
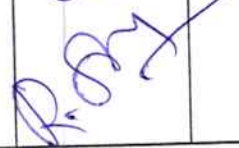


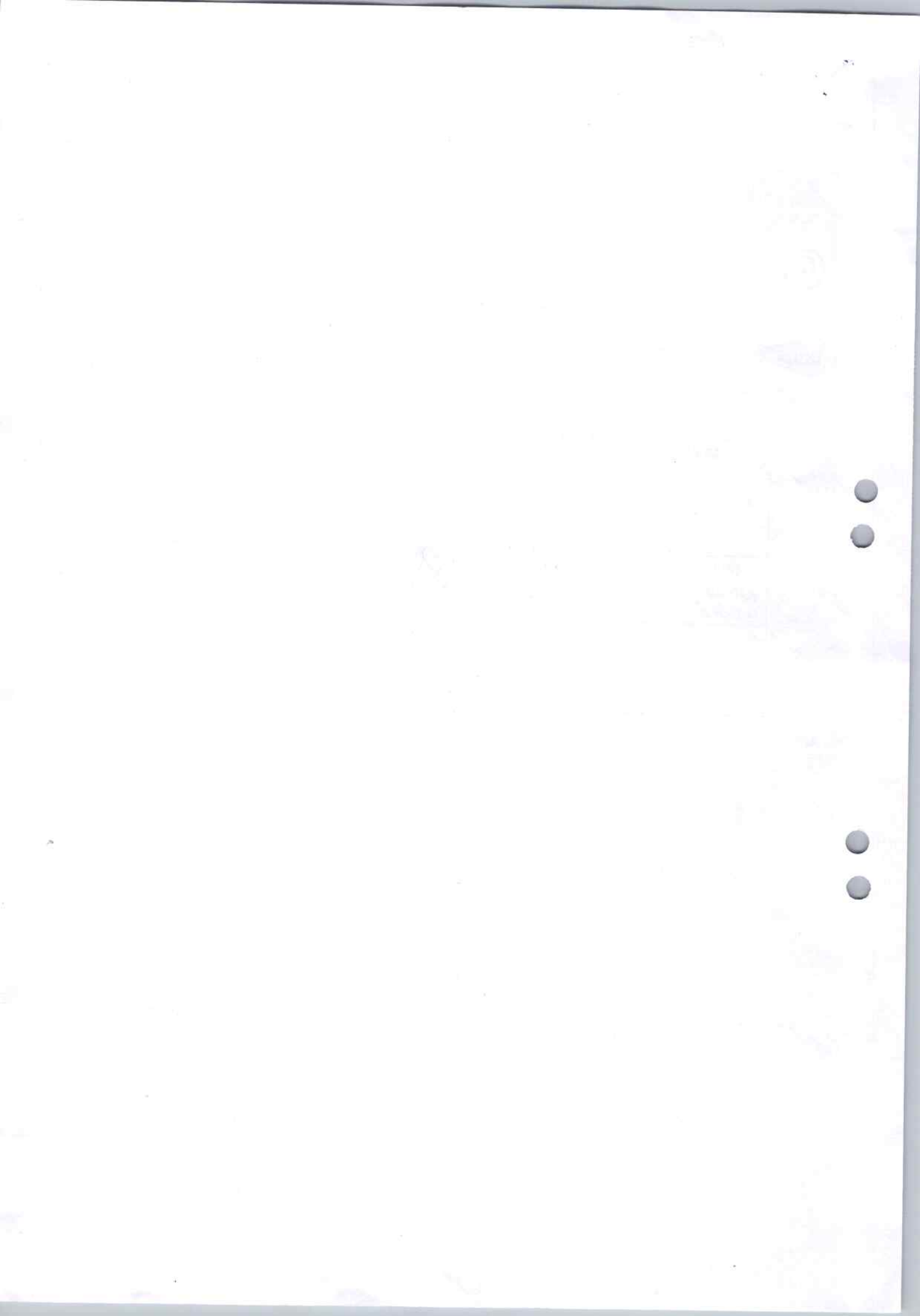
GUC-00074875 IP18-00036127
 Mrs THIRUPURASUNDARI. R
 17-07-1994 31 Y 11 M 6 D (F)
 Dr. PRIYADHARSHINI S M



DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin >		
Activity Sheet update by Nursing		24/6/26 at 6AM					
Activity Sheet update by Pharmacy							





ACTIVITY RECORD FOR BILLING

Name: MRS. THIRUPURASUNDARI. R.
 UHID No: 74875 IP No: 36127 Consultant: DR. priyadharsini Dept: CDR
 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
22/6/2026	7.05pm	CDR	7th Floor	[Signature]
22/6/26	9 AM	7th Floor	CDR	[Signature]
22/6/26	3.30pm	CDR	702	[Signature]

CROSS CONSULTATION VISIT

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
22/6/26	✓ Iu placement	①	1715206	<i>[Signature]</i>
22/6/26	✓ catheterization	①	1715704	<i>[Signature]</i>
22/6/26	✓ Blood reoperation	①	1715599	<i>[Signature]</i>
	① unit charges (PRBC)			
22/6/26	✓ Blood issue ^(cancelled)	①	26019800	<i>[Signature]</i>
22/6/26	✓ Iu placement	①	1715704	<i>[Signature]</i>
22/6/26	✓ Blood transfusion	①	1715704	<i>[Signature]</i>
22/6/26	Blood reoperation ^(cancelled)	①	1715724	<i>[Signature]</i>
23/6/26	✓ Blood issue ²⁶⁰¹⁹⁸⁵⁷	①	26019857	<i>[Signature]</i>
23/6/26	✓ Blood transfusion	①	1716035	<i>[Signature]</i>
24/6/2026	✓ Physiotherapy	①	1716230	
24/6/2026	✓ Iu placement	①	1716374	<i>[Signature]</i>

ANY OTHER INFORMATION:

VACUUM Assisted vaginal delivery C Epidural.

Date: 22/06/2026

Time: 4:00pm to 5:00pm

Duration: 1 hr

Dr: Prayashshini

Dr: ~~Prayashshini~~ Dr: Sreedevi

Delivery kit - }
Sample kit used }

Date: 24/6/2026 Time: 2:30 AM

Prepared By:

Staff Nurse <i>[Signature]</i>	Shift / Ward	Billing Assistant	Billing Supervisor
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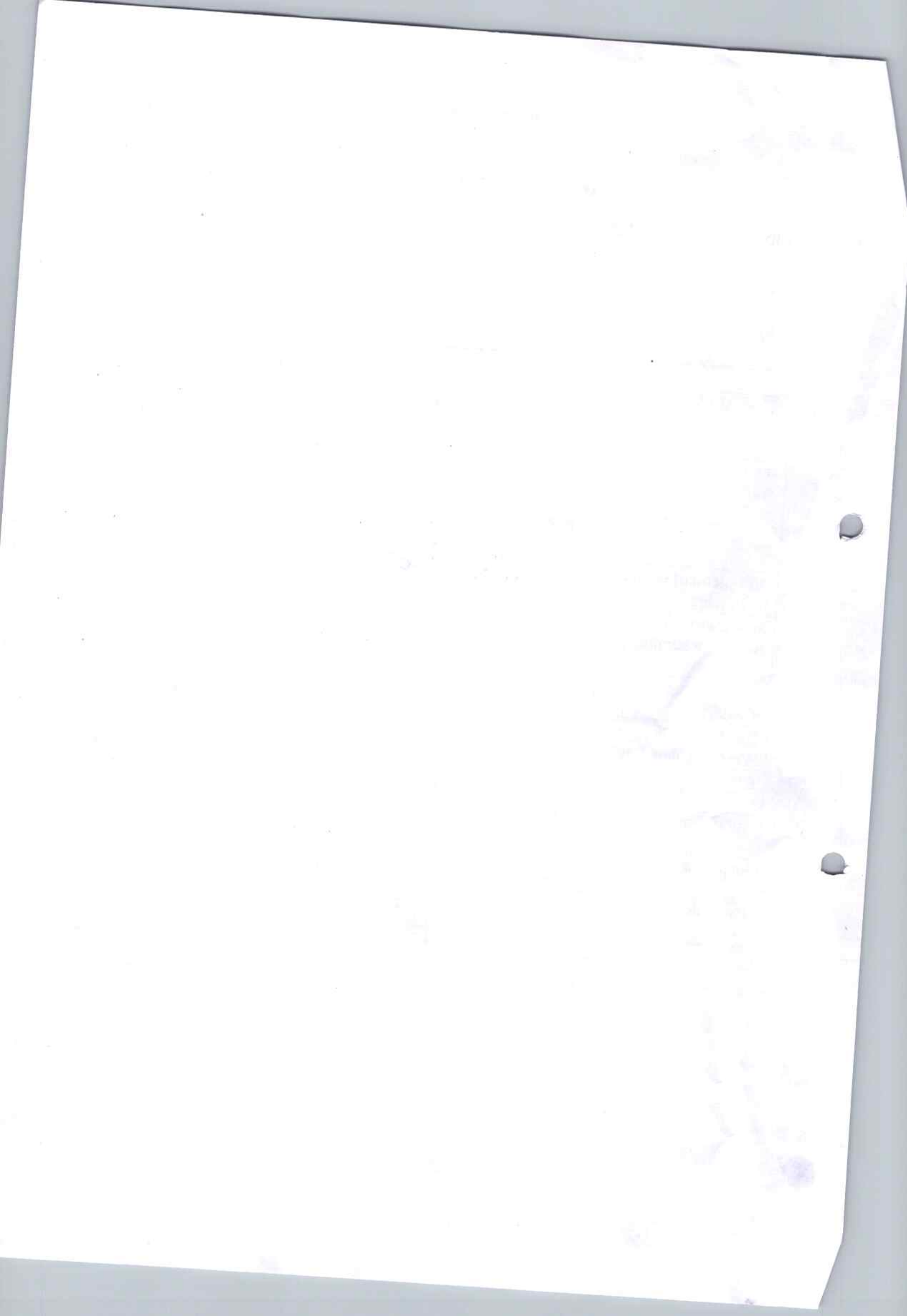
GUC-00074875 IP18-00036127
 Mrs THIRUPURASUNDARI. R
 17-07-1994 31 Y 11 M 6 D (F)
 Dr. PRIYADHARSHINI S M



DISCHARGE TRACKING SHEET

LOOR- NAME OF CONSULTANT-

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
	INTIME	OUT TIME			
Discharge Announcement					
Arrangement of File by Nursing		11 ¹⁰ AM	<i>[Signature]</i>		
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-00074875 IP18-00036127
 Mrs THIRUPURASUNDARI. R
 17-07-1994 31 Y 11 M 6 D (F)
 Dr. PRIYADHARSHINI S M



BED SIDE CHECK LIST FOR NURSES

Date:	23/6	24/6								
Doctor's Orders	yes	yes								
Carried out or not	yes	yes								
Bed Side										
Structured Handover done	yes	yes								
IV Site	yes	yes								
Central-Lines	no	nr								
Arterial Lines	no	nr								
Feeding Catheter	no	nr								
Urinary Catheter	no	nr								
Skin Care	yes	yes								
Eye Care	yes	yes								
Mouth Care	yes	yes								
Sterillum Bottle, Stethoscope	yes	yes								
Suction Bottle (Should be clean & empty)	yes	yes								
Intubation Tray	no	nr								
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	no	nr								
Ventilator Tubing, (Any Water, Blood)	no	nr								
Humidification	yes	yes								
Check all Infusion (Labelling, Correct Preparation)	yes	yes								
Chest Physio & Neb	no	nr								
Handed Over By Name :	[Signature]									
Signature :	[Signature]									
Date & Time:	24/6/2016 11:30 AM									
Hand Over Taken By Name :	[Signature]									
Signature :	[Signature]									
Date & Time:	23/6/2016 8 PM									

ADMISSION SHEET



Registration Details :

Admission No : IP18-00036127

Admit Date : 21-Jun-2026

Admit Time : 11:41 PM UHID : GUC-00074875

Patient Details :

Patient Name : Mrs THIRUPURASUNDARI. R

Guardian : Mr VENKATRAMAN.K

Gender : Female

Occupation :

Address (H) : 138, GERANIUM APT, GA KUNDALAKESI ST,
GANESH NAGAR Selaiyur Chennai Tamil Nadu
INDIA 600073

Age : 31 Y 11 M 4 D

DOB : 17-07-1994

Religion :

Martial Status :

Phone No : 8220496754/ 8870866355

E-mail : KVASAN93.KV@GMAIL.COM

Admission Details :

Bed Type : MICU

Room No : MICU 802

Bed No : MICU 802

Admission Type : First Visit

Ward Name : 8F-OT COMPLEX

Contact Details :

Name : Mr VENKATRAMAN.K

Contact Address : 138, GERANIUM APT, GA KUNDALAKESI
ST,GANESH NAGAR Selaiyur Chennai Tamil
Nadu INDIA 600073

Relationship : Husband

Phone No : 8220496754

[Handwritten Signature]
Signature

Doctor Details :

Doctor Name : Dr. PRIYADHARSHINI S M

Referral Doctor : Dr. Priyadharshini S M

Co-Consultant :

Specialisation : OBSTETRICS AND GYNECOLOGY

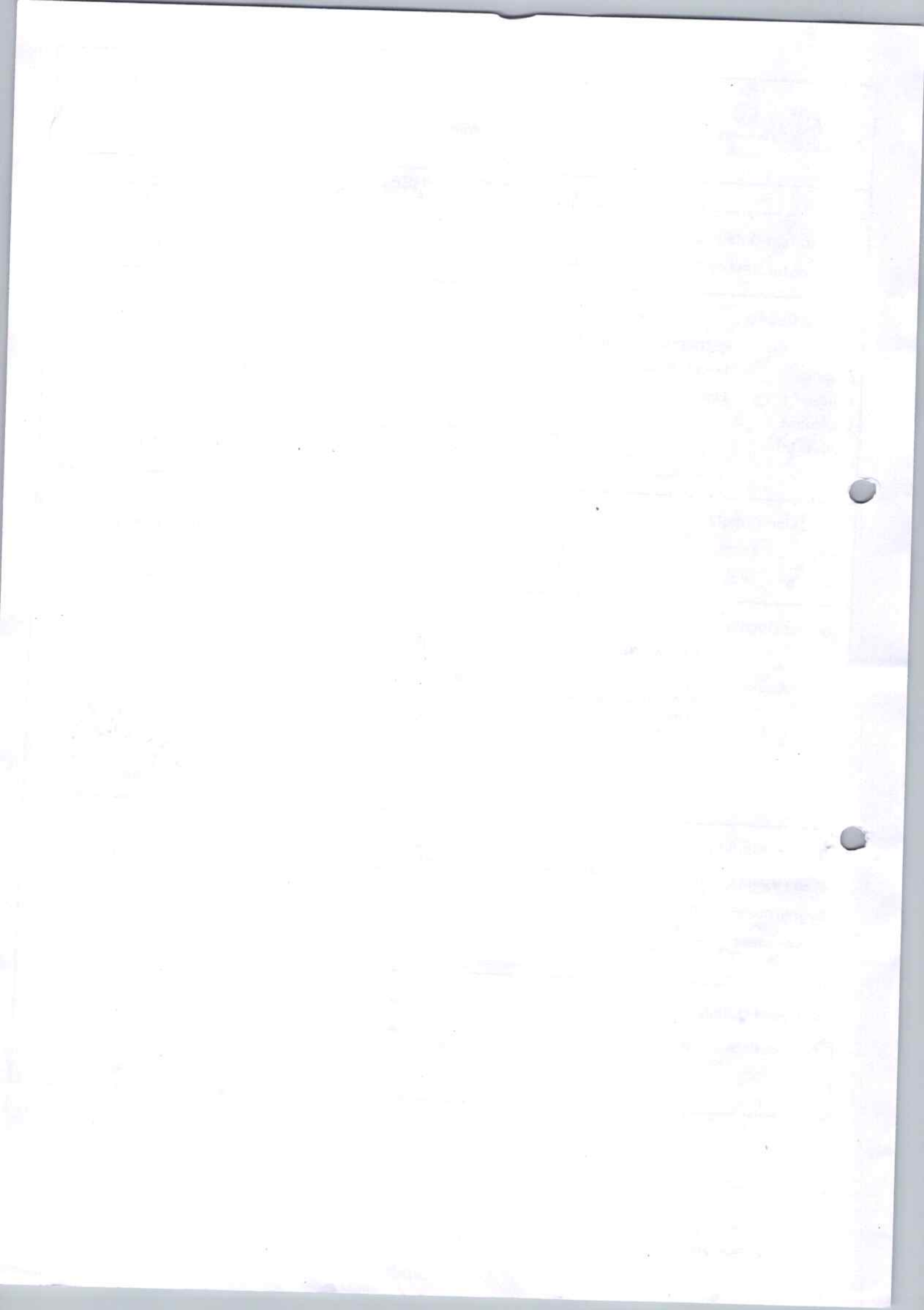
Phone No :

Payment Details :

Payment Mode : Cash

Deposit Amount : 7000.00

Payor Name : SELFPAY



GENERAL CONSENT FOR TREATMENT

Patient Name: Mrs THIRUPURASUNDARI. R
IP No: IP18-00036127
Consultant: Dr. PRIYADHARSHINI S M

Age : 31 Y 11 M 4 D
Sex: Female
Ward/Bed No: 8F-OT COMPLEX/MICU 802

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

Patient, be deemed advisable or necessary.

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

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

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

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

Note:

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

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

Signature of Patient/Relative: >

Name: Venkatesh K.

Relationship: Husband

Date: 21-06-2025

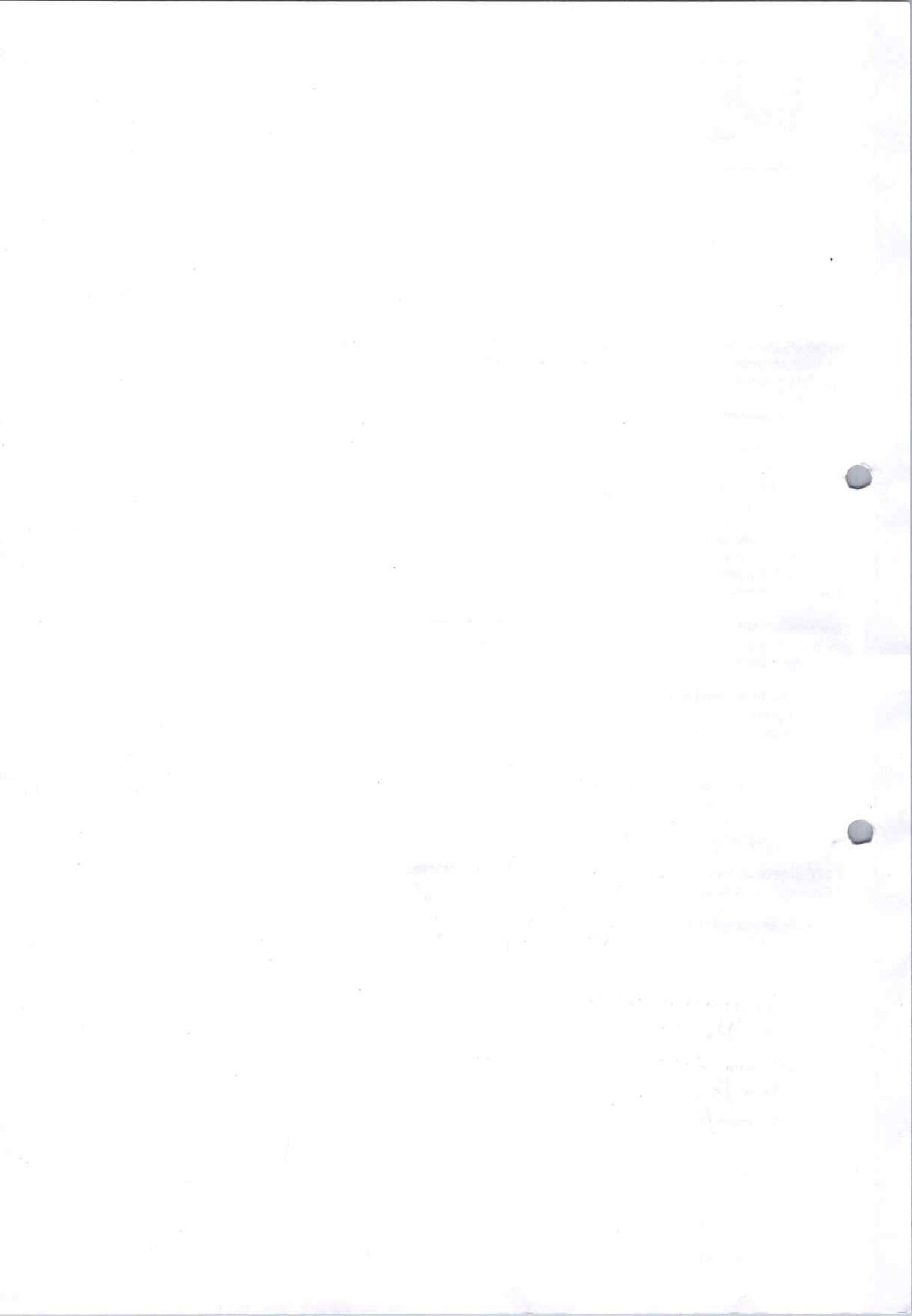
Time: 11:41

Witness Name: Aswin

Witness Signature:

Patient Address:

138, GERANIUM APT, GA
KUNDALAKESI ST, GANESH NAGAR
Selaiyur Chennai Tamil Nadu INDIA
600073





BILLING POLICY

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

DECLARATION

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

Patient Name : > THIRUPRASADAR.P.R	UHID Number : 74875
Self/Attendant Name : > VENKATRAMAN.K	Relation : > HUSBAND
Self/ Attendant Signature : > 	Name & Signature of Financial Counselor 
Phone Number : > 8870866355	





IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

4/0 pain abdomen ~~at 8:00~~ and back pain since 5pm

LMP: 12/10/25

EDD: 19/7/26

Corrected EDD:

GA: 36 weeks

Menstrual History: Regular: Yes No

3/28 days.

Obstetric Formula:

G4 P14 A2

Obstetric History:

G1: 2021; 36w3d | PPRDM | VACUUM
 G2: 2023; Missed miscarriage @ 9w; Medically Mx
 G3: 2025; Missed miscarriage @ 20w; S & E done

Obstetric Examination

Fundal Height: Nanganallur 15cm

Ut. Activity: Relaxed Mild Mod Severe

Liquor: Adequate Oligo Poly

PP: Cephalic Breech Others

Head Fifths Palpable: 4/5th

FHS: Normal Tachy Brady Absent

Present Pregnancy Record:

1/1/26: NT: 1-2MM; FTS low risk
 6/3/26: 20w5d | Anomalies A₁₀;

RISK FACTORS:

Anemia
 Low lying placenta

Per Speculum Examination

Draining: Present Absent Bleeding
 Colour of Liquor: Clear Meconium Blood Stained

Vaginal Examination

Cervix: Long 2cm long Partially effaced Effaced
 Os: Closed Dilated os admits 2 fingers

Membranes: Present Absent

Liquor: Clear Meconium Blood Stained

Presenting Part: Vertex Breech Others

Sutton: -3 -2 -1 0 +1 +2

Pelvis: Adequate Doubtful

Height: 151 cm

Weight: 72.6 kg

Allergies: Nil

Breast: Normal Abnormal

General Examination:

Consciousness: conscious Pallor: No

Icterus: No Edema: No

Temp: Afebrile PR: 90/min

BP: 120/70 DTR:

CVS: S1 S2 ⊕ RS NVBS

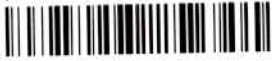
Liver/Spleen: Urine Output:

DIAGNOSIS

G4 P14 A2 | 36 weeks | Anemia corrected (Inj Ferrium SDony) (13/6/26)

Inj Betnesol 12mg IM
 given @ 10:30pm on
 21/6/26.

| Low lying placenta (0.9cm from os)



Family History: <p>Nil</p>	Surgical History: <p>Nil</p>
Medical History: <p>Nil</p>	Medication History: <p>MCBM 69 1-0-0 Speedral 1-1-0 Vehycal XT 0-0-1 F. Ecosprin 150mg 0-0-1 (stopped 19/6)</p>
Plan of Care: <p>Admission Pants preparation w/ contractions; draining PIV bleeding PIV CTG @ 4 H Inj. Taxim 1g IV 1-0-1 after test dose Spontaneous progression</p> <p>Inj. Tramadol 50mg IM & Inj. Betnesol 12mg IM</p>	Investigations: <p>CTG</p>

Doctor Name: Dr. Vinitha
Signature: *[Signature]*
Date & Time: 22/6/26 11:30pm

Consultant Name: Dr. Priyadharshini
Signature: *[Signature]*
Date & Time: 22/6/26 11:30pm

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 Mrs THIRUPURASUNDARI. R
 17-07-1994 31 Y 11 M 5 D (F)
 Dr. PRIYADHARSHINI S M



RESULT SHEET

Date	13/6	22/6/26	23/6/26	
Time				Blood group: O positive
Hb	9.4	7.9	7.8	
PCV	29	24	24	
RBC	3.51	2.82	2.80	
WBC	7.38	17.36	13.89	
N/L		84/12	76/16	
Platelets		1.2	1.76	
CRP				
ESR				8/5: TSH: 2.208
PCT				
RBS				ECG: Sinus Tachycardia; Short PR interval
Na				ECG } Normal
K				ECHO } EF: 72%
Cl				
Ca/Mg				
Phosphate				VDRL } NR
Urea				HIV } NR
Creatinine				HbsAg } NR
ALP				
SGPT				
SGOT				
T.Bill/Conj				
T.Protein				
S.Albumin				
S.Globulin				
A/G Ratio				
Uric Acid				
S.Amylase				
Sr.Lipase				
Blood Lactate				
S.Cholesterol				
PT/INR				
APTT				
CSF Protein / Sugar				
Cells		1822/7	1822/7	
N/L				

(1)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/6/26	S/B Dr. Vinithe	
6:00am	PT reviewed; No pain abdomen on left	
	O/E: GC fair; Afebrile	
	PIA: Ut term;	
	Cephalic; 2/20/10'	
	FH good	
	Plv: Cx: 2cm long;	
	OS: admits 2 fingers	
	Vx: -3 station	
	Memoranda	
	VAV Tams	C/O Dr. Priyadharshini
		CTG
		w/ contractions
		Shift to ward
22/6/26	C/O Dr. Priyadharshini	
6:45am		
	- T. Miso 25mg P/O	STAT
	- Shift to ward	
	- CTG @ 7:45am	
	- Reshift to LDR	@ 8:30am
	VAV Tams	



2



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/06/2026 11:05 AM	C/S/B Dr. Priyadharsini	
	P/A - uterus @ term (30/20"110)	<u>Advice</u>
<u>CTG - Reactive</u>	cephalic	- To start INJ. SYNTD @ 24m/hr
	FHS - good	- Strict CTG monitoring
	P/VG - 2cm long	- W/F contractions / Progress
	OS - 2cm dilated	- Inform (sos)
	membranes ⊕	
	Vertex @ -3	
	↓ SAP Arm done bleed liquor obtained	
	18/22/17	
22/06/2026 1pm	C/I/T Dr. Priyadharsini	
	- Pt clo Ted Lower Abdominal Pain	
	- To give Epidural Analgesia	
		<u>Advice</u>
		- Inform OT / Anaesthesia
		- Informed consent
	18/22/17	



3

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/06/2021	C/S/B Dr. Priyadharshini	
4:45pm	↓ Epidural Analgesia	
	O/E of uterus @ Term	Advice
	Moderately Acting (4c/35"110')	- Position for Labouring
<u>MTG - Reactive</u>	Cephalic	- Encourage Active Pushing
	FHS - good	- Continue INJ. SYNPR acceleration
	P/V - Cx - fully effaced	- Encourage Active Pushing
	os - fully dilated	
	Membranes Absent	
	Vertex @ +2 station	
	STB 2217	
22/06/2021	C/S/B Dr. Priyadharshini	
	VACUUM ASSISTED VAGINAL DELIVERY WITH RIGHT	
	MEDIOLATERAL EPISIOTOMY	
	Indication: Poor maternal efforts	
	S/B: Dr. Priyadharshini	
	A/B: Dr. Lucetta	
	↓ SAP, ↓ Epidural analgesia, Patient in dorsolithotomy position	
	Perineum painted and draped. With good uterine contractions	
	full cervical dilation 2% lignocaine local infiltration given.	
	In view of poor maternal efforts, Vacuum cup was applied in	
	vertex at +2 station. A right mediolateral episiotomy given	
	to deliver an alive preterm boy baby. Baby cried immediately	
	after birth. Cord clamped and cut. Baby handed over to	
	pediatrician. Cord blood for blood grouping and typing	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Collected. Placenta and membranes delivered into to moderate Atonic PPH of 750ml noted. Foley's tamponade of size 22 Fr inserted intrauterine and inflated with 50ml of distilled water. Inj. Methergine 0.2mg IV, 2 doses of Inj. Carboprost 200mcg IM, INJ. SYNTD 40 U in 500ml RL given Episiotomy inspected and sutured in layers using rapid vinyl. Instruments and swabs checked. Hemostasis secured.	
	Blood loss - 750ml	
	P/A - ut well contracted P/V - No undue Bleeding PV P/R - Rectal mucus & sphincter tone (N)	<u>Advice</u> - Normal diet - Plenty of oral fluids - IVF 10 RL @ 100ml/hr - INJ. TRAPIC 90mg IV 6hrs apart
B	Boy	
A	3.058 Kg	- INJ. SYNTD 40 U in 500ml RL x 2 qm
B	8/10, 9/10	- Hb/PCV after 6hrs 10pm & 6Am
Y	22.06.2026, 4:37pm	- INJ. MAGNEX FORTE 1.5g IV BD
		- T. ACTON OR 1g PO 1-1-1
		- T. PAN 40mg PO 1-0-1
		- 1/2 hrs Vitals monitoring
		- Ilochasting
		- 10 PRBC transfusion
		- catheterisation

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 17-07-1984 31 Y 11 M 5 D (F)
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PROGRESS NOTES AND DOCTOR'S ORDER

Mrs. Thirupurasundari

Date & Time	Progress Notes	Doctor's Order
22/06/2026 6:45 PM	Pre Transfusion Vitals T-N PR- 115/min BP- 133/60 mmHg RR- 20/min SpO2- 100%	Post Transfusion Vitals T- N (100°F) PR- 108/min BP- 102/64 mmHg SpO2 = 100% @ RA
	<div style="border: 1px solid black; border-radius: 50%; width: 150px; height: 150px; margin: 0 auto; display: flex; flex-direction: column; align-items: center; justify-content: center;"> <div style="display: flex; justify-content: space-between; width: 80%;"> Started @ 6:45 PM Ended @ 10:15 PM </div> <p style="text-align: center;">Positive</p> <p style="text-align: center;">No Allergic Reactions noted.</p> </div>	
22/6/2026 8:30 PM	S/B Mr Jaahima / Mr Shinya P2 L2 A2 / vacuum assisted vaginal delivery 0 hr	moderate PPH Foley tam 10 PR 8 cm
108 / 116 / 28 / RA	O/E pt afebrile no pallor no pedal edema CVS: S1, S2 no BAE P/A: uterus firm/contracted P/V: no undue bleeding Foley tamponade in situ	

GUC-00074675
 Mrs THIRUPURASUNDARI R
 17-07-1994 31 Y 11 M 6 D
 Dr. PRIYADHARSHINI S M (F)

Mrs. Thirupura Sundari

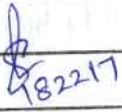

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/6/2026 6:40 AM	S/B Dr. Fahima / Dr. Divyalakshini pt-reviewed	10 PRBC transfused
PND-1	O/E: pt GC fair, afebrile P+ / PE+	Advice
T: 97.9°F	CVS / RS / NAD	- Normal diet.
PR: 97/min		- oral fluids.
BP: 112/70 mmHg	PLA: soft.	- monitor vitals.
U: 150ml clear	uterus contracted well	- follow drug chart.
Baby m/s	O/E: Gpi intact	- W/F ↑ bprv.
Breasts soft	BWNL	- Inform CBC.
23/06/2026 8AM	C/S/B Dr. Parithra / Dr. Shreedevi 10 PRBC transfused	C/S/O Dr. Priyadharsini Advice
PND-1	pt reviewed, Nil clo	- Normal diet
T: (N)	No clo giddiness, palpitations	- Plenty of oral fluids
PR: 70/min	O/E pt GC fair, Afebrile	- Vitals Monitoring
BP: 117/70 mmHg	P+ / No PE	- Follow drug chart
Collection - 20ml	CVS / RS / NAD	- I/O charting
UO - 200ml, clear		- W/F ↑ Bleeding PV
Hb - 7.8		- Inform (sos)
		- 70 Start 2nd PRBC in view of Hb 7.8.

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
Baby - m/s	P/A - soft	
Bl - Breast soft	Uterus well contracted	
	L/E - No undue bleeding PV	
		
<p><u>Vitals</u></p> <p>T - 37.2</p> <p>BP - 110/70</p> <p>PR - 84/min.</p>		
<p>23/6/2026</p> <p>11:45 PM</p> <p>Foley tamponade removed @ 2:10 AM</p>	<p>C/I/H Dr Priyadharsini</p> <ul style="list-style-type: none"> - To remove foley tamponade. - To continue PRBC transfusion. - Vitals monitoring. - CRD Removal after Blood transfusion & Shift to ward. - To do CBC c/m 6 AM (24/6/2026). 	

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 Mrs THIRUPURASUNDARI R
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 Dr. PRIYADHARSHINI S M



(6)





PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	↓ SAP, Foley tamponade removed 4g - No undue bleeding PV No clot passage.	
23/6/2026 12pm	C/S/B Dr. Priyadharsini - Pt looks comfortable. - 20 PRBC transfusion on flow. - To clamp CBD - on 2nd sensation, remove CBD, measure 1st void and then shift to ward	
23/6/2026 3pm	C/S/B Dr. Akshitha / Dr. Shreedevi Pt reviewed, Nil clo, No clo giddiness / Palpitations Voided 350ml, PVRU - 80ml	
T- (N) PR - 74/min BP - 112/60mmHg	OLE Pt GC fair, Afebrile P ⁺ / PE ⁺ CVS / RS / NAD	Advice - Normal diet - Plenty of oral fluids - vitals Monitoring - Follow drug chart
Baby - m/s BL - Breast soft Passed stools	PLA - ut well contracted soft LIE - No undue bleeding PV Epi wound healthy	- WIF ↑ Bleeding PV - To do CBC c/m b 4m (24/6/26) - Inform (SOS)
	 182217	Shift to ward

Patient Sticker



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/6/26 3PM	S/B Dr. Abdul / Dr. Shreedev.	
	PND #1 / P2L2 / ^{A2} Atonic PPH / MVD. • 2 O PR transfused • Atonic PPH	
	BP 100/60 mmHg - pt reviewed PR 95 bpm - no sp. complaints SpO ₂ 99% @ RA Jump (A)	<u>voided 350ml</u> Pleur: - monitor vitals. - S/P / DBF.
	B/L breast soft secretions minimal P/A: uterus vac. Baby m/s soft DBF BS (+) LIE: B/W/L Epi intact.	- normal diet - plenty of fluids. - ambulate - w/ ↑ bleeding PIV - follow drug orders - shift to ward
		 127425
23/6/26 9:30 PM	S/B Dr. Vinita	
	P2L2A2 vacuum delivery / APH O/E: GC fair; Afebrile P/A: Ut contracted soft; BS (+) LIE: B/W/L Epi wound intact	Adv: • Soft diet; Plenty of fluids • w/ ↑ Bleeding PIV • CAC 4M 6am • Inform SOS
	 121113	

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ISS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/6/20	C/S/B Dr. Parithima / Dr. Shreedevi	
9 Am		
TND-2	Pt reviewed, Nil/Cl	
	OLE Pt GC fair, Afebrile	Advice
T-N	P ^o IPE ^o	- Normal diet
PR - 74/min	CVS	- Plenty of oral fluids
BP - 112/60 mmHg	RS / NAD	- Vitals Monitoring
	P/A - ut well contracted	- Follow drug chart
Baby - M/S	Soft.	- WIF ↑ Bleeding PV
BL - Breast soft	HE - BWNL	- Process discharge
Voiding freely		
Passed stools	182217	
HB - 9.5		

Patient Sticker

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Dr. PRIYADHARSHINI S M



DRUG CHART

Date of Admission: 21/6/2016 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 **I** through it and a similar line through subsequent recording panels.
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
 - AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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



REGULAR PRESCRIPTIONS

Weight 72.6 kg Ward LD2

DRUG : INJ. TAXIM				Date Time	22/6/26																
Dose	Route	Frequency	Start Date	1am																	
1g	IV	1-0-1	22/6																		
Name & Signature of the Doctor Starting the Drugs:				<p>V. JAY (2113)</p> <p>1pm SP SP</p> <p>Stop</p>																	
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					
DRUG : INJ. MAGINEX FORTE				Date Time	22/6/26	24/6															
Dose	Route	Frequency	Start Date	8Am																	
1.5g	IV	1-0-1	22/6/26																		
Name & Signature of the Doctor Starting the Drugs:				<p>82217</p> <p>8pm SP SP</p> <p>12P PC</p> <p>Stop</p>																	
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					
DRUG : T. PAN				Date Time	22/6/26	24/6															
Dose	Route	Frequency	Start Date	7Am																	
40mg	PO	1-0-1	22/6/26																		
Name & Signature of the Doctor Starting the Drugs:				<p>82217</p> <p>7pm SP SP</p>																	
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					
DRUG : T. ACTON OR				Date Time	22/6/26	24/6															
Dose	Route	Frequency	Start Date	8Am																	
1g	PO	1-0-1	22/6/26																		
Name & Signature of the Doctor Starting the Drugs:				<p>82217</p> <p>2pm SP SP</p> <p>10pm SP SP</p> <p>PC</p>																	
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
22/6/26	12:30 AM	INJ. TAXIM	0.1 ml	ID	[Signature]	DR SN
22/6/26	1 AM	INJ. TAXIM	1g	IV	[Signature]	DR SN
22/6/26	7 AM	T. MISOPROSTOL	25 MCG	P/O	[Signature]	DR SN
22/6/26	9 AM	T. MISOPROSTOL	25 MCG	P/O	[Signature]	SA MD
22/6/26	9 AM	ENEMA	1	P/R	[Signature]	SA MD
22/6/26	10:30 AM	INJ. BETNESOL	12mg	Im	[Signature]	SA MD
22/6/26	4:37 PM	INJ. SYNTD	10 u	Im	[Signature]	SA MD
22/6	4:40 PM	INJ. TRAPIC	1g	IV	[Signature]	SA MD
22/6	4:40 PM	INJ. METHERGINE	0.2 mg	IV	[Signature]	SA MD

VERIFIED BY: Name Signature



I.V. FLUIDS CHART

Weight: 2.6 kg (DR) Ward: DR

Date	Time	Composition of i.v. Fluid (If infusion, mention ml/hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
22/6	11:20am	INJ. SYNTO 50 U in 500ml RL	IV	24 ml/hr	[Signature] 182217	[Signature] MD	22/6	[Signature] 182217	[Signature] MD
22/6	11:20am	IVF 10RL	IV	free flow	[Signature] 182217	SA MD	22/6	[Signature] 182217	[Signature] MD
22/6	1:30 pm	IVF 20RL	IV	Rush	[Signature] 182217	SA MD	22/6	[Signature] 182217	[Signature] MD
22/6	4:40pm	IVF 20RL	IV	Rush	[Signature] 182217	SA MD	22/6	[Signature] 182217	[Signature] MD
22/6	4:37pm	INJ. SYNTO 400 U in 500ml RL	IV	125 ml/hr	[Signature] 182217	SA MD	22/6	[Signature] 182217	[Signature] MD
22/6	4:50pm	INJ. GEFUFUSINE	IV	Rush	[Signature] 182217	SA MD	22/6	[Signature] 182217	[Signature] MD
22/6	9pm	INJ. SYNTO 400 U in 500ml RL	IV	20 ml/hr	[Signature] 182217	SA MD	22/6	[Signature] 182217	[Signature] MD
22/6	2AM	INJ. SYNTO 400 U in 500ml RL	IV	20ml/hr	[Signature] 159m	SA MD	24/6 2AM	[Signature]	[Signature]

Signature

VERIFIED BY : Name

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 Mrs THIRUPURASUNDARI. R
 17-07-1994 31 Y 11 M 6 D (F)
 Dr. PRIYADHARSHINI S M



REGULAR PRESCRIPTIONS

Weight 7.6 Ward LPR

Sheet No:

Signature
VERIFIED BY : Name

DRUG : <u>INJ. TRAPIL</u>				Date Time	<u>22/6/26</u>
Dose	Route	Frequency	Start Dt.	<u>11 pm</u>	<u>22/6/26</u>
<u>1g</u>	<u>IV</u>	<u>1-0-0</u>	<u>22/6/26</u>		
Name & Signature of the Doctor Starting the Drugs:					
<u>[Signature] 82217</u>					
Additional Instructions:					
<u>X(2) doses</u>				<u>5AM</u> <u>10:00</u> <u>15</u>	
Daily Doctor's Endorsement by a Sign					

DRUG : <u>T. LEFTUM</u>				Date Time	<u>24/6</u>
Dose	Route	Frequency	Start Dt.	<u>8AM</u>	
<u>500mg</u>	<u>PO</u>	<u>1-0-1</u>	<u>24/6/26</u>		
Name & Signature of the Doctor Starting the Drugs:					
<u>[Signature] 82217</u>					
Additional Instructions:					
				<u>8pm</u>	
Daily Doctor's Endorsement by a Sign					

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

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

DATE	TIME	DESCRIPTION	QUALIFICATION	STATUS	REMARKS
22/10	0600	1st shift	1st shift	1	
22/10	0730	2nd shift	2nd shift	1	
22/10	0900	3rd shift	3rd shift	1	
22/10	1030	4th shift	4th shift	1	
22/10	1200	5th shift	5th shift	1	
22/10	1330	6th shift	6th shift	1	
22/10	1500	7th shift	7th shift	1	
22/10	1630	8th shift	8th shift	1	
22/10	1800	9th shift	9th shift	1	
22/10	1930	10th shift	10th shift	1	
22/10	2100	11th shift	11th shift	1	
22/10	2230	12th shift	12th shift	1	

21/10/72



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 Mrs THIRUPURASUNDARI. R
 17-07-1994 31 Y 11 M 5 D (F)
 Dr. PRIYADHARSHINI S M

(C)



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: ICU Shifting to:

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	T-ECOSPIRIN	150mg	P/O			<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
2						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: [Signature] Dr. Vinitha

Date & Time: 21/6/2026 11:30 pm

Nurse Name & Signature: [Signature]

Date & Time: 21/06/2026 at 11:30 pm



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MEDICATION RECONCILIATION FORM

Drug Allergies: Nil Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: 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						<input type="checkbox"/> C <input type="checkbox"/> DC
2						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. S. Moodevi 182217

Date & Time: 22/6/26 @ 9 AM

Nurse Name & Signature: S. Madhuviraj / S. Lakshmi

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



MEDICATION RECOMMENDATION FORM

Drug Allergy: *None*

Medication Recommendation will be based on the following information:
[Examine & the time of intake] in the following manner:
of admission, and what was the

Shifting from *11:00 AM* to *7:00 AM*

S.No	(GENERIC NAME & BRAND NAME)	ROUTE	DOSE	Frequency	Remarks
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

MEDICATION HISTORY RECORDED / REVIEWED BY

Doctor Name & Signature: *[Signature]*

Date & Time: *[Date]*

Nurse Name & Signature: *[Signature]*

Date & Time: *[Date]*

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 Mrs THIRUPURASUNDESI R
 17-07-1994 31 Y 11 M - 0 (F)
 Dr. PRIYADHARSHINI S M

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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: LDR Shifted to: F02

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						<input type="checkbox"/> C <input type="checkbox"/> DC
2						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature :

Date & Time : 23/6/2026 @ 10am

Nurse Name & Signature: S. pasameswari 016008

Date & Time : 23/6/2026 @ 10am

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

Patient Sticker

①

NURSING SHIFT HAND OVER FORM

SITUATION		Diagnosis: <u>GA P, L, F₂ 36 weeks</u>						
SITUATION		Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known						
SITUATION		If Yes Specify:						
BACKGROUND		Surgery / Procedure:						
BACKGROUND		Post OP Day:						
BACKGROUND		Date	21/6/26	22/6/26	22/6/26	22/6/26	23/6/26	23/6/26
BACKGROUND		Shift	N	M	E	N	morning	E
BACKGROUND		Medical Condition (Any special condition to be noted):	-	-	-	-	-	-
BACKGROUND		Diet:	diets	diets	liquid	juice	Normal diet	diets
ASSESSMENT		Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
ASSESSMENT		Ventilation (RA, NP, NIV, VENTI):	RA	RA	RA	NA	RA	RA
ASSESSMENT		Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
ASSESSMENT		Vital Signs:	Temp: <u>98.2 F</u>		Temp: <u>98.2 F</u>		Temp: <u>98.2 F</u>	
ASSESSMENT		Res:	<u>20</u>	<u>20</u>	<u>20</u>	<u>22</u>	<u>20 bpm</u>	<u>21/12</u>
ASSESSMENT		SpO ₂ :	<u>100%</u>	<u>99%</u>	<u>100</u>	<u>100</u>	<u>99%</u>	<u>99%</u>
ASSESSMENT		Pulse:	<u>80</u>	<u>86</u>	<u>90/110</u>	<u>110/110</u>	<u>94 bpm</u>	<u>92/110</u>
ASSESSMENT		BP:	<u>120/70</u>	<u>107/58</u>	<u>100/60</u>	<u>100/70</u>	<u>100/60</u>	<u>100/70</u>
ASSESSMENT		LOC:	<u>conscious</u>	<u>conscious</u>	<u>conscious</u>	<u>conscious</u>	<u>conscious</u>	<u>conscious</u>
ASSESSMENT		Fall Risk Score:	<u>0</u>	<u>0</u>	<u>20</u>	<u>24</u>	<u>20</u>	<u>20</u>
ASSESSMENT		Pain Score:	<u>2/10</u>	<u>0/10</u>	<u>2/10</u>	<u>2/10</u>	<u>2/10</u>	<u>2/10</u>
ASSESSMENT		Skin Integrity:	<u>normal</u>	<u>normal</u>	<u>normal</u>	<u>normal</u>	<u>intact</u>	<u>normal</u>
RECOMMENDATIONS		Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
RECOMMENDATIONS		Physiotherapy:	-	-	-	-	NA	-
RECOMMENDATIONS		Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
RECOMMENDATIONS		Special Diet:	diets	diets	liquid	juice	Normal diet	diets
RECOMMENDATIONS		Critical Lab Test / Values:	-	-	-	-	-	-
RECOMMENDATIONS		Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
RECOMMENDATIONS		PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
RECOMMENDATIONS		DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
RECOMMENDATIONS		ADL (Dependent / Non Dependent):	<u>non dependent</u>	<u>non dependent</u>	<u>dependent</u>	<u>depen</u>	<u>dependent</u>	<u>DD</u>
RECOMMENDATIONS		Post Operative Procedure Special Orders:	-	-	-	-	-	-
RECOMMENDATIONS		Handed Over By Name:	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
RECOMMENDATIONS		Signature / ID:	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
RECOMMENDATIONS		Date:	<u>21/6/26</u>	<u>22/6/26</u>	<u>22/6/26</u>	<u>22/6/26</u>	<u>23/6/26</u>	<u>23/6/26</u>
RECOMMENDATIONS		Time:	<u>11:30</u>	<u>2:30am</u>	<u>8pm</u>	<u>3pm</u>	<u>8am</u>	<u>3pm</u>
RECOMMENDATIONS		Taken Over By Name:	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
RECOMMENDATIONS		Signature / ID:	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
RECOMMENDATIONS		Date:	<u>22/6/26</u>	<u>22/6/26</u>	<u>22/6/26</u>	<u>23/6/26</u>	<u>23/6/26</u>	<u>23/6/26</u>
RECOMMENDATIONS		Time:	<u>7:30am</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>

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 Mrs THIRUPURASUNDARI. R
 17-07-1994 31 Y 11 M 5 D (F)
 Dr. PRIYADHARSHINI S M

①



NURSING CARE RECORD

Date: 21/6/2026

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	11:30 pm	Achieve acceptable pain control and comfort.	12 AM	<ul style="list-style-type: none"> - Asses pain using pain scale - regularly - position patient comfortably - Monitor effectiveness of pain relief measures 	patient vital are stable	Reassessment done	D. S. [Signature]

GUC-00074875 IP18-00036127
 Mrs THIRUPURASUNDARI. R
 17-07-1994 31 Y 11 M 5 D (F)
 Dr. PRIYADHARSHINI S M



NURSING CARE RECORD



Date: 22/6/2022

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	7:30am	- Assess the patient General condition - provide psychological support to patient	8:30am	- Assessed the patient General condition - provided psychological support to patient	provided psychological support to patient	patient feel better.	PT
Afternoon	2pm	Achieve acceptable pain control & comfort	2:30 pm	Assess pain using pain scale regularly Administer analgesics as prescribed. position pt comfortably	patient was stable	Reassessment was done	SNABALY 01888
Night	8pm	Achieve Acceptable Pain control & comfort	9pm	Assess pain using Pain Scale → pt comfortable position. → Reassess analgesic as per doctor orders	patient was stable.	Reassessment done	PT

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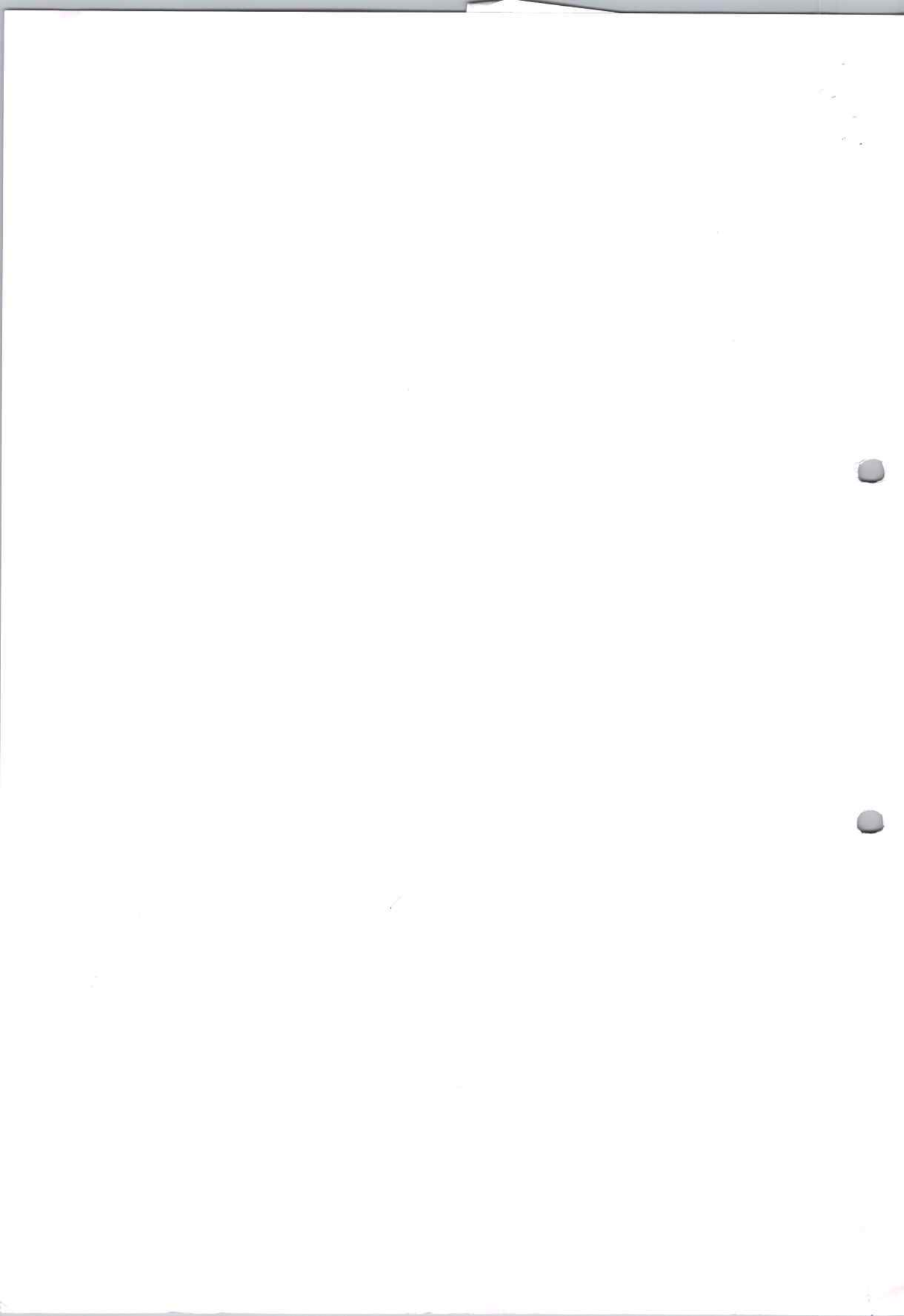
Patient Sticker

Early Warning Observation Score Chart - Obstetrics

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

		Date																												
		Time		8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7			
RESP (write rate in corresp. box)	> 30																													
	21 - 30																													
	11 - 20																													
	0 - 10																													
Saturations	94 - 100 %																													
	< 94 %																													
Administered O ₂ (L/min.)																														
Temp °C	40																													
	39																													
	38																													
	37																													
	36																													
	35																													
	< 35																													
Heart Rate	170																													
	160																													
	150																													
	140																													
	130																													
	120																													
	110																													
	100																													
	90																													
	80																													
	70																													
	60																													
	40																													
↑ Systolic Blood Pressure	190																													
	180																													
	170																													
	160																													
	150																													
	140																													
	130																													
	120																													
	110																													
	100																													
	90																													
	80																													
	70																													
60																														
50																														
↓ Diastolic Blood Pressure	130																													
	120																													
	110																													
	100																													
	90																													
	80																													
	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																														
TOTAL ORANGE SCORES																														
Nurse Initial																														

on Amniotic





2

Early Warning Observation Score Chart - Obstetrics

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

		Date	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																										
Saturations	0 - 10																										
	94 - 100 %																										
Administered O ₂ (L/min.)	< 94 %																										
Temp °C	40																										
	39																										
	38																										
	37																										
	36																										
	35																										
	< 35																										
Heart Rate	170																										
	160																										
	150																										
	140																										
	130																										
	120																										
	110																										
	100																										
	90																										
	80																										
	70																										
	60																										
	40																										
Systolic Blood Pressure	190																										
	180																										
	170																										
	160																										
	150																										
	140																										
	130																										
	120																										
	110																										
	100																										
	90																										
	80																										
	70																										
60																											
50																											
Diastolic Blood Pressure	130																										
	120																										
NEURO RESPONSE [✓]	Alert																										
	Voice																										
URINE mls / hour	> 30																										
	< 30																										
Proteinuria	Protein ++																										
	Protein > ++																										
Lochia	Normal																										
	Heavy / Foul																										
Liquor	Clear / Pink																										
	Green																										
TOTAL YELLOW SCORES																											
TOTAL ORANGE SCORES																											
Nurse Initial																											



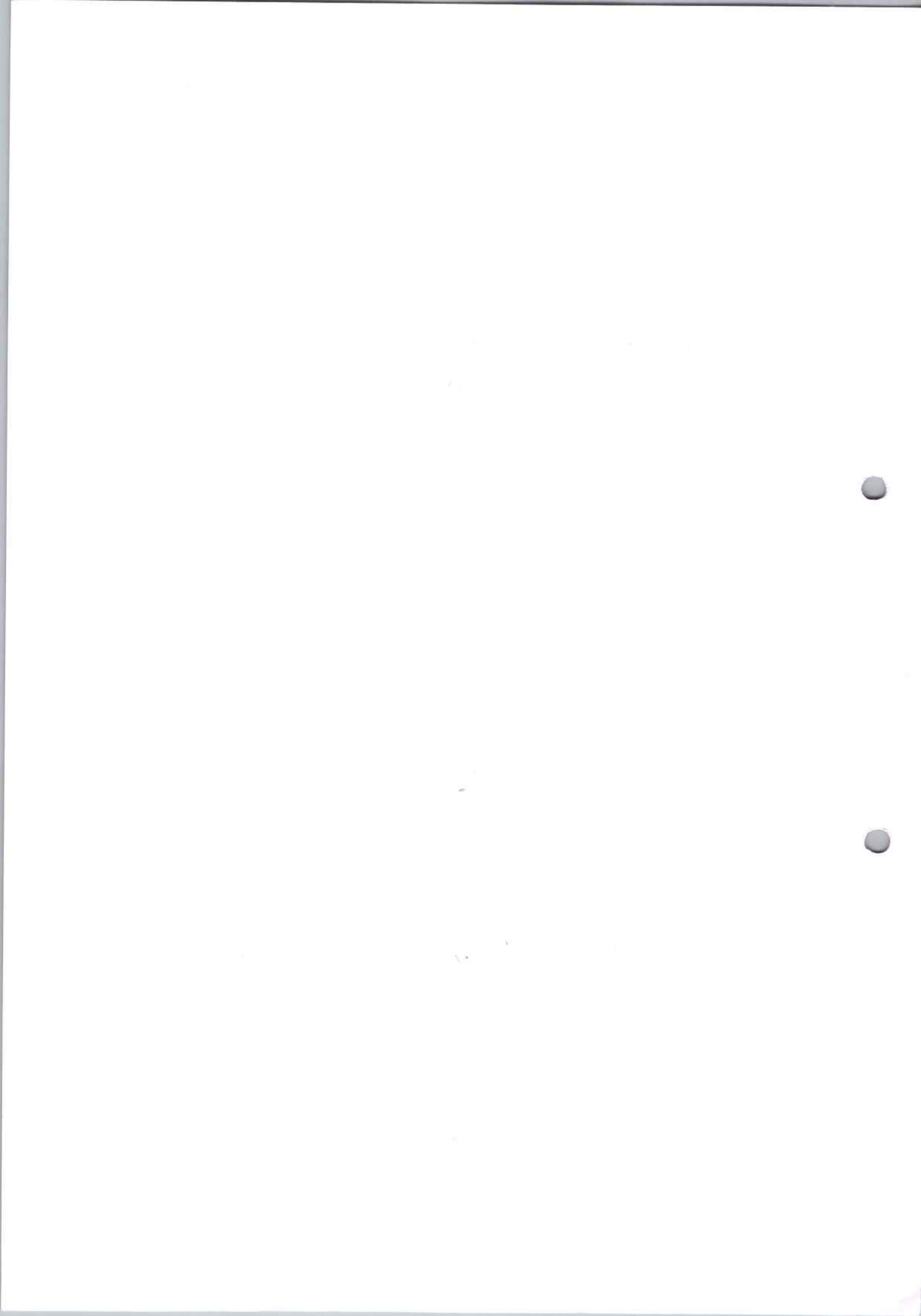


3

Early Warning Observation Score Chart - Obstetrics

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

Date		Time																								
23/6/26		8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20	20	20	20	20	20							20		20							20				
	0 - 10																									
Saturations	94 - 100 %	99	99	99	99	99							95		97							97				
	< 94 %																									
Administered O ₂ (L/min.)		RA	RA	RA	RA	RA							RA		RA							RA				
Temp °C	40																									
	39																									
	38	38.0				38.0				38.0				38.0		38.0						38.0				
	37																									
	36	36.0				36.0				36.0				36.0		36.0						36.0				
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110	92	82	90	82	78				78			78		78							78				
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
40																										
Systolic Blood Pressure	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110	100	112	90	116	110				112			110		110							112				
	100																									
	90																									
	80																									
	70																									
60																										
50																										
40																										
Diastolic Blood Pressure	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60	60	62	60	62	66				65			65		64							60				
	50																									
	40																									
	NEURO RESPONSE [✓]	Alert	✓	✓	✓	✓	✓							✓		✓							✓			
		Voice	✓	✓	✓	✓	✓							✓		✓							✓			
	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				
TOTAL ORANGE SCORES		0	0	0	0	0							0		0							0				
Nurse Initial		PR	PR	PR	PR	PR							PR		PR							PR				



GUC-00074875 IP18-00036127
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Patient :



FLUID CHART

Sheet No. : 1

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm	H ₂ O 100ml								200ml	0	DS	
	12:00 am									0	0	DS	
	01:00 am	H ₂ O 100								200ml	0	DS	
Total Intake : 200ml						Total Output : 400ml							
	02:00 am	H ₂ O 100ml.								0	0	DS	
	03:00 am									200ml	0	DS	
	04:00 am	H ₂ O 100ml.								150ml	0	DS	
	05:00 am									0	0	DS	
	06:00 am	H ₂ O 100ml.								150ml	0	DS	
	07:00 am	H ₂ O 100ml.								0	0	DS	
Total Intake : 400ml						Total Output : 500ml							
Total 24 hrs. Intake		600ml.				Total 24 hrs. Output		900ml					



FLUID CHART

Sheet No. : (2)

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

Date	Time	Intake				Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am	H ₂ O	1004								0	SA	
	09:00 am			544	RL					100	0	SA	
	10:00 am	TC	1004	24	1004					200	0	SA	
	11:00 am			724						200	0	SA	
	12:00 pm	TC	1004	724							0	SA	
	01:00 pm			96						200	0	SA	
Total Intake :		1040ml			RL		Total Output :					700ml	
	02:00 pm	H ₂ O	155	96	500				CB20	200	0	SA	
	03:00 pm	H ₂ O	100	125	500					150	0	SA	
	04:00 pm	H ₂ O	100	144						250	0	SA	
	05:00 pm	H ₂ O	100ml	192	500					250	0	SA	
	06:00 pm	H ₂ O	100	125	500					100	0	SA	
	07:00 pm	H ₂ O	100	125	500					250	0	SA	
Total Intake :		3240ml					Total Output :					1200ml	
	08:00 pm	H ₂ O	100	20									
	09:00 pm			20									
	10:00 pm	H ₂ O	100	20						300	0	SA	
	11:00 pm			20						200	0	SA	
	12:00 am	H ₂ O	1004	20						100	0	SA	
	01:00 am			20						200	0	SA	
Total Intake :		4200ml					Total Output :					900ml	
	02:00 am	H ₂ O	1004	20						100	0	SA	
	03:00 am			20						200	0	SA	
	04:00 am	H ₂ O	1004	20						150	0	SA	
	05:00 am			20						100	0	SA	
	06:00 am	H ₂ O	1004	20						75	0	SA	
	07:00 am			20						1504	0	SA	
Total Intake :		4200ml					Total Output :					775ml	
Total 24 hrs. Intake		5,180ml											
Total 24 hrs. Output		3,375ml											

FIN STATE

DATE: 12/31/2011

TIME: 10:58 AM

USER: [unclear]

DATE	TYPE	AMOUNT	BALANCE
12/31/11	DEPOSIT	100.00	100.00
12/30/11	DEPOSIT	200.00	300.00
12/29/11	DEPOSIT	150.00	450.00
12/28/11	DEPOSIT	100.00	550.00
12/27/11	DEPOSIT	50.00	600.00
12/26/11	DEPOSIT	50.00	650.00
12/25/11	DEPOSIT	50.00	700.00
12/24/11	DEPOSIT	50.00	750.00
12/23/11	DEPOSIT	50.00	800.00
12/22/11	DEPOSIT	50.00	850.00
12/21/11	DEPOSIT	50.00	900.00
12/20/11	DEPOSIT	50.00	950.00
12/19/11	DEPOSIT	50.00	1000.00
12/18/11	DEPOSIT	50.00	1050.00
12/17/11	DEPOSIT	50.00	1100.00
12/16/11	DEPOSIT	50.00	1150.00
12/15/11	DEPOSIT	50.00	1200.00
12/14/11	DEPOSIT	50.00	1250.00
12/13/11	DEPOSIT	50.00	1300.00
12/12/11	DEPOSIT	50.00	1350.00
12/11/11	DEPOSIT	50.00	1400.00
12/10/11	DEPOSIT	50.00	1450.00
12/9/11	DEPOSIT	50.00	1500.00
12/8/11	DEPOSIT	50.00	1550.00
12/7/11	DEPOSIT	50.00	1600.00
12/6/11	DEPOSIT	50.00	1650.00
12/5/11	DEPOSIT	50.00	1700.00
12/4/11	DEPOSIT	50.00	1750.00
12/3/11	DEPOSIT	50.00	1800.00
12/2/11	DEPOSIT	50.00	1850.00
12/1/11	DEPOSIT	50.00	1900.00
11/30/11	DEPOSIT	50.00	1950.00
11/29/11	DEPOSIT	50.00	2000.00
11/28/11	DEPOSIT	50.00	2050.00
11/27/11	DEPOSIT	50.00	2100.00
11/26/11	DEPOSIT	50.00	2150.00
11/25/11	DEPOSIT	50.00	2200.00
11/24/11	DEPOSIT	50.00	2250.00
11/23/11	DEPOSIT	50.00	2300.00
11/22/11	DEPOSIT	50.00	2350.00
11/21/11	DEPOSIT	50.00	2400.00
11/20/11	DEPOSIT	50.00	2450.00
11/19/11	DEPOSIT	50.00	2500.00
11/18/11	DEPOSIT	50.00	2550.00
11/17/11	DEPOSIT	50.00	2600.00
11/16/11	DEPOSIT	50.00	2650.00
11/15/11	DEPOSIT	50.00	2700.00
11/14/11	DEPOSIT	50.00	2750.00
11/13/11	DEPOSIT	50.00	2800.00
11/12/11	DEPOSIT	50.00	2850.00
11/11/11	DEPOSIT	50.00	2900.00
11/10/11	DEPOSIT	50.00	2950.00
11/9/11	DEPOSIT	50.00	3000.00
11/8/11	DEPOSIT	50.00	3050.00
11/7/11	DEPOSIT	50.00	3100.00
11/6/11	DEPOSIT	50.00	3150.00
11/5/11	DEPOSIT	50.00	3200.00
11/4/11	DEPOSIT	50.00	3250.00
11/3/11	DEPOSIT	50.00	3300.00
11/2/11	DEPOSIT	50.00	3350.00
11/1/11	DEPOSIT	50.00	3400.00
10/31/11	DEPOSIT	50.00	3450.00
10/30/11	DEPOSIT	50.00	3500.00
10/29/11	DEPOSIT	50.00	3550.00
10/28/11	DEPOSIT	50.00	3600.00
10/27/11	DEPOSIT	50.00	3650.00
10/26/11	DEPOSIT	50.00	3700.00
10/25/11	DEPOSIT	50.00	3750.00
10/24/11	DEPOSIT	50.00	3800.00
10/23/11	DEPOSIT	50.00	3850.00
10/22/11	DEPOSIT	50.00	3900.00
10/21/11	DEPOSIT	50.00	3950.00
10/20/11	DEPOSIT	50.00	4000.00
10/19/11	DEPOSIT	50.00	4050.00
10/18/11	DEPOSIT	50.00	4100.00
10/17/11	DEPOSIT	50.00	4150.00
10/16/11	DEPOSIT	50.00	4200.00
10/15/11	DEPOSIT	50.00	4250.00
10/14/11	DEPOSIT	50.00	4300.00
10/13/11	DEPOSIT	50.00	4350.00
10/12/11	DEPOSIT	50.00	4400.00
10/11/11	DEPOSIT	50.00	4450.00
10/10/11	DEPOSIT	50.00	4500.00
10/9/11	DEPOSIT	50.00	4550.00
10/8/11	DEPOSIT	50.00	4600.00
10/7/11	DEPOSIT	50.00	4650.00
10/6/11	DEPOSIT	50.00	4700.00
10/5/11	DEPOSIT	50.00	4750.00
10/4/11	DEPOSIT	50.00	4800.00
10/3/11	DEPOSIT	50.00	4850.00
10/2/11	DEPOSIT	50.00	4900.00
10/1/11	DEPOSIT	50.00	4950.00
9/30/11	DEPOSIT	50.00	5000.00
9/29/11	DEPOSIT	50.00	5050.00
9/28/11	DEPOSIT	50.00	5100.00
9/27/11	DEPOSIT	50.00	5150.00
9/26/11	DEPOSIT	50.00	5200.00
9/25/11	DEPOSIT	50.00	5250.00
9/24/11	DEPOSIT	50.00	5300.00
9/23/11	DEPOSIT	50.00	5350.00
9/22/11	DEPOSIT	50.00	5400.00
9/21/11	DEPOSIT	50.00	5450.00
9/20/11	DEPOSIT	50.00	5500.00
9/19/11	DEPOSIT	50.00	5550.00
9/18/11	DEPOSIT	50.00	5600.00
9/17/11	DEPOSIT	50.00	5650.00
9/16/11	DEPOSIT	50.00	5700.00
9/15/11	DEPOSIT	50.00	5750.00
9/14/11	DEPOSIT	50.00	5800.00
9/13/11	DEPOSIT	50.00	5850.00
9/12/11	DEPOSIT	50.00	5900.00
9/11/11	DEPOSIT	50.00	5950.00
9/10/11	DEPOSIT	50.00	6000.00
9/9/11	DEPOSIT	50.00	6050.00
9/8/11	DEPOSIT	50.00	6100.00
9/7/11	DEPOSIT	50.00	6150.00
9/6/11	DEPOSIT	50.00	6200.00
9/5/11	DEPOSIT	50.00	6250.00
9/4/11	DEPOSIT	50.00	6300.00
9/3/11	DEPOSIT	50.00	6350.00
9/2/11	DEPOSIT	50.00	6400.00
9/1/11	DEPOSIT	50.00	6450.00
8/31/11	DEPOSIT	50.00	6500.00
8/30/11	DEPOSIT	50.00	6550.00
8/29/11	DEPOSIT	50.00	6600.00
8/28/11	DEPOSIT	50.00	6650.00
8/27/11	DEPOSIT	50.00	6700.00
8/26/11	DEPOSIT	50.00	6750.00
8/25/11	DEPOSIT	50.00	6800.00
8/24/11	DEPOSIT	50.00	6850.00
8/23/11	DEPOSIT	50.00	6900.00
8/22/11	DEPOSIT	50.00	6950.00
8/21/11	DEPOSIT	50.00	7000.00
8/20/11	DEPOSIT	50.00	7050.00
8/19/11	DEPOSIT	50.00	7100.00
8/18/11	DEPOSIT	50.00	7150.00
8/17/11	DEPOSIT	50.00	7200.00
8/16/11	DEPOSIT	50.00	7250.00
8/15/11	DEPOSIT	50.00	7300.00
8/14/11	DEPOSIT	50.00	7350.00
8/13/11	DEPOSIT	50.00	7400.00
8/12/11	DEPOSIT	50.00	7450.00
8/11/11	DEPOSIT	50.00	7500.00
8/10/11	DEPOSIT	50.00	7550.00
8/9/11	DEPOSIT	50.00	7600.00
8/8/11	DEPOSIT	50.00	7650.00
8/7/11	DEPOSIT	50.00	7700.00
8/6/11	DEPOSIT	50.00	7750.00
8/5/11	DEPOSIT	50.00	7800.00
8/4/11	DEPOSIT	50.00	7850.00
8/3/11	DEPOSIT	50.00	7900.00
8/2/11	DEPOSIT	50.00	7950.00
8/1/11	DEPOSIT	50.00	8000.00
7/31/11	DEPOSIT	50.00	8050.00
7/30/11	DEPOSIT	50.00	8100.00
7/29/11	DEPOSIT	50.00	8150.00
7/28/11	DEPOSIT	50.00	8200.00
7/27/11	DEPOSIT	50.00	8250.00
7/26/11	DEPOSIT	50.00	8300.00
7/25/11	DEPOSIT	50.00	8350.00
7/24/11	DEPOSIT	50.00	8400.00
7/23/11	DEPOSIT	50.00	8450.00
7/22/11	DEPOSIT	50.00	8500.00
7/21/11	DEPOSIT	50.00	8550.00
7/20/11	DEPOSIT	50.00	8600.00
7/19/11	DEPOSIT	50.00	8650.00
7/18/11	DEPOSIT	50.00	8700.00
7/17/11	DEPOSIT	50.00	8750.00
7/16/11	DEPOSIT	50.00	8800.00
7/15/11	DEPOSIT	50.00	8850.00
7/14/11	DEPOSIT	50.00	8900.00
7/13/11	DEPOSIT	50.00	8950.00
7/12/11	DEPOSIT	50.00	9000.00
7/11/11	DEPOSIT	50.00	9050.00
7/10/11	DEPOSIT	50.00	9100.00
7/9/11	DEPOSIT	50.00	9150.00
7/8/11	DEPOSIT	50.00	9200.00
7/7/11	DEPOSIT	50.00	9250.00
7/6/11	DEPOSIT	50.00	9300.00
7/5/11	DEPOSIT	50.00	9350.00
7/4/11	DEPOSIT	50.00	9400.00
7/3/11	DEPOSIT	50.00	9450.00
7/2/11	DEPOSIT	50.00	9500.00
7/1/11	DEPOSIT	50.00	9550.00
6/30/11	DEPOSIT	50.00	9600.00
6/29/11	DEPOSIT	50.00	9650.00
6/28/11	DEPOSIT	50.00	9700.00
6/27/11	DEPOSIT	50.00	9750.00
6/26/11	DEPOSIT	50.00	9800.00
6/25/11	DEPOSIT	50.00	9850.00
6/24/11	DEPOSIT	50.00	9900.00
6/23/11	DEPOSIT	50.00	9950.00
6/22/11	DEPOSIT	50.00	10000.00
6/21/11	DEPOSIT	50.00	10050.00
6/20/11	DEPOSIT	50.00	10100.00
6/19/11	DEPOSIT	50.00	10150.00
6/18/11	DEPOSIT	50.00	10200.00
6/17/11	DEPOSIT	50.00	10250.00
6/16/11	DEPOSIT	50.00	10300.00
6/15/11	DEPOSIT	50.00	10350.00
6/14/11	DEPOSIT	50.00	10400.00
6/13/11	DEPOSIT	50.00	10450.00
6/12/11	DEPOSIT	50.00	10500.00
6/11/11	DEPOSIT	50.00	10550.00
6/10/11	DEPOSIT	50.00	10600.00
6/9/11	DEPOSIT	50.00	10650.00
6/8/11	DEPOSIT	50.00	10700.00
6/7/11	DEPOSIT	50.00	10750.00
6/6/11	DEPOSIT	50.00	10800.00
6/5/11	DEPOSIT	50.00	10850.00
6/4/11	DEPOSIT	50.00	10900.00
6/3/11	DEPOSIT	50.00	10950.00
6/2/11	DEPOSIT	50.00	11000.00
6/1/11	DEPOSIT	50.00	11050.00
5/31/11	DEPOSIT	50.00	11100.00
5/30/11	DEPOSIT	50.00	11150.00
5/29/11	DEPOSIT	50.00	11200.00
5/28/11	DEPOSIT	50.00	11250.00
5/27/11	DEPOSIT	50.00	11300.00
5/26/11	DEPOSIT	50.00	11350.00
5/25/11	DEPOSIT	50.00	11400.00
5/24/11	DEPOSIT	50.00	11450.00
5/23/11	DEPOSIT	50.00	11500.00
5/22/11	DEPOSIT	50.00	11550.00
5/21/11	DEPOSIT	50.00	11600.00
5/20/11	DEPOSIT	50.00	11650.00
5/19/11	DEPOSIT	50.00	11700.00
5/18/11	DEPOSIT	50.00	11750.00
5/17/11	DEPOSIT	50.00	11800.00
5/16/11	DEPOSIT	50.00	11850.00
5/15/11	DEPOSIT	50.00	11900.00
5/14/11	DEPOSIT		



FLUID CHART

Sheet No. : (3)

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

23/6/20		Intake				Output					IV Site Thrombophs Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am	H ₂ O	150ml	20ml						250ml	0	Dr	
	09:00 am	H ₂ O	200ml	20ml						250ml	0	Dr	
	10:00 am	H ₂ O	100ml	20ml						250ml	0	Dr	
	11:00 am	H ₂ O	150ml	20ml						250ml	0	Dr	
	12:00 pm	H ₂ O	100ml	20ml					polytemp	150ml	0	Dr	
	01:00 pm	H ₂ O	100ml	20ml					6 ml	100ml	0	Dr	
Total Intake :			1209 ml			Total Output :			1250 ml				
	02:00 pm	H ₂ O	100ml	20						300ml	0	Dr	
	03:00 pm	H ₂ O	100	20						350ml	0	Dr	
	04:00 pm	H ₂ O	100ml	20ml							0	Dr	
	05:00 pm	H ₂ O	200ml	20ml						200ml	0	Dr	
	06:00 pm			20ml						100ml	0	Dr	
	07:00 pm	H ₂ O	200ml								0	Dr	
Total Intake :			700ml + 100ml => 800			Total Output :			850ml + 100ml				
	08:00 pm										0	Dr	
	09:00 pm	H ₂ O	200							300	0	Dr	
	10:00 pm										0	Dr	
	11:00 pm										6	Dr	
	12:00 am	H ₂ O	200	20ml						200	0	Dr	
	01:00 am			20ml							0	Dr	
Total Intake :			200 + 80ml => 480ml			Total Output :			500				
	02:00 am			20ml							0	Dr	
	03:00 am	H ₂ O	100	20ml						200	0	Dr	
	04:00 am										0	Dr	
	05:00 am	H ₂ O	200								0	Dr	
	06:00 am										0	Dr	
	07:00 am	H ₂ O	200							200	0	Dr	
Total Intake :			500 + 40ml => 540ml			Total Output :			300				
Total 24 hrs. Intake		3100ml				Total 24 hrs. Output		3000ml					



NURSES NOTES



- No Known Drug Allergies
- Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
21/6/26	11:30 pm	Admission Notes 21/6/2026. patient with clo for abdominal pain Mrs. Thirupurasundari 44 years 36 weeks patient complain lower abdominal pain. patient come for 9pm patient. vit connective FHR present 145b/m patient conscious and oriented general condition fair checked vitals sign vitals are stable patient checked contra lovent 2 contractus 10 sec interns to Dr. Vinitha man pliyaman 9.30pm & B DR. vinitha admin vit 2 Fingur. stop order FHR was good on patient patient on stop at 9.30pm after 10.30pm & B DR. vinitha man admin to inj: Betnesol 12mg IM c give the order and inj: Toramal 50mg. im given order patient inj: Betnesol 12 mg IM given 10.30pm and inj: tramadol 50mg im given. after 1 hrs obs. after plan. 11.30pm & B DR. vinitha pt allens any pain is other pt complains for pain admin to admin order con out - Y DSS	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Y DSS
 07/17/26

NURSES NOTES



- No Known Drug Allergies
- Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
22/6/26	12.20 AM	S/B DR. Venitha advise to Inj. Taxim start order IV line also start patient 4 th etc next CTM - 1.30AM order con out	Y. Dheep OFFICER
	12.30 PM	patient IV line milk 18 u Back flen come - IV line put Bly ofal sobelus patient part masonation done. patient Inj: Taxim 0. ml test dose 10 given patient Conioy and oriented worsened condition Fen	Y. Dheep OFFICER
	1 AM	patient asking Inj: Taxim test, does any allergic reaction patient no complain for Macillereyn patient Inj: Taxim 1g IV pull dose given	Y. Dheep OFFICER
	1.30 AM	patient after voided CTM Connocting AHR present 142b/m patient Conioy and oriented worsened condition Fen	Y. Dheep OFFICER
	2 AM	S/B DR. Venitha mean advise CTM was Reactivity etc disconnocting order patient CTM stop patient checked.	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



2

NURSES NOTES



- No Known Drug Allergies
- Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
22/6/20	Confer	10 mins 2 contractions 15 sec inform to DR. venitha mam adu Mont AM 6AM other no complaint for patient	
	4AM	patient checked vital are stable patient conscious and oriented. Vaginal condition fair. patient checked contractions 10 mins 2 contractions 10 to 15 sec inform to DR. venitha	[Signature]
	6AM	STB DR. venitha plv examination 2cm long 2 cm finger adu AM. connected patient AM. connected. FHR present 140b/m patient conscious and oriented Vaginal condition fair patient vital are stable	[Signature]
	6:30 AM	STB DR. venitha mam adu AM stop order come out patient conscious and oriented vaginal condition fair	[Signature]
	7AM	STB DR. venitha mam adu T. meo 25mcg oral give the order	[Signature]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES



No Known Drug Allergies

Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
22/6/26	Contn	patient T-miso 25mg oral given patient shifts to ward patient morning case given patient post miso on 8am	[Signature]
	7:05 AM	patient handing over given 7th floor staff Nurse A	[Signature]
<u>Receiving Notes.</u>			
22/6/26	7:10AM	patient Receiving from LDR to 7th floor. handing over taken from LDR staff. Bed laid Assessment done. Conscious & Oriented. IV line ⊕ pattern. w/f the contractions, CTG monitor. vitals sig checked & recorded. vitals are stable. Plo chart monitored. CTG 8AM todo, patient shift to LDR @ 8:30AM. todo.	[Signature]
	7:30AM	patient details handing over to Morning duty staff.	[Signature]
	7:30AM	Morning duty on 22/6/26 patient details handing over taken from Night duty staff. patient conscious and oriented w/ low pattern.	[Signature]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

(5)

NURSES NOTES



No Known Drug Allergies

Drug Allergies Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		patient m On Normal diet.	
		patient m and nutan panel	
22/6/26	8 AM	Bath done	Shobha
		vital sign checked and recorded.	
	8:20 AM	CTU connected to patient.	Shobha
		CTU non reactive and RPR good.	
		Informed Dr. Shreedevi mam	Shobha
		give hot water now, and shift to fever LDR after CTU reads.	Shobha
	8:45 AM	CTU send to Jor. Akshitha mam advised by shift to LDR @ 9 AM.	
		CTU continue another 10 mins	Shobha
	9 AM	PT's shifted to LDR. PT's details Hand over given to LDR staff	Shobha
22/6/26	9 AM	receiving notes patient is receiving from 7th floor to LDR patient care hand over taken from 7th floor staff nurse patient was stable conscious & oriented IV line present & patent. Dr Akshitha advised to tab: m 250 mg for orally given to pt Enema also given to patient general condition fair	Shobha

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

- No Known Drug Allergies
 Drug Allergies

NIL

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
22/6/20	10Am	⇒ post miso cur was connected as per doctors orders FHR is good ⊕ provided comfortable position To Encourage Adequate uterine contractions	Abakha 01808
	10:30 Am	⇒ Dr. Akshitha Advised to Inj: Pethesol 12mg for Im given to patient FHR is good ⊕ Pt was stable	Shri Abakha 01808
	11Am	⇒ Stopped cur as per doctors orders FHR is good ⊕ Pt is walking To Encourage Adequate uterine contractions	Shri Abakha 01808
	11.5Am	patient seen by Dr. Priyadharsini patient Arm done clean liquor Advice for Inj - Syntocin 2mg/hr started Strict CTU monitoring Vitals Stable and records	Sharmika/010125
	11.30am	patient Inj - Syntocin started. 2mg/hr ON Flew uncounted guided - started	Shmu 01808
	1pm	⇒ Inj: Taxime 1gram dilute medication iv given to patient To Encourage Adequate uterine contractions FHR is good ⊕ Inj: syntain 7.2 ml/hr on going	Shri Abakha 01808

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



(H)

NURSES NOTES



- No Known Drug Allergies
- Drug Allergies N/A

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
22/6/26	1:10 pm	⇒ patient want Epidural Informed Dr: priyadharshini Do plr Examination shows 3cm dilatation Advised to pt shifted to LDR II	S/N Akalya 01808
	1:30 pm	⇒ Dr: sothesh seen by patient Explained about the procedure to patient. Shifting up position clean the spinal area. Epidural catheter Inserted Injection given to patient. Iv fluids RL room. Rushed catheterization was done by Dr: Akshita. A clear output cut was connected as per doctor's orders FHR is good ⊕ post Epidural cm was reactive. Syntocin started 7ml	→ Aboobya 01808
	3pm	⇒ Dr: priyadharshini seen the pt Do plr Examination shows 3cm dilated 1cm long / membranes Absent Vertex @ -3 Advised to left lateral position. continues cut continue inj: Syntocin. Titrated well. with for contraction. FHR is good	→ S/N Akalya 01808
	3:30 pm	⇒ Dr: priyadharshini Advised to @unit PRBC resuscitation Blood grouping & the Blood collected & resuscitation form. both. Sent to lab for crossmatching	→ S/N Akalya 01808

Man.: 2025 - 06
 Exp.: 2030 - 06
 Ref.: 106.303.0500
 Lot.: 14176
 Green = 121°C - 15 min.
 Sterilized = 134°C - 3.5 min.
STEAM
6 Type ISO 11140

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



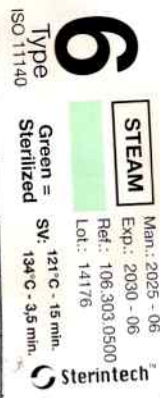
NURSES NOTES



- No Known Drug Allergies
- Drug Allergies

NW

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
22/6/26	4pm	<p>⇒ Dr. Priyadharsini DO PW Examination she is well Effaced 8cm dilated advised to lithotomy position to encourage pushing vacuum assessed vaginal delivery 2 Epidural</p>	<p>→ S/N Akshaya 01808</p>
	4:37 PM	<p>⇒ pt given to lithotomy position clean the perineum for povidone solution to encourage pushing Inj' 10x2% Infiltration was done. Poor maternal Effort so vacuum cup Applied baby head baby was delivered at 4:37pm a alive boy baby kept the placental cord in cup & clamped. Done cord Blood collected & sented to lab. placental was Expelled Inj. syntonin 10units 1m given Inj. syntonin 40units 2 RL 500ml connected on flow Inj. Dopice 190amL NS 100ml connected on flow PPH is there Bleeding so vacuum suction connected Dr. Priyadharsini Advised to Tab' miso 600 mg for sublingual given to pt Inj' methogeen 1m IV Inj' carboprost 1m given to pt</p>	<p>→ S/N Akshaya 01808</p>



NOTE : DO NOT WRITE OUTSIDE THE MARGINS



5

NURSES NOTES



- No Known Drug Allergies
- Drug Allergies

HLL

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
29/6/26	Continue Notes	⇒ No Bleeding control so another IV placement was done	
	4:55 PM	Dr. priyadharshini advised to IV fluids RL 500ml Rushed and gelo fish IV fluids connected. Tamponade Foley's 22 size inserted was done. Bleeding is controlled monitor the vital's minimal of bleeding BP is 110/80mmHg pulse is 130b/m. Informed Dr. priyadharshini suturing was done. Count collected 5 disposable tab. m280800mg kept the pt provided comfortable position.	
		Baby details: Date:- 29/06/2026 Time:- 04:45 PM weight:- 3.055 kg Sex:- BOY APGAR score 8/10/9/10	→ S/NAKALYA 018082
29/6/26	5:30 PM	⇒ patient complaints of sweating Informed Dr. priyadharshini advised to monitor the pt vital to give warmer. Inj. Taxim 1gram one dose given to pt O2 connected watch for Bleeding	→ S/NAKALYA 018082

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

No known Drug Allergies
 Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
22/06/20	6pm	<p>⇒ Dr: pavithra check Bleeding minimal & Bleeding catheter was done by Dr: pavithra.</p> <p>monitor vital with for bleeding</p> <p>No swelling pt was stable →</p>	Shatabdi 01800
	6:20 Pm	<p>⇒ B - Breast is soft</p> <p>U - Uterus was contracted</p> <p>B - Bowel movement present</p> <p>B - pt is CRD present output clear.</p> <p>L - Lochia Rubra present</p> <p>F - REEDA Assessment was done</p> <p>A - Apgar signs negative.</p> <p>E - pt Emotional good →</p>	Shatabdi 01800
	6:45 Pm	<p>⇒ Dr: pavithra advised to start Blood cross matching was done date, Bag Number, Expiry date, collected date checked and informed Dr: Pavithra.</p> <p>Before starting blood transfusion IV line good & pt vitals are Normal. OTR Blood ① units PRBC connected 45ml/hr NO Allergic reaction during Blood transfusion</p> <p>monitor the vital signs →</p>	Shatabdi 01800

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



5

NURSES NOTES

- No Known Drug Allergies
- Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
22/6/26	7pm		
	7:30 pm	<p>⇒ patient case hand over given to Night duty staff</p> <p>⇒ NIGHT DUTY</p>	Abalga D/809
22/6/26	7:30pm	<p>Patient report hand over taken from Evening duty staff</p> <p>She is active cry up below breast she is conscious & oriented, a febrile touch & axillary well. No oral feeds.</p>	
	8pm	<p>⇒ Patient vital signs stable. General condition fair.</p>	
	9pm	<p>⇒ PRBC on flow no allergic reaction Patient vital signs stable, General condition fair. Febrile touch 1-5pm given no allergic reaction</p>	
	10pm	<p>⇒ Tub. Dura 1gm Pls give</p>	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



6

NURSES NOTES

No Known Drug Allergies

Drug Allergies

NIL

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
29/6/16	1Am	=> B: Breast soft No engorgement => U: Uterus firm contracted well. => B: Breast areolae present => B: Patient in C&D last Out put 100ml => L: Lochia serosa present No evidence of Foul Smell => E: Peda assessment applicable => H: Homans sign negative => E: Patient emotional Stability good	→ [Signature]
	2Am	=> Patient slept well during night NO other complaints	→ [Signature]
	3Am	=> Temp: 98.4°F IT to Ds: Dryer muc. Advice to further breast	→ [Signature]
	4Am	=> Patient vital signs stable. General condition fair. Temp 98.4°C to 99.0°C	→ [Signature]
	6Am	=> CBC sent to lab reported. Patient vital signs stable. General condition fair	→ [Signature]
	7Am	=> Patient gave a strong burst of breast.	→ [Signature]
	7Am	=> Patient report had a	→ [Signature]

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		to morning duty staff	
23/6/26	7.40 am	Morning duty Notes: patient details handed over taken from Night duty staff. patient details conscious & oriented. vitals are checked & recorded. IV line kept in left & right hand. catheter present. foley tamponade present. Due medication given.	spn pasangan 016808
	8am	Direct breast feeding given. Baby sucking well. Baby mother side.	spn pasangan 016808
	8.30 am	Dr. Pavithra saw the patient checked bleeding advised to Hb - 7.8 mg/dl advised to today blood transfusion. post partum assessment done	spn pasangan 016808
		B => Breast soft. Direct breast feeding given.	
		U => Uterus contracted. pu bleeding normal	
		B => catheter present. I/o chest maintain	
		B => Bowel movement present	
		I => Lochia rubra present	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

No Known Drug Allergies

Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
23/6/26		E ⇒ REEDA assessment not applicable	
		H ⇒ Homan's sign negative	
		E ⇒ patient emotional status good.	S/o paravathi 016808
		9.45am - blood informed to blood bank blood issued. Dr. sreedevi s/o devi blood checked.	S/o paravathi 016808
	10 ¹⁰ Am	2nd unit PRBC issued will start at 10 ¹⁰ Am no allergic reaction vitals are checked and recorded, pv bleeding minimal no other complaints general condition is fair →	S/N. Anurag 016808
	10 ²⁰ Am	<div style="border: 1px solid black; border-radius: 50%; padding: 10px; width: fit-content; margin: auto;"> <p>Bag Blood group: O+ve Patient Blood group: O+ve (PRBC) St. date: 23/6/26 Bag No: 2647. St. time: 10 AM D.O.C - 23/6/26 D.O.E - 23/6/26 END DATE: 23/6/26 END TIME:</p> </div>	BP - 110/70 Pulse - 84 SpO2 - 99 Temp - 98.4°F RR - 24/min
	11:30am	patient side no complaints vitals are stable. pv bleeding normal.	S/o paravathi 016808

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES



- No Known Drug Allergies
- Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
23/6/26	11.45 am	Dr. pavithra saw the patient advised to remove foley tamponate. foley tamponate removed. 6ml collected.	
	12.30pm	Dr. priyadharsini saw the patient checked bleeding advised to roller clamp. Doctors orders called out.	sf/parameswari 016808
	12.45		sf/parameswari 016808
	1.10pm	Blood transfusion completed. There is no allergic history vitals are stable. patient side no complaints. blood bag send lab.	sf/parameswari 016808

ANNAI TERESA BLOOD BANK & APHERESIS CENTRE
 (Run by Little Roses Trust)
 LICENCE No.: 506/28C
 # No.946, 1st Floor, Bazaar Road, Ram Nagar (South) Madipakkam, Chennai - 91.
 Ph.: 044-22580803 Mobile : 9840143108 / 9840333108 / 9566468884
 E.mail : annaiteresabloodbank@gmail.com web: www.annaiteresabloodbank.com

CONCENTRATED HUMAN RED BLOOD CELLS I.P.
 Prepared From Blood Collected with anticoagulant citrate phosphate
 Dextrose solution. Whole blood 350 ml / 450 ml (IP 49ml / 63 ml)

BAG NO.	COLLECTION DATE	EXPIRY DATE	VOLUME
2647	26.06.26	01.08.26	289 ml

INSTRUCTIONS :

- Do not use if there is any visible evidence of deterioration.
- Storage temperature 2° to 6°
- Administer with warning.
- Mix well before use and do not vent
- Do not add any Medication.
- Use a Fresh clean, Sterile Transfusion set with filter
- Do not Dispense without Prescription.
- Check blood group on the label and recipients blood group before administration and properly identify intended recipient.
- No Atypical antibodies detected
- Shelf life 35 days / SAGM 42 Days.
- Transfusion Criteria ABO and Rh Specific X-match compatible

BLOOD GROUP

 Rh (D)
 POS

SCREENED : NEGATIVE / NON REACTIVE FOR : HBsAg, Anti HCV
 Anti HIV I & II, MP, VDRL, Irr, Ab - By CLIA METHOD
 PREPARED FROM A VOLUNTARY BLOOD DONOR

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



8

NURSES NOTES

- No Known Drug Allergies
- Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
23/6/20	12:30 pm	Clamp relaxed 300ml drains clear inform to Dr. Pavithra Advices reclamp again order comes out →	SIN Anur Oloom
	4:00 pm	2nd time sensation present D/F to Dr. Pavithra Advices Remove the catheter order comes out →	SIN Anur Oloom
	3pm	Patient voids 350ml D/F to Dr. Arshita mam Advices POE Bladder some shitted to ward order comes out →	SIN Anur Oloom
	3:30pm	transfer the patient 7th floor hand over given to 7th floor staff, to do CBC tomorrow morning 6am and plan for Discharge →	SIN Anur Oloom
	3:45pm	receiving notes pt received from 10th to 7th floor fracture detail handing over taken from IPR paramedics patient conscious and oriented iv line present patient is on normal diet. fracture union and motion franked →	SIN Anur Oloom

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

NURSES NOTES

No Known Drug Allergies

Drug Allergies MIL

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
2/21/6/12	4pm	Vital signs checked and Recorded. B - Breast soft. No Engorgement U - Uterus contracted. Involution present B - Bowel movement present. no pain U - Urine voided freely L - Lochia rubra present. No foul smell E - REEDA in absence present assessment done. H - Hoffman's sign Negative P - Emotional Status good	Ph
	6pm	10cc medication given as per doctor's order. Maintain Intake and Output chart	Ph
	7:00pm	Medication was given as per drug order maintain I/O chart and recorded	Ph
	7:30pm	PI details handing over quin to night duty staff	Ph

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 21/6/2026 Time of Arrival: 11:30pm Time Seen by Nurse: 11:30pm

1) Level of Consciousness: Conscious Semi-Conscious Unconscious

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

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

3) Vital Signs: Temperature: 98.1°f Pulse: 88 RR: 20 SpO₂: 100%¹⁰ BP: 120/70 Weight: 72.6 kg

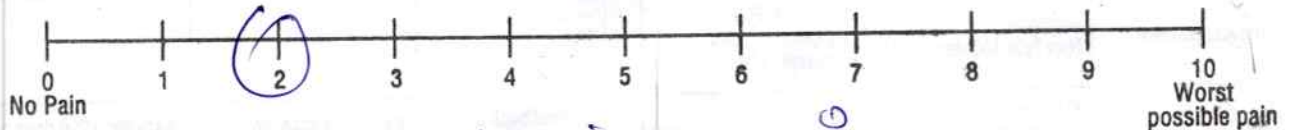
4) Gestational Criteria:

Gravida:	G	P	L1	A 2
----------	---	---	----	-----

LMP: 12/10/2025 EDD: 19/7/2026 Gestational Age: 36 weeks

Uterine Contraction	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Onset	Time	Frequency:
		<u>21/6/2026</u>	<u>5pm</u>	<u>10 min 2 contractions</u>
Membrane Rupture	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA	Onset	Time	Fluid Color:
Vaginal bleeding	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA	Onset	Time	Amount:
Pre Eclampsia Symptoms	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA	If Yes specify: Headache / Visual Symptoms / Pain Abdomen / Vomiting		
Good fetal Movement	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	If No specify:		

5) Pain Screening: Numerical Pain Scale (NPS)



- ① Location: lower abdominal pain
- ② Duration: 10 min 2 contractions Days / Weeks / Months (Strike out which is not applicable)
- ③ Character: mild
- ④ Frequency: 10 min 2
- ⑤ Interventions: comfortable position

6) Past History:

- a) Surgeries: D & C # 3/2005
- b) Medical: NIL

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	<ul style="list-style-type: none"> ● Acute onsite severe abdominal pain ● Altered level of consciousness ● Cord prolapse ● Severe respiratory distress ● Suspected sepsis 	<ul style="list-style-type: none"> ● Major trauma ● Shortness of breath ● Unplanned and unattended birth 	<ul style="list-style-type: none"> ● Abdominal/back pain greater than expected in pregnancy ● Flank pain / hematuria ● Nausea /vomiting and /or diarrhea with suspected dehydration 	<ul style="list-style-type: none"> ● Ongoing assessment from out patient clinic (for hypertension, blood work) ● Minor trauma (minor MVC/fall) ● Nausea/Vomiting and /or diarrhea ● Signs of infection (ie dysuria ,cough, fever, chills) 	<ul style="list-style-type: none"> ● Anything that does not seem to pose threat to mother or fetus ● Cervical ripening ● Out patient placenta previa protocols ● Pre-booked visits (ie Rh and progesterone injections, NST ● Assessment for version ● Rashes

Time seen by Doctor: 11:40pm

Nurse Name : D. Sobelwaro Nurse Signature: D. Sobelwaro

Date: 21/6/2026 Time: 11:40pm

P



LABOUR AND DELIVERY NURSING ASSESSMENT

Date of Admission: 21/6/2025

Baseline Information:

Admission From: ER OPD Admission Desk Others: specify ADP

Primary Language: Telugu English Hindi Others

Do you require an interpreter? Yes No

Source of Information: Patient Family Others

Personal belonging if any: Jewelry Nose Ring Bangles Anklets Finger Ring Bracelets

handed over to Husband

Allergies: Yes No Medications Blood Transfusion Food Other:

If yes, identify

Chief Complaints: patient come for abdomineral pain Doctor Notified on Admission: Yes No
 Name of the Doctor: DR. venitha
 Time Notified: 11:30 pm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
NIL	D&C # 2025	-

Blood Group: O+ve LMP: 12/10/25 EDD: 11/1/26 Gestational age during admission: 36 wks

Contractions: yes Vaginal Discharge: -

Obstetric History: G 6 P 1 L 1 A 2 Previous LSCS -

Height: 151 Weight: 72.6 BMI: 31.84
 Temp: 98.10F HR: 82 RR: 20 BP: 120/80 SpO₂: 100%

High Risk Factors: (Please select by ticking (✓) the box as applicable)

<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Rh Incompatibility	<input type="checkbox"/> Fertility Treatment
<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Previous LSCS	<input type="checkbox"/> Preterm Labour
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Gestational Hypertension	<input type="checkbox"/> Others: (Specify)
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Bad Obstetric History	
<input type="checkbox"/> Anemia	<input checked="" type="checkbox"/> Obesity (BMI)	
	<input type="checkbox"/> Twins / Multiple Pregnancy	

Patient Sticker

Family History: No Abnormalities Detected

- Heart Disease Hypertension Diabetes Stroke Seizures Kidney disease
 Liver disease Other

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

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

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

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

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

- Overweight Poor Appetite > 3 Days Needs Therapeutic Diet.
 Under Weight Diabetes Mellitus No Abnormality Detected

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

- Calm & Cooperative Restless Depressed Agitated Confused
 Others

Inform consultant for positive criteria

SOCIAL SCREENING:

1. Marital Status: Single Married Divorced Widow
2. Special Habits: Smoker: Yes No Alcohol Abuse: Yes No Drug Abuse: Yes No

Social History: Lives With Husband

Orientation has been given regarding the following aspects:

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

Above information given to MRS. THIRUPURASUNDARI

Name of Person Orientation was given to: Mrs. Thirupurasundari

Orientation not given Reason: Nil

Nurse Signature: D. Saha

Nurse Name: D. Saha

Date & Time: 21/10/2026 at 11.40pm



Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	21/6/26	22/6	22/6/26	Fall Risk Grading		
		Score						
History of Falling (immediately or w/in 3 months)	Yes	25				Risk Level	Morse Fall Score (MFS)	Action
	No	0	0	0	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15				Low Risk	0 - 24	Standard Fall Precaution
	No	0	0	0	0			
Ambulatory Aid	Furniture	30				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0	0	0			
IV / Heparin Lock or Saline	Yes	20			20	High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	No	0	0	0	0			
GAIT / Transferring	Impaired	20				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0	0	0	0			
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0	0	0	0			
Total Morse Fall Scale Score:			0	0	20			
		Signature	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>			

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

The first part of the paper discusses the importance of the...
 The second part of the paper discusses the importance of the...
 The third part of the paper discusses the importance of the...

The fourth part of the paper discusses the importance of the...
 The fifth part of the paper discusses the importance of the...

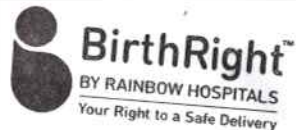
The sixth part of the paper discusses the importance of the...
 The seventh part of the paper discusses the importance of the...

The eighth part of the paper discusses the importance of the...
 The ninth part of the paper discusses the importance of the...

The tenth part of the paper discusses the importance of the...



Morse Fall Risk Assessment Form



Choose Highest Applicable Score from each Category		Date / Time	^N 22/6	^M 23/6	^N 24/6	Fall Risk Grading		
		Score				Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25		20		Low Risk	0 - 24	Standard Fall Precaution
	No	0						
Secondary Diagnosis (more than one diagnosis)	Yes	15	0	0	0	Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
Ambulatory Aid	Furniture	30	0	0	0	High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0	0	0			
IV / Heparin Lock or Saline	Yes	20		0	0	High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	No	0		20	20			
GAIT / Transferring	Impaired	20	0			High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10	20					
	Normal /On Bed Rest /Immobile	0	0					
Mental Status	Forgets limitations	15		0	0	High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0	0					
Total Morse Fall Scale Score:			20	0	0			
Signature			<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>			

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

GUC-00074875 IP18-00036127
 Mrs THIRUPURASUNDARI. R
 17-07-1994 31 Y 11 M 5 D (F)
 Dr. PRIYADHARSHINI S M



BRADEN 'Q' SCALE

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

					Date:	21/6/20	21/6	22/6	22/6
					Time:	N	M	E	N
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	4	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	
FRICITION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times.*	4	4	4	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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28	28	27	27
					Evaluator's Name	[Signature]	[Signature]	[Signature]	[Signature]

OFF RCH 01/08/20

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	<ul style="list-style-type: none"> ⑩ Regular Turning Schedule ⑩ Enable as much activity as possible ⑩ Protect the heels ⑩ Use pressure redistribution surfaces ⑩ Manage moisture, friction and shear ⑩ Advance to a higher level of risk if other major risk factors are present 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	<ul style="list-style-type: none"> ⑩ Use the Same Protocol as for "At Risk" Patients ⑩ Position patient at 30 degree lateral incline using foam wedges 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> ⑩ Follow the same protocol as for "Moderate Risk" Patients ⑩ In addition to regular turning schedule ⑩ Make small shifts in their position frequently 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	<ul style="list-style-type: none"> ⑩ Use same protocol as for "High Risk" Patients ⑩ Add a pressure redistribution surface for patients with severe pain or with additional risk factors. 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay



2

BRADEN 'Q' SCALE

		Date : 23/6 23/6 23/6					
		Time : M E N					
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4
'Activity The degree of physical activity'	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	3	3	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4
FRICITION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times.	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings 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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	3
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be < 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4
TOTAL SCORE		27	27	27			
Evaluator's Name		PR	PR	PR			

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 <small>(Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)</small>
15-18	At Risk	<ul style="list-style-type: none"> ⑩ Regular Turning Schedule ⑩ Enable as much activity as possible ⑩ Protect the heels ⑩ Use pressure redistribution surfaces ⑩ Manage moisture, friction and shear ⑩ Advance to a higher level of risk if other major risk factors are present 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	<ul style="list-style-type: none"> ⑩ Use the Same Protocol as for "At Risk" Patients ⑩ Position patient at 30 degree lateral incline using foam wedges 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
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Less than 9	Severe Risk	<ul style="list-style-type: none"> ⑩ Use same protocol as for "High Risk" Patients ⑩ Add a pressure redistribution surface for patients with severe pain or with additional risk factors. 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

BRADEN 'Q' SCALE

Patient Sticker

		Date:	Time:
Mobility	<p>1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.</p> <p>1. Bedfast: Confined to bed</p> <p>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.</p> <p>2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.</p> <p>3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.</p> <p>4. No limitations: Makes major and frequent changes in position without assistance.</p>		
'Activity The degree of physical activity'	<p>1. Bedfast: Confined to bed</p> <p>2. Chairfast: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.</p> <p>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.</p> <p>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.</p>		
Sensory Perception	<p>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.</p> <p>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.</p> <p>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.</p> <p>4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.</p>		
Moisture Degree to which skin is exposed to moisture	<p>1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.</p> <p>2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.</p> <p>3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.</p> <p>4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.</p>		
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	<p>1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.</p> <p>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.</p> <p>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.</p> <p>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.</p>		
Nutritional Usual food intake pattern	<p>1. 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.</p> <p>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.</p> <p>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.</p> <p>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.</p>		
Tissue Perfusion & Oxygenation	<p>1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.</p> <p>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.</p> <p>3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be < 2 seconds; serum pH is normal.</p> <p>4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.</p>		
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

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

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	<ul style="list-style-type: none"> • Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	<ul style="list-style-type: none"> • Use the Same Protocol as for "At Risk" Patients • Position patient at 30 degree lateral incline using foam wedges 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> • Follow the same protocol as for "Moderate Risk" Patients • In addition to regular turning schedule • Make small shifts in their position frequently 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	<ul style="list-style-type: none"> • Use same protocol as for "High Risk" Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors. 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

GJC-00074875 IP18-00036127
 Mrs THIRUPURASUNDARI. R
 17-07-1994 31 Y 11 M 5 D (F)
 Dr. PRIYADHARSHINI S M



7

PAIN ASSESSMENT FORM

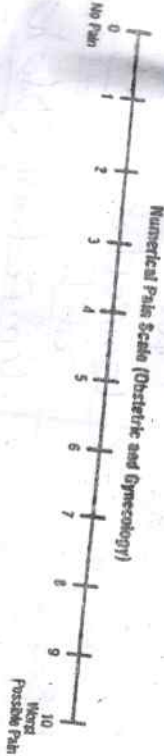
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
21/6/20	11pm	2/10	lower abdomen	Intermittent	Acute	Dull	Decreasing	Yes	comfortable position	Dhe 0171
22/6/20	2am	2/10	lower abdomen	Intermittent	Acute	Dull	Decreasing	Yes	comfortable position	Dhe 0171
22/6/20	4am	2/10	lower abdomen	Intermittent	Acute	Dull	Decreasing	Yes	comfortable position	Dhe 0171
22/6/20	6am	2/10	lower abdomen	Intermittent	Acute	Dull	Decreasing	Yes	nil	Dhe 0171
22/6/20	10am	0/10						Yes	nil	St
22/6/20	9am	2/10	lower abdomen	Intermittent	Acute	Dull	Decreasing	Yes	comfortable position	Ataka 0180
22/6/20	11am	2/10	lower abdomen	Intermittent	Acute	Dull	Decreasing	Yes	comfortable position	Ataka 0180
22/6/20	2pm	3/10	lower abdomen	Intermittent	Acute	Dull	Decreasing	Yes	Epidural given	Ataka 0180
22/6/20	6pm	2/10	Epistom side	Intermittent	Acute	Dull	Decreasing	Yes	comfortable position	Ataka 0180
22/6/20	8pm	1/10	Epistom side	Intermittent	Acute	Dull	Decreasing	Yes	comfortable position	Ataka 0180

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

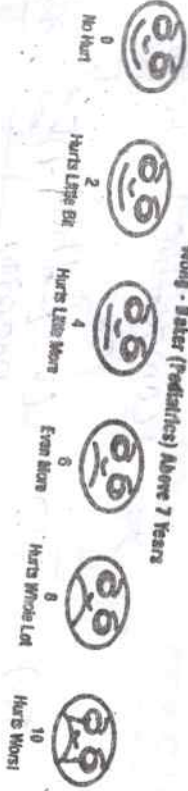
PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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



Wong - Baker (Faces) Above 7 Years



Neonatal Pain, Agitation and Sedation Scale (up to 1 Month)

Assessment Criteria	Sedation			Normal	Pain / Agitation
	-2	-1	0		
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	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arched, kicking constantly awake or Arouses minimally / no movements (not sedated)
Facial Expression	Mouth is lax	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression Irritable	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, SpO2, SaO2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO2, 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO2, less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator



2

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
23/6	12AM	1/10	Epistomy Site	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input checked="" type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Pt comfortable Position	Asp/01/17/20
23/6	6AM	1/10	Epistomy Site	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input checked="" type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	comfortable position	Asp/01/17/20
23/6/26	9am	1/10	epistomy site	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input checked="" type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	provide comfortable position	Asp/01/17/20
23/6/26	12pm	1/10	epistomy site	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	provide comfortable position	Asp/01/17/20
23/6	3PM	1/10	Epistomy wound	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input checked="" type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	comfort position	Asp/01/17/20
24/6/2024	6pm	0/10	nil	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	nil	Asp/01/17/20
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

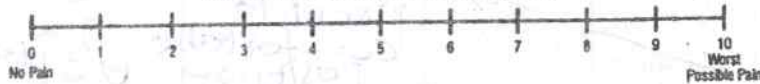
Re-assessment Frequency:
 1. Every eight hours for all hospitalized patients.
 2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 a) At least every 2 hours for the first 24 hours b) Then every 4 hours.
 c) Prior to pain-relieving intervention. d) Within 30 - 60 minutes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

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



GUC-00074875 IP18-00036127
 Mrs THIRUPURASUNDARI. R
 17-07-1994 31 Y 11 M 5 D
 Dr. PRIYADHARSHINI S M

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:

- Diagnosis 44 Pily 36 hr ^{Plan} Pain Management
- Treatment and Care Informed Consent
- Medication / Therapy (safety, effects/ side effect, interactions)
- Discharge Medication
- Infection Control Measures
- Diagnostic Test / Procedures
- Nutrition / Diet
- Fall Risk Education
- Safe use of Medical Equipment / Implantable Devices Safety
- Patient's / Family Rights
- Risk / Safety

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
21/6/26	11.30 pm	yes	patient educated re during contractions breathe in breathe out	patient	No Learning Barriers	oral	None	very	good	Deep
22/6/26	9 AM	YES	Educated about the pain management	pt	No Learning Barriers	oral	none	good	good	shiraj
23/6/26	8 am	yes	Educate about the pain management	patient	None	oral	None	yes	good	shiraj

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	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing	

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

Mechanism/s to overcome barrier/s:

1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify
2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference	

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

Form No. 101-1 (Rev. 07/2011)

Yes **No**
 1. Is the applicant a U.S. citizen or permanent resident?
 2. Is the applicant at least 18 years old?
 3. Is the applicant a high school graduate or GED holder?
 4. Is the applicant a U.S. resident for at least 12 months?
 5. Is the applicant a U.S. resident for at least 6 months?
 6. Is the applicant a U.S. resident for at least 3 months?
 7. Is the applicant a U.S. resident for at least 15 days?
 8. Is the applicant a U.S. resident for at least 7 days?
 9. Is the applicant a U.S. resident for at least 3 days?
 10. Is the applicant a U.S. resident for at least 1 day?

11. Is the applicant a U.S. resident for at least 12 months?
 12. Is the applicant a U.S. resident for at least 6 months?
 13. Is the applicant a U.S. resident for at least 3 months?
 14. Is the applicant a U.S. resident for at least 15 days?
 15. Is the applicant a U.S. resident for at least 7 days?
 16. Is the applicant a U.S. resident for at least 3 days?
 17. Is the applicant a U.S. resident for at least 1 day?

18. Is the applicant a U.S. resident for at least 12 months?
 19. Is the applicant a U.S. resident for at least 6 months?
 20. Is the applicant a U.S. resident for at least 3 months?
 21. Is the applicant a U.S. resident for at least 15 days?
 22. Is the applicant a U.S. resident for at least 7 days?
 23. Is the applicant a U.S. resident for at least 3 days?
 24. Is the applicant a U.S. resident for at least 1 day?

Form No. 101-1 (Rev. 07/2011)

25. Is the applicant a U.S. resident for at least 12 months?
 26. Is the applicant a U.S. resident for at least 6 months?
 27. Is the applicant a U.S. resident for at least 3 months?
 28. Is the applicant a U.S. resident for at least 15 days?
 29. Is the applicant a U.S. resident for at least 7 days?
 30. Is the applicant a U.S. resident for at least 3 days?
 31. Is the applicant a U.S. resident for at least 1 day?

32. Is the applicant a U.S. resident for at least 12 months?
 33. Is the applicant a U.S. resident for at least 6 months?
 34. Is the applicant a U.S. resident for at least 3 months?
 35. Is the applicant a U.S. resident for at least 15 days?
 36. Is the applicant a U.S. resident for at least 7 days?
 37. Is the applicant a U.S. resident for at least 3 days?
 38. Is the applicant a U.S. resident for at least 1 day?

39. Is the applicant a U.S. resident for at least 12 months?
 40. Is the applicant a U.S. resident for at least 6 months?
 41. Is the applicant a U.S. resident for at least 3 months?
 42. Is the applicant a U.S. resident for at least 15 days?
 43. Is the applicant a U.S. resident for at least 7 days?
 44. Is the applicant a U.S. resident for at least 3 days?
 45. Is the applicant a U.S. resident for at least 1 day?

Form No. 101-1 (Rev. 07/2011)

46. Is the applicant a U.S. resident for at least 12 months?
 47. Is the applicant a U.S. resident for at least 6 months?
 48. Is the applicant a U.S. resident for at least 3 months?
 49. Is the applicant a U.S. resident for at least 15 days?
 50. Is the applicant a U.S. resident for at least 7 days?
 51. Is the applicant a U.S. resident for at least 3 days?
 52. Is the applicant a U.S. resident for at least 1 day?

53. Is the applicant a U.S. resident for at least 12 months?
 54. Is the applicant a U.S. resident for at least 6 months?
 55. Is the applicant a U.S. resident for at least 3 months?
 56. Is the applicant a U.S. resident for at least 15 days?
 57. Is the applicant a U.S. resident for at least 7 days?
 58. Is the applicant a U.S. resident for at least 3 days?
 59. Is the applicant a U.S. resident for at least 1 day?

60. Is the applicant a U.S. resident for at least 12 months?
 61. Is the applicant a U.S. resident for at least 6 months?
 62. Is the applicant a U.S. resident for at least 3 months?
 63. Is the applicant a U.S. resident for at least 15 days?
 64. Is the applicant a U.S. resident for at least 7 days?
 65. Is the applicant a U.S. resident for at least 3 days?
 66. Is the applicant a U.S. resident for at least 1 day?



ПРОЦЕДУРА ЗАПИСИ НА УЧЕНИЦИТЕ



GUC-00074875 IP18-00036127
 Mrs THIRUPURASUNDARI. R
 17-07-1994 31 Y 11 M 5 D (F)
 Dr. PRIYADHARSHINI S M



CONSENT FOR BLOOD TRANSFUSION

Patient Name : Age: Gender :
 UHID No.: Ward/Bed No.

GUC-00074875 IP18-00036127
 Mrs THIRUPURASUNDARI. R
 17-07-1994 31 Y 11 M 5 D (F)
 Dr. PRIYADHARSHINI S M



Type of Blood Product :

10 PRBC

I hereby give my consent for whole blood transfusion / blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for HIV antibodies, Hepatitis B surface antigens, Hepatitis C antibodies, Malaria and Syphilla. I have also been explained that transfusion transmitted infections can vary rarely occur even with screened blood, especially if it is in the "window period" and also due to various other infections which have not been screened for. I also understand that any blood component transfusions carry risk of transfusion associated reactions.

All the above-mentioned risks have been explained to me by the doctor treating me / my patient in the language that I fully understand and I accept the same and give my consent for the whole blood component transfusion to me / my Patient named

Name of Patient / Attendant MRS. THIRUPURASUNDARI.

Signature of Patient / Attendant /

Date 22/06/2026

Time : 3:20 pm

Relationship with Patient: patient

CONSENT FOR BI
DANA HEIN

Patient Name: _____
DOB: _____
Type of Blood Product: _____

I, the undersigned, being the parent or legal guardian of the above-named patient, do hereby consent to the use of the patient's blood for the purpose of _____

Signature of Parent/Guardian: _____

Signature of Physician: _____

Date: _____

SI.No. 2997 NARCOTIC PRESCRIPTION FORM (PATIENT COPY)

Patient Name : <i>Ms. Thiruvudai Sundari . K</i>		Age: <i>27 YEARS</i>	Gender: <i>FEMALE</i>
UHID No: <i>000-00074245</i>	IP No: <i>13-00036127</i>	Date: <i>22/06/2026</i>	Date: <i>22/06/2026</i>
Diagnosis: <i>G4 P1 L1, 1 36 weeks + 1 day / EPIDURAL ANALGESIA</i>		Time:	
PRESCRIPTION DETAILS (Tick only one of the following)			
S.No.	Drug Name	Dosage / No. Vials / Ampoule	Remarks
1.	Inj Fentanyl Citrate (100 mcg/2ml)	<i>100mcg / ①</i>	-
2.	Fentanyl Citrate 25 mcg patch	-	-
3.	Morphine Inj 10 MG / ML	-	-
4.	Pethidine 50 MG / 1ML	-	-
Doctor Name: <i>DR SATHISH</i>		Doctors Medical Council Registration No. <i>71590</i>	
Signature: <i>[Signature]</i>		<i>162217</i>	

NARCOTIC DISPENSING FORM APPENDIX 4 - FORM NO. 3E (Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: *13-00036127* Date: *22/06/2026*
 Aadhaar No. of the patient(optional):

1.	Name	Remarks		
2.	Complete postal address (with contact number, if any)	<i>13 GANDHI NAGAR, SELAIKUR, CHENNAI, TAMIL NADU, INDIA</i>		
3.	Brief description of the illness	<i>G4 P1 L1, 1 36 WEEKS + 1 DAY / EPIDURAL ANALGESIA</i>		
4.	Whether registered with any other registered medical practioner / recognized medical institution (if yes, details to be recorded)			
5.	Details of essential narcotic drugs dispensed			
Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient	Remarks, if any
<i>22/06/2026</i>	<i>INJ-FENTANYL CITRATE 100mcg</i>	<i>①</i>	<i>[Signature]</i>	

Dispensed by (Name & ID No.): *[Signature]*

Signature: *[Signature]*

Received by (Name & ID No.): *[Signature]*

Signature: *[Signature]*

Time: *2.30 pm*



Rainbow Children's Hospital
 A HOSPITAL OF THE UNIVERSITY OF CHICAGO

RAINBOW CHILDREN'S MEDICARE LIMITED
 # 157 - 180, Anna Road, Gully, Chennai - 600 015

**NARCOTIC PRESCRIPTION FORM
 (PATIENT COPY)**

2007

Sl. No.

Sl. No.	Drug Name	Quantity	Frequency
1	Paracetamol 500 mg	10 tablets	PO q 6h
2	Amoxicillin 500 mg	10 tablets	PO q 8h
3	Clonidine 0.1 mg	10 tablets	PO q 12h
4	Hydrocodone 5 mg	10 tablets	PO q 4h

Prescription details (to be filled in by the doctor)

Patient Name: _____
 UDD No: _____
 Date: _____

**NARCOTIC DISPENSING FORM
 APPENDIX A - FORM NO. 32
 (Details of the Patient to whom Essential Narcotic Drugs Dispensed)**

1. Patient Name: _____
 2. Address: _____
 3. Telephone No: _____
 4. Date of Birth: _____
 5. Date of Dispensing: _____
 6. Name of the Dispensing Doctor: _____
 7. Signature of the Doctor: _____
 8. Signature of the Patient: _____

Dispensed by (Name & D. No.)
 Received by (Name & D. No.)
 Date



CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MAC

GUC-00074875 IP18-00036127
 Mrs THIRUPURASUNDARI. R
 17-07-1994 31 Y 11 M 5 D (F) Age :
 Dr. PRIYADHARSHINI S M
 Patient Name :
 Gender: M F - IP
 Ward / Bed No. : Anaesthesiologist: C. SATHISH CHANDER
 Operative procedure planned : LABOUR EPIDURAL + LSCS

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief without numbness can be achieved by infusing weak solutions of local anesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

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

- Heart disease
- Hypertension
- Diabetes mellitus
- Renal failure
- Hepatic disorders
- Shock
- Multiple organ failure
- Polytrauma / RTA
- Incapacitating COPD
- Others : HEADACHE, HYPOTENSION

Comments :

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

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient the above mentioned operation / Diagnostic / Therapeutic procedures
LABOUR EPIDURAL + LSCS

I authorize and give consent for anaesthesia (Regional / General Anesthesia / Monitored anesthesia care (MAC)) as considered appropriate by the anaesthetic team.

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anesthesia.

I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, asthmatic reactions, headaches.

I authorize the anaesthetic team to perform any additional procedures (for example, CVP line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter in need arises.

I understand that the above mentioned consultant anesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

Pregnant: Yes No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

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

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

Patient / Patient Attendant :

Signature : *[Signature]*
Name : *Mrs. Thiripurasundari*
Relationship with Patient: *patient*
Date & Time : *22/6/25 2pm*

Witness :

Signature : *[Signature]*
Name : *Venkatraman K*
Date & Time : *22/6/25 2pm*

Doctor (who is taking the consent) :

Signature : *[Signature]*
Name : *SATHISH*
Date & Time : *22/6/25 2pm*

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



Name: THIRUPANA SUNDARI Age: 31Y Sex: F UHID.No:

Date: 22/6/26 Time: Proposed Operation: LSCS

Diagnosis:

B.P / CRT: 110/70 H.R: 70/m Weight: ASA Physical Status: 1 2 3 4 5

Laboratory Data:				
Hgb: <u>9.4</u>	Glucose:	Protein:	HIV:	X-Ray:
PCV:	Urea:	Alb:	HBS Ag:	ECG:
WBC:	Creat:	Total Bill:	HCV:	2D Echo:
Plate:	Na:	Dir. Bill:	Blood group: <u>O+ve</u>	Stress/Angio:
PT:	K:	LDH:	T3:	Other:
PTT:	Ca++:	Alk phos:	T4:	
INR:	Mg++:	Amylase:	TSH: <u>2.2</u>	<u>EF T2%</u>
	Cl-:	SGOT/SGPT:		

Allergies: NK

Medical History: CVS:

RESP: Diabetes:

CNS:

Renal:

Hepatic / GE: Physical Activity: on T. Escapirny

Others:

Past Anaesthetic History: Anaemia

Physical Exam: low hygi placenta

Airway: MP 1 2 3 4 Mouth Opening: Mentohyoid Distance: Neck: Teeth:

Lungs: BACCP

Heart: S1S2

CNS: MAD

Pregnant: Yes No NA Venous Access Site: Spine Exam for regional:

Anaesthetic Plan: MAC REGIONAL GA-ETT LMA

Peri-Operative Plan Explained to the Patient: Yes No

CURRENT MEDICATIONS	DOSAGE

- Pre-Operative Instructions:**
- DVT Prophylaxis :
 - NIL ORAL $\left\{ \begin{array}{l} \text{Water / ORS 2 Hours} \\ \text{Others 6 Hours} \end{array} \right.$
 - Informed Consent: Standard High Risk
 - Post Operative Pain Management: Discussed with Patient
 - Other Instructions:

Signature: sch Name: SATHYU

Patient Sticker

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Time Received : Time Discharged :

< RESP • PULSE > BLOOD PRESSURE	250		250	IV Cannula Site :
	240		240	<input type="checkbox"/> O ₂ Mask <input type="checkbox"/> Nasal Prongs
230		230	<input type="checkbox"/> Tracheostomy <input type="checkbox"/> T-Piece	
220		220	<input type="checkbox"/> Oral Airway <input type="checkbox"/> Nasal Airway	
210		210	Vomiting : <input type="checkbox"/> Yes <input type="checkbox"/> No Drug:	
200		200	NG Tube : <input type="checkbox"/> Yes <input type="checkbox"/> No	
190		190	Drain: <input type="checkbox"/> Yes <input type="checkbox"/> No	
180		180	Urinary Catheter: <input type="checkbox"/> Yes <input type="checkbox"/> No	
170		170	Chest Tube: <input type="checkbox"/> Yes <input type="checkbox"/> No	
160		160	Nil Oral <input type="checkbox"/> Yes <input type="checkbox"/> No	
150		150	IV Fluids:	
140		140	Oral Feeds:	
130		130		
120		120		
110		110		
100		100		
90		90		
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50		50		
40		40		
30		30		
20		20		
10		10		
0		0		
SPO ₂				

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature

Pain Tool Used: N PASS FLACC Wong Baker NPS

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 relieving intervention
 - d. With in 30-60 minutes after pain relief intervention

Anaesthesiologist Name :

Transferred to Unit by (PACU):

Anaesthesiologist Signature:

Date & Time:

Date & Time:

PACU Nurse Name :

PACU Nurse Signature:

Date & Time:

ANNAI TERESA BLOOD BANK & APHERESIS CENTRE

(Run by Little Roses Trust)

LICENCE No.: 506/28C

No.946, 1st Floor, Bazaar Road, Ram Nagar (South) Madipakkam, Chennai - 91. Ph.: 044-22580803, 48616108

Mobile : 9840143108, 9840333108 E.mail : annaiteresabloodbank@gmail.com web : www.annaiteresabloodbank.com

COMPATIBILITY REPORT

Patient's Name..... Mrs. Thiropura Sundari R Age : 31 yrs Sex : F
Patient's Blood Group & Rh Typing..... O positive IP No : - Ward : -
Hospital Name :..... Rainbow children's Hospital. (Guc)
Bag Blood Group & Rh Typing..... O positive DATE : 23.06.26 TIME : 1:15 AM

S.No.	BAG NUMBER	COMPONENTS	DATE OF COLLECTION	DATE OF EXPIRY	SEG.No.
<u>1.</u>	<u>2647</u>	<u>DRBC</u>	<u>20.06.26</u>	<u>01.08.26</u>	<u>MDD63725</u>

Major X Matching : Saline / Alb / AHG / Column (Gel)

Minor X Matching : Saline / Alb / AHG / Column (Gel)

COMPATIBLE

Cross Matched by..... Yuvraj

Checked by.....

Dr. C.FLORENCE, MBBS
(Reg. No. 127546)
Medical Officer

ANNALS OF THE ENTOMOLOGICAL SOCIETY OF AMERICA

Volume 51, Number 1, February 1960

Number of Pages: 1-100

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The Biology of the Larva of the Housefly, *Musca domestica* L. (Diptera: Muscidae)
The Biology of the Larva of the Housefly, *Musca domestica* L. (Diptera: Muscidae)
The Biology of the Larva of the Housefly, *Musca domestica* L. (Diptera: Muscidae)

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GUC-00074875 IP18-00036127
 Mrs THIRUPURASUNDARI R
 17-07-1994 31 Y 11 M 6 D (F)
 Dr. PRIYADHARSHINI S M



BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 23/6/2026 Time: 10.10AM
 Blood Group of the Patient: O-POSITIVE Blood Group on the Blood Bag: O-POSITIVE
 Blood Bank Issue No: 26019857 Date of Collection: 20.6.26 Date of Expiry: 1.08.26
 Date & Time of Starting Transfusion: 23/6/26 at 10:10AM Planned duration of Transfusion: 23/6/26 @ 1.10 pm
 Check for Correct Unit: Correct Patient:
 Blood products cross checked by: Nurse 1: S/N. PARAMESWARAI Nurse 2: S/N. DEVI
 Before starting transfusion vitals: Temp: 98°F HR: 84b/min RR: 20b/min BP: 110/70 SpO₂: 99%

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
<u>23/6/26</u>	<u>10AM</u> 15 Min	<u>84b/min</u>	<u>98°F</u>	<u>110/70</u>	<u>99%</u>	-	-	-	-
	<u>10:15AM</u> 15 Min	<u>82b/min</u>	<u>98.1°F</u>	<u>108/68</u>	<u>98%</u>	-	-	-	-
	<u>10.30AM</u> 30 Min	<u>84b/min</u>	<u>98°F</u>	<u>102/70</u>	<u>99%</u>	-	-	-	-
	<u>11AM</u> 30 Min	<u>72b/min</u>	<u>97.8°F</u>	<u>100/68</u>	<u>98%</u>	-	-	-	-
	<u>11.30AM</u> 30 Min	<u>76b/min</u>	<u>98°F</u>	<u>100/70</u>	<u>99%</u>	-	-	-	-
	<u>12PM</u> 1 Hr	<u>76b/min</u>	<u>98°F</u>	<u>100/68</u>	<u>99%</u>	-	-	-	-
	<u>1PM</u> 1 Hr	<u>72b/min</u>	<u>98°F</u>	<u>100/70</u>	<u>99%</u>	-	-	-	-
	<u>1.10pm</u>	<u>90b/min</u>	<u>98°F</u>	<u>90/60</u>	<u>98%</u>	-	-	-	-

Comments: patient vitals Monitored and recorded. Maintained I/O. No allergic Reactions during Transfusion

Name of the Incharge-Nurse: Anur Name of the Nurse: S/N parameswari
 Signature of the Incharge-Nurse: [Signature] Signature of the Nurse: [Signature]
 Date & Time: 23/6/26 @ 1.10pm Date & Time: 23/6/2026 @ 1.10pm

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patient monitored and recorded. The patient was given 10.0ml of 0.1% adrenaline every 15 minutes.

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CATLA

Rainbow Children's Hospital

Blood Storage Center

No, 157, Annasalai, Guindy, Chennai - 600015



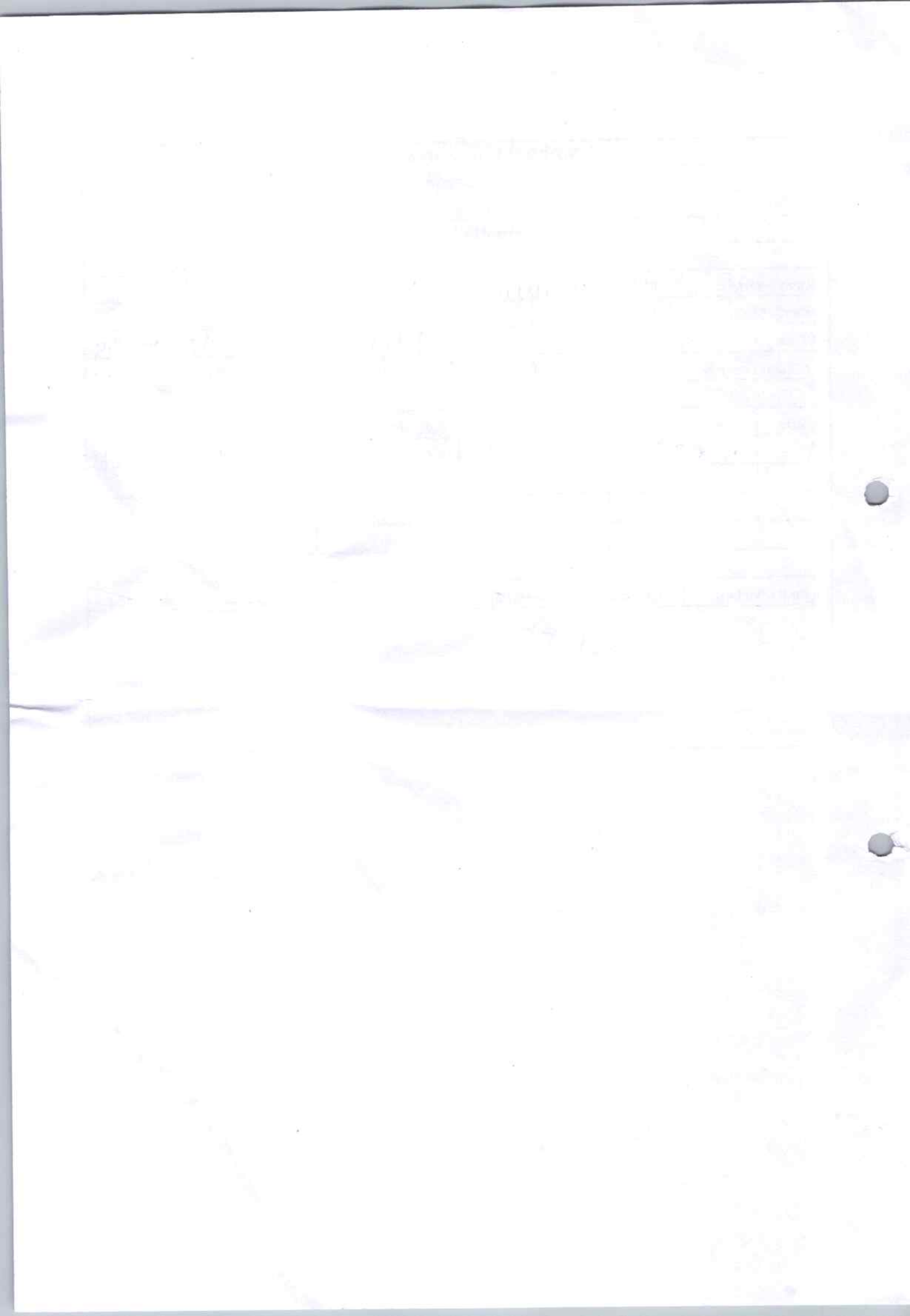
Compatibility Report

Patient's Name :	Mrs. Thirupura Sundari	Age/Sex	31y 1 F
Patient's Blood Group & Rh Typing			
GUC No	94875	Ward	LDR
Order No	1715599		
Bag Blood Group & Rh Typing	O +ve	Date	22/6/16
		Time	10:30 pm

S.No	Bag Number	Components	Date of Collection	Date of Expiry	Seg No
1	2320	PRBC	26/5/26	7/7/26	6AA 66080

Major X Matching :	Saline/Alb/AHG/Colum (Gel)	Minor X Matching :	Saline/Alb/AHG/Colum (Gel)
--------------------	----------------------------	--------------------	----------------------------

Cross Matched By: C. Luth Medical Officer: _____



GUC-00074875 IP18-00036127
Mrs THIRUPURASUNDARI. R
17-07-1994 31 Y 11 M 6 D (F)
Dr. PRIYADHARSHINI S M



PARTOGRAPH

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

LABOUR

Labour: Spont IOL-PGE 1 E2 Others
Indications for IOL-Accel: None Oxytocin
Memb. Repture Type: SROM PROM ARM
Presentation: Vertex Breech Others

INTRA PARTUM COMPLICATION

Maternal: None Pyrexia HTN Others
Liquor: Adequate Oligo Poly Clear
 Blood Meconium Cord:
Shoulder Dystocia: Yes No

DELIVERY DETAILS

Anesthesia: None Epidural
Non-epi: Local Spinal General
Del. Type: SVD Asst. Breech Twins
AVD: Outlet Low Forceps Ventouse
 Trails of Forceps
Indications: Poor maternal efforts
Application, Locking & Traction:
Duration of Instrumentation:
No. of Pulls:
Catherised: Yes No
Type: Fileys Plain
Perineum: Intact Episiotomy Tear
Suture Material Used: Rapid Vicryl

STAGE III

Placenta: Normal Abnormal RP Clots
 CCT Retained MRP
PPH: Atomic (moderate) Traumatic None
Lacerations:
Cervical:
Perineal: Episiotomy
Others:
Prophylaxis: Synocinon, Prostin
Blood Loss: 750ml
Blood Transfusion: Yes
Other Details (if any):
Rectal Examination: Normal

DURATION OF LABOUR

1st Stage: 6 hours
2nd Stage: 10 mins
3rd Stage: 5 mins
Duration of Active Pushing:
No. of VE'S:

BABY DETAILS

Gender: Boy
Weight: 3.058 kg
APGAR: 8/10, 9/10
Date and Time of Delivery: 22/06/2026 4:37pm
LW Doctor: Dr. Priyadharshini
LW Sister:

PARTOGRAPH

Name:

Obstetrics Formula:

Blood Group Type:

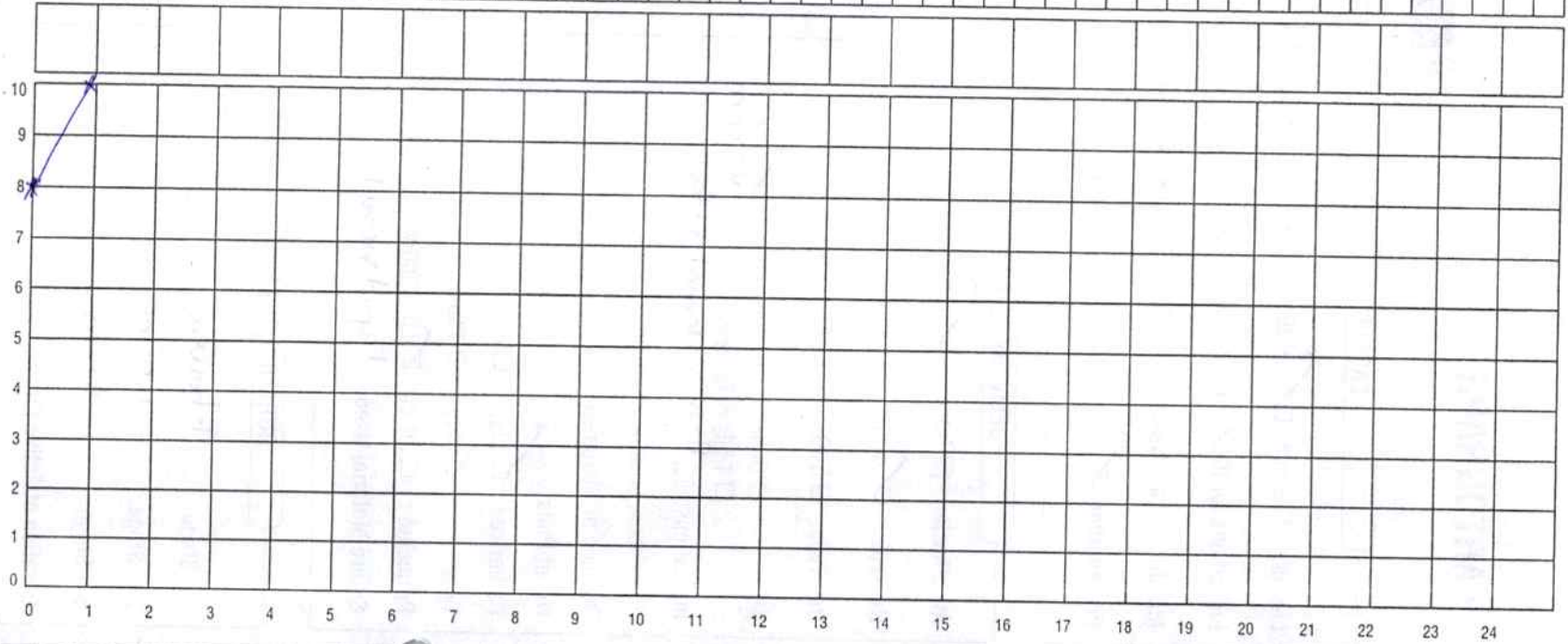
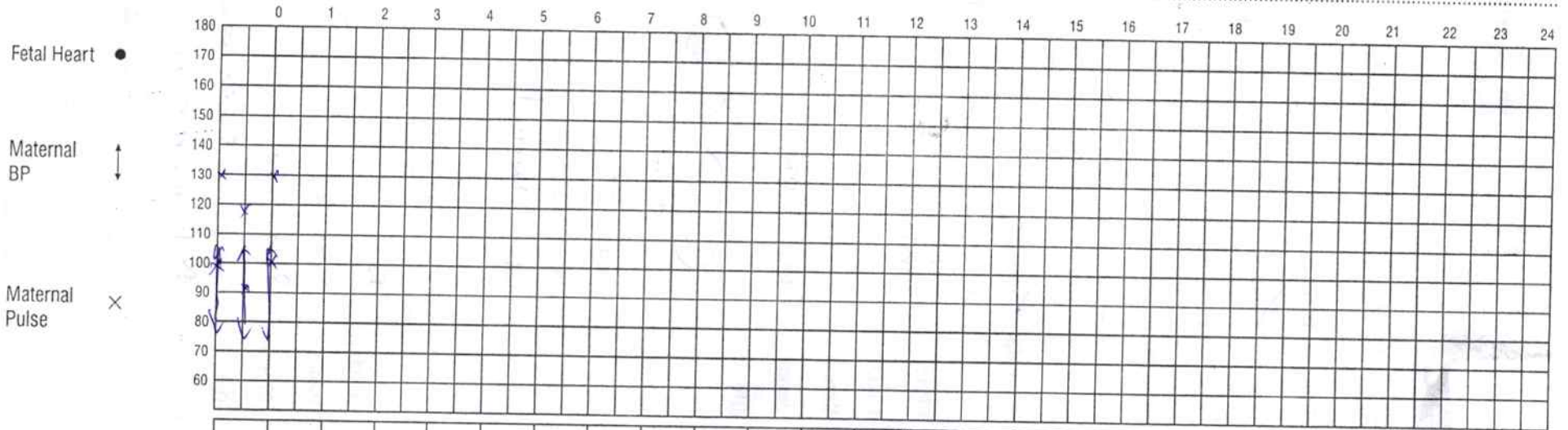
Memb. Ruptured:

SROM

PROM

ARM

Risk Factors:



Record of Labor:

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

Time: Signature:

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

Time: Signature:

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

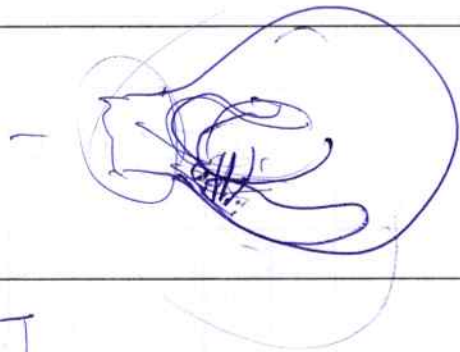
Time: Signature:

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:



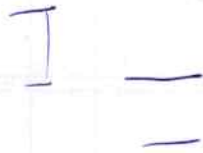
Time: Signature:

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:



Time: Signature:



It takes a lot to treat the little.

Patient Label

GUC-00074875 IP18-00036127
 Mrs THIRUPURASUNDARI R
 17-07-1994 31 Y 11 M 5 D (F)
 Dr. PRIYADHARSHINI S M



OBSTETRICIAN	Dr. Priyadhaeshini	
ANAESTHETIST	Dr. Sathish	
ASSISTANT	Dr. Lucetta	
DATE	22/06/2026	
TIME	4:37 pm	
PLACE	LABOUR WARD	THEATRES

CONSENT <input checked="" type="radio"/> VERBAL / <input type="radio"/> WRITTEN	EPISIOTOMY <input checked="" type="radio"/> YES / <input type="radio"/> NO	BLADDER EMPTIED? FOLEY IN/OUT <input checked="" type="radio"/> NO
ANALGESIA LOCAL / PUDENDAL AMOUNT USED <u>10m</u> MLS OF _____ <input checked="" type="radio"/> EPIDURAL / <input type="radio"/> SPINAL GA	CTG <input checked="" type="radio"/> NORMAL / <input type="radio"/> SUSPICIOUS / <input type="radio"/> PATHOLOGICAL (WRITE FULL DETAILS IN MAIN NOTES IF NOT NORMAL CTG)	LIQUOR CLEAR / <input checked="" type="radio"/> BLOOD STAINED / <input type="radio"/> MECONIUM ABDOMINAL FINDINGS <input checked="" type="radio"/> / 5 PALPABLE

NUMBER OF CMs DILATED STATION OF PRESENTING PART	VAGINAL EXAMINATION -1 / 0 / +1 / <input checked="" type="radio"/> +2 / +3					
POSITION DOA / LOA / ROA / ROP / LOP / DOP / <input checked="" type="radio"/> LOT / ROT						
CAPUT <input checked="" type="radio"/> 0 + ++ +++						
MOULDING <input checked="" type="radio"/> 0 + ++ +++						

Vacuum KIWI CUP / NEVILLE BARNES / WRIGLEYS / KIELLANDS / SIMPSONS		INSTRUMENT USED
MANUAL ROTATION YES / <input checked="" type="radio"/> NO	TIME OF APPLICATION 4:36 pm	No. OF TRACTIONS
ABANDONED YES / <input checked="" type="radio"/> NO (FULL DETAILS IN NOTES)	TIME OF DELIVERY 4:37 pm	LENGTH OF DELIVERY

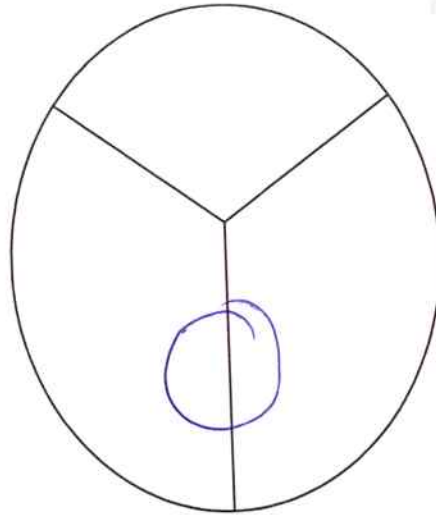
Rainbow Children's Medicare Limited

No. 157, Saidapet, Near Little Mount Metro Station, Guindy, Chennai - 600015.

For Appointments call: 1800 2122

you can take "ONLINE APPOINTMENT" from our website at ANY TIME : Log on to "www.rainbowhospitals.in"

Brief description of delivery and perineal repair.
 (Please mark ventouse position on diagram)



EXTENT OF TEAR
 EPISIOTOMY / 1ST degree / 2ND degree / 3A / 3B / 3C / 4TH degree
 (If 3rd or 4th, please complete proforma)

SUTURE MATERIAL USED 2/0 VICRYL (number.....) 3/0 VICRYL (number.....) OTHER? <i>Rapid vicryl (277)</i>	SUTURE TECHNIQUE CONTINUOUS/INTERUPTED SKIN CLOSED? <input checked="" type="radio"/> YES / NO	PR <input checked="" type="radio"/> YES / NO	PV <input checked="" type="radio"/> YES / NO
FOLEY CATHETER <input checked="" type="radio"/> YES / NO REMOVE (SHOULD REMAIN IN SITU FOR MIN OF 12HRS IF REGIONAL BLOCK USED)	SWAB COUNT PRE - REPAIR <i>Correct</i> POST - REPAIR <i>Correct</i> PARACETAMOL 1GM PR YES / NO	ANTIBIOTICS <input checked="" type="radio"/> YES / NO (PRESCRIBE ON DRUG CHART)	ANALGESIA <input checked="" type="radio"/> YES / NO (PRESCRIBE ON DRUG CHART)
	DICLOFENIC 100MGS PR <input checked="" type="radio"/> YES / NO		

BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 22/06/2026 Time: 06:45
 Blood Group of the Patient: O+ve Blood Group on the Blood Bag: O+ve
 Blood Bank Issue No: 2320 Date of Collection: 26/5/26 Date of Expiry: 7/7/2026
 Date & Time of Starting Transfusion: 22/6/26 at 06:45pm Planned duration of Transfusion: 22/6/26 @ 10:45pm
 Check for Correct Unit: Correct Patient:
 Blood products cross checked by: Nurse 1: S. N. Abalya/01809 Nurse 2: S. N. Devi/015760
 Before starting transfusion vitals: Temp: 98°F HR: 115b/m RR: 20b/m BP: 113/60 SpO₂: 100%

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
22/6/26	15 Min 6:15 PM	115	98°F	113/60	100%	NIL	NIL	NIL	NIL
22/6/26	15 Min 6:30 PM	120		120/70	100%	NIL	NIL	NIL	NIL
22/6/26	15 Min 7:15 PM	123		121/60	100%	NIL	NIL	NIL	NIL
22/6/26	30 Min 7:30 PM	120	98°F	118/78	100%	NIL	NIL	NIL	NIL
22/6/26	30 Min 7:45 AM	114		110/70	100%	NIL	NIL	NIL	NIL
22/6	1 Hr 8 PM	113		117/74	100%	NIL	NIL	NIL	NIL
22/6	1 Hr 8 PM	110		116/76	100%	NIL	NIL	NIL	NIL
22/6	9 PM	106		117/74	99%	NIL	NIL	NIL	NIL
22/6	10 PM	108	98.0°F	118/90	99%	NIL	NIL	NIL	NIL

Comments: During blood transfusion no allergic reaction. Patient vital sign stable.

Name of the Incharge-Nurse: S. N. Devi Name of the Nurse: Sobeswari 017178
 Signature of the Incharge-Nurse: [Signature] Signature of the Nurse: [Signature]
 Date & Time: 22/6/26 @ 10:45pm Date & Time: 23/6/26 @ 10:45pm

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Handwritten text in the middle section, appearing to be a list or series of entries.

Main body of handwritten text, organized into several columns and rows, possibly a ledger or data table.

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RISK ASSESSMENT TOOL FOR DEEP VEIN THROMBOSIS

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

Date: 21/6/20

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 ⁺ 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		01
Signature of the Nurse	<i>Dhoby</i>	
Action Plan		

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.



INDUCTION OF LABOR CONSENT

Name: Mrs. Thirupurasundari Age: Gender: Male Female

UHID.No : Date:

You are scheduled for an induction of labor on (date) at (weeks of gestation).

The reason for your induction is

The goal of induction of labor is to achieve vaginal delivery by starting uterine contractions before the spontaneous start of labor.

Induction of labor for a medical indication is done when continuation of pregnancy is considered detrimental to the health of the mother or fetus. This can be done at any stage of pregnancy irrespective of fetal maturity if there is a valid indication.

Elective induction of labor (scheduled induction without a medical indication) may not be done until you are at least 39 weeks. This is important so that your newborn does not have complications due to possible prematurity.

The alternative to induction of labor is to wait for labor to start spontaneously.

I have read the information provided and also discussed the process with my doctor.

I understand the risks and benefits of this procedure and wish to proceed.

Patient
Signature: [Signature]
Name: THIRUPURASUNDARI
Date & Time: 22/6/2026 at 7am

Patient Attendant:
Signature: [Signature]
Name: Vendatrasan. K.
Relationship with Patient: Husband.
Date & Time: 22/6/2026 at 7am

Doctor:
Signature: [Signature]
Name: Dr. Priyitha
Date & Time: 22/6/26 at 7am

Witness
Signature:
Name:
Date & Time:

10/1/20

THURSDAY

Mrs. Thompson

1. ...
 2. ...
 3. ...
 4. ...
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 7. ...
 8. ...
 9. ...
 10. ...

Handwritten notes or signatures in the lower left quadrant.



THURSDAY

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10/1/20

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INFORMED CONSENT FOR VAGINAL BIRTH



GUC-00074875 IP18-00036127
 Mrs THIRUPURASUNDARI. R
 17-07-1994 31 Y 11 M 5 D (F)
 Dr. PRIYADHARSHINI S M



Patient Name :

UHID No :

Gender: Male

Time :

I hereby authorized the performance of the following procedure:

- The Procedure has been explained to me in general terms and I understand that:
- The indication requiring the procedure of vaginal birth is pregnancy.
- The purpose of this procedure of vaginal birth pregnancy.
- The purpose of this procedure is to deliver the bay vaginally.

The outcome of the vaginal birth is the delivery of infant through birth canal either naturally or with possible use of force vacuum extraction. An episiotomy (a cut performed for enlarging of the vaginal opening in the space between the vaginal and the rectum) may be performed as part of a vaginal delivery.

Should vaginal delivery be unsuccessful, delivery by cesarean section with an abdominal incision under appropriate anesthesia may be necessary.

In an attempt to deliver the baby either naturally or with the help of instrument i.e. forceps or vacuum, there may be risks of: infection, allergic reaction, scarring, blood loss, need for blood transfusion, pain and discomfort, injury to urinary tract, possible injury to the baby (laceration, hematoma, skull fracture, nerve injury and brain injury) and possible future pelvic floor dysfunction.,

I understand and accept that there are complications, benefits, alternatives including the remote risk of death or serious disability, which exists for me and my baby.

I am aware that in most cases, vaginal delivery results in a healthy mother and baby; however, I realize that there are no guarantees.

I voluntarily consent to the procedures described or otherwise referred to herein. I am aware that they will be performed by a qualified gynecologist.

Name of the Doctor performing the procedure:

Consentee :

Signature :

Name : THIRUPURASUNDARI

Date & Time : 22/6/26 at 7am

Witness :

Signature :

Name :

Date & Time :

Patient Attendant :

Signature :

Name : Venkatesan K.

Relationship with Patient: Husband.

Date & Time : 22/6/2026 - at 7am

Doctor (who is taking the consent) :

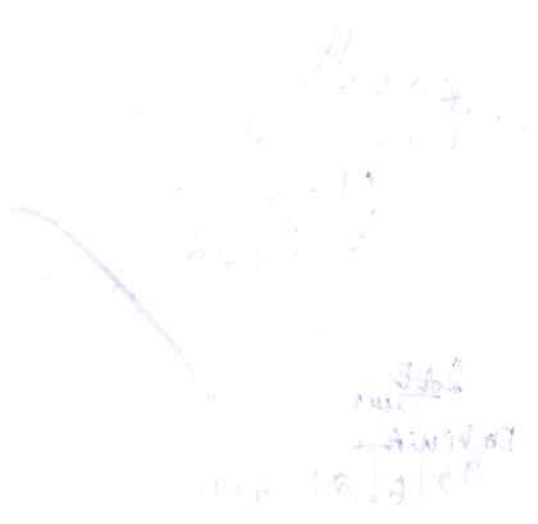
Signature :

Name : Dr. V. Priyadharshini

Date & Time : 22/6/26 7am

1. List the informant's name

Faint, illegible text, possibly bleed-through from the reverse side of the page.



1. Informant's name

2. Informant's address



BREAST FEEDING HANDOVER AND ASSESSMENT FORM

1. Breastfeeding initiated?

- a. Yes b. No

2. If No, Reason

3. Nipple condition:

- a. Nipple well formed
 b. Flat nipple
 c. Inverted nipple
 d. Short nipple

4. Milk flow:

- a. Good
 b. Drops of colostrums
 c. Dry

5. Steps for Positioning and attachment:

- a. Baby goes to the breast
 b. Mother always sits with a back support
 c. Ear-shoulder-hip should be in a straight line
 d. The baby takes a latch on the areola and not on the nipple



Feeding Positions:
Cross Cradle



Feeding Positions:
Football / Clutch

6. Was the position explained:

- a. Yes
- b. No

7. For Caesarian mothers: N/A

- a. Mother is required sit and feed from the 4th feed
- b. Please explain football hold

8. NICU admission: N/A

- a. Mother needs to stimulate her breast for 2 min every 2 hours

9. Additional notes: NLL

Date: 22/6/2026

Continuity of Care:

Baby is mother side

g - 1 23/6/26

A - 2 L - 2

T - 2 A - 2

C - 2 T - 2

A - 2 C - 1

g 11 - 1

8
P. Verbon

Handover given by S/M Abdul

Handover taken by S/M Verbon

Signature [Signature]

Signature [Signature]

Date & Time: 22/6/2026

Date & Time: 23/6/2026 @ 3:45pm



①

URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 22/06/2026

Date of Removal: removed at 4 pm

Parameters	Date	Shift Time						
Need for the Catheter			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hand Hygiene			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Usage of Sterile Equipment			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the Collection bag below the level of bladder			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Check the Tube for Obstruction (Free of Kinking)			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is Catheter dated as policy			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Collecting bag is been emptied regularly?			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Maintenance of closed system for the catheter			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dressing clean and dry?			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the line removed as Policy?			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Performance of Perineal Care			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Onset of New Fever			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asses for the leakage at the site of insertion			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of the Nurse								
Signature of the Nurse			<i>S. K. Aravind</i>					

ANNUAL BONDAGE CHECK LIST



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2

URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 22/06/2020

Date of Removal:

Removed at 2⁰⁰ PM 23/6

Parameters	Date	Shift Time	22/6/20		23/6		23/6				
			E	N		morning					
Need for the Catheter			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hand Hygiene			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Usage of Sterile Equipment			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the Collection bag below the level of bladder			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Check the Tube for Obstruction (Free of Kinking)			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is Catheter dated as policy			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Collecting bag is been emptied regularly?			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Maintenance of closed system for the catheter			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dressing clean and dry?			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the line removed as Policy?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Performance of Perineal Care			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Onset of New Fever			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asses for the leakage at the site of insertion			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of the Nurse			SINABALI		SINABALI						
Signature of the Nurse			[Signature]		[Signature]						

UNITED STATES DEPARTMENT OF JUSTICE

MEMORANDUM FOR THE ATTORNEY GENERAL
SUBJECT: [Illegible]

DATE: [Illegible]

TO: [Illegible]

FROM: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED
[Illegible]

(2)

PATIENT TRANSFER FORM

①



GUC-00074875 IP18-00036127
 Mrs THIRUPURASUNDARI R
 17-07-1994 31 Y 11 M 5 D (F)
 Dr. PRIYADHARSHINI S M



Date & Time of Admission 21/06/2026 at 11.41pm		Date & Time of Transfer Order 22/6/2026 at 7.5 AM
Treating Consultant Name Dr. Priyadharshini	Transfer Ordered by Dr. Umitha	Reason for Transfer Furth mgt.
From Unit CPR	To Unit 7th Floor	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	Di: Taris 1g - ②	
2.	Dwalt - ②	
3.	DS 4 coml - ②	
4.	under pad - ②	
5.	New pad - ①	

Shifting Summary / Notes Written by Doctor : Yes No

Name & Signature of Person who is Transferring S.N. Sobeswari	Name of Person Ordered Transfer Dr. Umitha
--	---

Patient & Clinical Records Received by : *[Signature]*

Date & Time of Patient Received : 22/6/26 at 7:10 AM

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

- Unavailable Bed
- Nurse not Available
- Available Bed not ready

PATIENT TRANSFER FORM

<p>1. Name of Patient: <i>John Doe</i></p>	
<p>2. Room Number: <i>101</i></p>	
<p>3. Date of Transfer: <i>12/15/20</i></p>	
<p>4. Reason for Transfer: <i>Transfer to ICU</i></p>	
<p>5. Name of Referring Doctor: <i>Dr. Smith</i></p>	
<p>6. Name of Receiving Doctor: <i>Dr. Jones</i></p>	
<p>7. Signature of Referring Doctor: <i>[Signature]</i></p>	
<p>8. Signature of Receiving Doctor: <i>[Signature]</i></p>	
<p>9. Date of Receiving Doctor's Signature: <i>12/15/20</i></p>	
<p>10. Time of Patient's Arrival: <i>10:00 AM</i></p>	
<p>11. Name of Receiving Unit: <i>ICU</i></p>	
<p>12. Name of Receiving Nurse: <i>[Name]</i></p>	
<p>13. Name of Receiving Physician Assistant: <i>[Name]</i></p>	
<p>14. Name of Receiving Respiratory Therapist: <i>[Name]</i></p>	
<p>15. Name of Receiving Dietician: <i>[Name]</i></p>	
<p>16. Name of Receiving Pharmacist: <i>[Name]</i></p>	
<p>17. Name of Receiving Social Worker: <i>[Name]</i></p>	
<p>18. Name of Receiving Case Manager: <i>[Name]</i></p>	
<p>19. Name of Receiving Transporter: <i>[Name]</i></p>	
<p>20. Name of Receiving Security: <i>[Name]</i></p>	

B. Williams

[Faint handwritten notes and illegible text]

[Handwritten notes: Dr. Jones, Dr. Smith, 12/15/20]

1. I have read this form and understand its contents. Yes No

2. I have read this form and understand its contents. Yes No

PATIENT TRANSFER FORM

2



GUC-00074875 IP18-00036127
 Mrs THIRUPURASUNDARI R
 17-07-1994 31 Y 11 M 5 D (F)
 Dr. PRIYADHARSHINI S M



Date & Time of Admission 21/6/26 @ 11.41 PM	Date & Time of Transfer Order 22/6/26 @ 9.30 AM	
Treating Consultant Name Dr. Priyadharshini	Transfer Ordered by Dr. Vinita	Reason for Transfer LOR
From Unit 1 st floor	To Unit LOR	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File IP file - ①	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant. Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what?

Medications / Consumables / Surgicals / Hand over

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

Shifting Summary / Notes Written by Doctor : Yes No

Name & Signature of Person who is Transferring S/N Saurin	Name of Person Ordered Transfer Dr. Vinita
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Patient & Clinical Records Received by :
S/N Araba / 01800

Date & Time of Patient Received : 22/6/2026 at 8.45 AM

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

- Unavailable Bed
- Nurse not Available
- Available Bed not ready



ATTENDANCE FORM

Name	Age	Sex	Grade	Attendance
John Doe	10	M	5	Present
Jane Smith	9	F	4	Absent
Bob Johnson	11	M	6	Present
Alice Brown	8	F	3	Absent
Charlie White	12	M	7	Present
Diana Green	10	F	5	Absent
Frank Black	11	M	6	Present
Grace King	9	F	4	Absent
Henry Lee	10	M	5	Present
Ivy Hill	11	F	6	Absent
Jack King	12	M	7	Present
Karen Lee	10	F	5	Absent
Leo King	11	M	6	Present
Mia King	9	F	4	Absent
Noah King	10	M	5	Present
Olivia King	11	F	6	Absent
Peter King	12	M	7	Present
Quinn King	10	F	5	Absent
Rachel King	11	F	6	Present
Samuel King	12	M	7	Absent
Tina King	10	F	5	Present
Uma King	11	F	6	Absent
Victor King	12	M	7	Present
Wendy King	10	F	5	Absent
Xavier King	11	M	6	Present
Yvonne King	12	F	7	Absent
Zoe King	10	F	5	Present

PATIENT TRANSFER FORM

3



GUC-00074875 IP18-00036127
 Mrs THIRUPURASUNDARI. R
 17-07-1994 31 Y 11 M 5 D (F)
 Dr. PRIYADHARSHINI S M



Date & Time of Admission 21/6/2026 at 11:41pm		Date & Time of Transfer Order 23/6/2026 at 3:30pm
Treating Consultant Name Dr. Priyadharshini	Transfer Ordered by Dr. Panithra	Reason for Transfer Further treatment
From Unit LDR	To Unit JMP floor	Information to Attendant Yes <input type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File Whole IP files	Number of Imaging Films CPR	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	T. para	8
2.	T. pam	9
3.	Inj. Tragic	4
4.	Under pad	2
5.		

Shifting Summary / Notes Written by Doctor : Yes No
 PT shifted to

Name & Signature of Person who is Transferring S. Ananya 018058	Name of Person Ordered Transfer Dr. Panithra
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Patient & Clinical Records Received by : V. Anand
 A. Anand

Date & Time of Patient Received : 23/6/2026 @ 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

PATIENT TRANSFER FORM

Patient Name & Room

Receiving Unit

Date

Time

Number of Patients in Unit

Whole No.

Fraction

Sex

Name

Receiving Agency

Time of Patient Received

Time of Transfer to Receiving Agency

Handwritten notes in the top left section, including 'Admission' and 'Discharge'.

Handwritten notes in the middle section, including 'Admission' and 'Discharge'.

Handwritten notes in the middle-right section, including 'Admission' and 'Discharge'.

Handwritten notes in the bottom-left section, including 'Admission' and 'Discharge'.

Handwritten notes in the bottom-middle section, including 'Admission' and 'Discharge'.

Handwritten notes in the bottom-right section, including 'Admission' and 'Discharge'.