
| Handed Over By Name : | [illegible] | K. Abhi | [illegible] | | | | | | |
| Signature : | [illegible] | [illegible] | [illegible] | | | | | | |
| Date & Time: | 22/6/26 11PM | 23/6/26 | [illegible] | | | | | | |
| Hand Over Taken By Name : | K. Abhi | [illegible] | | | | | | | |
| Signature : | [illegible] | [illegible] | | | | | | | |
| Date & Time: | [illegible] | 23/6/26 8pm | | | | | | | |

Rainbow Children's Hospital

BirthRight by Rainbow

**Rainbow Children's Hospital - Guindy**

Door No.157 to 160, Anna Salai, Guindy, Guindy ,Chennai ,Tamil Nadu, INDIA ,600015.
TEL NO :044-40122444
WEB : https://rainbowhospitals.in

# ADMISSION SHEET

## Registration Details :

**Admission No** : IP18-00036137 **Admit Date** : 22-Jun-2026 **Admit Time** : 08:57 PM **UHID** : GUC-00091617

## Patient Details :

| | | | |
|---|---|---|---|
| **Patient Name** | : Mrs DIVYA DS | **Age** | : 32 Y 9 M 19 D |
| **Guardian** | : MOHAMED SATHAM HUSSAIN | **DOB** | : 03-09-1993 |
| **Gender** | : Female | **Religion** | : |
| **Occupation** | : | **Martial Status** | : |
| **Address (H)** | : NO 19 H3 2 ND FOLOOR Pippen apavk keer Keelakattalai Kanchipuram Tamil Nadu INDIA 600117 | **Phone No** | : 9094090797/ 9791984512 |
| | | **E-mail** | : no@gmail.com |

## Admission Details :

| | | | | | |
|---|---|---|---|---|---|
| **Bed Type** | : MICU | **Bed No** | : MICU 805 | **Ward Name** | : 8F-OT COMPLEX |
| **Room No** | : MICU 805 | **Admission Type** | : First Visit | | |

## Contact Details :

| | | | |
|---|---|---|---|
| **Name** | : MOHAMED SATHAM HUSSAIN | **Relationship** | : Husband |
| **Contact Address** | : NO 19 H3 2 ND FOLOOR Pippen apavk keer Keelakattalai Kanchipuram Tamil Nadu INDIA 600117 | **Phone No** | : |

P. [signature]

**Signature**

## Doctor Details :

| | | | |
|---|---|---|---|
| **Doctor Name** | : Dr. MATHANGI RAJAGOPALAN | **Specialisation** | : OBSTETRICS AND GYNECOLOGY |
| **Referral Doctor** | : Self | **Phone No** | : |
| **Co-Consultant** | : | | |

## Payment Details :

| | | | |
|---|---|---|---|
| **Payment Mode** | : Cash | **Deposit Amount** | : 0.00 |
| | | **Payor Name** | : SELFPAY |

Rainbow Children's Hospital

BirthRight Rainbow

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## GENERAL CONSENT FOR TREATMENT

| **Patient Name:** | **Mrs DIVYA DS** | **Age :** | **32 Y 9 M 19 D** |
|---|---|---|---|
| **IP No:** | **IP18-00036137** | **Sex:** | **Female** |
| **Consultant:** | **Dr. MATHANGI RAJAGOPALAN** | **Ward/Bed No:** | **8F-OT COMPLEX/MICU 805** |

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 [illegible]rance 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 cl[illegible]ance. In case of failing the submission, I will pay 200/- Rs.
(R[illegible]eivers 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: MOHAMED SATHAM HUSSAIN

Relationship: HUSBAND.

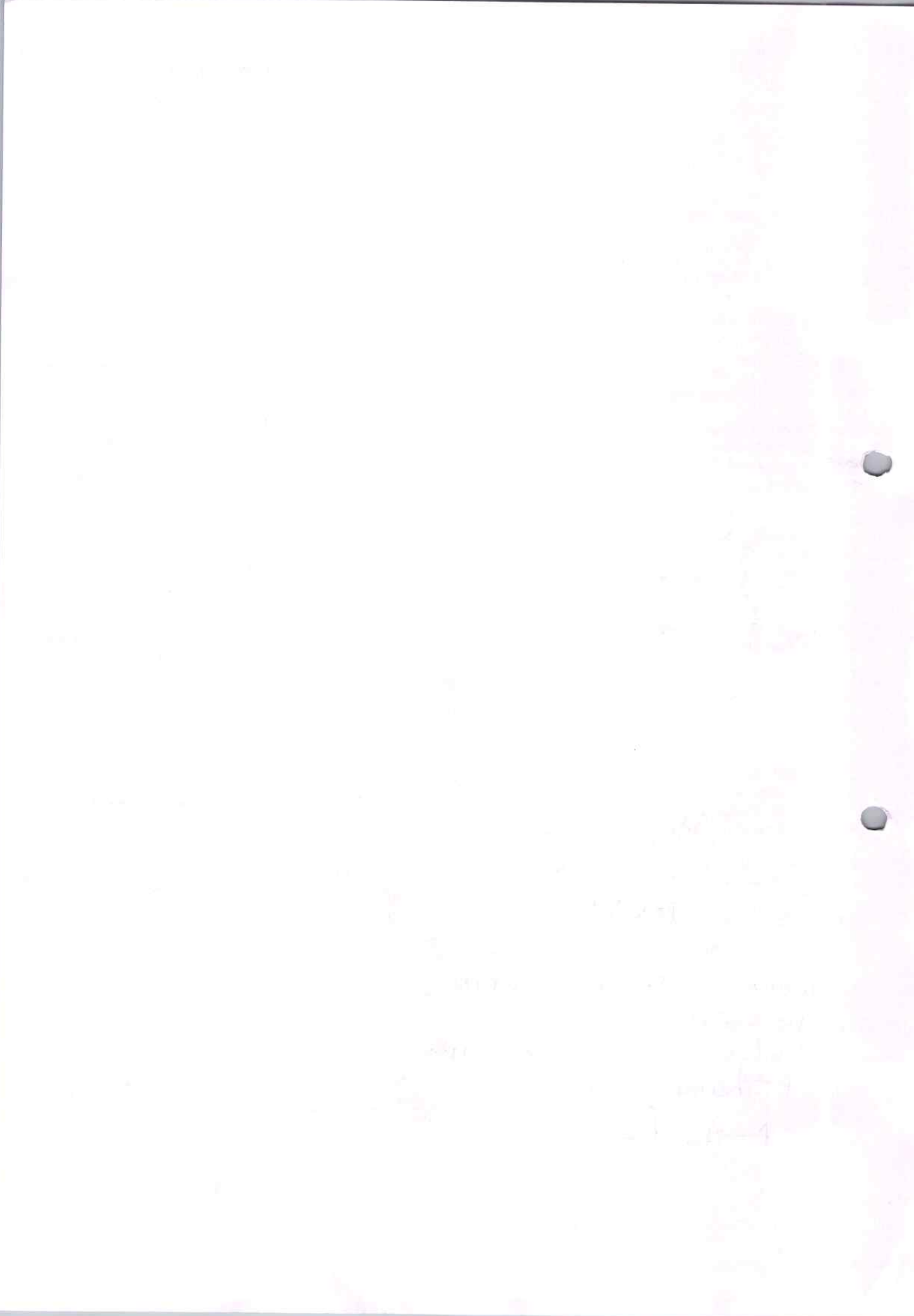
Date: 22/06/26

Time: 08:57PM

Wittness Name: P. Thamarai Selvan

Wittness Signature:

Patient Address:
NO 19 H3 2 ND FOLOOR Pippen apavk keer Keelakattalai Kanchipuram Tamil Nadu INDIA 600117



# BILLING POLICY

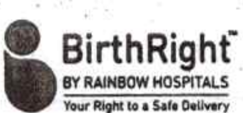
- Billing Cycle: - Bed charges will be calculated based on 12PM to 12PM checkout. Settlement post 12PM, room rent will be charged for half day extra & post 6PM, it will be charged for full day. Less than 24 hours stay will be considered as one day.
- Room Rent inclusive of Bed, Nursing, Consultation Charges and all other charges, like Diet, Investigations, IP or OP Procedures, Equipment, Cross Consultations, Blood/ Blood Products, Implants, Ward Consumables, Infection Preventive Measure Charges, Pharmacy and Consumables will be charged extra.
- 5% GST Charges applicable on more than INR 5,000/- Bed Charges which was effective from 18.07.2022 as per the GST Council.
- As per the G.O.I. guidelines, we can collect Rs 1,99,999/- only in cash mode, balance patient can pay through Credit Card/ Debit Card/ NEFT / RTGS / Demand Draft and Online Payment.
- In the event of TPA / Cashless denial or approval not received due to any reason then hospital tariff will be applicable and any discount or special rates given to TPA's / Corporate won't 9eapplicable.
- If the Surgery/ Procedures performed in emergency hours (8PM-6AM), Public Holiday and on Sunday will be charged 30% extra.
- Asst. Surgeon and Anesthetist Charges will be charged 30% on the Surgeon Charges.
- Admission will be done according to the ward category chosen by the patient; charges will be applicable as per the ward category. All charges vary as per Room category, except Pharmacy and consumables.
- Patient / Guardian Self Attested Government ID proof is mandatory to submit at the admission.
- TPA/Insurance Processing Fee applicable for all Insurance Cases.
- In our hospital there is "No Discounts Policy". Kindly co-operate.
- No Duplicate/ Second copy of OP or IP bill will be issued.
- In case the patient is shifted from lower category to higher category, all the charges like consultant visits, investigations, operations and procedures etc. from
- the date of admission will be charged according to the higher category.
- If the patient is shifted to the ICU, the attendant should vacate the room. If the attender occupies the room, it will be charged as per dual occupancy.
- Room eligibility is purely subject to TPA approval. Proportionate difference of the bill amount is applicable in case the patient opts for higher category higher than the TPA approved, which has to paid by the patient and may not be reimbursed by the TPA / Insurance Company at later stage.
- For Non - Medicals, Disposables, Consumables, Infusion Pump, Taxes, Implants, HIV/ HbsAg, Medical Records, Insurance Processing Fee, Double Occupancy and Registration Charges, Etc., credit cannot be extended. These items are not payable to us as per insurance company norms (Depends on the TPA/Insurance Co. T&C).
- It takes time for cash discharge is a minimum 3-4hrs. and in the case of insurance, it will take a minimum 6-7hrs.
- Difference, if any between the final bill amount arid amount permitted / approved by the TPA or total bill amount in case of denial from TPA, has to be paid by the patient.
- Two attendants are permitted with patients in Deluxe, Private Rooms and only one is permitted in the rest of the categories of rooms. No attendant is permitted in ICU's.
- All the refunds more than Rs.5,000/- will be refunded through NEFT within 7 Bank working days.
- Patient attendant can collect for Interim/provisional bill of the patient from the billing section on daily basis. Interim Bill shall be based on the acknowledged services in HIS. Final Bill of the patient may vary from the Interim bill based on actual update taken on the day of discharge. It is requested that patients/attendants enquire daily about the bill amount from billing section and pay the outstanding as on that day. You are requested to clear your outstanding amount on daily basis before 12 PM. **Patient bill outstanding should not be increase more than 10,000/-**

## DECLARATION

I have attended the Financial Counselling desk & understood the expected costs & other conditions applicable. In this case, the TPA/Insurance Company rejects the claim for whatsoever reasons at any point of time after discharge. I promise to settle the claim with the hospital as per Hospital Cash Tariff.

| | |
|---|---|
| Patient Name : MRS. DIVYA DS | UHID Number : 91617 |
| Self/Attendant Name : MOHAMED SATHAM HUSSAIN | Relation : HUSBAND |
| Self/ Attendant Signature : [signature]<br>Phone Number : | Name & Signature of Financial Counselor [signature] |

GUC-00091617 IP18-00036137
Mrs DIVYA DS
03-09-1993 32 Y 9 M 19 D (F)
Dr. MATHANGI RAJAGOPALAN




# IP ADMISSION SHEET FOR OBSTETRICS

**Presenting Complaints** Quickening
Able to perceive well.
Admitted for cerclage for short cervix

**LMP:** 15/02/2026 **EDD:** 22/11/2026

**Corrected EDD:** **GA:** 18+1 weeks

**Obstetric Formula:** Primigravida

**Menstrual History:** Regular: ☑ Yes ☐ No
m/s: 6 months

**Obstetric Hostory:**
I - PP, spontaneous conception

**Obstetric Examination**

Fundal Height: 18 weeks

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

**Present Pregnancy Record:**
- Booked & immunised.
- NT - N, FTS screen Neg. placenta - low lying covers os

Liquor: ☐ Adequate ☐ Oligo ☐ Poly

PP: ☐ Cephalic ☐ Breech Others ________

Head Fifths Palpable: ________

**RISK FACTORS:**
* hypothyroid.
* Short cervix.
* low lying placenta (previously)
* UTI Recurrent Rx

FHS: ☑ Normal ☐ Tachy ☐ Brady ☐ Absent

**Per Speculum Examination** (–)

Draining: ☐ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

**Vaginal Examination** (–)

Cervix: ☐ Long ☐ Partially effaced ☐ Effaced

Height: 169 cm

Os: Closed ________ Dilated ________

Weight: 64.3 kg

Allergies: Food Allergy - BRINJAL

Membranes: ☐ Present ☐ Absent

Breast: ☑ Normal ☐ Abnormal

Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

General Examination:

Consciousness: full Pallor: No

Presenting Part: ☐ Vertex ☐ Breech ☐ Others

Icterus: No Edema: NO

Sutton: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Temp: Normal PR: 84/mt.

Pelvis: ☐ Adequate ☐ Doubtful

BP: 110/70 DTR:

CVS: RS

Liver/Spleen: Urine Output:

**DIAGNOSIS**

Primigravida / 18+1 weeks / Obstetric Cholestasis / Short cervix (2.2 cm)
O positive
Spont-conception

For Cervical encerclage

Patient Sticker

| Family History: | Surgical History: |
|---|---|
| Mother - HTN<br>Father - DM | Nil |
| **Medical History:**<br>Hypothyroid x 1 year<br>Obstetric Cholestasis from 9/6/26.<br>Recurrent UTI - Klebsiella Rx (9/5/26) | **Medication History:** Tab. UDILIV 300 1-0-1<br>Tab. THYRONORM 25mcg OD<br>Tab. DYDROGESTERONE 10mg BD<br>Cap. HOP SR 300mg BD<br>Tab. NEUROBION FORTE / Tab. HOMIN OD |
| **Plan of Care:** I/T Dr. Mathangi<br>Advice<br>- Admission<br>- Plan: Cervical encerclage in view of short cervix (2.2cm) on 23.6.26 @ 9:30Am<br>- NPO from 12Am.<br>- IVF @ 125ml/hr.<br>- Informed consent.<br>- Inform OT.<br>- Cap. CANSOFT CL PV HS x 2 days<br>- Shift to ward.<br>- Reshift to LDR at 8 Am 23.6.26<br>- Tab. THYRONORM 25mcg OD 6Am | **Investigations:**<br>CBC<br><br>Bedside USG<br>FHR - 154 BPM<br>unstable lie. |

Doctor Name: Dr. Jahima / Dr. Divyalakshmi

Signature: [signature] 164288.

Date & Time: 22/6/26, 9pm

Consultant Name: Dr. Mathangi

Signature: [signature] 164288

Date & Time: 22/6/26, 9pm

GUC-00091617 IP18-00036137
Mrs DIVYA DS
03-09-1993 32 Y 9 M 19 D (F)
Dr. MATHANGI RAJAGOPALAN

# RESULT SHEET

| | | | | | | |
|---|---|---|---|---|---|---|
| Date | 31/3 | 22/6 | | | | |
| Time | | | | | O | POSITIVE |
| Hb | 11.8 | | | | | |
| PCV | | | | | | |
| RBC | | | | | HIV | |
| WBC | | | | | HBsAg | NR |
| N/L | | | | | VDRL | |
| Platelets | | | | | | |
| CRP | | | | | | |
| ESR | | | | | TSH – | 3.0 |
| PCT | | | | | | |
| RBS | | | | | | |
| Na | | | | | | |
| K | | | | | | |
| Cl | | | | | | |
| Ca/Mg | | | | | 16/6/26 | |
| Phosphate | | | | | | |
| Urea | | | | | SGOT – | 31 |
| Creatinine | | | | | SGPT | 44. |
| ALP | | | | | Bile acid | - 30 |
| SGPT | | | | | | |
| SGOT | | | | | | |
| T.Bill/Conj | | | | | | |
| T.Protein | | | | | | |
| S.Albumin | | | | | | |
| S.Globulin | | | | | | |
| A/G Ratio | | | | | | |
| Uric Acid | | | | | | |
| S.Amylase | | | | | | |
| Sr.Lipase | | | | | | |
| Blood Lactate | | | | | | |
| S.Cholesterol | | | | | | |
| PT/INR | | | | | | |
| APTT | | | | | | |
| CSF Protein / Sugar | | | | | | |
| Cells | | | | | | |
| N/L | | | | | | |

| Date | | | | | | |
|---|---|---|---|---|---|---|
| Time | | | | | | |
| CUE - Alb | | | | | | |
| CUE - Sugar | | | | | | |
| CUE - Ketones | | | | | | |
| CUE - PUS Cells | | | | | | |
| CUE - RBC Cells | | | | | | |
| CUE | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Stool Pus Cell | | | | | | |
| OVA / Cyst | | | | | | |
| Occult Blood | | | | | | |
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Culture and Sensitivities : ........................................

........................................

........................................

........................................ 16/6/[illegible]

Radiology : USG : SLIUG – $17^{+2}$ weeks

X-Ray : placenta - anterior

ECHO : SDP – 3.5

CT : $C_x$ : 2.5 cm

MRI Internal os closed.

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

22/6 $C_x$ = 2.2 cm

GUC-00091617 IP18-00036137
Mrs DIVYA DS
03-09-1993 32 Y 9 M 19 D (F)
Dr. MATHANGI RAJAGOPALAN

# PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|---|---|---|
| 23/06/2026 | Patient received in pre-delivery | |
| | 9Am C/S/B Dr. Pavithra / Dr. Shreedevi | |
| GA - 18wks+2days | | |
| | O/E Pt GC fair, Afebrile | Advice |
| T-(N) | P° / PE° | - NPO |
| PR- 78/min | CVS | - IVF 1O RL @ 100ml/hr |
| BP- 118/72 mmHg | RS NAD | - vitals Monitoring |
| | P/A - uterus @ 18wks | - Pre-op medications |
| Bedside USG | Relaxed | - Void before shifting to OT |
| SLIUG | FHS - good | - Inform OT / Anesthetist |
| FHR - 169 bpm | | - Shift to OT after mam's Orders |
| | 182217 | |
| | | |
| 23/06/2026 10:30 am | Case Received in MIW - C/S/B Dr. Pavithra. | |
| | o/e | |
| | Pt GC fair | Advice |
| T-(N) | afebrile | |
| BP - 100/70 mmHg. | P° / PE° | - NPO x 4 hours |
| PR - 66/min | CVS | - IVF @ 125ml/hour |
| | RS NAD. | - Vitals monitoring |
| Bedside USG | P/A - Uterus 18 WKS | - Follow drug chart |
| FHS good | Relaxed | - CBD @ 4PM |
| | FP (+), FHS good | |

11468.

Patient Sticker

# PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|---|---|---|
| 23/6/26 | S/B Dr. [illegible] / Dr. Shweedas. | |
| 3PM | | |
| O-tne | pt reviewed. | |
| | no sp complaints. | |
| | o/E: afebrile. | |
| BP 100/60mmHg. | GC fair | |
| PR 80bpm. | P° IPE° | Plan: |
| SpO2 99% @ RA | P/A: uterus @ 18w | - monitor vitals |
| temp (N) | Relaxed | - kanji 6pm. |
| | FH (+). | - soft solid diet 8pm. |
| | L/E: SVP dry | - FH monitoring |
| | Foley's insitu | - Look bleeding P/V |
| | clear urine | - inform (SOS) |
| | LHUO = 100ml. | - follow drug orders. |
| | | - CBD till 4pm |
| | | - I/O charting |
| | [signature] | - d/s tomorrow. |
| | 128455 | - shift to ward. |
| 23/6/26 | SB Dr. Vinitha | |
| 10 PM | Pt reviewed; No Ho | Voided |
| | O/E: GC fair; Afebrile | Adv: |
| BP: 100/68 | P° IPE° | Kanji Soft diet |
| PR: 80/min | P/A: Ut @ 18w; | Plenty of fluids |
| SpO2: 99% RA | Relaxed; FH good | I/O chart |
| | L/E: BWNL | D/S tomorrow |
| [signature] 12113 | | Inform SOS |

GUC-00091617
Mrs DIVYA DS
IP18-00036137
03-09-1993
32 Y 9 M 20 D (F)
Dr. MATHANGI RAJAGOPALAN

# PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|---|---|---|
| 24/6/26 | | |
| 9Am | C/S/B Dr. Pavithra / Dr. Shreedevi | |
| GA - 18 + 3days | Pt reviewed, c/o white discharge (watery) | |
| T - (N) | | |
| PR - 78/min | O/E Pt GC fair, Afebrile | Advice |
| BP - 108/70mmHg | P°/PE° | - Soft diet |
| | CVS / RS NAD | - Plenty of oral fluids |
| Bedside USG | P/A uterus @ 18weeks | - Vitals monitoring |
| SLIUG | Relaxed | - Follow drug chart |
| FHS + | FHS - good | - SYP. DUPHALAC 15ml PO STAT |
| | | - Process discharge |
| | | - Inform (SOS) |
| | [signature] 182217 | |

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

Patient Sticker

# PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
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GUC-00091617 IP18-00036137
Mrs DIVYA DS
03-09-1993 32 Y 9 M 20 D (F)
Dr. MATHANGI RAJAGOPALAN

# MEDICATION RECONCILIATION FORM

Drug Allergies: .......................................................... ☑ 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: 7th floor .................. Shifted to: LDR ..................

| 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 | | | | | | ☐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 : ..........................................

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

Nurse Name & Signature: ..........................................

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

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

GUC-00091617 IP18-00036137
Mrs DIVYA DS (F)
03-09-1993 32 Y 9 M 19 D
Dr. MATHANGI RAJAGOPALAN

# MEDICATION RECONCILIATION FORM

Drug Allergies: ............ ☑ 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: LWR Shifted to: 7th 7100 4

| S.No | MEDICATION NAME (GENERIC NAME CAPITAL LETTERS) | DOSE (mg, mcg) | ROUTE (PO, NG, SC, IV) | FREQUENCY | LAST DOSE Date / Time | ON ADMISSION / SHIFTING |
|---|---|---|---|---|---|---|
| 1 | Tab. THYRONORM | 25mcg | PO | OD | | ☑ C ☐ DC |
| 2 | Tab. DYDROGESTERONE | 10mg | PO | BD | | ☑ C ☐ DC |
| 3 | Cap. MOP SR 300mg | 300mg | PO | BD | | ☑ C ☐ DC |
| 4 | Tab. UDILIV | 500mg | PO | BD | | ☑ C ☐ DC |
| 5 | Cap. CANSOFT CL | 1 cap | PV | HS | | ☑ C ☐ DC |
| 6 | | | | | | ☐ C ☐ DC |
| 7 | | | | | | ☐ C ☐ DC |
| 8 | | | | | | ☐ C ☐ DC |
| 9 | | | | | | ☐ C ☐ DC |
| 10 | | | | | | ☐ C ☐ DC |

** C- Continue, DC - Discontinue*

**MEDICATION HISTORY RECORDED / VERIFIED BY**

Doctor Name & Signature : Dr. Divyalakshmi 164288

Date & Time : 22/6/26 at 9PM.

Nurse Name & Signature: S. Aparna

Date & Time : 22/6/26 at 9pm

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

GUC-00091617 IP18-00036137
Mrs DIVYA DS
03-09-1993 32 Y 9 M 20 D (F)
Dr. MATHANGI RAJAGOPALAN

# MEDICATION RECONCILIATION FORM

Drug Allergies: ........................................ ☑ 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: ......O.T...... Shifted to: ......M.I.C.U.......

| 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 | | | | | | ☐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 : ........................

Date & Time : ......22/6/26 10 a.m......

Nurse Name & Signature: ......S/N. Sangeetha......

Date & Time : ......23/6/26 at 9:50......

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

GUC-00091617 IP18-00036137
Mrs DIVYA DS
03-09-1993 32 Y 9 M 19 D (F)
Dr. MATHANGI RAJAGOPALAN

# DRUG CHART

Date of Admission: 22/6/26 Drug Allergies: ☑ 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 ....................

GUC-00091617 IP18-00036137
Mrs DIVYA DS
03-09-1993 32 Y 9 M 19 D (F)
Dr. MATHANGI RAJAGOPALAN

## REGULAR PRESCRIPTIONS

Weight. 64.3 kg Ward. LDR

**DRUG:** Tab. THYRONORM

| Dose | Route | Frequency | Start Date |
|---|---|---|---|
| 25mg | PO | OD | 23/6 |

Name & Signature of the Doctor Starting the Drugs: [signature] 164288

Additional Instructions:

Daily Doctor's Endorsement by a Sign

| Date / Time | 23/6 | 24/6 |
|---|---|---|
| 6AM | D.P. A.A | P.C D.R |

**DRUG:** Tab. UDILIV

| Dose | Route | Frequency | Start Date |
|---|---|---|---|
| 300mg | PO | 1-0-1 | 22/6 |

Name & Signature of the Doctor Starting the Drugs: [signature] 164288

Additional Instructions:

Daily Doctor's Endorsement by a Sign

| Date / Time | 22/6 | 23/6 | 24/6 |
|---|---|---|---|
| 9AM | / | / | S.N V.P |
| 9PM | [initials] | P.C D.R | |

**DRUG:** Tab. DYDROGESTERONE

| Dose | Route | Frequency | Start Date |
|---|---|---|---|
| 10mg | PO | 1-0-1 | 22/6 |

Name & Signature of the Doctor Starting the Drugs: [signature] 164288

Additional Instructions:

Daily Doctor's Endorsement by a Sign

| Date / Time | 22/6 | 23/6 |
|---|---|---|
| 9AM | / | |
| 9PM | [initials] | |

Stop

**DRUG:** Cap. HOP SR 300mg

| Dose | Route | Frequency | Start Date |
|---|---|---|---|
| 300mg | PO | BD | 22/6 |

Name & Signature of the Doctor Starting the Drugs: [signature] 164288

Additional Instructions:

Daily Doctor's Endorsement by a Sign

| Date / Time | 22/6 | 23/6 |
|---|---|---|
| 10AM | / | |
| 10PM | [initials] | |

Stop

GUC-00091617 IP18-000361…
Mrs DIVYA DS 32 Y 9 M 19 D (F)
03-09-1993
Dr. MATHANGI RAJAGOPALAN

Weight. 64.3kg Ward. LDR

| 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. | |

| 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. | |

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

## STAT / ONCE ONLY DRUGS

| Date | Time | Medication | Dosage & Other Instructions | Route | Signature | Nurses |
|---|---|---|---|---|---|---|
| 23/6 | 7.50AM | Inj. SUPACEF | 0.1ml | ID | 16428 | Aswini DR |
| 23/6 | 7.50AM | Inj. PAN | 40mg | IV | 16428 | DR |
| 23/6 | 7.50AM | Inj. EMESET | 4mg | IV | 16428 | DR |
| 23/6 | 9.30AM | Inj. SUPACEF | 1.5gm | IV | 16428 | TJ MD |
| 23/6 | 10Am | INJ TRAPIC | 500mg | IV | 16462 | |
| 23/6 | 11:30Am | C. SUSTEN | 300mg | PV | 12462 | SP SD |
| 23/6 | 8pm | INJ. SUPACEF | 1.5g | IV | 182217 | P.U D.R |
| | | SYP. DUPHALAC | 15ml | PO | 182217 | |
| | | | | | | |

GUC-00091617 IP18-00036137
Mrs DIVYA DS
03-09-1993 32 Y 9 M 19 D (F)
Dr. MATHANGI RAJAGOPALAN

# I.V. FLUIDS CHART

Weight. 64.3kg Ward. 7th floor

| Date | Time | Composition of IV Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc) | Route | Flow Rate ml/hr | Doctor Sign | Nurse Sign | Date of Stopping | Doctor Sign | Nurse Sign |
|---|---|---|---|---|---|---|---|---|---|
| 23/6 | 6Am | IVF RL | IV | 125 ml/hr | [signature] 16428 | D.R AA | 23/6 | [signature] 15462 | |
| 23/6 | 9.50 am | IVF RL 10 | IV | [illegible] | [signature] 15464 | [signature] 020324 | 23/6 | [signature] 15462 | [signature] |
| | | | | | | | | | |
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VERIFIED BY : Name ............ Signature ............

GUC-00091617 IP18-00036137
Mrs DIVYA DS
03-09-1993 32 Y 9 M 20 D (F)
Dr. MATHANGI RAJAGOPALAN

Sheet No: ............

# REGULAR PRESCRIPTIONS

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

**DRUG :** Cap. CANSOFT CL

| Dose | Route | Frequency | Start Dt. |
|---|---|---|---|
| 1 cap | PV | HS | 22/6 |

Name & Signature of the Doctor Starting the Drugs: 154428

Additional Instructions: x 3 doses

**Daily Doctor's Endorsement by a Sign**

| Date/Time | 22/6 | 23/6 | 24/6 |
|---|---|---|---|
| 10pm | SD / SS | Deepa / Vinni | |

**DRUG :** C. AUGMENTIN

| Dose | Route | Frequency | Start Dt. |
|---|---|---|---|
| 625mg | PO | 1-1-1 | 24/6/24 |

Name & Signature of the Doctor Starting the Drugs: 182217

Additional Instructions:

**Daily Doctor's Endorsement by a Sign**

| Date/Time | 24/6 | 24/6 |
|---|---|---|
| 8Am | / | S.N / V.A |
| 2pm | | |
| 10pm | | |

D1

**DRUG :** C. PAN D

| Dose | Route | Frequency | Start Dt. |
|---|---|---|---|
| 40mg | PO | 1-0-1 | 24/6/24 |

Name & Signature of the Doctor Starting the Drugs: 182217

Additional Instructions:

**Daily Doctor's Endorsement by a Sign**

| Date/Time | 23/6 | 24/6 |
|---|---|---|
| 7Am | / | P.K / D.R |
| 7pm | ES / AP | - |

**DRUG :** C. SUSTEN

| Dose | Route | Frequency | Start Dt. |
|---|---|---|---|
| 300mg | PV | 1-0-1 | 24/6/24 |

Name & Signature of the Doctor Starting the Drugs: 182217

Additional Instructions:

**Daily Doctor's Endorsement by a Sign**

| Date/Time | 23/6 | 24/6 |
|---|---|---|
| 8Am | / | S.N / V.A |
| 8pm | P.K / D.R | |

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

GUC-00091617 IP18-00036137
Mrs DIVYA DS
03-09-1993 32 Y 9 M 20 D (F)
Dr. MATHANGI RAJAGOPALAN

# REGULAR PRESCRIPTIONS

Sheet No: ............ Weight 64.3kg Ward 1st floor

**DRUG:** T. PARACETAMOL

| Dose | Route | Frequency | Start Dt. |
|---|---|---|---|
| 1g | PO | 1-1-1 | 23/6/26 |

Name & Signature of the Doctor Starting the Drugs: 182217

Additional Instructions:

Daily Doctor's Endorsement by a Sign

| Date/Time | 23/6 | 24/6 |
|---|---|---|
| 8Am | | S.N / V.A |
| | SP | |
| 2pm | SP | |
| 10pm | P.U / D.R | |

**DRUG:** T. DUPHASTON

| Dose | Route | Frequency | Start Dt. |
|---|---|---|---|
| 10mg | PO | 1-0-1 | 23/6/26 |

Name & Signature of the Doctor Starting the Drugs: 182217

Additional Instructions:

Daily Doctor's Endorsement by a Sign

| Date/Time | 23/6 | 24/6 |
|---|---|---|
| 8Am | / | S.N / V.A |
| 8pm | P.K / D.R | |

**DRUG:** INJ. TRAPIC

| Dose | Route | Frequency | Start Dt. |
|---|---|---|---|
| 1g | IV | 1-1-1 | 23/6/26 |

Name & Signature of the Doctor Starting the Drugs: 182217

Additional Instructions:

Daily Doctor's Endorsement by a Sign

| Date/Time | 23/6 |
|---|---|
| 8Am | / |
| | SP |
| 2pm | SP |
| 10pm | P.K / D.R |

**DRUG:** NICARDIA R

| Dose | Route | Frequency | Start Dt. |
|---|---|---|---|
| 10mg | P/O. | 1-0-1 | 23/6/26. |

Name & Signature of the Doctor Starting the Drugs: 127435

Additional Instructions: inform BP before giving dose.

Daily Doctor's Endorsement by a Sign

| Date/Time | |
|---|---|
| 7AM | |
| 7PM | |

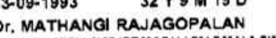
STOP

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

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

Patient

GUC-00091617 IP18-00036137
Mrs DIVYA DS
03-09-1993 32 Y 9 M 19 D (F)
Dr. MATHANGI RAJAGOPALAN



# Early Warning Observation Score Chart - Obstetrics

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

22/6/18

| | 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 | | | | | | | | | | | | | 22 | | | | 22 | | | | 20 | | | |
| | 11 - 20 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 0 - 10 | | | | | | | | | | | | | | | | | | | | | | | | |
| Saturations | 94 - 100 % | | | | | | | | | | | | | 99% | | | | 98% | | | | 99% | | | |
| | < 94 % | | | | | | | | | | | | | | | | | | | | | | | | |
| Administered $O_2$ (L/min.) | | | | | | | | | | | | | | RA | | | | RA | | | | RA | | | |
| Temp °c | 40 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 39 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 38 | | | | | | | | | | | | | | | | | 97.8°F | | | | 98.2°C | | | |
| | 37 | | | | | | | | | | | | | 99°F | | | | ⊕ | | | | ⊕ | | | |
| | 36 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 35 | | | | | | | | | | | | | | | | | | | | | | | | |
| | < 35 | | | | | | | | | | | | | | | | | | | | | | | | |
| Heart Rate | 170 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 160 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 150 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 140 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 130 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 120 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 110 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 100 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 90 | | | | | | | | | | | | | 84/m | | | | 84/m | | | | 78/m | | | |
| | 80 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 70 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 60 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 50 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 40 | | | | | | | | | | | | | | | | | | | | | | | | |
| ↑ Systolic Blood Pressue | 190 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 180 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 170 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 160 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 150 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 140 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 130 | | | | | | | | | | | | | | | | | 108 | | | | 118 | | | |
| | 120 | | | | | | | | | | | | | 110 | | | | | | | | | | | |
| | 110 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 100 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 90 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 80 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 70 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 60 | | | | | | | | | | | | | | | | | (84) | | | | (78) | | | |
| | 50 | | | | | | | | | | | | | | | | | | | | | | | | |
| ↓ Diastolic Blood Pressure | 130 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 120 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 110 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 100 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 90 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 80 | | | | | | | | | | | | | 70 | | | | 68 | | | | 72 | | | |
| | 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 SCORES | | | | | | | | | | | | | | 0 | | | | 0 | | | | 0 | | | |
| TOTAL ORANGE SCORES | | | | | | | | | | | | | | 0 | | | | 0 | | | | 0 | | | |
| Nurse Initial | | | | | | | | | | | | | | [signature] | | | | [signature] | | | | [signature] | | | |

On Admission

GUC-00091617 IP18-00036137
Mrs DIVYA DS
03-09-1993 32 Y 9 M 20 D (F)
Dr. MATHANGI RAJAGOPALAN

# Early Warning Observation Score Chart - Obstetrics

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

| 23/6/20 | 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 | 20 | | 20 | 20 | 18 | 18 | 18 | 18 | 20 | | | | 20 | | | | 20 | | | | 20 | | | |
| | 0 - 10 | | | | | | | | | | | | | | | | | | | | | | | | |
| Saturations | 94 - 100 % | 99% | | 99% | 99 | 99% | 99% | 100 | 100 | 99% | | | | 97% | | | | 98% | | | | 97 | | | |
| | < 94 % | | | | | | | | | | | | | | | | | | | | | | | | |
| Administered $O_2$ (L/min.) | | RA | | RA | RA | RA | RA | RA | RA | RA | | | | RA | | | | RA | | | | RA | | | |
| Temp °c | 40 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 39 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 38 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 37 | 98°F | | 97°F | 98°F | 98°F | 98°F | 98°F | 98°F | 97.8°F | | | | 98.0°F | | | | 98.2°F | | | | 98.0°F | | | |
| | 36 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 35 | | | | | | | | | | | | | | | | | | | | | | | | |
| | < 35 | | | | | | | | | | | | | | | | | | | | | | | | |
| Heart Rate | 170 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 160 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 150 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 140 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 130 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 120 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 110 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 100 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 90 | 80b/m | | 80b/m | | | | | | 80b/m | | | | 86b/m | | | | 88b/m | | | | 88b/m | | | |
| | 80 | | | | 66 | 80 | 80 | 80 | 80 | | | | | | | | | | | | | | | | |
| | 70 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 60 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 50 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 40 | | | | | | | | | | | | | | | | | | | | | | | | |
| ↑ Systolic Blood Pressure | 190 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 180 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 170 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 160 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 150 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 140 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 130 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 120 | 110 | | 110 | 109 | 110 | 100 | 102 | 108 | 100 | | | | 112 | | | | 110 | | | | 108 | | | |
| | 110 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 100 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 90 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 80 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 70 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 60 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 50 | | | | | | | | | | | | | | | (79) | | | | (80) | | | | | |
| ↓ Diastolic Blood Pressure | 130 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 120 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 110 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 100 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 90 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 80 | 70 | | 70 | | | | | | | | | | 65 | | | | 66 | | | | 70 | | | |
| | 70 | | | | 70 | 70 | 70 | 62 | 72 | 68 | | | | | | | | | | | | | | | |
| | 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 SCORES | | 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 | | | |
| | Nurse Initial | [illegible] | | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | | | | [illegible] | | | | [illegible] | | | | [illegible] | | | |

GUC-00091617 IP18-00036137
Mrs DIVYA DS 32 Y 9 M 19 D (F)
03-09-1993
Dr. MATHANGI RAJAGOPALAN

# FLUID CHART

Sheet No. : (1)

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

| 22/6/26 | | Intake | | | | Output | | | | | IV Site Thrombo-phlebitis Score | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Date | Time | Nature of Fluid | Route | | | NG | Diarrhoea | Vomit | Drainage | Urine | | 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 | → | on | Admission | | ← | | | | | | |
| | 10:00 pm | HW | 100ml | | | | | | | | No IV line | [illegible] |
| | 11:00 pm | H2O | 150ml | | | | | | | 300 | | [illegible] |
| | 12:00 am | N | | | | | | | | | NO | AA |
| | 01:00 am | P | | | | | | | | | IV line | AA |
| Total Intake : 250ml O | | | | | | Total Output : 300 | | | | | | |
| | 02:00 am | | | | | | | | | | No | AA |
| | 03:00 am | N | | | | | | | | | IV line | AA |
| | 04:00 am | | | | | | | | | 250 | | AA |
| | 05:00 am | P | | | | | | | | | 0 | AA |
| | 06:00 am | O | [illegible] | 125 ml | | | ✓ | | | | 0 | AA |
| | 07:00 am | | | 125 ml | | | | | | 300 | 0 | AA |
| Total Intake : 250ml | | | | | | Total Output : 550 | | | | | | |

| Total 24 hrs. Intake | 500ml. |
|---|---|

| Total 24 hrs. Output | 850 ml |
|---|---|

GUC-00091617 IP18-00036137
Mrs DIVYA DS
03-09-1993 32 Y 9 M 20 D (F)
Dr. MATHANGI RAJAGOPALAN

# FLUID CHART

Sheet No. : 2

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

| Date | Time | Nature of Fluid | Intake Route: Mouth | I.V | N.G | Output: NG | Diarrhoea | Vomit | Drainage | Urine | IV Site Thrombo-phlebitis Score | Sign. Nurse |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 23/6/26 | 08:00 am | NPO | | RL 125 | | | | | | | | |
| | 09:00 am | NPO | | 125 | | | | | | 200ml | 0 | [illegible] |
| | 10:00 am | NPO | | RL 500ml | | | | | | 200ml | 0 | [illegible] |
| | 11:00 am | NPO | | 125 | | | | | | — | 0 | [illegible] |
| | 12:00 pm | NPO | | 125 | | | | | | 75ml | 0 | [illegible] |
| | 01:00 pm | NPO | | 125ml | | | | | | 100ml | 0 | [illegible] |
| Total Intake : 1125ml | | | | | | | | | | 100 | 0 | [illegible] |
| | | | | | | Total Output : | | | | 675ml | | |
| | 02:00 pm | 2-3pm [illegible] | 50ml | 125ml | | | | | | 100ml | 0 | [illegible] |
| | 03:00 pm | TC water | 200 | 125ml | | | | | | 100ml | 0 | [illegible] |
| | 04:00 pm | | | 125ml | | | | | | [illegible] 100ml | 0 | V.A |
| | 05:00 pm | Fruit [illegible] | 200ml | 125ml | | | | | | 250ml | 0 | VA |
| | 06:00 pm | $H_2O$ | 100ml | 125ml | | | | | | 250ml | 0 | V.A |
| | 07:00 pm | | | 125ml | | | | | | | 0 | VA |
| Total Intake : 550ml + 750ml | | | | | | | | | | | | |
| | | | | | | Total Output : | | | | 850ml | | |
| | 08:00 pm | $H_2O$ | 200 | | | | | | | | 0 | P.V |
| | 09:00 pm | | | | | | | | | | 0 | P.V |
| | 10:00 pm | Juice | 200 | [illegible] 100ml | | | | | | 300 | 0 | P.V |
| | 11:00 pm | | | | | | ✓ | | | | 0 | P.V |
| | 12:00 am | $H_2O$ | 100 | | | | | | | 200ml | 0 | P.V |
| | 01:00 am | | | | | | | | | | 0 | P.V |
| Total Intake : 500+100=>600ml | | | | | | | | | | | 0 | P.V |
| | | | | | | Total Output : | | | | 500ml | | |
| | 02:00 am | | | | | | | | | | | |
| | 03:00 am | $H_2O$ | 150 | | | | | | | | 0 | P.V |
| | 04:00 am | | | | | | | | | 300ml | 0 | P.V |
| | 05:00 am | | | | | | | | | | 0 | P.V |
| | 06:00 am | Milk | 150 | | | | | | | 250ml | 0 | P.V |
| | 07:00 am | $H_2O$ | 100 | | | | | | | | 0 | P.V |
| Total Intake : 400ml | | | | | | | | | | | 0 | P.V |
| | | | | | | Total Output : | | | | 550ml | | |

| Total 24 hrs. Intake | 3425ml |
|---|---|

| Total 24 hrs. Output | 2575 mL |
|---|---|

IP18-00036137
GUC-00091617
Mrs DIVYA DS (F)
32 Y 9 M 19 D
03-09-1993
Dr. MATHANGI RAJAGOPALAN

# NURSING CARE RECORD

Date: 22/6/26

**Goals**

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

| | Time | Plan of Care | Time | Implementation | Evaluation | Re-Assessment | Nurse Name & Signature |
|---|---|---|---|---|---|---|---|
| Morning | | | | | | | |
| Afternoon | | | | | | | |
| Night | 8pm | Achieve pain acceptable control & comfort | 8pm | => Asses pain using pain scale regularly<br>=> Administer analgesic prescribed.<br>=> Provide position comfortable | Patient was enjoys comfort | Reassessment done | [illegible] |

Docu. No; RCH /FRM / CLINICAL / 148

# NURSING CARE RECORD

Date: 23/6/26

**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 | 8.30 AM | Ensure adequate hydration and Electrolyte Balance | 8AM | * Monitor IV fluids<br>* Assess for dehydration<br>* Monitor output intake chart | Maintained Fluid Balance to some extend. | Reassessment Done | [signature] 6/6720 |
| Afternoon | 3pm | Ensure adequate Hydration & electrolyte Balance | 3pm | Monitor Intake and output charts<br>assess for dehydration or fluid overload<br>Check electrolyte value when indicated | maintained fluid balance to same extend. | Re-assessment was done | [signature] 607738 |
| Night | 8pm | Ensure Adequate Hydration to Electrolyte Balance | 7pm | Maintain Intake output chart<br>Administer medication | Maintained fluid balance | Re-assessment done | P.B 6021 |

Docu. No: RCH /FRM / CLINICAL / 148

GUC-00091617 IP18-00036137
Mrs DIVYA DS
03-09-1993 32 Y 9 M 19 D (F)
Dr. MATHANGI RAJAGOPALAN

# NURSES NOTES

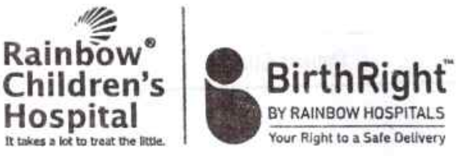
☑ No Known Drug Allergies

☐ Drug Allergies ........................

| DATE | TIME | (ALL ENTRIES MUST BE SIGNED, DATED AND TIMED) | SIGNATURE |
|---|---|---|---|
| 22/6/26 | 8:57pm | → ADMISSION NOTES | |
| | | Mrs. Divya DS / 32yrs F | |
| | | under Dr. Mathangi; She is | |
| | | Primi 18th wks, Short cervix (2cm) | |
| | | for cervical circumclage. She is | |
| | | conscious & oriented, afebrile | |
| | | taking orally & tolerating | |
| | | well. Voided freely. Patient | |
| | | [illegible] | |
| | 9PM | general condition fair. | → [illegible] 011794 |
| | | → [illegible] | |
| | 10pm | Advice to patient shift to | |
| | | ward NPO 12AM [illegible] | [illegible]/011794 |
| | 10:30 pm | → Patient shift to ward | |
| | | hand over to 7th floor staff | [illegible]/011776 |
| | | Reciving Notes. | |
| 22/6/26 | 11pm. | Patient Reciving from LDR to | |
| | | 7th floor. Patient details handing | |
| | | over to from LDR staff. → | [illegible] |
| | | Patient Bed Side Assessment done. | |
| | | Conscious & Oriented. Patient No | |
| | | IV line. Pt taken diet. → | [illegible] |
| | 12Am | Patient vitals sign checked & | |
| | | Recorded. vitals are Stable. T/O | |
| | | Chart monitored. No any other | |
| | | complaints. Patient urine & | |
| | | Motion passed. → | [illegible] |

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker




# NURSES NOTES

☑ No Known Drug Allergies

☐ Drug Allergies ....Nil

| DATE | TIME | (ALL ENTRIES MUST BE SIGNED, DATED AND TIMED) | SIGNATURE |
|---|---|---|---|
| 23/6/26 2AM. | | Dr. Mathangi mam Adviced. | |
| | | Today OT plan 9:30AM, NPO | |
| | | from 12AM, IVF @ 125ml/hr | |
| | | flow Reshift to LDR at 8AM. | |
| | | flow the Advice | [signature] |
| 4Am. | | Patient vitals sign checked & | |
| | | Recorded. vitals sign are stable. | |
| | | I/O chart monitored. patient | |
| 6AM. | | parts preparation done. IV line | |
| | | ⊕ pattern. IV fluids RL 500ml | |
| | | 125ml/hr on flow. No any | |
| | | other complaints. patient | |
| | | NPO @ 12Am.. | [signature] |
| 7:30AM | | patient handing over to | |
| | | morning duty staff. | [signature] |
| 8AM | 8AM | Patient pre medication | |
| | | given Inj. Pan 40mg, Inj. Emeset | |
| | | 4mg, Inj. Supacef 0.1ml SD is | |
| | | given as per doctor's orders | [signature] |
| | | Patient shifted to LDR. | |
| | | details handing over to | |
| | | 7th floor staff nurse | [signature] |
| | | Morning Duty (23/6/26) | |
| | 8AM | Patient Received from 7th floor | |
| | | to LDR. Patient care Handing | |
| | | over taken from 7th floor staff. | |
| | | Monitored vitals and Recorded. | |

**NOTE : DO NOT WRITE OUTSIDE THE MARGINS**

GUC-00091617
Mrs DIVYA DS
03-09-1993
Dr. MATHANGI RAJAGOPALAN
IP18-00036137
32 Y 9 M 20 D
(F)

# NURSES NOTES

☑ No Known Drug Allergies

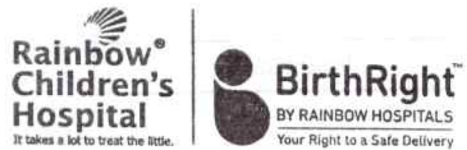
☐ Drug Allergies ........................................

| DATE | TIME | (ALL ENTRIES MUST BE SIGNED, DATED AND TIMED) | SIGNATURE |
|---|---|---|---|
| 23/6/20 | | Maintained I/O. Patient | |
| | | General condition. IV cannula | |
| | | observed. pain assessment | |
| | | Done. No any other complaints | [signature] 0/6/20 |
| | 9.30AM | patient doesn't have any allergic | |
| | | Reactions after Inj. Supacef 0.1ml | |
| | | ID. Inj. Supacef 1.5g IV given | |
| | | as per doctor order. patient | |
| | | Shifted from MICU to OT. | |
| | | patient care Handing over | |
| | | given to OT staff | [signature] 0/6/20 |
| | | OT Notes. | |
| 23/6/20 | 9:35Am | patient hand over taken | [signature] |
| | | from LDR staff. While | |
| | | receiving the patient is | |
| | | conscious & oriented. vitals | |
| | | checked & recorded pulse: 80 b/m | |
| | | R = 20 b/m, BP = 110/80 mmHg Temp Ⓝ, $SPO_2$ = 100% | |
| | | spinal Anaesthesia given by | [signature] |
| | | DR. mohan. procedure started | |
| | 9:45 Am | at 9:45Am. Vitals on monitoring | |
| | | pulse: 80 b/m, R = 20 b/m, BP = 100/70 mmHg | |
| | | Temp Ⓝ, $SPO_2$ = 100%. procedure | [signature] |
| | | went on well. procedure done | |
| | | Gauze count corrected. Suturing | |
| | 10:25Am | done. patient shifted to MICU. patient | |
| | | documents & details hand over given to MICU staff | |

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

# NURSES NOTES




☑ No Known Drug Allergies

☐ Drug Allergies ....................

| DATE | TIME | (ALL ENTRIES MUST BE SIGNED, DATED AND TIMED) | SIGNATURE |
|---|---|---|---|
| 23/6/26 | 10.30 am | MICU received Notes | |
| | | patient received from | |
| | | OT. patient conscious & | |
| | | oriented. Vitals are checked, | |
| | | recorded. receiving output | |
| | | Nil. cervical encirclage | |
| | | done. Catheter present. | |
| | | post op orders received. | S/N paramgr 016808 |
| | 11.30 am | Dr. pavithra saw the patient | |
| | | checked per speculum | |
| | | 1 piece of gauze removed | |
| | | T. Suston 300mg P/V kept. | S/N paramgr 016808 |
| | 12.30pm | patient general condition | |
| | | fair. vitals are checked & | |
| | | recorded. patient | |
| | | maintain NPO. I/O chart | |
| | | maintain. | S/N paramgr 016808 |
| | 1pm | Maintained I/O. Monitored | |
| | | vitals and Recorded. IVF RL | |
| | | 125ml/hr on connected. No | |
| | | any other complaints | [signature] 016720 |
| | 1.35pm | patient are handing over given | |
| | | Evening duty staff | [signature] 016720 |
| | | | |
| | | | |
| | | | |

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00091617 IP18-00036137
Mrs DIVYA DS (F)
03-09-1993 32 Y 9 M 20 D
Dr. MATHANGI RAJAGOPALAN

# NURSES NOTES

(3)

☑ No Known Drug Allergies

☐ Drug Allergies ........................................

| DATE | TIME | (ALL ENTRIES MUST BE SIGNED, DATED AND TIMED) | SIGNATURE |
|---|---|---|---|
| | | Evening duty | |
| 23/6/20 | 1:30pm | pt mrs. Divya. pt care hand over taken from morning duty staff. pt conscious & oriented. IV line ⊕ in pattern. No PV bleeding. she is on NPO. 500ml RL 125 ml/h going on infusion. Encourage to mobilize. | S/N Pooja |
| | 2pm | pt vital signs checked & recorded. Administered medication as per doctor order. maintain I/O chart. | S/N Pooja |
| | 2:30pm | pt oral started by sips of warm water as per doctor order. Encourage to mobilize. DVT, morse fall, Braden assessment done. | S/N Pooja |
| | 3pm | pt have no c/o vomiting. TC water given. Dr. Akshatha advice to shift ward. follow drug chart. FHR checked by Dr. Akshitha ⊕. CBD removal at 4pm order carried out. | Pooja |
| | 3:45pm | pt shifted to ward as per doctor order. pt care hand over given to 7th floor staff | Pooja |

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

# NURSES NOTES

☑ No Known Drug Allergies

☐ Drug Allergies ..........

| DATE | TIME | (ALL ENTRIES MUST BE SIGNED, DATED AND TIMED) | SIGNATURE |
|---|---|---|---|
| | | Receiving Notes On 23/6/26 | |
| 23/6/26 | 3:45pm | Patient received from WOR to 1st floor. Patient details handing over taken from S/N pooja patient conscious and oriented IV line patent. Patient on clear liquid diet, Kanji @ 6pm, Soft diet @ 8pm. CBD remove plan @ 4pm. IVF RL 125ml/h on flow of the patient → | [signature] |
| | 4pm | CBD removed @ 4pm. Vital signs checked and Recorded. IVF RL 125ml/hr on flow of the patient → | [signature] |
| | 6pm | Kanji given. Maintain Intake and Output chart → | [signature] |
| | 7.30pm | Patient details handing over on Night duty staff → | [signature] |
| | | Night duty | |
| 23/6/26 | 7-30pm | Patient details handover taken over Evening to Night duty. patient is IV line ⊕, CBD removal after voided, tomorrow plan discharge | P. [signature] 60774 |
| | 8.00pm | patient vitals checked and recorded. | P. [signature] 60774 |

**NOTE : DO NOT WRITE OUTSIDE THE MARGINS**

Docu. No. : RCH /FRM / CLINICAL / 089

Patien[t Name] GUC-00091617 IP18-00036137 ..........................
Mrs DIVYA DS
03-09-1993 32 Y 9 M | D (F
Dr. MATHANGI RAJAGOP...N
MRD I[P] No.:.....................
Age :... ..........Sex: ☐ M ☐ F
Consultant :.............................................................

# PHLEBITIS ASSESSMENT

## CANNULA 1

Date : 23/6/26 Time: 6AM
Location : Left cephalic vein
Size : 18G.
Cannula inserted by : S/N. Ranjitha

| Date | Time | Phlebitis | Infiltration | Nursing Intervention | Sign |
|---|---|---|---|---|---|
| 23/6/26 | 6AM | ☐Yes ☑No | ☐Yes ☑No | Pattern | [signature] |
| 〃 | 8AM | ☐Yes ☑No | ☐Yes ☑No | Observ | [signature] |
| | 10AM | ☐Yes ☑No | ☐Yes ☑No | Observ | [signature] |
| | 12PM | ☐Yes ☑No | ☐Yes ☑No | Observ | [signature] |
| 23/6 | 2PM | ☐Yes ☑No | ☐Yes ☑No | Observ | [signature] |
| | 4PM | ☐Yes ☑No | ☐Yes ☑No | Observ | [signature] |
| | 6PM | ☐Yes ☑No | ☐Yes ☑No | Observ | [signature] |
| | 10PM | ☐Yes ☑No | ☐Yes ☑No | Observ | P.le |
| 24/6/26 | 2AM | ☐Yes ☑No | ☐Yes ☑No | Observ | P.le |
| 〃 | 6AM | ☐Yes ☑No | ☐Yes ☑No | Observ | P.le |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |

Cannula removed : ☐Yes ☐No, if yes date and time :
RX any initiated : ☐Yes ☐No ☐NA If Yes specify-
Phlebitis score:

## CANNULA 2

Date : Time:
Location :
Size :
Cannula inserted by :

| Date | Time | Phlebitis | Infiltration | Nursing Intervention | Sign |
|---|---|---|---|---|---|
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |

Cannula removed : ☐Yes ☐No, if yes date and time :
RX any initiated : ☐Yes ☐No ☐NA If Yes specify-
Phlebitis score:

**NOTE :** ❋ To be assessed within 30 minutes of insertion.
❋ Every 2 hours if on fluid infusion.
❋ Every 4 hours if only on IV medication.

V.I.P. SCORE (VISUAL INFUSION PHLEBITIS SCORE)........ Next page

# PHLEBITIS ASSESSMENT AND MANAGEMENT RECORD

## CANNULA 3

Date : Time:

Location :

Size :

Cannula inserted by :

| Date | Time | Phlebitis | Infiltration | Nursing Intervention | Sign |
|---|---|---|---|---|---|
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |

Cannula removed : ☐Yes ☐No, if yes date and time :

RX any initiated : ☐Yes ☐No ☐NA If Yes specify-

Phlebitis score:

## CANNULA 4

Date : Time:

Location :

Size :

Cannula inserted by :

| Date | Time | Phlebitis | Infiltration | Nursing Intervention | Sign |
|---|---|---|---|---|---|
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |
| | | ☐Yes ☐No | ☐Yes ☐No | | |

Cannula removed : ☐Yes ☐No, if yes date and time :

RX any initiated : ☐Yes ☐No ☐NA If Yes specify-

Phlebitis score:

**NOTE :** ✱ To be assessed within 30 minutes of insertion.
✱ Every 2 hours if on fluid infusion.
✱ Every 4 hours if only on IV medication.

### V.I.P. SCORE (VISUAL INFUSION PHLEBITIS SCORE)

| 0 | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| IV site appears healthy | ONE of the following is evident: ✱ Slight pain near I.V. site or slight redness near I.V site | TWO of the following is evident: ✱ Pain near I.V. Site ✱ Erythema ✱ Induration | ALL of the following is evident: ✱ Pain along path of cannula ✱ Erythema ✱ Induration | ALL of the following is evident and extensive: ✱ Pain along path of cannula ✱ Erythema ✱ Induration ✱ Palpable venous cord | ALL of the following is evident and extensive: ✱ Pain along path of cannula ✱ Erythema ✱ Induration ✱ Palpable venous cord ✱ Pyrexia |
| OBSERVE CANNULA | OBSERVE CANNULA | RESITE / REMOVE CANNULA | RESITE / REMOVE CANNULA CONSIDER TREATMENT | RESITE / REMOVE CANNULA CONSIDER TREATMENT | INITIATE TRETMENT RESITE / REMOVE CANNULA |

GUC-00091617 IP18-00036137
Mrs DIVYA DS
03-09-1993 32 Y 9 M 19 D (F)
Dr. MATHANGI RAJAGOPALAN

# Morse Fall Risk Assessment Form

| Choose Highest Applicable Score from each Category | | Date / Time | D 22/6/26 | M 23/6/26 | E 23/6/26 |
|---|---|---|---|---|---|
| | | Score | | 20 | 20 |
| History of Falling (immediately or w/in 3 months) | Yes | 25 | | | |
| | No | 0 | 0 | 0 | 0 |
| Secondary Diagnosis (more than one diagnosis) | Yes | 15 | | | |
| | No | 0 | 0 | 0 | 0 |
| Ambulatory Aid | Furniture | 30 | | | |
| | Crutches, Cane(S), Walker | 15 | | | |
| | None /Bed Rest /Nurse Assist | 0 | 0 | 0 | 0 |
| IV / Heparin Lock or Saline | Yes | 20 | | 20 | 20 |
| | No | 0 | 0 | | 0 |
| GAIT / Transferring | Impaired | 20 | | | |
| | Weak (uses touch for balance) | 10 | | | |
| | Normal /On Bed Rest /Immobile | 0 | 0 | 0 | 0 |
| Mental Status | Forgets limitations | 15 | | | |
| | Oriented to own ability | 0 | 0 | 0 | 0 |
| Total Morse Fall Scale Score: | | | | 20 | 20 |
| | | Signature | [signature] | [signature] | [signature] |

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

Tick (✓) whichever precaution taken.

**Risk Level and Interventions**

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

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

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

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

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

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

# Morse Fall Risk Assessment Form

| Choose Highest Applicable Score from each Category | | Date / Time | N | 24/10 M | |
|---|---|---|---|---|---|
| | | Score | 20 | 20 | |
| History of Falling (immediately or w/in 3 months) | Yes | 25 | | | |
| | No | 0 | 0 | 0 | |
| Secondary Diagnosis (more than one diagnosis) | Yes | 15 | | | |
| | No | 0 | 0 | 0 | |
| Ambulatory Aid | Furniture | 30 | | | |
| | Crutches, Cane(S), Walker | 15 | | | |
| | None /Bed Rest /Nurse Assist | 0 | 0 | 0 | |
| IV / Heparin Lock or Saline | Yes | 20 | 20 | 20 | |
| | No | 0 | 0 | 0 | |
| GAIT / Transferring | Impaired | 20 | | | |
| | Weak (uses touch for balance) | 10 | | | |
| | Normal /On Bed Rest /Immobile | 0 | 0 | 0 | |
| Mental Status | Forgets limitations | 15 | | | |
| | Oriented to own ability | 0 | 0 | 0 | |
| Total Morse Fall Scale Score: | | | 20 | 20 | |
| | | Signature | P. [signature] 60394 | [signature] | |

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

Tick (✓) whichever precaution taken.

**Risk Level and Interventions**

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

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

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

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

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

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

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

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Mrs DIVYA DS
03-09-1993 32 Y 9 M 19 D (F)
Dr. MATHANGI RAJAGOPALAN

# BRADEN 'Q' SCALE

| | | | | Date : / Time : | D 12H | M 23/6/26 | E 23/6 | N 23/6 |
|---|---|---|---|---|---|---|---|---|
| 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 | 3 | 3 | 3 |
| Sensory Perception | **1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface. | **2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body. | **3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities. | **4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort. | 4 | 4 | 4 | 4 |
| Moisture Degree to which skin is exposed to moisture | **1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned. | **2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours. | **3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours. | **4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours. | 4 | 4 | 4 | 4 |
| **FRICTION-SHEAR** **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another | **1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction. | **2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. | **3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down. | **4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times." | 4 | 4 | 4 | 4 |
| Nutritional Usual food intake pattern | **1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement. | **2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. | **3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered. | **4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation. | 4 | 0/1 | 1 | 2 |
| 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 | 24 | 24 | 25 |
| | | | | **Evaluator's Name** | [signature] | [signature] 01630 | [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 | • Regular Turning Schedule<br>• Enable as much activity as possible<br>• Protect the heels<br>• Use pressure redistribution surfaces<br>• Manage moisture, friction and shear<br>• Advance to a higher level of risk if other major risk factors are present | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay |
| 13-14 | Moderate Risk | • Use the Same Protocol as for **"At Risk"** Patients<br>• Position patient at 30 degree lateral incline using foam wedges | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay |
| 10-12 | High Risk | • Follow the same protocol as for **"Moderate Risk"** Patients<br>• In addition to regular turning schedule<br>• Make small shifts in their position frequently | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay |
| Less than 9 | Severe Risk | • Use same protocol as for **"High Risk"** Patients<br>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors. | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay |

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Mrs DIVYA DS
03-09-1993 32 Y 9 M 21 D (F)
Dr. MATHANGI RAJAGOPALAN

# BRADEN 'Q' SCALE

(2)

| | 1 | 2 | 3 | 4 | Date : / Time : | | | |
|---|---|---|---|---|---|---|---|---|
| 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. | | | | |
| "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. | | | | |
| 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. | | | | |
| 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. | | | | |
| **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." | | | | |
| 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. | | | | |
| 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. | | | | |
| | | | | **TOTAL SCORE** | | | | |
| | | | | **Evaluator's Name** | | | | |

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

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| 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<br>• Enable as much activity as possible<br>• Protect the heels<br>• Use pressure redistribution surfaces<br>• Manage moisture, friction and shear<br>• Advance to a higher level of risk if other major risk factors are present | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay |
| 13-14 | Moderate Risk | • Use the Same Protocol as for **"At Risk"** Patients<br>• Position patient at 30 degree lateral incline using foam wedges | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay |
| 10-12 | High Risk | • Follow the same protocol as for **"Moderate Risk"** Patients<br>• In addition to regular turning schedule<br>• Make small shifts in their position frequently | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay |
| Less than 9 | Severe Risk | • Use same protocol as for **"High Risk"** Patients<br>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors. | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay |

Mrs DIVYA DS 32 Y 9 M 19 D (F)
03-09-1993
Dr. MATHANGI RAJAGOPALAN

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

# PAIN ASSESSMENT FORM

| Date | Time | Pain Score (0/10) | Location | Duration | Acuity | Character | Modifying Factors | Patient / Family Educated | Intervention | Sign |
|---|---|---|---|---|---|---|---|---|---|---|
| 22/6/20 | 9pm | 0/10 | – | ☐ Continuous ☐ Intermittent | ☐ Acute ☐ Chronic | ☐ Sharp ☐ Dull ☐ Aching ☐ Burning | ☐ Increasing ☐ Decreasing | ☑ Yes ☐ No | No Pain | [illegible] 01176 |
| 23/6/26 | 3AM | 0/10 | – | ☐ Continuous ☐ Intermittent | ☐ Acute ☐ Chronic | ☐ Sharp ☐ Dull ☐ Aching ☐ Burning | ☐ Increasing ☐ Decreasing | ☑ Yes ☐ No | Nil | [illegible] |
| 23/6/26 | 8Am | 0/10 | – | ☐ Continuous ☐ Intermittent | ☐ Acute ☐ Chronic | ☐ Sharp ☐ Dull ☐ Aching ☐ Burning | ☐ Increasing ☐ Decreasing | ☑ Yes ☐ No | Nil | [illegible] 01672 |
| 23/6/26 | 12pm | 0/10 | Nil | ☐ Continuous ☐ Intermittent | ☐ Acute ☐ Chronic | ☐ Sharp ☐ Dull ☐ Aching ☐ Burning | ☐ Increasing ☐ Decreasing | ☑ Yes ☐ No | No pain | [illegible] 016808 |
| 23/6/26 | 8pm | 0/10 | Nil | ☐ Continuous ☐ Intermittent | ☐ Acute ☐ Chronic | ☐ Sharp ☐ Dull ☐ Aching ☐ Burning | ☐ Increasing ☐ Decreasing | ☑ Yes ☐ No | Nil | [illegible] |
| 24/6/26 | 12Am | 0/10 | Nil | ☐ Continuous ☐ Intermittent | ☐ Acute ☐ Chronic | ☐ Sharp ☐ Dull ☐ Aching ☐ Burning | ☐ Increasing ☐ Decreasing | ☑ Yes ☐ No | Nil | P. Kani 6022 |
| 24/06/26 | 6Am | 0/10 | Nil | ☐ Continuous ☐ Intermittent | ☐ Acute ☐ Chronic | ☐ Sharp ☐ Dull ☐ Aching ☐ Burning | ☐ Increasing ☐ Decreasing | ☑ Yes ☐ No | Nil | P. [illegible] 607261 |
| 24/6/26 | 8Am | 0/10 | – | ☐ Continuous ☐ Intermittent | ☐ Acute ☐ Chronic | ☐ Sharp ☐ Dull ☐ Aching ☐ Burning | ☐ Increasing ☐ Decreasing | ☐ Yes ☑ No | Nil | [illegible] |
| | | | | ☐ 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.

(P.T.O)

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# PAIN ASSESSMENT TOOLS

**Numerical Pain Scale (Obstetric and Gynecology)**

0 No Pain — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 Worst Possible Pain

**Wong - Baker (Pediatrics) Above 7 Years**

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

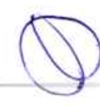
**FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)**

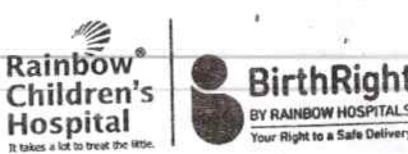
| CATEGORY | SCORING | | |
|---|---|---|---|
| | 0 | 1 | 2 |
| Face | No Particular expression or smile | Occasional Grimace or Frown, withdraw, Disoriented | Frequent to constant frown, quivering chin, clenched jaw |
| Legs | Normal Position or Relaxed | Uneasy, restless, tense | Kicking, or legs brawn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

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

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

GUC-00091617 IP18-00036137
Mrs DIVYA DS
03-09-1993 32 Y 9 M 19 D (F)
Dr. MATHANGI RAJAGOPALAN






# INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

**Part - I.**

Patient's / Learner Language: Tamil    Patient / Learner Literacy: ☐ Read ☐ Write ☑ Speak    Willingness to Learn: Yes ✓ No    Healthcare Literacy: Yes ☐ No ☑

**Identified Education Needs:**

1. Diagnosis (Preg 18 days)
2. Treatment and Care
3. Plan
   Pain Management
4. Informed Consent
5. Medication / Therapy (safety, effects/ side effect, interactions)
6. Discharge Medication
7. Infection Control Measures
8. Diagnostic Test / Procedures
9. Nutrition / Diet
10. Fall Risk Education
11. Safe use of Medical Equipment / Implantable Devices Safety
12. Patient's / Family Rights
13. Risk / Safety

**Part - II**

| Date | Time | Need Identified | Information Taught | Use codes from the list in part III: Person Taught | Learning Barriers | Teaching Tools | Mechanism/s to overcome barrier/s | Understanding | Comments | Designation / Signature |
|---|---|---|---|---|---|---|---|---|---|---|
| 22/6 | 9pm | yes | Health education given to NPO status | Patient | No learning barrier | Verbal | none | good | - | [signature] |
| 23/6/26 | 10am | yes | Educate Inform about NPO | Patient | None | Oral | None | yes | good | [signature] |
| 24/6 | [illegible] | yes | follow up [illegible] | Pt | None | Oral | None | yes | [illegible] | [signature] |
| | | | | | | | | | | |

**Part - III: CODES**

**Who was taught:** PT: Patient ✓   F: Father   M: Mother   S: Spouse   Sn: Son   D: Daughter   C: Caregiver   O: Other (Specify) ..........

**Learning Barriers:**
1. No Learning Barriers ✓
2. Physical Impairment
3. Emotional Barriers
4. Language Barrier
5. Educational Level
6. Desire / Motivate to Learn
7. Impaired Thought Process/Cognitive limitations
8. Responsibilities at Home
9. Cultural Differences
10. Financial Difficulties
11. Beliefs and Values
12. Impaired Vision/ or Hearing
13. Cultural/Religion Practice
14. Others (Specify ..........

**Teaching Tools Used:** A: Audio   D: Demonstration   V: Video   O: Oral ✓   P: Printed

**Mechanism/s to overcome barrier/s:**
1. None ✓
2. Obtain translator
3. Reassurance & Support
4. Teach Family / Others
5. Respect values & beliefs
6. Respect Cultural / Religion Preference
7. Other, Specify ..........

**Understanding:** 1. Verbalizes Understanding ✓   2. Demonstrates Understanding   3. Needs Review

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GUC-00091617 IP18-00036137
Mrs DIVYA DS
03-09-1993 32 Y 9 M 20 D (F)
Dr. MATHANGI RAJAGOPALAN

# OPERATION NOTES

| Surgeon : DR. mathangi | Asst. Surgeon : DR. priyadharsini / DR. pavithra |
|---|---|
| Anesthetist : DR mohan / DR. priya | OT Nurse : S/N. Guna |

Pre-Operative Diagnosis: SHORT CERVIX. (Cx length - 2.2cm).

Surgical Procedure :

CERVICAL ENCIRCLAGE.

| Weight : 64.3 kg. | Date : 23/6/26. | Start Time : 9:35Am | End Time : 10:25Am |
|---|---|---|---|

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes: ↓ SAP, ↓ Spinal anaesthesia, patient in dorsal

Findings: lithotomy position, local parts painted and draped. Posterior vaginal wall depressed with Sims Speculum. Anterior and posterior lip of cervix held with Sponge holding forceps.

Findings - Short cervix
No bulging membrane noted.

Procedure Notes: Mc Donald's Stitch done circumferentially with Mersilene tape and knot placed Right posterolaterally. minimal bleeding noted from outer lip of cervix, secured with rapid vicryl. No Bleeding P/V noted at the end of procedure. C. Susten 200mg kept P/V. Catheterisation done. TVS done → Post Encirclage, FHS good.

| Amount of Blood Loss: | Blood Transfused (in ML) |
|---|---|
| - | |

Name and Number of Surgical Specimen sent for examination:

-

Patient Sticker

## POST-SURGICAL CARE PLAN FORM

Post-Operative Monitoring Parameters /Frequency:

Advice

- NPO x 4 hours

Wound Care: - IVF @ 125ml/hour.

- Inj SUPACEF 1.5g IV Stat (1 more dose).
- ~~C. AUGMENTIN 625mg PO 1-1-1~~

Drain /Special Lines/Catheters:

- T. PANTOPRAZOLE 40mg PO 1-0-1.
- T. PARACETAMOL 1g PO 1-1-1.

Special Patient Positioning and Requirements:

- C-SUSTEN 300mg PO 1-0-1
- T. DUPHASTON 10mg PO 1-0-1.

Nutritional Instructions:

- Inj TRAPIC 1g IV 1-1-1 (2 more doses)
- CBD till 4PM.

When to Start Mobilization:

- Discharge tomorrow.
- Cansoft CL @ night x (3) days

Special Referrals:

The new order for all required medications documented in the doctor order/medication sheet:

☐ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

Name of the Surgeon: Dr. Mathangi.

Signature of the Surgeon: for [signature]

Date & Time: 23/06/2026

# PRE - OPERATIVE CHECK LIST

Date: 23/6/2026

Patient's Name : MRS. DIVYA DS Age : 32yrs Gender : ☐ M ☑ F

Blood Group : O +ve UHID : 916177 / 36137

Planned Surgery : Cervical Encerclage Surgeon : DR. MATHANGI

Anesthetist : ............ Date & Time of Operation : 23/6/2026 at 9:30AM

***Tick Appropriate Boxes***

To be filled by Nurse Incharge / Senior Nurse :

| S.No | INSTRUCTIONS | YES | NO | NA |
|---|---|---|---|---|
| 1. | Weight checked and recorded? T. Wt: 64.3Kg | ☑ | ☐ | ☐ |
| 2. | Is the patient fasting for over 6 hours Pre-Operatively? | ☑ | ☐ | ☐ |
| 3. | Check Pre-OP Investigations & Results (CBP, Blood Group, BT, CT, PT / APTT, Viral Screening, CXR etc) available before starting the procedure | ☑ | ☐ | ☐ |
| 4. | Enema given / Bowel Preparation | ☐ | ☑ | ☐ |
| 5. | Remove all ornaments, etc and sterile gown given | ☑ | ☐ | ☐ |
| 6. | Is Blood arranged as required? | ☐ | ☑ | ☐ |
| 7. | If Blood has been ordered - is Blood bag ready? | ☐ | ☑ | ☐ |
| 8. | IV Cannula to be placed / IV fluids if indicated | ☑ | ☐ | ☐ |
| 9. | Pre Anesthetic consultation with anesthesiologist | ☑ | ☐ | ☐ |
| 10. | Pre Medications Given? (Sedatives / etc) | ☑ | ☐ | ☐ |
| 11. | Skin Preparation | ☑ | ☐ | ☐ |
| 12. | Site is marked | ☐ | ☐ | ☑ |
| 13. | Surgery consent / High Risk consent taken by surgeon? (Consent should be taken by the operating surgeon only) | ☑ | ☐ | ☐ |
| 14. | Implants are available | ☐ | ☐ | ☑ |
| 15. | Equipment is avaialble | ☑ | ☐ | ☐ |
| 16. | Other (if any) | ☐ | ☑ | ☐ |

**NOTE:** if any of above is ticked "NO" Discuss with the registrar / consultant immediately

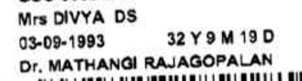
Billing Clearance taken

Billing Executive Name : ............ Nurse In-Charge Name: Rejitha

Billing Executive Signature : [signature] Signature of Nurse In-Charge : [signature]

Date & Time : ............ Date & Time : 23/6/2026 at 4Am

Doc. No. : RCH / FRM / CLINICAL / 107



# INFORMED CONSENT FOR SURGERY SPECIAL PROCEDURE

Patient Name : Mrs. Divya Gender: ☐ Male ☑ Female Age : 32 years

UHID No : Date : 22/6/26

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

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

CERVICAL ENCERCLAGE
(Ind: SHORT CERVIX) upon Mrs. DIVYA DS
(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, infection, injury to adjacent structures, anesthesia related complications, NICU stay.

**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:

**Consentee :**
Signature : D. Divya
Name : D.S.DIVYA
Date & Time : 22/6/26

**Patient Attendant :**
Signature : R. [illegible]
Name : R. Mohamed Rathan Hussain
Relationship with Patient: Husband
Date & Time : 22/6/26

**Witness :**
Signature :
Name :
Date & Time :

**Doctor (who is taking the consent) :** 164288
Signature :
Name : DR. DIVYALAKSHMI.S.R
Date & Time : 22/6/26, 9 PM

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

# CONSENT FORM FOR ANAESTHESIA

Patient Name : ................................ Age : .................. Gender : Male ☐ Female ☐

UHID NO: ................................ Surgeon Name: ................................

Anaesthesiologist : Dr. M.Ram .................... Operative procedure planned : Revised Shirodkar.

**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 : hypotension, [illegible], bradycardia

- 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 the above mentioned operation / Diagnostic / Therapeutic procedures.

I authorize and give consent for anaesthesia ( ☑ Regional / ☐ General Anesthesia / ☐ Monitored Anesthesia Care as considered appropriate by the anaesthesia 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 anaesthesia 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.

I have been explained all my queries in the language understood by me.

**Patient / Patient Attendant :**

Signature : DS Divya

Name : Mrs. DIVYA. DS.

Relationship with Patient: Patient

Date & Time : 26/6/26

**Witness :**

Signature : R. [signature]

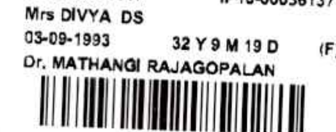
Name : Mohmed Sethan Hesin R

Date & Time : 26/6/26

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

Signature : [signature] Name : Dr. M.Ram Date & Time : 22/6/26.

Docu. No. : RCH / FRM / CLINICAL / 021



**Department of Anaesthesiology**

# PRE-ANAESTHETIC EVALUATION

Name: ............ Age: ............ Sex: ............ UHID.No : ............

Date: ............ Time: ............ Proposed Operation: cervical encirclage

Diagnosis: Primi / 18 wks + 1d / hypothyroid / obstetric cholestasis

B.P / CRT: ............ H.R: ............ Weight: 64.3 kg ASA Physical Status: ☐1 ☑2 ☐3 ☐4 ☐5

**Laboratory Data:**

| | | | | |
|---|---|---|---|---|
| Hgb: 11.4 | Glucose: | Protein: | HIV: NR | X-Ray: |
| PCV: | Urea: | Alb: | HBS Ag: NR | ECG: |
| WBC: | Creat: | Total Bill: | HCV: NR | 2D Echo: |
| Plate: 2.07 | Na: | Dir. Bill: | Blood group: O+ve | Stress/Anglo: |
| PT: | K: | LDH: | T3 | Other: |
| PTT: | Ca++: | Alk phos: | T4 | |
| INR: | Mg++: | Amylase: | TSH 3.0 | |
| | Cl -: | SGOT/SGPT: 31/44 | **Allergies:** NKDA | |

**Medical History:** CVS :

RESP : Diabetes :

CNS : Hypothyroid x 1 year

Renal :

Hepatic / GE : Physical Activity:

Others :

**Past Anaesthetic History:** nil

**Physical Exam:**

**Airway:** MP 1 ②③ 4 Mouth Opening: Adeq Mentohyoid Distance: N Neck: N Teeth: N

**Lungs :**

**Heart:** WNL

**CNS:**

Pregnant: ☑ Yes ☐ No ☐ NA | Venous Access Site : 18 G (+) Spine Exam for regional : (N)

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

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

| CURRENT MEDICATIONS | DOSAGE |
|---|---|
| T. Thyronorm | 25 mg OD |
| | |
| | |
| | |

**Pre-Operative Instructions:**

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours; → Others 6 Hours
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☑ Discussed with Patient
5. Other Instructions:

............

............

Signature: [signature] 15460 Name: Dr Priyadharshini

Patient Sticker

# ANAESTHESIA CHART

**Pre Induction Assessment:**

| **Change in Patient Condition:** ☐ Yes ☑ No | Fasting Status: 6 hrs | |
|---|---|---|
| **Physical Status:** | Patient Identified ✓ | ☑ Consent Present | ☑ Chart Reviewed |

H.R: 74/min | B.P / CRT: 110/70 | $SpO_2$: 100 | R.R: 20/min | Last Feed:

Pre-OP Diagnosis: Plain | Operation: Cervical encirclage | Date 23/6/26

Surgeon: Dr. Mathangi | Anaesthesiologist: Dr Mohan / Dr Priya | Technician: Mr Raja

TIME: 9.35am ... 10 Am

$N_2O$ /AIR /$O_2$ LPM

HALO /ISO /SEVO

Drugs:

Inj Tranexamic acid 500mg IV

Antibiotic

Suppository

Blood Loss

$FIO_2$ / $SaO_2$

$ETCO_2$

ECG: sinus rhythm

Temperature

Urine Output

NOTES

Fluids / Blood: 10RL on flow

B.P
V Systolic
Λ Diastolic
X Mean
• Heart Rate

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

240 220 200 180 160 140 120 100 80 60 40 20 10 0

LAB Values: ABG / GRBS / Others

☑ Equipment Checked and Functional
☑ BP
☑ Cuff Site: ...
☐ Art Site: ...
☑ EKG Lead
☐ Temp Site
☐ $FIO_2$ Monitor
☐ Agent Monitor
☑ Pulse Oximeter
☐ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position: Lithotomy
☑ Pressure Points Checked

**Eye Care:**
☐ Oint
☐ Tape
☐ Padding
☑ Awake

**Temp:**
☐ HME ☐ Fluid Warmer
☐ Cling Film ☐ OH Warmer
☐ Hugger's ☐ Cotton Wool
☐ Other

**Times:**
Anaes Start: 9.35am
OP Start: ...
OP End: ...
Leave OR: ...

**Anaesthesia:**
☐ GA
☐ Monitored Anaesthesia Care
☑ Regional

**Line (Size & Location)**
☐ CVP: ...
☐ ART: ...
☐ IV: ...
☐ IV: 18G (L) DVL
☐ IV: ...

**Induction**
☐ IV ☐ Inhal
☐ Pre $O_2$ ☐ RSI
☐ Others

☐ Mask ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
ETT# ... at ... cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug: ...

☐ Awake ☐ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# ... Attempts: ...
Difficulty Why? ...

☐ Bilat = BS
☐ Semi-Closed Circle
☐ Closed Circle
☐ Other

**Regional:**
Extremity   Specify: ...
☑ Spinal ☐ Epidural ☐ Caudal
Others: ...
Position: Sitting
Site: L3 L4
Needle Size: 25 G Depth: Quincke
Parasthesia ☐ Yes ☐ No
Catheter at skin ... cm
Drug Name & Conc: Bupivacaine
Bolus: 2.4 ml 0.5% (H)
Infusion: ...
Block Level: T10
Comments: ...
Transportation to
☐ PACU ☑ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☐ NA

Name of the Doctor: Dr Priya
Signature of the Doctor: [signature] 15h10

Patient Sticker

# POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : S/N Sangeetha    Time Received : ..............    Time Discharged : ..............

✓ RESP •PULSE ˄ ˅ BLOOD PRESSURE (chart scale 250 – 0, SPO₂)

IV Cannula Site : ..............

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

Vomiting : ☐ Yes ☐ No    Drug: ..............
NG Tube : ☐ Yes ☐ No
Drain: ☐ Yes ☐ No
Urinary Catheter: ☐ Yes ☐ No
Chest Tube: ☐ Yes ☐ No
**Nil Oral** ☐ Yes ☐ No

IV Fluids: ..............
Oral Feeds: ..............

| POST ANAESTHESIA SCORE (Modified Aldrete Score) | | | IN | MINUTES 30 | 60 | 90 | OUT | SCORING INTERPRETATION |
|---|---|---|---|---|---|---|---|---|
| Able to move 4 extremities voluntary or on command<br>Able to move 2 extremities voluntary or on command<br>Able to move 0 extremities voluntary or on command | = 2<br>= 1<br>= 0 | ACTIVITY | 1 | | | | 1 | A Minimum Total Score of 8 is Required for Discharge<br><br>Exceptions to this, are to be explained in the space below by the Discharging Physician: |
| Able to deep breathe & cough freely<br>Dyspnea or limited breathing<br>Apneic | = 2<br>= 1<br>= 0 | RESPIRATION | 2 | | | | 2 | |
| BP ± 20 of Pre Anaesthetic leve<br>BP ± 20-50 of Pre Anaesthetic leve<br>BP ± 50 of Pre Anaesthetic leve | = 2<br>= 1<br>= 0 | CIRCULATION | 2 | | | | 2 | |
| Fully awake<br>Arousable on calling<br>Not responding | = 2<br>= 1<br>= 0 | CONSCIOUSNESS | 2 | | | | 2 | |
| Pink<br>Pale, dusky, blotchy, jaundiced, other<br>Cyanotic | = 2<br>= 1<br>= 0 | COLOR | 2 | | | | 2 | |
| | | TOTAL | 9 | | | | 9 | |

## PAIN ASSESSMENT AND MANAGEMENT FORM

| Date | Time | Pain Score | Intervention | Signature |
|---|---|---|---|---|
| 23/6 | | 0/10 | NPO x 2 hrs | [signature] 13/10 pm |
| | | | | |
| | | | | |
| | | | | |

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

Anaesthesiologist Name : Dr Priya
Anaesthesiologist Signature: [signature] 13/10 pm
Date & Time: 23/6/26.

PACU Nurse Name : S/N Sangeetha
PACU Nurse Signature: Priya 0203N
Date & Time: 23/6/26

**Reassessment Frequency:**

1. Every eight hours for all hospitalized patients.
2. For post surgical patient, patient with chronic pain, patient with severe pain
   a. Every 2 hours for first 24 hours
   b. After 24 hours every 4 hours
   c. Prior to pain reliving intervention
   d. With in 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU): S/N Sangeetha 0203N,
Date & Time: 23/6/26 at

Patient Sticker

Department of Anaesthesiology

# EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : ...............................................................................................................................

Any other issues :

a) .................................................................................................................................................................

b) .................................................................................................................................................................

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

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

Catheter Removed by and Tip Inspected : ....................................................................................................

Patient Satisfaction : ....................................................................................................................................

Discharge /Shifting ordered by

Doctor Signature: ..................................................................

Doctor Name: ......................................................................

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

GUC-00091617 IP18-00036137
Mrs DIVYA DS
03-09-1993 32 Y 9 M 19 D (F)
Dr. MATHANGI RAJAGOPALAN

# OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 22/6/26 Time of Arrival: 8:57 pm Time Seen by Nurse: 8:57 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: NIL

3) **Vital Signs:** Temperature: 98.4°F Pulse: 84/m RR: 24/m SpO₂: 100% BP: ............ Weight: ............

4) **Gestational Criteria:**

| Gravida: | G 1 | P – | L – | A – |
|---|---|---|---|---|

LMP: 15/12/26 EDD: 02/11/26 Gestational Age: 18th days

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

5) **Pain Screening:**

**Numerical Pain Scale (NPS)**

0 No Pain — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 Worst possible pain

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

6) **Past History:**

a) Surgeries: NIL

b) Medical: Hypothyroidism, UTI

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(P.T.O.)

Patient Sticker

7) **Allergy:** ☐ Yes ☑ No, If Yes : ..........

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

9) **Prenatal Medical History:**

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

**Triage Category:** (Please tick on the category)

***Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)***

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

**OBCU Obstetrical Triage Acuity Scale (OTAS)**

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

Time seen by Doctor: Dr. Divya.

Nurse Name : BIN Nuzeth .......... Nurse Signature: [signature]

Date: 22/6/26 .......... Time: 8:57PM

# RISK ASSESSMENT TOOL FOR DEEP VEIN THROMBOSIS

POSTNATAL ASSESSMENT AND MANAGEMENT (TO BE ASSESSED ON DELIVERY SUITE)

Date: 22/6/26

| Pre - Existing Risk Factors | Tick | Score |
|---|---|---|
| Previous VTE (except a single event related to major surgery) | | 4 |
| Previous VTE provoked by major surgery | | 3 |
| Known high-risk thrombophilia | | 3 |
| Medical comorbidities e.g. cancer, heart failure; active systemic lupus erythematosus, inflammatory polyarthropathy or inflammatory bowel disease; nephrotic syndrome; type I diabetes mellitus with nephropathy; sickle cell disease; current intravenous drug user | | 3 |
| Family history of unprovoked or estrogen-related VTE in first-degree relative | | 1 |
| Known low-risk thrombophilia (no VTE) | | 1 |
| Age (≥35 years) | | 1 |
| Obesity | | 1 or 2 |
| Parity ≥ 3 | | 1 |
| Smoker | | 1 |
| Gross varicose veins | | 1 |
| **Obstetric Risk Factors** | | |
| Pre-eclampsia in current pregnancy | | 1 |
| ART/IVF (antenatal only) | | 1 |
| Multiple pregnancy | | 1 |
| Caesarean section in labour | | 2 |
| Elective caesarean section | | 1 |
| Mid-cavity or rotational operative delivery | | 1 |
| Prolonged labour (24 hours) | | 1 |
| PPH (1 litre or transfusion) | | 1 |
| Preterm birth $37^{+0}$ weeks in current pregnancy | | 1 |
| Stillbirth in current pregnancy | | 1 |
| **Transient Risk Factors** | | |
| Any surgical procedure in pregnancy or puerperium except immediate repair of the perineum, e.g. appendectomy, postpartum sterilization | | 3 |
| Hyperemesis | | 3 |
| OHSS (first trimester only) | | 4 |
| Current systemic infection | | 1 |
| Immobility, dehydration | | 1 |
| **Total** | | |
| **Signature of the Nurse** | 0 | [signature] 01/Feb |
| **Action Plan** | | |

Docu. No. : RCH / GDY /FRM / CLINICAL / 116

## RISK ASSESSMENT FOR VENOUS THROMBOEMBOLISM (VTE)

✓ If total score ≥ 4 antenatally, consider thromboprophylaxis from the first trimester.

✓ If total score 3 antenatally, consider thromboprophylaxis from 28 weeks.

✓ If total score ≥ 2 postnatally, consider thromboprophylaxis for at least 10 days.

✓ If admitted to hospital antenatally consider thromboprophylaxis.

✓ If prolonged admission (≥3 days) or readmission to hospital within the puerperium consider thromboprophylaxis.

For patient with an identified bleeding risk, the balance of risks of bleeding and thrombosis should be discussed in consultation with a haematologist with expertise in thrombosis and bleeding in pregnancy.

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

# PATIENT TRANSFER FORM

GUC-00091617 IP18-00036137
Mrs DIVYA DS
03-09-1993 32 Y 9 M 20 D (F)
Dr. MATHANGI RAJAGOPALAN

| | Date & Time of Admission | Date & Time of Transfer Order |
|---|---|---|
| | 22/6/26 at 8.57pm | 23/6/26 at |
| **Treating Consultant Name** | **Transfer Ordered by** | **Reason for Transfer** |
| Dr. Mathangi | Dr. Mathangi | Shifted to OT [illegible] for encorage. |
| **From Unit** | **To Unit** | **Information to Attendant** |
| MICU | OT | Yes ☑ No ☐ |
| **Number of Sheets in Clinical File** | **Number of Imaging Films** | **Personal belongings including clinical documents. If any handed over to attendant** |
| IP Files | | Yes ☐ No ☐ If yes, what ? |

Medications / Consumables / Surgicals / Hand over

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

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

| Name & Signature of Person who is Transferring | Name of Person Ordered Transfer |
|---|---|
| S/N. Fauzia [signature] 016720 | Dr. Mathangi |

Patient & Clinical Records Received by : [signature]

Date & Time of Patient Received : 23/6/26 at 9:35Am

**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

| GUC-00091617 IP18-00036137<br>Mrs DIVYA DS<br>03-09-1993 32 Y 9 M 20 D (F)<br>Dr. MATHANGI RAJAGOPALAN | Date & Time of Admission<br>23/6/26 at: 8:50pm | Date & Time of Transfer Order<br>23/6/26 at: 8AM |
|---|---|---|
| Treating Consultant Name<br>Dr. Mathangi | Transfer Ordered by<br>Dr. Faahima | Reason for Transfer<br>Cervical Encerclage |
| From Unit<br>7th floor | To Unit<br>LDR | Information to Attendant<br>Yes ☑ No ☐ |
| Number of Sheets in Clinical File<br>IP file | Number of Imaging Films<br>— | Personal belongings including clinical documents. If any handed over to attendant<br>Yes ☐ No ☑<br>If yes, what ? |

Medications / Consumables / Surgicals / Hand over

| Sl.No. | Item Name | Quantity |
|---|---|---|
| 1. | Inj. Supacef 1.5 gm | 1 |
| 2. | OSY 10 mg | 1 |
| 3. | RL 500 ml | 1 |
| 4. | IV set | 1 |
| 5. | | |

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

| Name & Signature of Person who is Transferring | Name of Person Ordered Transfer |
|---|---|
| S/N. [signature] Brobun | Dr. Faahima |

Patient & Clinical Records Received by : Sr. Fairfoh 26120

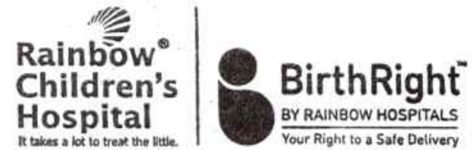
Date & Time of Patient Received : 23/6/26 at 8AM

**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




| UC-00_31617 IP18-00036137<br>Mrs DIVYA DS<br>03-09-1993 32 Y 9 M 19 D<br>Dr. MATHANGI RAJAGOPALAN | Date & Time of Admission<br>22/6/26 at 8:57 PM | Date & Time of Transfer Order<br>22/6/26 at 10 PM |
|---|---|---|
| Treating Consultant Name<br>Dr. mathangi | Transfer Ordered by<br>Dr. Divya | Reason for Transfer<br>Further treatment |
| From Unit<br>LDR | To Unit<br>4th Floor | Information to Attendant<br>Yes ☐ No ☐ |
| Number of Sheets in Clinical File<br>IP file - | Number of Imaging Films | Personal belongings including clinical documents. If any handed over to attendant<br>Yes ☐ No ☐<br>If yes, what ? |

Medications / Consumables / Surgicals / Hand over

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

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

| Name & Signature of Person who is Transferring | Name of Person Ordered Transfer |
|---|---|
| S/N Aswathi / 011740 | Dr. Fathima |

Patient & Clinical Records Received by : [signature] 021225

Date & Time of Patient Received : 22/6/26 at: 11PM

**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

Treating Consultant Name

From Unit

Number of Sheets in Clinical File

| Sl.No. | |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

Shifting Summary / Notes Written by Doctor: Yes

Name & Signature of Person who is Shifting

Patient & Clinical Records Received by

Date & Time of Patient Received

If the transfer order time & Completion time ...

Unavailable Bed

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

# PATIENT TRANSFER FORM

GUC-00091617 IP18-00036137
Mrs DIVYA DS
03-09-1993 32 Y 9 M 20 D (F)
Dr. MATHANGI RAJAGOPALAN

| | Date & Time of Admission | Date & Time of Transfer Order |
|---|---|---|
| | 22/6/26 | 23/06/26 at 3.48pm |
| **Treating Consultant Name** | **Transfer Ordered by** | **Reason for Transfer** |
| Dr. mathangi | Dr. Akshitha | pt care |
| **From Unit** | **To Unit** | **Information to Attendant** |
| UDR | J05 | Yes ☑ No ☐ |
| **Number of Sheets in Clinical File** | **Number of Imaging Films** | **Personal belongings including clinical documents. If any handed over to attendant** |
| IP & DP file | – | Yes ☐ No ☑ If yes, what ? |

Medications / Consumables / Surgicals / Hand over

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

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐
Dr. Akshitha

| Name & Signature of Person who is Transferring | Name of Person Ordered Transfer |
|---|---|
| S. Pooja [signature] | Dr. Akshitha |

Patient & Clinical Records Received by :

Date & Time of Patient Received : [signature] 23/6/24 @ 3.45pm

**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

GUC-00091617 IP18-00036137
Mrs DIVYA DS
03-09-1993 32 Y 9 M 20 D (F)
Dr. MATHANGI RAJAGOPALAN

| | Date & Time of Admission | Date & Time of Transfer Order |
|---|---|---|
| | 23/6/26 at 8:57pm | 23/6/26 at |
| **Treating Consultant Name** | **Transfer Ordered by** | **Reason for Transfer** |
| DR. Mathangi | DR. Mohan | Further management |
| **From Unit** | **To Unit** | **Information to Attendant** |
| OT | MICU. | Yes ☑ No ☐ |
| **Number of Sheets in Clinical File** | **Number of Imaging Films** | **Personal belongings including clinical documents. If any handed over to attendant** |
| (1) Clinical file | — | Yes ☐ No ☑<br>If yes, what ? |

Medications / Consumables / Surgicals / Hand over

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

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

| Name & Signature of Person who is Transferring | Name of Person Ordered Transfer |
|---|---|
| S/N. Sangeetha Pump 02034 | DR. Mohan |

Patient & Clinical Records Received by : S/N paravathy 016808

Date & Time of Patient Received : 23/6/26 @ 10.30 a

**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

GUC-00091617 IP18-00036137
Mrs DIVYA DS
03-09-1993 32 Y 9 M 20 D (F)
Dr. MATHANGI RAJAGOPALAN

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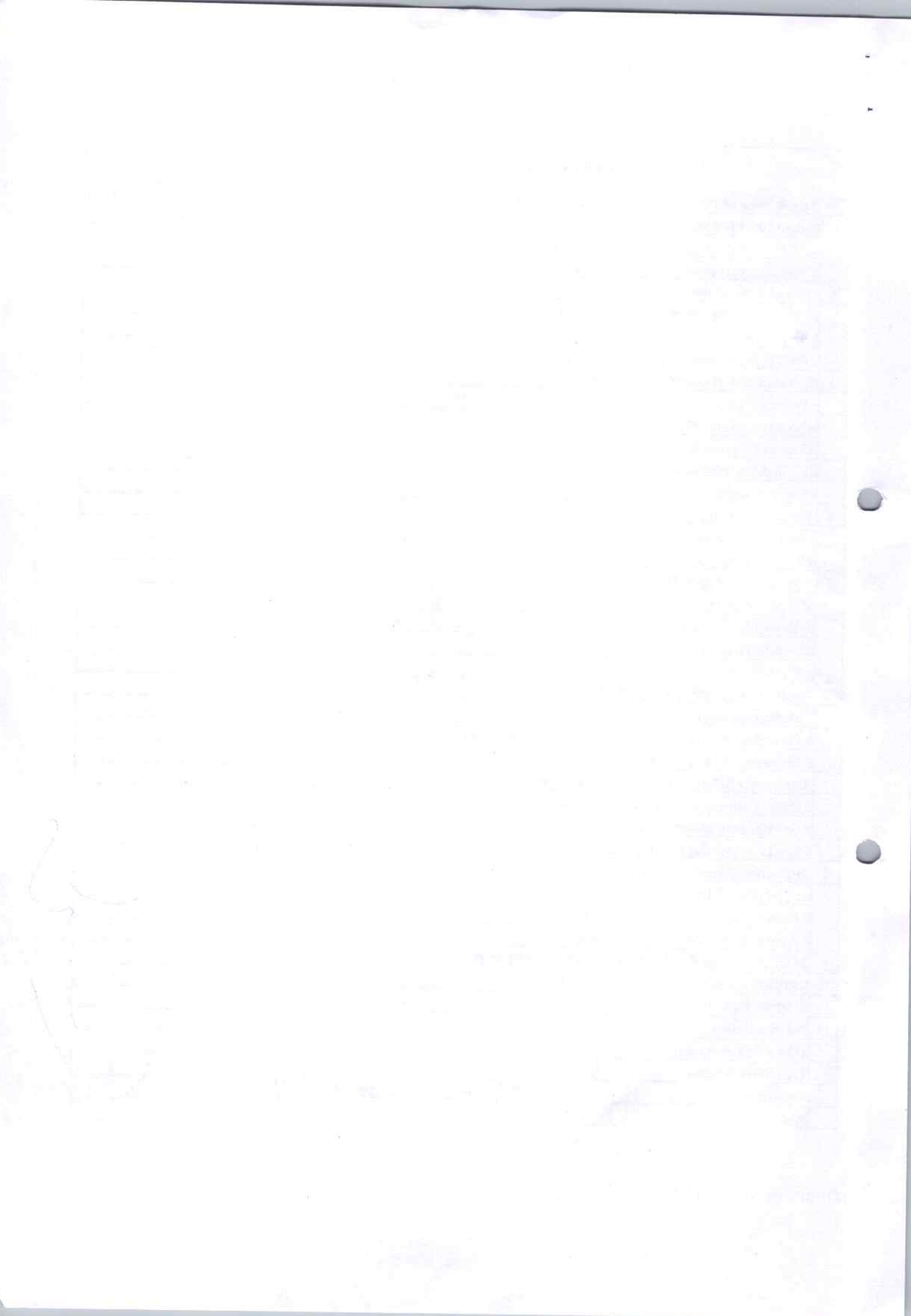
# PATIENT TRANSFER NURSING HANDOVER CHECKLIST

**Date & Time of Transfer:** 23/6/26 at 10:25am FNTM : OT **TRANSFERRED TO :** MICU

| | | YES/NO | REMARKS |
|---|---|---|---|
| 1 | **Patient Identification** | | |
| | a.Patient Identification Patient name, age, UHID/hospital number confirmed | Yes | |
| | b.Surgical procedure & correct site verified | Yes. | |
| 2 | **Airway & Breathing** | | |
| | a.Oxygen delivery (mask/cannula/ventilator) secured | NA | |
| | b.$SpO_2$ within safe range | Yes | $SpO_2$ = 100% |
| | c.If ETT: position confirmed, ties secure, cuff inflated | NA | |
| 3 | **Circulation & Hemodynamic Stability** | | |
| | a.IV lines secured & infusion running correctly | Yes | |
| | b.No active uncontrolled bleeding | Yes | |
| | c.Last vitals recorded before transfer | Yes | |
| | d.Central line hubs are closed | NA | |
| | e.Dressing Intact | NA | |
| 4 | **Pain Assessment** | | |
| | a.Pain score assessed & analgesia given | Yes | |
| | b.Reassessment done | Yes | |
| 5 | **Wound, Dressings & Drains** | | |
| | a.Surgical dressing intact | NA | |
| | b.All drains fixed, output noted | | |
| | c.Catheter secure & urine output recorded | | |
| | d.Splints/casts/traction devices stabilized | NA | |
| 6 | **Medications Pre & Post-Op Orders** | | |
| | a.Medications due time noted | Yes | |
| | b.Pre & Post-op instructions (NPO, position, mobilization) communicated | Yes | |
| | c.Emergency meds given in OT (time & dose documented) | Yes. | |
| 7 | **Equipment Safety & Transport Preparedness** | | |
| | a.Oxygen cylinder full & ambu bag at bedside | NA | |
| | b.Bed/side rails up and brakes applied | Yes | |
| | c.Special positioning maintained as per surgery | Yes | Supine |
| 8 | **High-Risk Patient Safety (if applicable)** | | |
| | a.Chest tube: underwater seal below chest level | NA | |
| | b.Epidural catheter secure, infusion checked | NA | |
| | c.Pressure areas protected (heels/elbows) | NA | |
| 9 | **BLOOD AND BLOOD PRODUCTS TRANSFUSED** | NA | |
| 10 | **REPORTS AND LABS HANDED OVER** | Yes | |
| 11 | **BIOPSY/HPE SENT** | NA | |
| 12 | **Documentation** | | |
| | a.Documentation completeness | Yes | |
| | **Transferring Nurse:** Pushpa 02023R. | | |
| | **Receiving Nurse :** Sr. Parameshwari/01680 | | |
| | **Signature of Incharge:** 01724 | | |

RCH/GDY/FRM/CLINICAL/598



GUC-00091617 IP18-00036137
Mrs DIVYA DS
03-09-1993 32 Y 9 M 20 D (F)
Dr. MATHANGI RAJAGOPALAN

# SAFETY CHECKLIST

Surgeon : DR. mathangi
Asst. Surgeon : DR. Priyadharsini
Anaesthetist : DR. Mohan
Scrub Nurse : S/N. Aruna

Patient Name : Mrs. Divya DS Age : 32y Gender : F
UHID No. : 91617 Surgery Name : Cervical Encirclage
Date : 23/6/26 In-time : 9:35Am Out-time : 10:25Am

Rainbow Children's Hospital

## Before Induction of Anaesthesia ➢ ➢

**SIGN IN** Time: 9:40Am

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

**Site Marked** ☐Yes ☐No ☑NA

**Anaesthesia Safety Check Completed** ☑Yes ☐No

**Pulse Oximeter on Patient & Functioning** ☑Yes ☐No

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

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

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

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

Signature : [signature]

Name : DR. Mohan

## Before Skin Incision ➢ ➢

**TIME OUT** Time: 9:45Am

**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? ☐Yes ☑No ☐NA

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

**Nursing Team Reviews:**
- Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☐Yes ☑No

**Is Essential Imaging Displayed?** ☐Yes ☑No

Power Supply, Earthing, Power Backup and functioning of equipment checked. ☑Yes ☐No

6 Type ISO 11140 | STEAM | Green = Sterilized | Man.: 2025 - 06 Exp.: 2030 - 06 Ref.: 106.303.0500 Lot.: 14176 | SV: 121°C - 15 min. 134°C - 3,5 min. | Sterintech

Signature : For [signature] 182217

Name : DR. mathangi

## Before Patient Leaves Operating Room

**SIGN OUT** Time: 10:25Am

**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] 014418

Name : S/N. Arunadevi

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

GUC-00091617 IP18-00036137
Mrs DIVYA DS
03-09-1993 32 Y 9 M 20 D (F)
Dr. MATHANGI RAJAGOPALAN

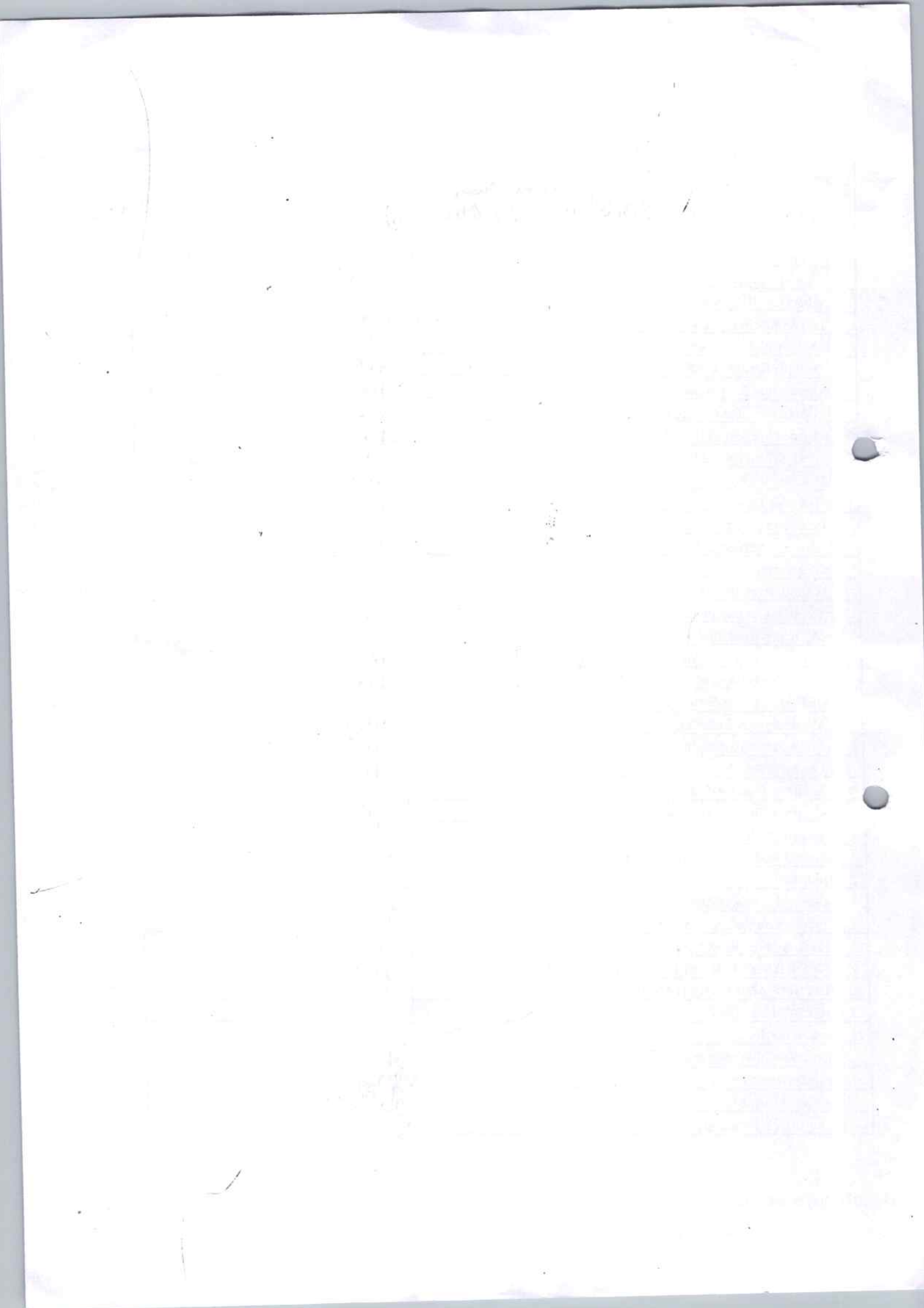
RCH/GDY/FRM/CLINICAL/598

# PATIENT TRANSFER NURSING HANDOVER CHECKLIST

Date & Time of Transfer: 23/6/2026 at 8 Am 7th floor. TRANSFERRED TO: MCW.

| | | YES/NO | REMARKS |
|---|---|---|---|
| 1 | Patient Identification | | |
| | a.Patient Identification Patient name, age, UHID/hospital number confirmed | yes | |
| | b.Surgical procedure & correct site verified | yes | |
| 2 | Airway & Breathing | | |
| | a.Oxygen delivery (mask/cannula/ventilator) secured | no | |
| | b.$SpO_2$ within safe range | yes | |
| | c.If ETT: position confirmed, ties secure, cuff inflated | no | |
| 3 | Circulation & Hemodynamic Stability | no | |
| | a.IV lines secured & infusion running correctly | yes | |
| | b.No active uncontrolled bleeding | no | |
| | c.Last vitals recorded before transfer | yes | |
| | d.Central line hubs are closed | no | |
| | e.Dressing Intact | no | |
| 4 | Pain Assessment | | |
| | a.Pain score assessed & analgesia given | no | |
| | b.Reassessment done | no | |
| 5 | Wound, Dressings & Drains | | |
| | a.Surgical dressing intact | yes | |
| | b.All drains fixed, output noted | | |
| | c.Catheter secure & urine output recorded | NA | |
| | d.Splints/casts/traction devices stabilized | no | |
| 6 | Medications Pre & Post-Op Orders | | |
| | a.Medications due time noted | yes | |
| | b.Pre & Post-op instructions (NPO, position, mobilization) communicated | yes | |
| | c.Emergency meds given in OT (time & dose documented) | no | |
| 7 | Equipment Safety & Transport Preparedness | | |
| | a.Oxygen cylinder full & ambu bag at bedside | yes | |
| | b.Bed/side rails up and brakes applied | yes | |
| | c.Special positioning maintained as per surgery | yes | |
| 8 | High-Risk Patient Safety (if applicable) | | |
| | a.Chest tube: underwater seal below chest level | no | |
| | b.Epidural catheter secure, infusion checked | no | |
| | c.Pressure areas protected (heels/elbows) | no | |
| 9 | BLOOD AND BLOOD PRODUCTS TRANSFUSED | no | |
| 10 | REPORTS AND LABS HANDED OVER | no | |
| 11 | BIOPSY/HPE SENT | no | |
| 12 | Documentation | | |
| | a.Documentation completeness | yes | |
| | Transferring Nurse: | [signature] | |
| | Receiving Nurse : | [signature] | |
| | Signature of Incharge: | [signature] | |

RCH/GDY/FRM/CLINICAL/598



GUC-00091617 IP18-00036137
Mrs DIVYA DS
03-09-1993 32 Y 9 M 20 D (F)
Dr. MATHANGI RAJAGOPALAN

# SSI PREVENTION CHECKLIST

Rainbow Children Hospital

| S.No | INTERPRETATION | PERFORMED |
|---|---|---|
| | PREOPERATIVE | |
| 1 | Do not remove hair at the surgical site unless the presence of hair will affect the procedure. Use clipper if necessary | yes |
| 2 | Decolonize surgical patients with skin antiseptic(Chlorhexidine bath /wipes) | yes |
| 3 | Antibiotic prophalaxis given within 60mts prior to skin incision | yes |
| 4 | Use a checklist based on the world health organization-19 item surgical checklist to ensure adherence to best practice | yes |
| | INTRAOPERATIVE | |
| 5 | Using chlorhexidine gluconate and alcohol-containing skin preparatory agent in combination | yes |
| 6 | Maintain normothermia during the surgical procedure (>36 deg C) | yes |
| | POSTOPERATIVE | |
| 7 | Maintain and monitor blood glucose levels regardless of diabetes status between 110 and 150 mg/dl | NO |
| 8 | Application of incisional negative pressure wound dressing | NO |