

GUC-00079451 IP18-00036178
Mrs SNEHALI KOUSHIK
04-04-1988 38 Y 2 M 21 D (F)
Dr. PRIYADHARSHINI S M



SURGERY DETAILS

Date : 25/6/26
Patient Name: Mrs. Snehali Koushik Date of Birth: 04/04/1988 Age: 38y
Gender: Female Ward: OT UHID No.: 79451/36178
Date of Surgery: 25/6/26 OT-1 OT-2 OT-3 OT-4 OBG OT-1 OBG OT-2
Name of the Surgery: Emergency LSCS.

Time in : 2:20pm Time Out : 3:30pm

	NAME	AMOUNT
1. Surgeon	Dr. Priyadharsini	
2. Anaesthetist	Dr. Mohan	
3. Assistant Surgeon	Dr. Lucetta, Dr. Pavithra	
4. OT Technician	Mr. Shyam	
5. Circulating Nurse	C/N. Thanushya	
6. Assistant Nurse	S/N. Agalya	

Special Equipment: Laparoscopy Bronchoscope Harmonic Morcelator
 C-ARM Cystoscopy Versa Point Liver Cusa
 Neuro Cusa Others

Signature of the Surgeon


Signature of Circulating Nurse

Order No:

Order by:

Record finalized done by Agalya 26/6/26

SURGERY LISTINGS

501

Baby detail

Baby: Boy

Time: 2.39pm

Wt: 2.754 kg



OT-4
 BSM LSCS
CONSUMABLES OF OT



Circulating staff: T. Jayanta Technician: Shyam Date: 25/6/20 Time:

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube			Major Pack LSCS		01	Inj Vit.K		01
LMA			Sutures 23A7		01	Cord Clamp		1
ECG leads (A/P/N)		3	1526		01	Suction Catheter		
HME filter: A/P/N						Feeding Tube BPR		1
Syringes: 10 cc		2				Vaccum Suction Set		
05 cc		2	Gloves PE 65		05	Surgical Gloves G2P		1
02 cc		2	PE 6		02	Gauze Pack		1
01 cc			PE 7		02	Syringe 1ml/2ml		1
Cautery plate (A/P/N)		1	Surgical blade 22		01	Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL		4	Cautery pencil		01	Duxeteriomc		2
NS: 10ml/100ml/500ml/1000ml		01	Koochies			Protogown		01
Synto		5	Ointments			OT Table Sheet		01
Ribxmix		2	Suction Catheter					
Fentanyl			Cap, Mask					
Morphine			Gauze Pack R10		02			
Ketamine			Mop Pack		02			
Propofol			Steristrip					
Rocuronium			Underpad		01			
Glycopyrolate			Draw sheet					
Myopyrolate			Abgel					
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
CABPOST		1	Tegaderm 8591		01			
Suppositories			Ioban					
Anamol: 80mg / 250mg / 170 mg			Double J Stent					
Supridol: 100mg			Vaccum Suction set		01			
Justin: 12.5 mg / 25mg / 100mg		01	Plastic Bed Sheet					
Tab. Misoprost: 100mg		01	Betadine Solution		02			
			Microshield					
			Cotton Balls					
			Latex Gloves		10P			
			Ramdione Scrub					
			Saral					

Surgeon: Anaesthesiologist: Nurse: Agalya OT Technician:
 Order No.: Ordered by:
 Doc. No.: RCH / FRM / GENERAL / 125



RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

Door No.157 to 160, Anna Salai, Guindy, Guindy Chennai Tamil Nadu INDIA
600015

Tel No : 044-40122444

VAT TIN : 33AABCR4014M1ZK

CIN : L85110TG1998PLC029914

DL NO :

Registered Office: 8-2-120/103/1, Survey No.403, Road No.2, Banjara Hills, Hyderabad 500034, Telangana.

INPATIENT ISSUES AGAINST ORDERS



IP No IP18-00036178
 Patient Name Mrs SNEHALI KOUSHIK
 Age/Sex 38 Y 2 M 21 D / Female
 Date 25/06/2026 16:44
 Payor SELF PAY
 UHID GUC-00079451

Ward 8F-OT COMPLEX
 Bed Name MICU 804
 Order No 18-0001717229
 Prescription No PRIP18-0623122
 Dispensed Date 25/06/2026 17:06

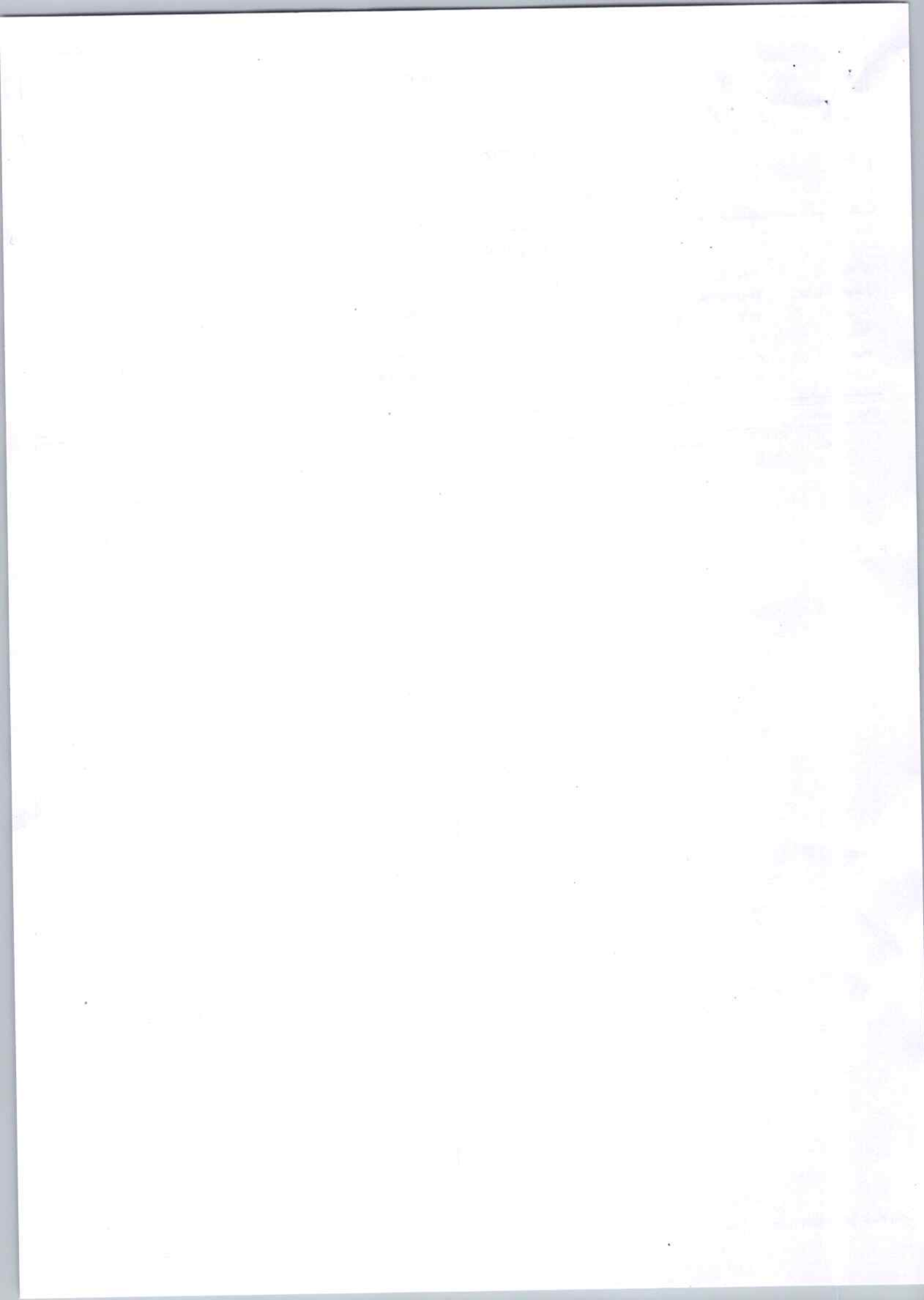
S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	SGLOVE 7.0(POWDER FREE)	ANSEL	GENERAL	240601021T	06/27	2	128.00	256.00
Total :							128.00	256.00

Receiver Name

for RAINBOW CHILDREN'S MEDICARE LIMITED

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN





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Door No.157 to 160, Anna Salai, Guindy, Guindy Chennai Tamil Nadu INDIA
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INPATIENT ISSUES AGAINST ORDERS



IP No IP18-00036192
Patient Name Baby B/O SNEHALI KOUSHIK
Age/Sex 0 Y 0 M 0 D 2 H / Male
Date 25/06/2026 16:59
Payor SELF PAY
UHID GUC-00093081

Ward 7F-PVT/SUITE
Bed Name CRDL-SUITE712-1
Order No 18-0001717236
Prescription No PRIP18-0623120
Dispensed Date 25/06/2026 17:04

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	Encore Microptic gloves-6.5		H	260501801T	05/29	1	128.00	128.00
2	GAUZE 7.5X7.5 12 PLY (5 NOS) NON XRAY	Bapuji Surgicals	GENERAL	M2641119	04/30	1	100.00	100.00
3	KLICK CLAMP	ROMSONS		G26A040003	12/30	1	39.00	39.00
Total :							267.00	267.00

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INPATIENT ISSUES AGAINST ORDERS



IP No IP18-00036178

Patient Name Mrs SNEHALI KOUSHIK

Age/Sex 38 Y 2 M 21 D / Female

Date 25/06/2026 16:44

Payor SELFPAY

UHID GUC-00079451

Ward 8F-OT COMPLEX

Bed Name MICU 804

Order No 18-0001717228

Prescription No PRIP18-0623121

Dispensed Date 25/06/2026 17:06

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	Encore Microptic gloves-6.5		H	260501801T	05/29	5	128.00	640.00
2	GAUZ SWAB 10 X 10 CM 12PLY 5S X-RAY	Bapuji Surgicals	GENERAL	M2545021	11/29	3	123.00	369.00
3	JUSTIN SUPPOSITORIES 100 MG 5 S	Neon Laboratories Ltd	H	BLNP274053	11/28	1	18.74	18.74
4	LSCS DRAPE PACK	Mediblu	H	1010626	05/29	1	2,250.00	2,250.00
5	MISOPROST TAB 600MCG1S	CIPLA LIMITED	H	6GH0162	08/27	1	105.12	105.12
6	MONOCRYL 3-0 NW 1326	ETHICON SUTURES-J&J	C1	T5119	09/30	1	997.00	997.00
7	MOPS 30X30 8PLY 5S X-RAY	DATT MEDI PRODUCTS	H	M2542SF037	06/29	2	1,020.00	2,040.00
8	NITRILE EXAMINATION GLOVES P F- MEDIUM	ELITE MEDICALS	GENERAL	ENPF030020	11/28	2	25.00	50.00
9	NS 100ML ACCULIFE - EH	Aculife Health Care Pvt.Ltd(Nirlif		1C2613680	02/29	1	44.93	44.93
10	PROTO GOWN (ADULT)	Diamond Medicare	GENERAL	1010626	05/29	1	250.00	250.00
11	QUICKSUITE OT TABLE SHEET MIDLINE SUTEL		H	2606021	06/31	1	775.00	775.00
12	RAMADINE SOLUTION 10% 100 ML	RAMAN & WEIL PVT LTD		RC26011	12/27	1	103.00	103.00
13	SGLOVE # 6 (POWDER FREE)	ANSEL		260301001T	03/29	2	128.00	256.00
14	SURGICAL BLADE 22	Surgeon	GENERAL	051125	10/30	1	7.67	7.67
15	TEGADERM WITH PAD (8591)BIG 9CM*25CM	3M HEALTHCARE	GENERAL	R03260906	02/29	1	814.50	814.50
16	UNDERPADS CARE 60 X 90 (FRIENDS)			06062026	12/30	1	205.00	205.00
17	VACCUME SUCTION SET	ROMSONS	GENERAL	K26C010031	02/31	1	739.00	739.00
18	VICRYL PLUS 1 VP - (2347)	ETHICON SUTURES-J&J	C1	0T5063	08/30	2	951.00	1,902.00
Total :							8,684.96	11,566.96

for RAINBOW CHILDREN'S MEDICARE LIMITED

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Door No.157 to 160, Anna Salai, Guindy, Guindy Chennai Tamil Nadu INDIA
600015
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Registered Office: 8-2-120/103/1, Survey No.403, Road No.2, Banjara Hills, Hyderabad 500034, Telangana.

INPATIENT ISSUES AGAINST ORDERS



IP No IP18-00036192
Patient Name Baby B/O SNEHALI KOUSHIK
Age/Sex 0 Y 0 M 0 D 2 H / Male
Date 25/06/2026 16:59
Payor SELFPAY
UHID GUC-00093081

Ward 7F-PVT/SUITE
Bed Name CRDL-SUITE712-1
Order No 18-0001717235
Prescription No PRIP18-0623117
Dispensed Date 25/06/2026 17:00

Sl.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
	DSYRINGE 1ML (BD)	BECTON DICKINSON (BD)	GENERAL	6043348	01/31	1	24.00	24.00
	INFANT FEEDING TUBE-5	ROMSONS	GENERAL	G 5C010610	02/30	1	64.00	64.00
Total :							88.00	88.00

Receiver Name

for RAINBOW CHILDREN'S MEDICARE LIMITED

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

**RAINBOW CHILDREN'S MEDICARE LIMITED****Rainbow Children's Hospital - Guindy**

Door No.157 to 160, Anna Salai, Guindy, Guindy Chennai Tamil Nadu INDIA
600015
Tel No : 044-40122444

VAT TIN : 33AABCR4014M1ZK**CIN :** L85110TG1998PLC029914**DL NO :**

Registered Office: 8-2-120/103/1, Survey No.403, Road No.2, Banjara Hills, Hyderabad 500034,
Telangana.

INPATIENT ISSUES AGAINST ORDERS

IP No	IP18-00036178	Ward	8F-OT COMPLEX
Patient Name	Mrs SNEHALI KOUSHIK	Bed Name	MICU 804
Age/Sex	38 Y 2 M 21 D / Female	Order No	18-0001717227
Date	25/06/2026 16:44	Prescription No	PRIP18-0623119
Payor	SELPAY	Dispensed Date	25/06/2026 17:01
UHID	GUC-00079451		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	BIOXAMIC 500 MG INJ	Biocare Pharmaceuticals	H	C3BIO004	01/28	2	73.23	146.46
2	CABOPROST INJ AMP 250 MCG 1 ML	Neon Laboratories Ltd	H	097132	08/27	1	318.50	318.50
3	DSYRINGE 10ML (NIPRO)	NIPRO	GENERAL	026B24K67	01/31	2	21.83	43.66
4	DSYRINGE 5ML.(NIPRO)	NIPRO	GENERAL	26C03K96	02/31	2	21.56	43.12
5	DSYRINGS 2.5ML(NIPRO)	NIPRO	GENERAL	26B04K17	01/31	2	11.25	22.50
6	D WATER 10 ML AMPULE	Aculife Health Care Pvt.Ltd(Nirilif	H	2254574	10/28	2	2.58	5.16
7	E.C.G ELECTRODES (ADULT)	JMS	GENERAL	12226S08G	03/28	3	32.34	97.02
8	EVATOCIN (OXYTOCIN) INJ 5 IU 1 ML	Neon Laboratories Ltd	H	091690	02/28	5	18.90	94.50
9	PREGELLED SURGICAL PLATES(ADULT)	Erbee	GENERAL	17032026	12/29	1	1,275.00	1,275.00
10	RL 500 ML CLOSED SYSTEM	Fresenius Kabi India Pvt Ltd		1D262078	03/29	4	69.39	277.56
Total :							1,844.58	2,323.48

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name**Authorized Signature**

Pharmacist Name : GRACE PAUL RAJAN

PATIENT DISCHARGE INTIMATION FROM NURSING STATION

CLEARANCE FOR DRUGS AND DISPOSABLES BILLING

Name of the Patient: Mrs SNEHALI KUSHIK
UHID No:
Ward: 7th Floor
Date: 27/6/2026
IP18-00036178
04-04-1988 38 Y 2 M 23 D (F)
Dr. PRIYADHARSHINI S M
Gender:
Room No: 707

Certified that in respect of the above patient:

- a. There are no drugs for return
- b. Emergency cupboard issues have been replenished
- c. No pending indents are there against above patient
- d. Checked the bed side cupboard of the bed
- e. Checked by the patient's Mother / Father in the room

Patient Authorised Sign

Date:

Time:

Nurse Sign

Date: 27/6/2026

Time: 6:00

Pharmacy Sign

Date: 27/6/26

Time:

PATIENT DISCHARGE FROM PLAN
 (FOR NURSING STAFF)

DATE: 2-14-65

NAME OF PATIENT: [illegible]

AGE: [illegible]

SEX: [illegible]

ROOM NO: [illegible]

DATE OF ADMISSION: [illegible]

REASON FOR ADMISSION: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[Handwritten signature]

DATE OF DISCHARGE: [illegible]

TIME OF DISCHARGE: [illegible]

BY: [illegible]

[Handwritten signature]

TIME: [illegible]

PLACE: [illegible]

INITIALS: [illegible]

DEPARTMENT: [illegible]

GUC-00079451 IP18-00036178
 Mrs SNEHAJ KOUSHIK
 04-04-1988 38 Y 2 M 22 D (F)
 Dr. PRIYADHARSHINI S M



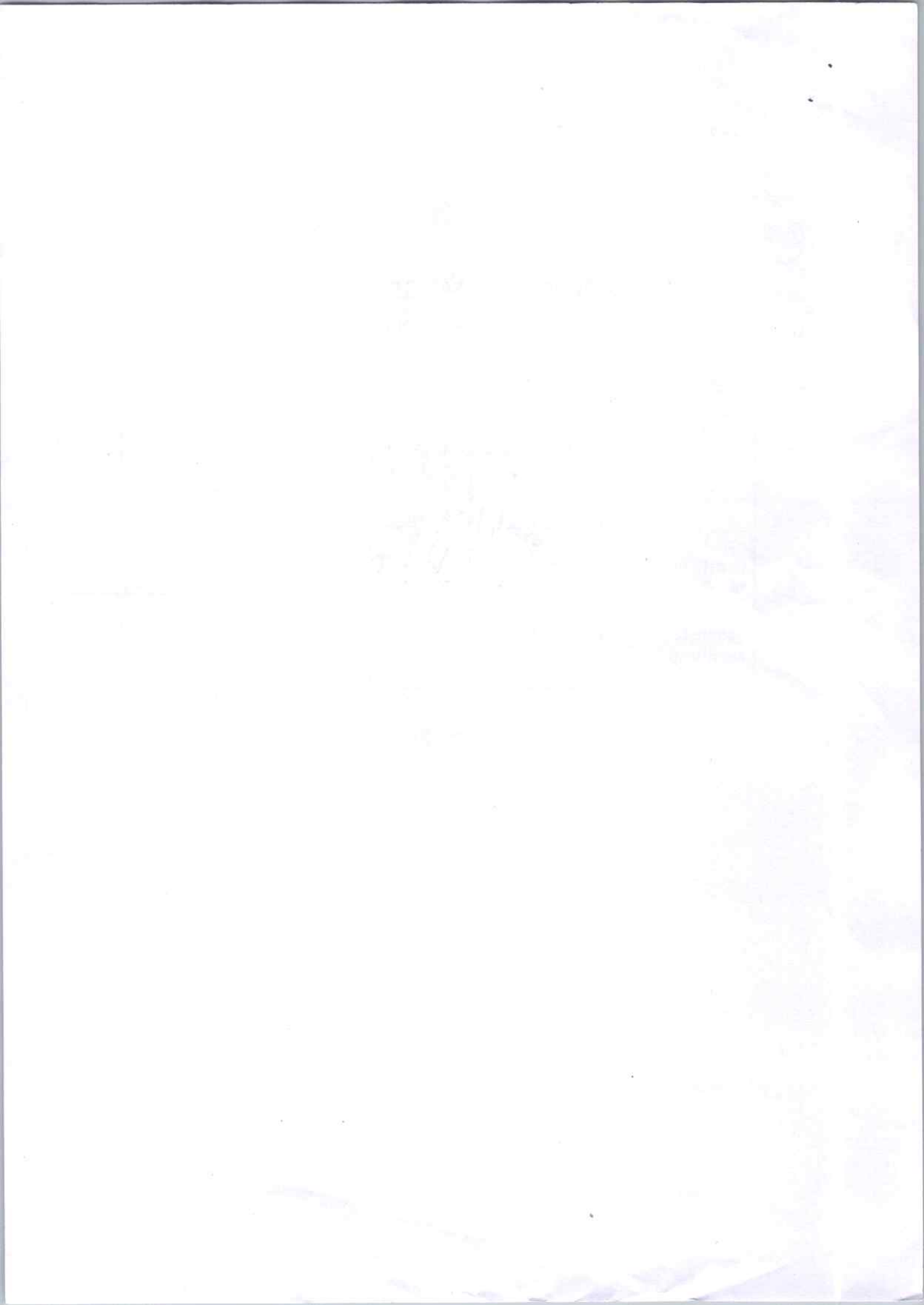
Rainbow Children's Hospital



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			<i>27/6/26 at 6AM</i>				
Activity Sheet update by Pharmacy							



ACTIVITY RECORD FOR BILL

GUC-00079451 IP18-00038178
 Mrs SNEHALI KOUSHIK
 04-04-1988 38 Y 2 M 21 D (F)
 Dr. PRIYADHARSHINI S M



Name: Mrs. Sneha Kous



UHID No: 74451 IP No: 36172 Consultant: Priyadharshini Dept: LDR

Date of Admission: 25/6/26 Time: Date of Discharge: Time:

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
25/6/26	2:30 pm	LDR	OT	[Signature]
25/6/26	3:30 pm	OT	MICU	[Signature]
26/6/26	12:30 AM	MICU	7th floor	[Signature]

CROSS CONSULTATION VISIT

	Doctor Name	Date	Order No.	Signature
1. ✓	PAC	25/6/2026	1717232	[Signature]
2. ✓	Dr. Rucha	26/6/26	1717588	[Signature]
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
25/6/26	✓ In Placenta	①	1716223	<i>[Signature]</i>
25/6/26	✓ Catheterisation	①	1717233	<i>[Signature]</i>
26/6/26	✓ Diet Counselling	①	1717572	A. D. (018336)
26/6/26	✓ Physio	①	1717796	<i>[Signature]</i>

ANY OTHER INFORMATION:

Procedure name: Emergency LSC

Surgeon name: Dr. Priyadharshini

Assist Surgeon name: Dr. Lucette, Dr. Paritha

Anaesthetist name: Dr. Mohan

In time: 2:20pm

Out time: 3:30pm

Date: 27/6/2026 Time: 6 AM

Prepared By:

Staff Nurse <i>[Signature]</i> Quoblos	Shift / Ward	Billing Assistant	Billing Supervisor
----------------------------------------------	--------------	-------------------	--------------------

GUC-00079451 IP18-00038178
Mrs SNEHALI KOUSHIK
04-04-1988 38 Y 2 M 23 D (F)
Dr. PRIYADHARSHINI S M



DISCHARGE TRACKING SHEET

UHID-

FLOOR-

NAME OF CONSULTANT-

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
	INTIME	OUT TIME			
Discharge Announcement					
Arrangement of File by Nursing		27/6/18	<i>[Signature]</i>		
Preparation of Discharge Summary		10:30 AM	<i>[Signature]</i>		
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

11/11/11



ADMISSION SHEET

Registration Details :



Admission No : IP18-00036178

Admit Date : 25-Jun-2026

Admit Time : 05:46 AM UHID : GUC-00079451

Patient Details :

Patient Name : Mrs SNEHALI KOUSHIK

Age : 38 Y 2 M 21 D

Guardian : Mr KOUSHIK SEKHAR

DOB : 04-04-1988

Gender : Female

Religion :

Occupation :

Martial Status :

Address (H) : 10 revanathan colony West Mambalam
Chennai Tamil Nadu INDIA 600033

Phone No : 7358734049

E-mail : no@gmail.com

Admission Details :

Bed Type : MICU

Bed No : MICU 804

Ward Name : 8F-OT COMPLEX

Room No : MICU 804

Admission Type : First Visit

Contact Details :

Name : Mr KOUSHIK SEKHAR

Relationship : Husband

Contact Address : 10 revanathan colony West Mambalam
Chennai Tamil Nadu INDIA 600033

Phone No : 7358734049


Signature

Doctor Details :

Doctor Name : Dr. PRIYADHARSHINI S M

Specialisation : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self

Phone No :

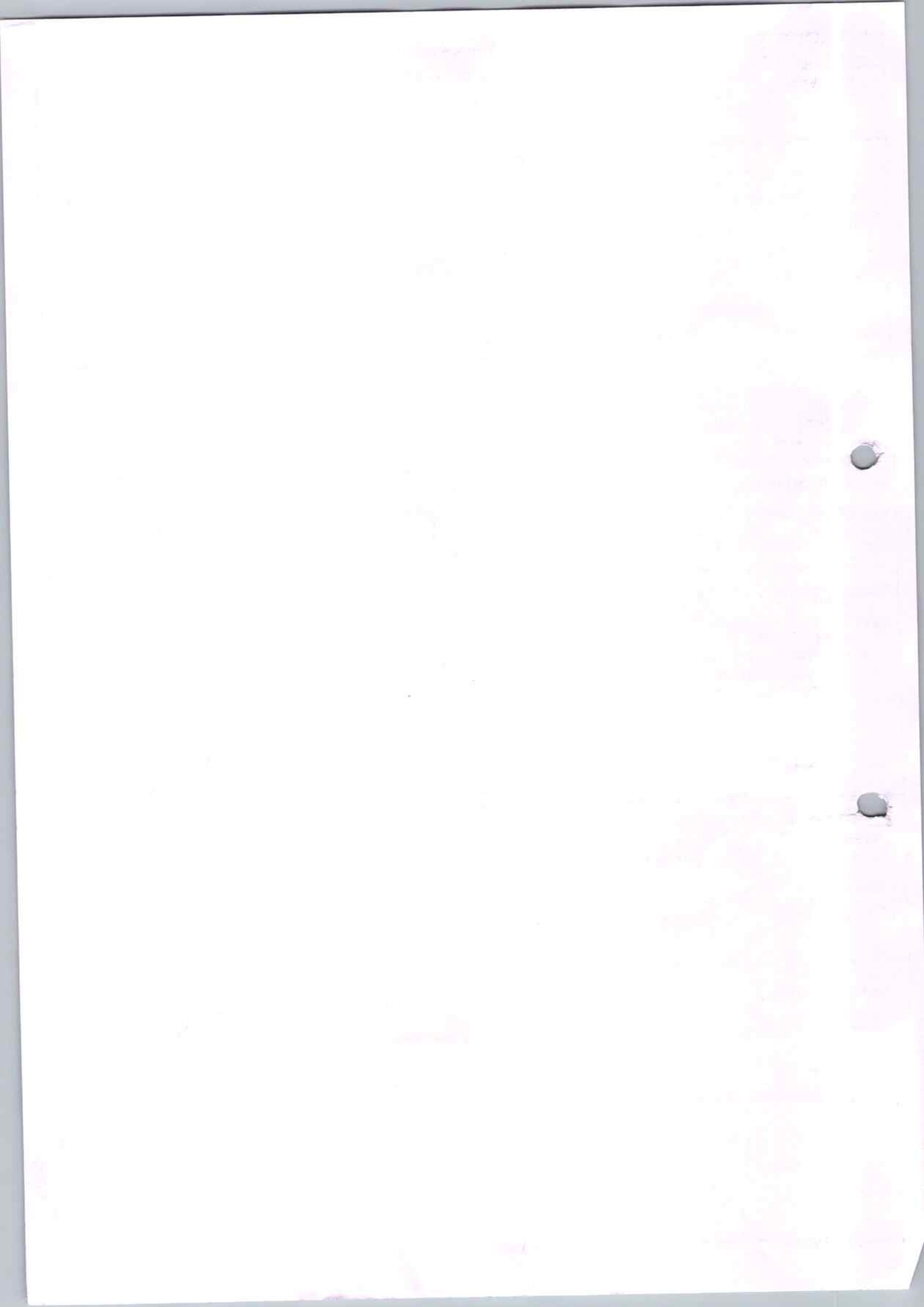
Co-Consultant :

Payment Details :

Payment Mode : Cash

Deposit Amount : 7000.00

Payor Name : SELFPAY



GENERAL CONSENT FOR TREATMENT

Patient Name: Mrs SNEHALI KOUSHIK Age : 38 Y 2 M 21 D
IP No: IP18-00036178 Sex: Female
Consultant: Dr. PRIYADHARSHINI S M Ward/Bed No: 8F-OT COMPLEX/MICU 804

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.

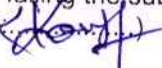
In giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science 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:

Relationship:

Date:

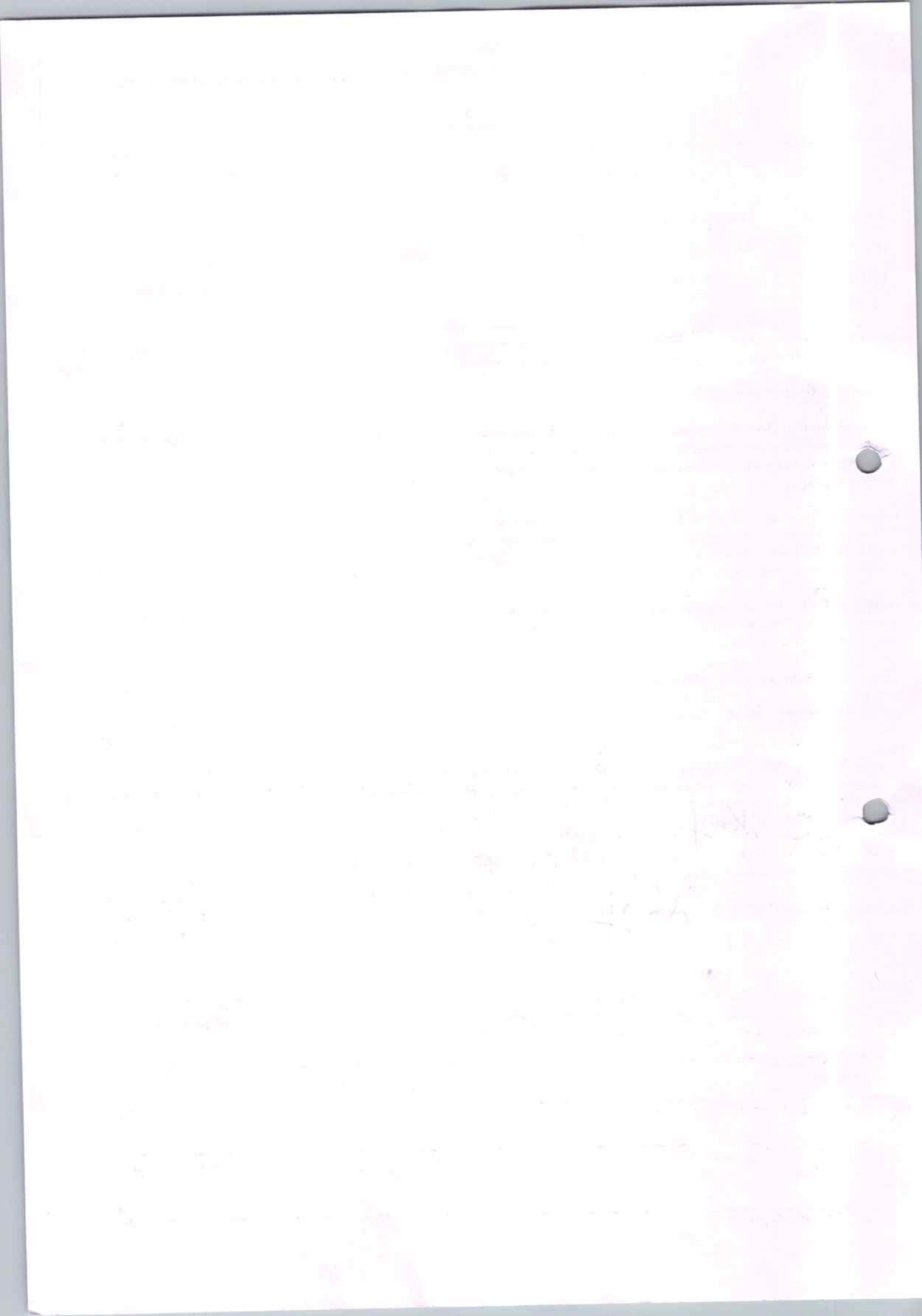
Time:

Witness Name:

Witness Signature:

Patient Address:

10 revanathan colony West
Mambalam Chennai Tamil Nadu INDIA
600033



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 :	UHID Number :
Self/Attendant Name :	Relation :
Self/ Attendant Signature : Phone Number :	Name & Signature of Financial Counselor

Mrs.

GUC-00079451 IP18-00036178
Mrs SNEHALI KOUSHIK
04-04-1988 38 Y 2 M 21 D (F) *white*
Dr. PRIYADHARSHINI S M

Patient Sticker



IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints: *Able to PFM. c/o pain abdomen on and off - no go leaking/bleeding pv.*

LMP: *03/10/2025* EDD: *10/07/2026*
Corrected EDD: GA: *37+6 weeks*

Obstetric Formula: *Primigravida*

Menstrual History: Regular: Yes No

Obstetric History:

Obstetric Examination

I - PP, spontaneous conception

Fundal Height: *Term 2-3/20sec/10 mins*

Present Pregnancy Record:
- Booked & immunised
- NT (N), NIPT - low risk
- Anomaly scan (N)

Ut. Activity: Relaxed Mild Mod Severe
Liquor: Adequate Oligo Poly
PP: Cephalic Breech Others _____
Head Fifts Palpable: *4/5*
FHS: Normal Tachy Brady Absent

RISK FACTORS:

- Cervical stitch in situ
- Short primi.

Per Speculum Examination (-)

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

Vaginal Examination

Cervix: Long Partially effaced Effaced
Os: Closed _____ Dilated *1 finger loose*

Height: *140.8* cm
Weight: *47.7* kg
Allergies: *NIL*

Membranes: Present Absent
Liquor: Clear Meconium Blood Stained
Presenting Part: Vertex Breech Others
Sutton: -3 -2 -1 0 +1 +2
Pelvis: Adequate Doubtful
gynaecoid

Breast: Normal Abnormal
General Examination:
Consciousness: *full* Pallor: *NO*
Icterus: *NO* Edema: *NO*
Temp: *(N)* PR:
BP: DTR: *(+)*
CVS: *S1 S2 (+)* RS *NAD*
Liver/Spleen: *soft* Urine Output: *adequat*

DIAGNOSIS

Elderly Primigravida / 37+6 weeks / Cervical stitch in situ / Early labour
A1 positive

Patient Sticker

<p>Family History: Father - Diabetic</p>	<p>Surgical History: I/v/o short cervix 2.1cm Cervical emergence at 20⁺5 weeks - (26/2/26)</p>
<p>Medical History: M/O OI Fibroid uterus - Two intramural fibroid 2.5x2.5cm and 0.9x0.9cm posterior myometrium</p>	<p>Medication History: Tab ECOSPIRIN 50mg HS.</p>
<p>Plan of Care: 2/1 Dr. Priyadharshini <u>Admission</u> - Admission. - parts preparation - secure IV line. - Ij: TAXIM 1gm IV BD (ATD) - w/f contractions. - Infom SOS. - IVF @ 10 RL (25ml/hr) - <u>Plan</u>: cervical suture removal at 8pm</p>	<p>Investigations: CTG <u>Bedside USG</u> SLUG Fh good AFI - 8 to 9cm.</p>

Doctor Name: Dr. Mohana / Dr. Divyalakshmi
Signature: *[Signature]*
Date & Time: 25/6/26, 6 AM

Consultant Name: Dr. Priyadharshini
Signature: *[Signature]*
Date & Time: 25/6/26, 6 AM

GUC-00079451 IP18-00036178
 Mrs SNEHALI KOUSHIK 38 Y 2 M 21 D (F)
 04-04-1988
 Dr. PRIYADHARSHINI S M



RESULT SHEET

Date	16/6/26	26/6/26			
Time					A POSITIVE
Hb	12.2	9.6			
PCV	40.6	29			
RBC	4.14	3.28			
WBC	10090	15.49			
N/L		81/13			
Platelets	1.74	1.64			
CRP					
ESR	20 ↑				
PCT					
RBS	F- 66.9				TSH- 1.23
Na	PP- 83.5				
K					
Cl					Hb electrophoresis (N)
Ca/Mg					Rubella - Immune
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					ECG ? (N)
T.Bill/Conj					Echo EF-60%
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

[Handwritten signature]
 16/2/26 82217



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/6/2021	C/S/B Dr. Priyadharshini	
8:40AM	Pt clo Lower Abdominal Pain	
	↓ SAP, Patient in dorsolithotomy position.	
	Cervical stitch removed.	
	O/E Pt Gc fair, Afebrile	
	P/PE°	
CTG - Reactive	CVS	Advice
	RS MAD	- To give diet
	P/A - uterus @ Term	- Check FHS
	(10/15" / 10')	- To start INJ. SYNTD @
	cephalic	2uml/hr after breakfast
	FHS - good	- Then liquid diet
	P/v - Cx - Thick effaced	- Continuous CTG
	OS - 3cm dilated	- Continuous monitoring
	Bom ⊕	- W/F contractions / Progress
	Vertex @ - 3	
	↓ SAP, ARM done clear liquor drained	- To start INJ. SYNTD & titrate accordingly.

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/6/26 11:05 AM	<p>SB Dr. Priyadharsini</p> <p>Pt reviewed; no pain abdomen</p> <p>Plv: Ut term; Acting FH good.</p> <p>Pvr: Cx well effaced Os: 6cm dilated Vx: -2 station</p>	<p>Adv:</p> <ul style="list-style-type: none"> Inj Epidasin 2cc IV Continuous CTG
25/6/26 12:11:3		
25/6/26	C/S/B Dr. Priyadharsini / Dr. Parithra	
2:00 PM	<p>ole</p> <p>Plv - Cx well effaced Os 6cm dilatation Vx @ -2 station Caput ⊕</p>	<p>Advise</p> <p>Epidural analgesia given at 1:30 PM.</p> <ul style="list-style-type: none"> Plan Emerg ESCS in view of fetal distress Cathelexisation Pre-medication
<p>CTG fetal Bradycardia up to 90 bpm.</p>		



2

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Case Received in view	
25/06/2026 2:30pm	C/S/B Dr. Panithas	
D/S	of	Advice
T-100 BP-110/80 PR-100/min.	PT-6 fair afebrile P/PE WS RS/NAD	- NPO x 3 hours - Vitals monitoring - Follow drug chart - CBC from 8am - CXR on POD-1
Babymilk	P/A - Ut from 2 and WCU	
UA - 95ml	crossing dry	
	US - No undue bleeding p/v	
25/6/26 9:10pm	S/B Dr. Abhilita	
A/HV	PODHO / Am. LS CS / P/LI	
	@37w6d	
	fetal distress	
BP	102/60mmHg. PT reviewed	
PR	84bpm. no sp. complaints	
SpO2	99% @ RA. OIc: stable (100°F)	
Temp	100°F	
	6L fever	
	P/PE	
	P/A: uterus w/c	
	soft	
	BS ⊕	
	crossing dry	



3

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/06/2026 9:30 AM POD-1	C/S/B Dr. Vinitha / Dr. Shreedan	
T-N	Pt reviewed, Nil clo	<u>Advice</u>
PR- 80/min	O/E Pt GC fair, Afebrile	- soft diet
BP- 114/76 mmHg	p° IPE°	- Plenty of oral fluids
	W/S	- vitals monitoring
	RS / NAD	- Follow drug chart
	PIA- ut well contracted	- Wt ↑ Bleeding PV
Hb- 9.6	soft, BS⊕	- measure & inform 1st void
PCV- 29	Dressing ⊕ & Dry	- Inform (SOS)
Baby- M/S	L/E - BWNL	- INT. FERRIUM 300mg IV
BL- Breast soft		in 100ml NS slow IV 20mins
Flatus passed		
26/6/26 3 pm	S/R Dr. Dnyalashini / Dr. Shreedan	
POD-1	Pt. reviewed Nil clo -	<u>Advice</u>
T-N	P/E: Pt GC fair, afebrile	- Continue same orders
PR- 80/min	p° IPE°	- Amoxicillin
BP- 110/80mmHg		- 3x: Magnex forte till discharge
passed flatus	PIA: soft, BS⊕	
	ut. well contracted	
Voiding freely	dressing dry	
	L/E: BWNL	

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/6/2016	O/S/B Dr. Panitha.	
APM	Pt reviewed.	
POD 1	O/S	
	Pt ac fair	Advice
T. (N)	afebrile	- Soft diet
BP- 90/60	P/Pa	- Plenty of orals
PR- 80/min	WS / RS / NAD	- Vitals monitoring
	P/A - soft, BS (+)	- Follow drug chart
Baby m/s	Ut from & cont well.	- Syrup Cremaphin
B/L Breast soft.	Dressing dry.	ISME HS
Rashed flanks		
Not passed stools.	U/S - No undue bleeding P/V.	
27/6/26	S/B Dr. Abhishek / Dr. [Signature]	
9:30 AM	Pt reviewed	
	passed stools	
	voiding freely.	
	O/E: afebrile	
BP 106/60 mmHg	GC fair	Plan:
PR 82 bpm	P° / PE°	- monitor vitals
SPO2 99% @ RA.	P/A: uterus w/c	- normal diet
Jamp (+)	soft	- ambulate
	BS (+)	- plenty of fluids
	dressing dry	- follow drug orders
	L/E BWHL	[Signature]

128435

Patient Sticker



CROSS CONSULTATION FORM

Doctor Name : Date : Time :

Diagnosis :
GUC-00079451 IP18-00036178
Mrs SNEHALI KOUSHIK
04-04-1988 38 Y 2 M 22 D (F)
Dr. PRIYADHARSHINI S M

Hospital :



Type of Referral :

- Emergency
- Urgent
- Non Urgent

Referred for : Opinion Co-Management Transfer of care

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature: _____

Findings and Recommendations :

26/10/20

S/B Physiotherapist

patient conscious, oriented & afebrile.

Assessment

chest B/c symmetry
type: Abdominal thoracic breathing

DVT : Aular scale : No risk.

Functional Assessment :

FIM score - (7) independent.

Consultant : Physiotherapist -

Name : Sangari J. Signature : Date & Time :

Advice

- Deep breathing exercise
- Pelvic bridging & tilt
- Bed mobility exercise
- Pelvic floor exercise
- Posture
- walking



MEDICATION RECONCILIATION FORM

Drug Allergies: ADI 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: OT Shifted to: NIW'

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	A. TRIPIC	1gm	IV	STAT	25/6/26 2:40 pm	<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
2	Z. CANSO PLUR	250mg	IM	STAT	25/6/26 2:45 pm	<input type="checkbox"/> C <input checked="" 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

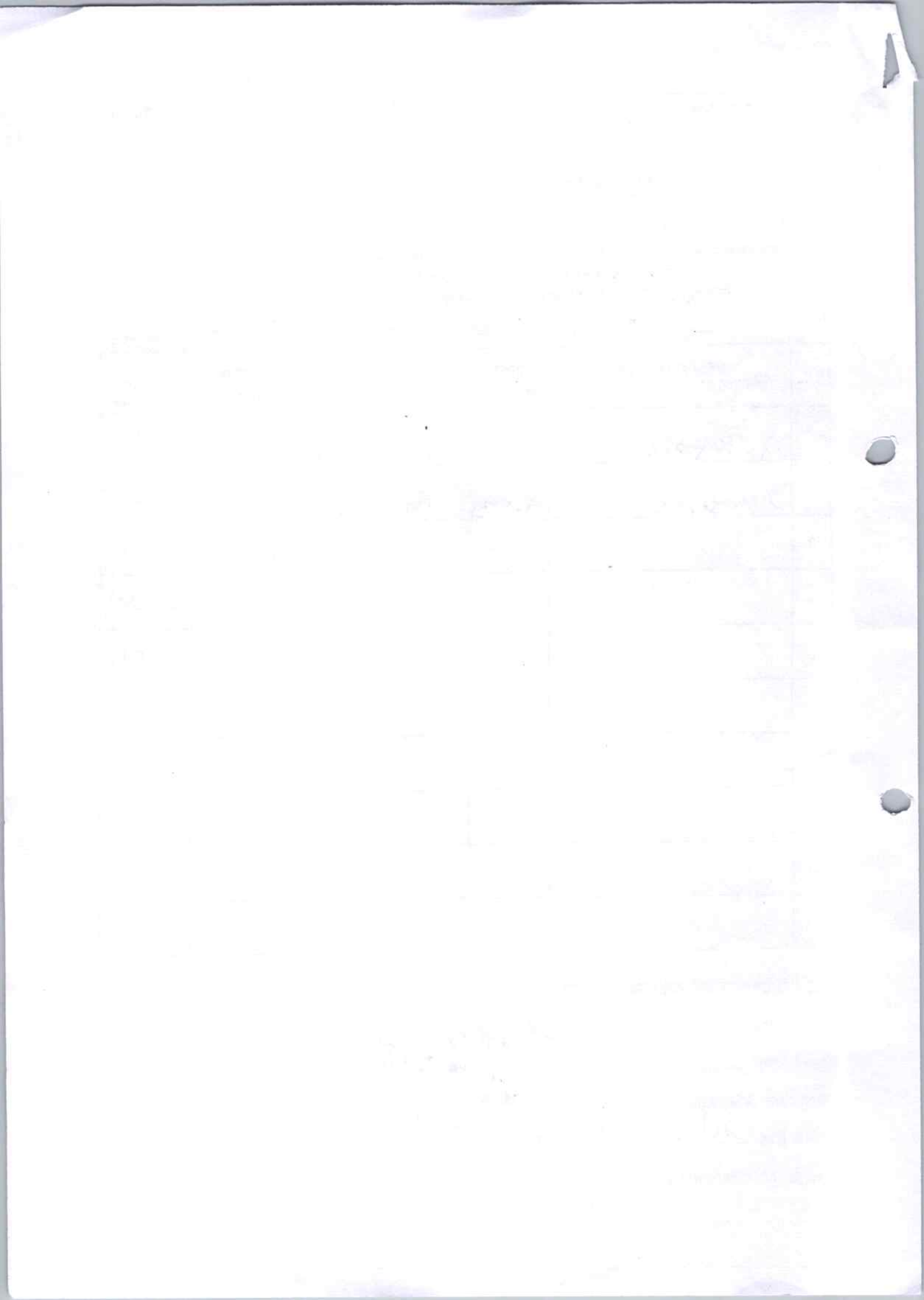
MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : [Signature]

Date & Time : 25/6/26 2:55 [Signature]

Nurse Name & Signature: [Signature]

Date & Time : 25/6/26 @ 3:30pm [Signature]



Patient Sticker

GUC-00079451 IP18-00036178
Mrs SNEHALI KOUSHIK
04-04-1988 38 Y 2 M 21 D (F)
Dr. PRIYADHARSHINI S M



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: Shifted 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						<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
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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 : *104288 Dr. Dnyalakshmi*

Date & Time : *25/6/20, 6 AM*

Nurse Name & Signature: *Dr. N. S. Teja*

Date & Time : *25/6/20 6 AM*

GUC-00079451 IP18-00036178
 Mrs SNEHALI KOUSHIK
 04-04-1988 38 Y 2 M 21 D (F)
 Dr. PRIYADHARSHINI S M



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 Shifted to: ICU

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. Paritosh

Date & Time :

Nurse Name & Signature : Dr. Sobelma

Date & Time : 25/6/2026 at 2.50 pm



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: NICU Shifted to: 4th floor ward

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	1HS MAGMAX FORTE	150mg	IV	1-0-1	25/6/26	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
2	1HS PAM	40mg	IV	1-0-1	25/6/26	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
3	1HS PARA	19m	IV	1-1-1	25/6/26	<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
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10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Shalini

Date & Time : 26/6/26 12:30 AM

Nurse Name & Signature : S. Shalini

Date & Time : 26/6/26 at 12:30 AM



I.P. No.

Sheet No.

Wards

Weight (kg)

REGULAR PRESCRIPTIONS

DRUG : INJ. CEFOTAXIM

Date: 25/6
Time: 7AM SS

Dose	Route	Frequency	Start Dt.
1g	IV	100-1	25/6/20

Name & Signature of the Doctor starting the Drugs: [Signature] 182217

Additional Instructions: 7pm

Daily Doctor's Endorsement by a Sign.

DRUG : INJ MAGNEX FORTE

Date: 25/6, 26/6, 27/6
Time: 8AM, 8 PM, 8 PM

Dose	Route	Frequency	Start Dt.
1.5g	IV	100	25/6

Name & Signature of the Doctor starting the Drugs: [Signature]

Additional Instructions: Till discharge 124682

Daily Doctor's Endorsement by a Sign. [Signature]

DRUG : INJ PANTOPRAZOLE

Date: 25/6, 26/6
Time: 7AM, 7 PM

Dose	Route	Frequency	Start Dt.
40mg	IV	100	25/6

Name & Signature of the Doctor starting the Drugs: [Signature]

Additional Instructions: 124682

Daily Doctor's Endorsement by a Sign. [Signature]

DRUG : INJ PARACETAMOL

Date: 25/6, 26/6
Time: 8AM, 4PM, 8 PM, 11PM, 5 PM

Dose	Route	Frequency	Start Dt.
1g	IV	100	25/6

Name & Signature of the Doctor starting the Drugs: [Signature]

Additional Instructions: 124682

Daily Doctor's Endorsement by a Sign. [Signature]

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

DRUG : Tab - ZERODOL SP				Date	26/6	Time	07:00
Dose	Route	Frequency	Start Dt.				
1 tab	PO	1-1	26/6	8AM / TP			
Name & Signature of the Doctor starting the Drugs:				164288			
Additional Instructions:				SPARK			
Daily Doctor's Endorsement by a Sign.							

DRUG : Tab - PAN				Date	26/6	Time	07:00
Dose	Route	Frequency	Start Dt.				
40mg	PO	1-1	26/6	8AM / DP / PR			
Name & Signature of the Doctor starting the Drugs:				164288			
Additional Instructions:				SS			
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.							



John J. ...

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

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

STAT / ONCE ONLY DRUGS

DATE	TIME	MEDICATION	DOSAGE & OTHER INSTRUCTIONS	ROUTE	SIGNATURE	NURSES
25/6	6AM	Ly. TAXIM	0.1ml	ID	[Signature]	SD CS
25/6	7AM	Ly. TAXIM	1gm	IV	[Signature]	SD SS
25/6	11:10am	INS. EPIDOSIN	2cc	IV	[Signature]	WD SN
25/6/26	2:40 pm	INT. SYTOCIN	5U	iv	[Signature]	PT AG
25/6/26	2:30pm	INT. TRANEXAMIC ACID	1g	iv	[Signature]	PT AT
25/6/26	2:40 pm	INT. CARBOADOL	0.25mg	im	[Signature]	PT AT
25/6/26	2:20 pm	Ly TAXIM	1g	IV	[Signature]	PT AT
25/6/26	2:20pm	Ly PAN	40mg	IV	[Signature]	PT AT
25/6/26	2:20pm	Ly EMESET	4mg	IV	[Signature]	PT AT
25/6/26	3:40 pm	Ly magnex forte	0.1ml	id	[Signature]	PT AT

STATE OF MARYLAND

DATE	DESCRIPTION	AMOUNT	INITIALS	REMARKS
1/1/19
1/2/19
1/3/19
1/4/19
1/5/19
1/6/19
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1/25/19
1/26/19
1/27/19
1/28/19
1/29/19
1/30/19
1/31/19

GUC-00079451 IP18-00038178
 Mrs SNEHALI KOUSHIK
 04-04-1988 38 Y 2 M 21 D (F)
 Dr. PRIYADHARSHINI S M



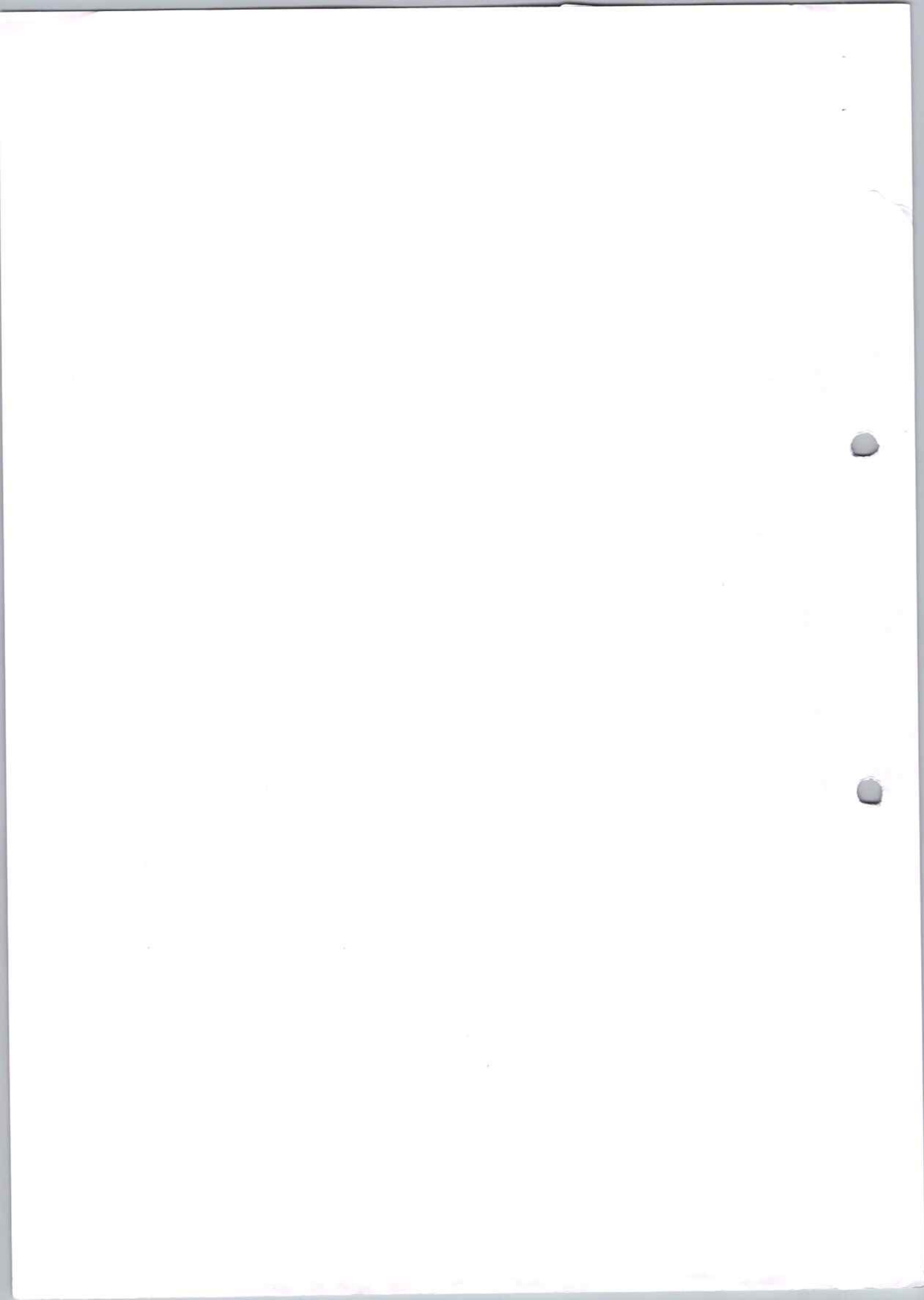
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Early Warning Observation Score Chart - Obstetrics

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

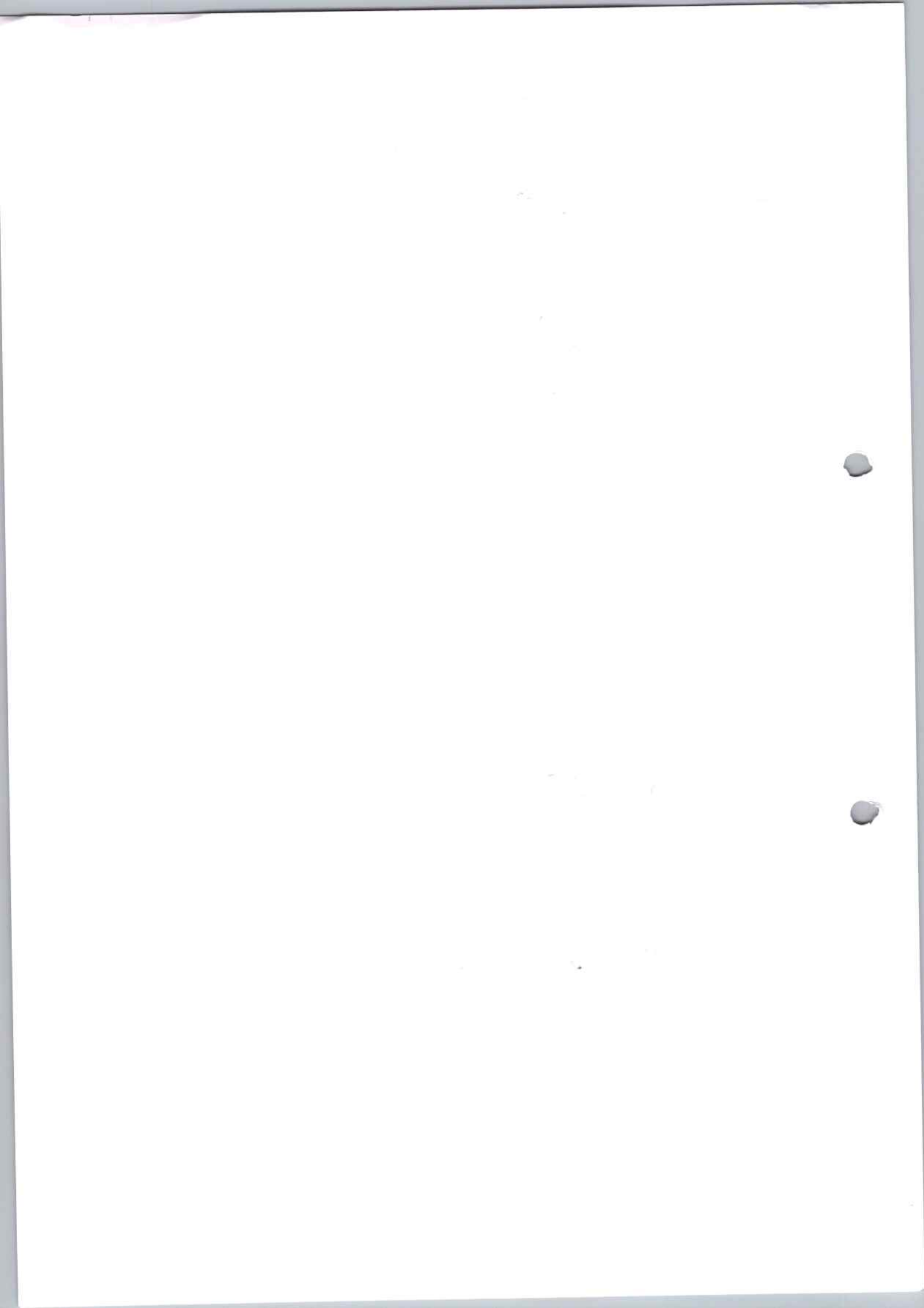
		Date	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	
RESP (write rate in corresp. box)	> 30																										
	21 - 30																										
	11 - 20	22	22	22	22	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	
	0 - 10																										
Saturations	94 - 100 %	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	
	< 94 %																										
Administered O ₂ (L/min.)			10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	
Temp ^c	40																										
	39																										
	38																										
	37	96	96	96	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	
	36																										
	< 35																										
Heart Rate	170																										
	160																										
	150																										
	140																										
	130																										
	120																										
	110																										
	100	80	80	80	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98
	90																										
	80																										
	70																										
	60																										
	50																										
40																											
Systolic Blood Pressure	190																										
	180																										
	170																										
	160																										
	150																										
	140																										
	130																										
	120																										
	110	110	110	110	118	110	108	110	108	110	108	110	108	110	108	110	108	110	108	110	108	110	108	110	108	110	
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Diastolic Blood Pressure	130																										
	120																										
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	100																										
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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																											





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	
		Time	8 AM				12 PM				4				8				12			4					
RESP (write rate in corresp. box)	> 30																										
	21 - 30																										
	11 - 20		02				02				02				02				18					20			
	0 - 10																										
Saturations	94 - 100 %		99%				99%				99%				98%									97%			
	< 94 %																										
Administered O ₂ (L/min.)			RA				RA				RA				RA				RA				RA				
Temp °C	40																										
	39																										
	38																										
	37																										
	36		97.2 F					97.2 F							98 F					97.8 F					98 F		
	35																										
	< 35																										
Heart Rate	170																										
	160																										
	150																										
	140																										
	130																										
	120																										
	110																										
	100																										
	90																										
	80		88 bpm					88 bpm								88 bpm											
	70																										
	60																										
	50																										
40																											
Systolic Blood Pressure	190																										
	180																										
	170																										
	160																										
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Diastolic Blood Pressure	130																										
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	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		0				0				0				0					0				0				
TOTAL ORANGE SCORES		0				0				0				0					0				0				
Nurse Initial		RA				RA					RA				RA				RA				RA				



Patient Stic

GUC-00079451 IP18-00038178
 Mrs SNEHALI KOUSHIK
 04-04-1988 38 Y 2 M 21 D (F)
 Dr. PRIYADHARSHINI S M



①



ID CHART

Sheet No. :

- 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			
25/6/20													
	08:00 am	Water	100ml										
	09:00 am	wa	50ml	24ml	100ml					150ml	0	per	
	10:00 am			4b	100ml						0	per	
	11:00 am	Th	200ml	Stop	100ml					100ml	0	per	
	12:00 pm				100ml						0	per	
	01:00 pm				100ml					100ml	0	per	
Total Intake :			950ml			Total Output :					950ml		
	02:00 pm	NPO		125ml						100	0	Dr.	
	03:00 pm	NPO		130ml						110ml	0	R	
	04:00 pm	NPO		125ml						75	0	Dr	
	05:00 pm	NPO		125ml						150	0	Dr	
	06:00 pm	Tea	30ml	125ml						200	0	Dr	
	07:00 pm	Tea	150ml	125ml						75	0	Dr	
Total Intake :			2.105ml			Total Output :					710ml		
	08:00 pm			125ml						100ml	0	Dr	
	09:00 pm	Water	100ml	125ml						75ml	0	Dr	
	10:00 pm	Water	100ml	125ml						200ml	0	Dr	
	11:00 pm	Water	100ml	125ml						250ml	0	Dr	
	12:00 am			125ml						100ml	0	Dr	
	01:00 am			125ml						200ml	0	Dr	
Total Intake :			300 + 750ml => 1050ml			Total Output :					695ml		
	02:00 am			125ml						200	0	Dr	
	03:00 am	Juice	150ml	125						150	0	Dr	
	04:00 am			125						250	0	Dr	
	05:00 am			125						250	0	Dr	
	06:00 am			125						100	0	Dr	
	07:00 am	Kanji	150ml	125						250	0	Dr	
Total Intake :			300 + 750ml => 1050ml			Total Output :					1800ml		
Total 24 hrs. Intake		5155ml											
Total 24 hrs. Output		3035ml											

GUC-00079451 IP18-00036178
 Mrs SNEHALI KUSHIK
 1988 38 Y 2 M 21 D (F)
 Dr. PRIYADHARSHINI S M



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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

FLUID CHART

Sheet No. : 2

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

26/6/26

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	H ₂ O 300ml											
	09:00 am												
	10:00 am									250ml	0		
	11:00 am	H ₂ O 300ml									0		
	12:00 pm									350ml	0		
	01:00 pm	H ₂ O 100ml									0		

Total Intake : 700ml

Total Output : 350ml

	02:00 pm	water 250ml									0		
	03:00 pm	water 300ml									0		
	04:00 pm	milk 200ml								300ml	0		
	05:00 pm										0		
	06:00 pm	water 200ml								250ml	0		
	07:00 pm	water 200ml								150ml	0		

Total Intake : 1150ml

Total Output : 900ml

	08:00 pm										0		
	09:00 pm	H ₂ O 100ml									0		
	10:00 pm										0		
	11:00 pm	H ₂ O 200ml								300ml	0		
	12:00 am	milk 100ml									0		
	01:00 am										0		

Total Intake : 400

Total Output : 500

	02:00 am										0		
	03:00 am	H ₂ O 100ml									0		
	04:00 am									250ml	0		
	05:00 am										0		
	06:00 am	H ₂ O 100ml									0		
	07:00 am	milk 200ml									0		

Total Intake : 400

Total Output : 650

Total 24 hrs. Intake : 2,700

Total 24 hrs. Output : 2,400ml

GUC-00079451 IP18-00036178
 Mrs SNEHALI KOUSHIK
 04-04-1986 38 Y 2 M 21 D (F)
 Dr. PRIYADHARSHINI S M

Patient Sticker



NURSING CARE RECORD

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Date: 25/6/26

Goals

- Maintain Airway and Oxygenation
- Maintain Personal Hygiene
- Identify Potential Complications

- Relieve Pain & Discomfort
- Prevent Infection
- Any Others. Specify.....

- Maintain Fluid Balance
- Meet Elimination Needs

- Improve Activity Tolerance
- Ensure Safety

- Maintain Good Nutritional Status
- Early Ambulation Reduce Anxiety

- Maintain Skin Integrity
- Patient & Family Education

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am	Promote adequate nutrition.		-> encouraged oral intake.	evaluated oral intake & charted.	No evidence of dehydration.	[Signature] 6/25/26
Afternoon	2pm	Achieve acceptable pain control & comfort.	2.30 pm	- Assess pain using pain scale regularly. -> position patient comfortably.	patient vital signs stable.	Reassessment done.	[Signature] 6/25/26
Night	8pm	Achieve Acceptable Pain Control & Comfort	8.30 pm	- Assess Pain using Pain scale regularly - Administer Analgesics as Prescribed - Position patient comfortably	Pain was Reduced	Reassessment was done	[Signature] 04/07/26

GUC-00079451 IP18-00036178

Mrs SNEHALI KOUSHIK
04-04-1988 38 Y 2 M 22 D (F)
Dr. PRIYADHARSHINI S M



NURSING CARE RECORD



Date: 26/6/26

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning 11:30 AM	Maintain good nutritional status	8 AM	Encouraged to take soup	Evaluate input & output	Patient stable	Su 01824
Afternoon 1:30 PM	Maintain good nutritional status	2 PM	Encourage the patient to take take orally	Evaluate intake & output	Reassessment Done	San 6024
Night 8 PM	→ To Relieve from pain & discomfort	11 PM	→ Assessed the pain level of the patient → monitored vital signs → maintained I/O chart → Administered medication as per doctor's order	Relieved from pain & discomfort	Reassessment was done	BF 02149

Patient Stic

NOTES NOTES
 (USE BALL POINT PEN ONLY)



- No Known Drug Allergies
- Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
25/6/26	6AM	<p>⇒ Admission notes</p> <p>Mrs. SNEHALI Koushik 38y 17m Under Dr. Priyadharshini. She is elderly primi Gravida. Cervical stretch in situ, while storing the patient conscious and Oriented. A fetal tracing seen by fetal Doppler. Voided freely. Patient vital signs checked & recorded. General condition fair, CTG corrected reaction FHR good. Under aseptic technique, Placental preparation was done, In placenta done. Syntexin 0.1mg TDS given.</p>
	7AM	<p>⇒ CTG disconnected reaction FHR good. Fetal movement good. Syntexin 1gm TDS full dose given, No allergic reaction.</p>
	7:30 ^m	<p>⇒ Patient report hand over to morning duty staff</p> <p>⇒ night Morning duty report on 25/6/26</p> <p>Pt comes over from the night duty staff. Pt conscious & oriented to time Present Pt general condition is good</p>
	8:00 ^m	<p>Pt vital checked & recorded. Pt is in mild abdominal pain. Pt general condition is good.</p>

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

ben
25/6/26

Patient Sticker

NURSES NOTES

(USE BALL POINT PEN ONLY)

No Known Drug Allergies

Drug Allergies

25/6/26

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
	9:00 ^{am}	S/O to Priyadharsini man examination in the perineal & SAP perineal desitotomy position. cervical exam removed. Plv examination done 3cm dilation. ARM done Uterus 12man. Pt turned @ diet. Synto 5ml. Paracetamol 500mg.
	9:20 ^{am}	S/O to Priyadharsini man comes in. Synto 24 ml. Spao. FHR 160/min on flow. CTU connecting. FHR is good. PTA is 140-142 b/min. Continue O2.
	10:00 ^{am}	Pt vital count & removed. FHR 160/min on flow. Pt clo in pain. O2 continue. PTA is good.
	10:45 ^{am}	Patient clo in pain and pushing. Turned to Priyadharsini man order in Synto stop continue O2 monitoring. FHR 160/min on flow.
	11:10 ^{am}	S/O to Priyadharsini man Plv examination done 6cm dilation. Synto 24ml. Spao. slow. In firm as per dvtas. order no need Synto. Spao program. CTU connecting. FHR is good.
	12:00 ^{pm}	Pt vital count & removed. Pt general condition is good. O2 on going. PTA is good.

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES
 (USE BALL POINT PEN ONLY)

- No Known Drug Allergies
- Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
	12:45 pm	SB DR. mathagi ^o mam examination in the Plus condition. Pt wants to pain.
	1:30 pm	Dr. Petadine. patient file handing over to evening duty staff Dr wants to Epidural Evening duty (256 dose).
	2:30 pm	patient handing over taken by morning duty staff patient consi consi and oriented vaginal condition Feels (at P/L) bladder even low dilatin DR. venitha mam admin Epidural
	2 pm	Inform to DR. Sathish admin Epidural was done. patient consi and oriented vaginal condition Feels vital are stable. Inform to DR. priyadevchi mam patient on continuous FHR (+) 144b/m patient No complaint Feels pain
	2:10 pm	SB DR. venitha mam catheterisation done left D wals 10ml ins
	2:20 pm	patient on going on fetal desu inform to DR. venitha SBDR. priyadevchi mam FHR was shifted to patient Dr. Taren (y r Dr. pen yom iv, Dr. Ench 2ml y glur patient handu over given at start

non 018760
 non 018760
 [Signature]

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

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

[Signature]

Patient Sticker

NURSES NOTES

(USE BALL POINT PEN ONLY)

No Known Drug Allergies

Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		<u>OT Notes</u>
25/6/26	2:20 pm	→ patient received. From LDR to OT. Anaesthesia given by Dr. Mohan Under Epidural Anaesthesia done. ⇒ printing and draping done. Surgery Successfully completed. ⇒ Surgery done by Dr. Priyadharsini, Dr. Lucetta. ⇒ Foley's catheter in situ drain urine.
		<u>Baby details</u>
		Baby: Boy
		Time: 2:39pm
		wt: 2.75kg
		⇒ Baby shifted to Mother Side.
		⇒ pt vitals signs checked and recorded.
		Tem: 98.4°F HR: 64b/min SpO2: 100% BP: 110/70mmHg
	3:30 pm	⇒ patient shifted to MIU and patient handover to MIU staff.
25/6/26	3:30pm	<u>Receiving Notes (25/6/26)</u> patient Receiving OT. Es mico patient eme ces done patient conscious and oriented General condition vital are. Stable PIV bleeding <u>menem</u>

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



3

NURSES NOTES



No Known Drug Allergies

Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
25/6/26	3.40 pm	<p>Dr. Prithvi mam admit Inj: magnex forte start order patient Inj: magnex per 0.1ml test dose is given</p>	<p>[Signature]</p>
	4.20 pm	<p>patient checked vital are stable p/y bleeding minimal patient asking Inj: magnex forte test dose any allergy admit patient No allergy patient Inj: magnex forte 1.5g IV given</p>	<p>[Signature]</p>
	5pm	<p>patient checked vital signs vital are stable B - Breast are soft provides DBF U - uterus was well contracted B - Bowel movement present B - Bladder patient CBD L - Lochia present, No evidence for smelliness R - REEDA Assessment not applicable A - Homan's sign Negative</p>	<p>[Signature]</p>

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
25/6/26	6pm	e-Emotional status good - patient stool passed	[Signature]
		inform EPR. stripw main surgical dress changed	
	6.30 pm	patient vital are stable. PLV bleeding minimal - patient oral start water	[Signature]
		patient conscious and oriented. General condition fair	[Signature]
	7pm	patient vital are stable. patient appearing after water any vomiting NO emulsions patient TC water given	[Signature]
		PLV bleeding minimal	[Signature]
	7.30 pm	patient handing over given night duty starts Nurse	[Signature]
	8.30 pm	Night duty on 25/6/26 Report Received from Evening duty staff to Night duty staff Patient conscious & oriented	
		In low patient, No swelling vital sign checked & recorded	
		vital sign are stable	[Signature]
		CBE @ urine drained well.	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



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NURSES NOTES



- No Known Drug Allergies
- Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
25/6/26		← Continuous 25/6/26 → Patient liquid diet. IV PC 125ml/hr on flow	
	9:10 pm	Pr Bleeding Minimal Temp 100°F informed Dr. Akshitha She advice Trj. paracetamol 1gm	
	9:20 pm	Trj. Magnex forte 1.5gm now. Trj. paracetamol 1gm IV given	
	10:30 pm	Trj. Magnex forte 1.5gm IV given Temp checked 99.2°F informed Dr. Akshitha	Shalini 24071
		B - Breast Soft, No enlargement U - uterus well contracted B - Bowel Movement present B - Bladder C/D ⊕ urine drained well. L - Lochia Rubra present R - Rooda ^{present} Not Applicable. H - Homan's sign Negative. E - patient Emotional Status good	Shalini 24072
	11 pm	Temp checked Temp - 100.2°F informed Dr. Akshitha	Shalini 24072
	12:30 pm	Pr Bleeding Minimal vital signs checked & Recorded Temp - 99.3°F informed Dr. Akshitha	Shalini 24072

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
		← continuous 26/6/26 →	
26/6/26	12:30 pm	Temp. Q2H. Tepid sponge give ward patient shifted to 4th floor ward.	J. Kest 20707
		Receiving Notes	
26/6/26	12:40 pm	patient received from LDR to 7th floor. IVF - 125ml/hour CBD 8 AM, CBC 6 AM Clm	
		IV Medication, Konyi 7 AM soft diet. 9 AM, liquid diet	→ P. Kest 6000
	2:00 pm	patient is sleeping well, No complaints, Intake/output maintained	→ P. Kest 6000
	4:00 pm	patient vitals checked and recorded.	→ P. Kest 6000
	6:00 pm	patient morning routine care given and diet Mellin's given and recorded. Intake/output maintained.	→ P. Kest 6000
	7:30 pm	patient details handover given to morning duty staff	→ P. Kest

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



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NURSES NOTES



- No Known Drug Allergies
- Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
26/6	7-30 AM	<p>← Urging duty →</p> <p>→ patient detail handing over taken by Night duty SLW</p> <p>→ patient was conscious and oriented. patient was acting alert & vitals pattern</p>	<p><i>[Signature]</i></p> <p>018346</p>
	8:00 AM	<p>vitals were checked and recorded maintain</p> <p>stocast no other</p> <p>Complaints, CBD removed</p>	<p><i>[Signature]</i></p> <p>018346</p>
	09:00 AM	<p>B - Breathing normal</p> <p>C - Cerebral is contracted</p> <p>B - Bowel movement normal</p> <p>B - Bladder voided</p> <p>L - Lochia Rubra present</p> <p>E - Moods Anxious</p> <p>H - Human sign negative</p> <p>E - patient Emotional Status</p>	<p><i>[Signature]</i></p> <p>018346</p>
	8 AM	<p>→ Due medication as given at per day Chart daily</p> <p>→ Dr. Priyadharsini met with the patient and gave advice to attend, continue</p>	<p><i>[Signature]</i></p> <p>018346</p>
	10 AM	<p>→ 1st void urine passed</p> <p>But not measured instead</p>	<p><i>[Signature]</i></p> <p>018346</p>
		<p>no</p>	<p><i>[Signature]</i></p> <p>018346</p>

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
26/6		patient ambulated without support at staff nurse under physiotherapist	
	12pm	→ vitals all checked and rechecked vitals all stable	
		→ Dr. Sreedevi gave advice to Raj: Iron spony	Dr 019244
	12:30 PM	→ Raj: ferritin spony in stock intolerance over 20 units	
		ended at 12:00 pm	Dr 019244
	1 PM	→ Mandatory leads & septal	
	1:30 PM	→ patient detail healthy over given to Every duty	Dr 019244
		Evening Duty	
26/6/26	1:30 PM	The Patient details handing over taken from evening morning duty staff. Patient is conscious and oriented Patient is on room air. Iv line present Iv line pattern	Raj Bottle
	2 PM	No any other fresh complaints Patient is stable. Due medications are given as per doctor's order	Raj Bottle

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

☐ Drug Allergies nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
26/6	4 PM	vital signs are checked and recorded vital signs are stable. B - Breast is soft U - uterus is contracted B - Bowel movement normal B - urine voided L - Lochia Rubra Present E - Perineal Assessment Done H - Homan Sign Negative E - Patient Emotional Status good	<u>Jan</u> Gore
	6 PM	Due medications are given as per doctor's order I/O chart maintained	<u>Jan</u> Gore
	7:30 PM	The patient details handed over given to night duty staff.	
26/6/26	7 PM	Night duty notes on 26/6/26 patient details taken over from evening duty staff using IPBAR method. on Assessment patient is conscious, oriented and alert. All-MSIS, Skin Assessment done. I/ur is present and patient, no pain or tenderness	<u>Jan</u> Gore

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

NURSES NOTES

No Known Drug Allergies

Drug Allergies None known nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
26/6/26	8pm	<p>← Continue after →</p> <p>vitals checked and recorded all are hemodynamically stable</p> <p>B - Breast is soft & no engorgement U - Uterus is well contracted B - Bowel pattern was normal B - on loopy voiding L - Lochia Rubra is present E - PAIN assessment done A - Human sign is negative G - Emotional Response was good</p>	R. Jones 26/6/26
	10pm	<p>Due medication given as per the drug chart</p>	
	10pm	<p>Due medication given as per the drug chart</p>	R. Jones 26/6/26
27/6/26	12am	<p>vitals checked & recorded, all are hemodynamically</p>	
	2am	<p>patient slept well, no specific complaints</p>	R. Jones 26/6/26
	9am	<p>vitals checked and recorded, all are hemodynamically stable</p>	
	6am	<p>Due medication given as per drug chart</p>	
	7am	<p>Spide IDO chart maintained</p>	R. Jones
	7:20 am	<p>patient details handed over to morning duty staff using SBAR method</p>	26/6/26

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



CAESAREAN SECTION OPERATIVE NOTES

Surgeon's Name: <i>Dr. Priyadharshini</i>	Date of Delivery: <i>25/06/2026</i>
Assistant Surgeon: <i>Dr. Lucetta / Dr. Panithra.</i>	Time of Delivery: <i>2:39 PM</i>
Anaesthetist's Name: <i>Dr. Mohan.</i>	Gender of Baby: <i>Boy</i>
Type of Anaesthesia: <i>Spinal Anaesthesia</i>	Weight of Baby: <i>2.754 Kg.</i>
Neonatologist: <i>Dr. Poopitha.</i>	AGPAR Score: <i>8/10, 9/10</i>
Scrub Nurse: <i>S/N Mrs. Agalye</i>	NICU Admission: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Pre-Operative Diagnosis:

Elective Emergency Indication: *Fetal Distress.*
 Urgency
 Immediate Threat to life of woman or fetus
 Maternal or fetal compromise not immediately life threatening
 No maternal or fetal compromise but needs early delivery
 Delivery timed to suit woman and staff
 Decision time: Knief to rectus:
 CTG Description: *Fetal Bradycardia.*
 If there was a delay give the reasons:

Surgical Procedure:

Emergency Lower Segment Caesarean Section.

Post Operative Diagnosis:

Pit / Post LSCS

Peri-Operative Complications:

Amount of Blood Loss: *350 ml*

Blood Transfused (in ML):

Name and Number of Surgical Specimen sent for examination:

Examination Findings when Appropriate:

Presentation: Cephalic Breech Other Cervical Dilatation: cm
 5th Palpable: Fetal Position:
 Station: -3 -2 -1 0 +1 +2 Moulding: None + ++ +++
 Caput: + ++ +++ Meconium: None + ++ +++
 Bladder Catheterized: Yes No Urine: Clear Blood Stained

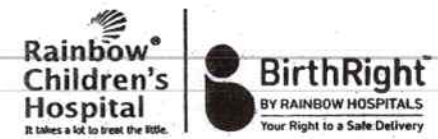
Skin Incision: Pfannenstiel Transverse Midline Other
 Uterine Incision: Lower Segment Classical Inverted T J Incision
 Previous Scar: Intact Thinned out Ruptured No Scar
 Incision Through Placenta: Yes No
 Delivery of head: Manual Forceps
 Liquor: Clear Meconium: I II III Blood Offensive Not Offensive
 Delivery of Placenta: Manual CCT Complete Incomplete Piecemeal
 Cord Appearance: Cord around the neck Yes No
 Appearance of placenta: Cavity explored Yes No
 Uterus, tubes and ovaries: Normal Not Normal Sterilization: Yes No

Uterine Closure: One Layer Two Layers Suture
 Peritoneal Closure: Pelvic Abdominal None Suture
 Sheath Closure: Suture
 Fat Closure: Yes No Suture
 Skin Closure: Subcuticular Mattress Suture
 Vaginal Evacuated Yes No
 Drain: Yes No Remove in days Await instructions
 Catheter: Yes No Remove in days Await instructions
 Swap & Instruments count correct? Yes No Post-op Antibiotics Yes No
 Intra-Operative Antibiotics Cover: Yes No Thromboprophylaxis Yes No

Post-Operative Notes: - NPO X 3 hours
 - Inj Magnex forte 1.5g IV 107 (A7D)
 - Inj PANTOPRAZOLE 40mg IV 107
 - Inj PARACETAMOL 1g IV 107
 - Inj TRAMADOL 50mg IM SOS
 - CBD 4m 8AM
 - CRC on POD1

Doctor Name: Dr. Priyadharsini Doctor Signature: [Signature] 12/6/21
 Date & Time: 25/06/2026

JUC-00079451 IP18-00036178
 Mrs SNEHALI KUSHIK 38 Y 2 M 21 D (F)
 04-04-1988
 Dr. PRIYADHARSHINI S M



URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 25/6/20 Date of Removal: 26/6/20 @ 8:00 am

Parameters	Date	Shift Time	<u>25/6/20</u> E	<u>25/6/20</u> NI	<u>26/6</u> H			
Need for the Catheter			<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
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 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 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
Is the Collection bag below the level of bladder			<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
Check the Tube for Obstruction (Free of Kinking)			<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
Is Catheter dated as policy			<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
Collecting bag is been emptied regularly?			<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
Maintenance of closed system for the catheter			<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
Dressing clean and dry?			<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
Is the line removed as Policy?			<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
Performance of Perineal Care			<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
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 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 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
Name of the Nurse			<u>D. Sobhan</u>	<u>S. Shalini</u>	<u>S. Sanyal</u>			
Signature of the Nurse			<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>			

GUC-00079451 IP18-00036178

Mrs SNEHALI KUSHIK
04-04-1988 38 Y 2 M 21 D (F)
Dr. PRIYADHARSHINI S M



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
25/6/26	6 AM	1/10	Lower Abdomen pain	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input 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 type="checkbox"/> No	Comfortable position	Shalinis 24072
25/6/26	9 AM	2/10	Lower abd pain	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input 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 type="checkbox"/> No	Comfortable position	Shalinis
25/6/26	2 PM	2/10	Lower abd pain	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input 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	Comfortable position	Shalinis
25/6/26	4 PM	2/10	Lower abd pain	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input checked="" type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Comfortable position	Shalinis
25/6/26	6 PM	2/10	Lower abd pain	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input checked="" type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Comfortable position	Shalinis
25/6/26	8 PM	1/10	Surgical 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	Comfortable position	Shalinis 24072
26/6/26	2 AM	0/10	-	<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	N/A	P. 60
26/6	8 AM	1/10	-	<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	Provide pharmacologic therapy	Shalinis
26/6	2 PM	1/10	-	<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 type="checkbox"/> No	Comfortable position	Shalinis
26/6	8 PM	1/10	-	<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 type="checkbox"/> No	Provide comfortable	Shalinis 02149

Re-assessment Frequency:

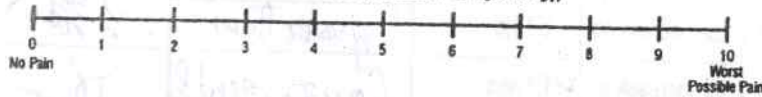
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 - a) At least every 2 hours for the first 24 hours
 - b) Then every 4 hours.
 - c) Prior to pain pain-relieving intervention.
 - d) Within 30 - 60 minutes after pain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

PAIN ASSESSMENT TOOLS

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

Wong - Baker (Pediatrics) Above 7 Years



GUC-00079451 IP18-00036178
 Mrs SNEHALI Koushik
 04-04-1988 38 Y 2 M 23 D (F)
 Dr. PRIYADHARSHINI S M



2



PAIN ASSESSMENT FORM

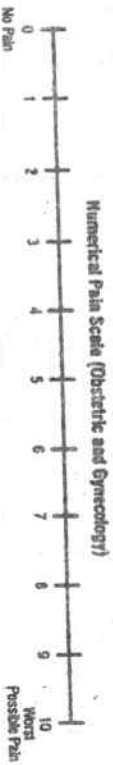
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
27/6	2AM	1/10	-	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<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	Position	RPR 02/13
27/6	8AM	0/10	-	<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 checked="" type="checkbox"/> No	nil	DRUG 02/13
				<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		
				<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 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, withdrawn, 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	Archid, rigid, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Cont. it, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort



Wong - Baker (Preschool) Above 7 Years



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

Assessment Criteria	Sedation		Normal	Pain / Agitation
	-2	-1		
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	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	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
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched fists, fists or finger splay Body is not tense
Vital Signs HR, RR, BP, SaO ₂	No variability with stimuli Hyperventilation 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

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 04-04-1988 38 Y 2 M 21 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:	25/6	25/6	25/6	25/6
					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	5	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	1	1
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	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	24	24
Docu. No. : RCH /FRM / CLINICAL / 119					Evaluator's Name	Shalini 01401	Shalini 01401	Shalini 01401	Shalini 01401

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



BRADEN 'Q' SCALE

Date: 28/6/2016
 Time: 4 E 2 M

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.	3	3	3	3
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICION-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.	7	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			
Docu. No. : RCH/FRM / CLINICAL / 119					26 26 26 26			
					Evaluator's Name			
					Olpy 02049			

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

GUC-00079451 IP18-00036178
 Mrs SNEHALI KOUSHIK
 04-04-1988 38 Y 2 M 21 D (F)
 Dr. PRIYADHARSHINI S M



Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	N. Y. E			Fall Risk Grading		
		Score	24/6/26	28/6/26	25/6/26	Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25				Low Risk	0 - 24	Standard Fall Precaution
	No	0	0	0	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0	0	0	0			
Ambulatory Aid	Furniture	30				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		26	26	Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	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			0	High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0	0	0	0			
Total Morse Fall Scale Score:			0	20	20			
		Signature	Shalini	Sanjay	Dr. P. S. M.			

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

1. The first step in the risk assessment process is to identify the hazards. This involves looking at the process and identifying any potential sources of harm.

2. The next step is to assess the risk. This involves estimating the likelihood of the hazard occurring and the severity of the consequences if it does.

3. Once the risk has been assessed, the next step is to develop control measures to reduce the risk to an acceptable level.

4. The final step is to implement the control measures and monitor the risk regularly to ensure it remains at an acceptable level.

Task	Start	End	Duration	Dependencies	Resources	Notes
Identify Hazards	1	2	1			
Assess Risk	2	3	1	Identify Hazards		
Develop Control Measures	3	4	1	Assess Risk		
Implement Control Measures	4	5	1	Develop Control Measures		
Monitor Risk	5	6	1	Implement Control Measures		

Morse Fall Risk Assessment Form



 Name: _____

 Date: _____

 Room: _____

(1)

(2)



Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	N	M	F	Fall Risk Grading		
		Score				Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25				Low Risk	0 - 24	Standard Fall Precaution
	No	0	0	0	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0	0	0	0			
Ambulatory Aid	Furniture	30				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				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20	20	20	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:			20	20	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
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- 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-00079451 IP18-00035178
 Mrs SNEHALI KOUSHIK
 04-04-1988 38 Y 2 M 21 D (F)
 Dr. PRIYADHARSHINI S M



Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	N	M	Fall Risk Grading		
		Score	26/6/22	27/6	Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25			Low Risk	0 - 24	Standard Fall Precaution
	No	0	0	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15			Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0	0	0			
Ambulatory Aid	Furniture	30			High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Crutches, Cane(S), Walker	15					
	None /Bed Rest /Nurse Assist	0	0	0			
IV / Heparin Lock or Saline	Yes	20			Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0					
GAIT / Transferring	Impaired	20	20	20	High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10					
	Normal /On Bed Rest /Immobile	0	0	0			
Mental Status	Forgets limitations	15			High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0	0	0			
Total Morse Fall Scale Score:			20	20			
Signature			<i>[Signature]</i> 27/6/22	<i>[Signature]</i> 27/6			

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

Имя Фамилия

Р/П
 03/16

Номер
 100000

Дата выдачи
 10.10.2016



GUC-00079451 IP18-00036178
 Mrs SNEHALI KOUSHIK
 04-04-1988 38 Y 2 M 21 D (F)
 Dr. PRIYADHARSHINI S M



RISK ASSESSMENT TOOL FOR DEEP VEIN THROMBOSIS

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

Date: 25/6/26

Pre - Existing Risk Factors		Tick	Score
Previous VTE (except a single event related to major surgery)			4
Previous VTE provoked by major surgery			3
Known high-risk thrombophilia			3
Medical comorbidities e.g. cancer, heart failure; active systemic lupus erythematosus, inflammatory polyarthropathy or inflammatory bowel disease; nephrotic syndrome; type I diabetes mellitus with nephropathy; sickle cell disease; current intravenous drug user			3
Family history of unprovoked or estrogen-related VTE in first-degree relative			1
Known low-risk thrombophilia (no VTE)			1
Age (≥ 35 years)	1		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		1	
Signature of the Nurse		<i>Shalini</i> 04/07/26	
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.

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD



Part - I.

Patient's / Learner Language: Tamil Patient / Learner Literacy: Read Write Speak

Willingness to Learn: Yes No Healthcare Literacy: Yes No

Identified Education Needs:

- | | | | |
|-----------------------------------------------|----------------------------------------------------------------------|---------------------------------|----------------------------------------------------------------|
| 1. <u>Buy 3776</u>
Diagnosis | Plan | 6. Discharge Medication | 10. Fall Risk Education |
| 2. <u>Identify Drug</u>
Treatment and Care | 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices Safety |
| | 4. Informed Consent | 8. Diagnostic Test / Procedures | 12. Patient's / Family Rights |
| | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet | 13. 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		
25/6/20	7AM	enformed Consent	Explains about informed Consent Normal.	Patient	Learning barrier	Verbal	none	good	-	[Signature]
26/6	8AM	yes	explain about infection Control	Patient	no	Verbal	no	good	-	[Signature]
27/6	8AM	no	Health education about Nutrition / Diet	Patient	no	verbal	None	good	-	[Signature]

Part - III: CODES

Who was taught: 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 <input checked="" type="checkbox"/>	2. Demonstrates Understanding <input type="checkbox"/>	3. Needs Review <input type="checkbox"/>
-----------------------------------------------------------------	--------------------------------------------------------	------------------------------------------

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Priyadharsini
 Asst. Surgeon : Dr. Smita & Dr. Prayitha
 Anaesthetist : Dr. Mohan
 Scrub Nurse : S.N. Agalga

GUC-00079451 IP18-00036178
 Mrs SNEHALI KOUSHIK
 04-04-1988 38 Y 2 M 21 D (F)
 Dr. PRIYADHARSHINI S M

Age : Gender :
 Primary Name :
 In-time : 2:20pm Out-time : 3:30pm



Before Induction of Anaesthesia >>

Before Skin Incision >>

Before Patient Leaves Operating Room

SIGN IN Time: 2:25pm

Patient Has Confirmed

Identity Yes No
 Site Yes No
 Procedure Yes No
 Consent Yes No

Site Marked Yes No NA

Anaesthesia Safety Check Completed Yes No

Pulse Oximeter on Patient & Functioning Yes No

Does Patient have a:

Known Allergy? Yes No

Difficult Airway / Aspiration Risk?

Yes, & Equipment / Assistance Available Yes No

Risk of > 500ml Blood Loss (7ml/kg In Children)?

Yes, and Adequate Intravenous Access and Fluids Planned Yes No NA

Blood Units Reserved Yes No NA

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

Signature : [Signature]
 Name : S.N. Agalga

TIME OUT Time: 2:32pm

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

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm

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

Anticipated Critical Events

Surgeon Reviews:

What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? Yes No NA

Anaesthesia Team Reviews:

Are There Any Patient-specific Concerns? Yes No NA

Nursing Team Reviews:

Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? Yes No NA

Is Essential Imaging Displayed? Yes No NA

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

Signature :
 Name :

SIGN OUT Time: 3:30pm

Nurse Verbally Confirms with the Team:

The Name of the Procedure Recorded Yes No

That Instrument, Sponge and Needle Counts are Correct (or Not Applicable) Yes No NA

The Specimen is Labelled (including patient name) Yes No NA

Whether there are any Equipment Problems to be addressed Yes No NA

To Surgeon, Anaesthetist and Nurse:

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

Signature : [Signature]
 Name : S.N. Agalga

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GUC-00079461 IP18-00036178
 Mrs SNEHALI KOUSHIK
 04-04-1988 38 Y 2 M 21 D (F)
 Dr. PRIYADHARSHINI S M



 		PATIENT TRANSFER NURSING HANDOVER CHECKLIST	
Date & Time of Transfer: 25/6/26 @ 3:30pm		TRANSFERRED TO: Miu	
1	Patient Identification	YES/NO	REMARKS
	a. Patient Identification Patient name, age, UHID/hospital number confirmed	Yes	
	b. Surgical procedure & correct site verified	Yes	
2	Airway & Breathing		
	a. Oxygen delivery (mask/cannula/ventilator) secured	NA	
	b. SpO ₂ within safe range	NA	
	c. If ETT: position confirmed, ties secure, cuff inflated	NA	
3	Circulation & Hemodynamic Stability		
	a. IV lines secured & infusion running correctly	Yes	
	b. No active uncontrolled bleeding	Yes	
	c. Last vitals recorded before transfer	Yes	
	d. Central line hubs are closed	NA	
	e. Dressing Intact	NA	
4	Pain Assessment		
	a. Pain score assessed & analgesia given	NA	
	b. Reassessment done	NA	
5	Wound, Dressings & Drains		
	a. Surgical dressing intact	Yes	
	b. All drains fixed, output noted	NA	
	c. Catheter secure & urine output recorded	Yes	
	d. Splints/casts/traction devices stabilized	NA	
6	Medications Pre & Post-Op Orders		
	a. Medications due time noted	NA	
	b. Pre & Post-op instructions (NPO, position, mobilization) communicated	Yes	
	c. Emergency meds given in OT (time & dose documented)	NA	
7	Equipment Safety & Transport Preparedness		
	a. Oxygen cylinder full & ambu bag at bedside	NA	
	b. Bed/side rails up and brakes applied	NA	
	c. Special positioning maintained as per surgery	NA	
8	High-Risk Patient Safety (if applicable)		
	a. Chest tube: underwater seal below chest level	NA	
	b. Epidural catheter secure, infusion checked	NA	
	c. Pressure areas protected (heels/elbows)	NA	
9	BLOOD AND BLOOD PRODUCTS TRANSFUSED	NA	
10	REPORTS AND LABS HANDED OVER	NA	
11	BIOPSY/HPE SENT	NA	
12	Documentation		
	a. Documentation completeness	Yes	
	Transferring Nurse: 		
	Receiving Nurse: 		
	Signature of Incharge: 		

10/1/77

10/1/77



INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE



Patient Name :

GUC-00079451 IP18-00036178
 Mrs SNEHALI KOUSHIK
 04-04-1988 38 Y 2 M 21 D (F)
 Dr. PRIYADHARSHINI S M

Gender: Male Female Age :

UHID No :



Date :

Instruction:

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

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

Emergency Lower Segment Caesarian Section

upon

IND - fetal Distress

(Name of the Patient)

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

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

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

Bleeding, Infection, Blood Transfusion, Anaesthesia complication,
 Bowel & Bladder injury, NICU stay.

My signature on this form indicates that

1. I have read and understood the information provided in this form
2. My doctor had adequately explained to me the operation or procedure along with the complications written above, along with the risks, benefits and other information.
3. I have had a chance to ask my surgeon questions.
4. I have received all the information I desire concerning the operation or procedure and
5. I authorize the consent to the performance of the operation or procedure.

Name of the Doctor who is performing the Surgery / Procedure: Dr. Priyadharshini

Consentee :

Signature : *Snehal*

Name : MRS. SNEHALI KOUSHIK.

Date & Time : 25/6/2026

Patient Attendant :

Signature : *Kaush*

Name :

Relationship with Patient:

Date & Time :

Witness :

Signature :

Name :

Date & Time :

Doctor (who is taking the consent) :

Signature : *Panitra*

Name : Dr. Panitra

Date & Time :



The first step in the process is to identify the problem. This involves gathering information and understanding the context of the issue. Once the problem is identified, the next step is to develop a plan of action. This plan should be realistic and achievable, and it should be based on a thorough understanding of the problem.

The plan should also take into account the resources available and the time constraints. It is important to have a clear timeline and to assign responsibilities to specific individuals. Once the plan is developed, the next step is to implement it. This involves putting the plan into action and monitoring progress.

It is important to be flexible and to be willing to make adjustments as needed. The final step in the process is to evaluate the results. This involves assessing the impact of the plan and determining whether the problem has been solved.

The second step in the process is to identify the solution. This involves brainstorming ideas and evaluating them. The solution should be effective and sustainable, and it should be based on a thorough understanding of the problem.

The third step in the process is to implement the solution. This involves putting the plan into action and monitoring progress.

The fourth step in the process is to evaluate the results. This involves assessing the impact of the plan and determining whether the problem has been solved.

The fifth step in the process is to reflect on the experience. This involves thinking about what was learned and how it can be applied in the future.

The sixth step in the process is to share the results. This involves communicating the findings of the project to others and seeking feedback.

CONSENT FORM FOR ANAESTHESIA



Patient Name :

GUC-00079451 IP18-00036178
 Mrs SNEHALI KOLSHIK
 04-04-1988 38 Y 2 M 21 D (F)
 Dr. PRIYADHARSHINI S M

UHID NO:



Anaesthesiologist :

Age : Gender : Male Female

Surgeon Name: Dr. Pijushree

Operative procedure planned : Emergency CS

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 anaesthetics 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 / Renal Tubular Acidosis
- Incapacitating Chronic Obstructive Pulmonary Disease
- Others : Hypertension, dehydration

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

Raymond

DECLARATION BY PATIENT / GUARDIAN / PROXY

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

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

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

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

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

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

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

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

Patient / Patient Attendant :

Signature : Snehal

Name : Ms. Snehal

Relationship with Patient : patient

Date & Time : 25/6/2018

Witness :

Signature : [Signature]

Name : Ms. Kolshya Sekher

Date & Time : 25/6/2018

Doctor (who is taking the consent) :

Signature : [Signature]

Name : [Signature]

Date & Time : 25/6/2018 2:30pm

Handwritten notes at the top left, including "2 (3)..." and "110" in a circular stamp.

Main body of the assessment form with various sections, checkboxes, and faint printed text.

Handwritten notes in the middle section, including "Buenos Aires" and "Argentina" written vertically.

Handwritten notes at the bottom left, including "1000" and "10000" written vertically.

Handwritten notes at the bottom right, including "1000" and "10000" written vertically.

Small handwritten notes at the bottom left corner.

Small handwritten notes at the bottom center.

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



Name: Age: Sex: UHID.No :
 Date: 25/6/20 Time: 3:30 pm Proposed Operation: Emergency CS
 Diagnosis: Pain in FO
 B.P / CRT: 10/8 H.R: 66/min Weight: 6.5 kg ASA Physical Status: 1 2 3 4 5

Laboratory Data:
 Hgb: 12.2 Glucose: Protein: HIV: 300 X-Ray:
 PCV: Urea: Alb: HBS Ag: 300 ECG:
 WBC: Creat: Total Bill: HCV: 300 2D Echo:
 Plate: 1.24 Na: Dir. Bill: Blood group: Stress/Anglo:
 PT: K: LDH: T3 Other:
 PTT: Ca++: Alk phos: T4
 INR: Mg++: Amylase: TSH 1.23 Amc
 Cl-: SGOT/SGPT:

Medical History: CVS: **Allergies:**
 RESP: Diabetes:
 CNS:
 Renal:
 Hepatic / GE:
 Others: Physical Activity: METS 4

Past Anaesthetic History:

Physical Exam:

Airway: MP 2 3 4 Mouth Opening: Mentohyoid Distance: Neck: Teeth:
 Lungs: 4/4
 Heart: 120
 CNS: 1/2

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

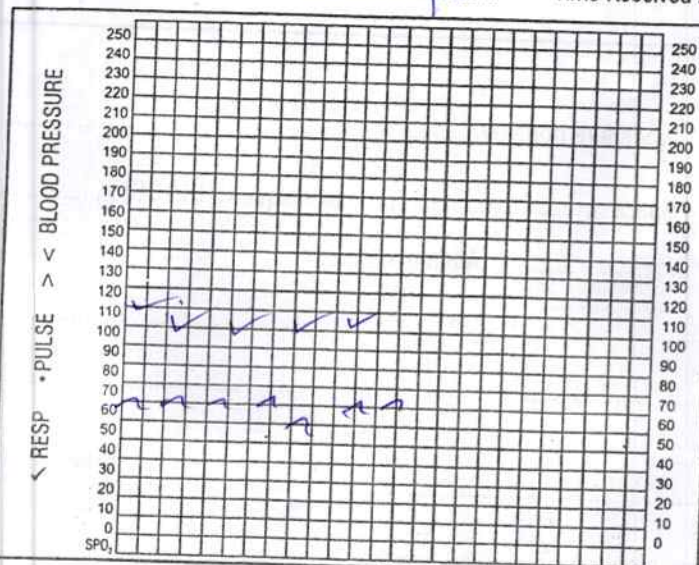
- Pre-Operative Instructions:**
- DVT Prophylaxis :
 - NIL ORAL $\left\{ \begin{array}{l} \text{Water / ORS 2 Hours} \\ \text{Others 6 Hours} \end{array} \right.$
 - Informed Consent: Standard High Risk
 - Post Operative Pain Management: Discussed with Patient
 - Other Instructions:

Signature: [Signature] Name: [Signature]

Patient Sticker

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: Thamshya Time Received: 3:30pm Time Discharged: _____



IV Cannula Site: _____

O₂ Mask Nasal Prongs

Tracheostomy T-Piece

Oral Airway Nasal Airway

Vomiting: Yes No Drug: _____

NG Tube: Yes No

Drain: Yes No

Urinary Catheter: Yes No

Chest Tube: Yes No

Mil Oral: Yes No

IV Fluids: _____

Oral Feeds: _____

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	ACTIVITY	1				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:
Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0	RESPIRATION	2				
BP ± 20 of Pre Anaesthetic level = 2 BP ± 20-50 of Pre Anaesthetic level = 1 BP ± 50 of Pre Anaesthetic level = 0	CIRCULATION	2				
Fully awake = 2 Arousable on calling = 1 Not responding = 0	CONSCIOUSNESS	2				
Pink = 2 Pale, dusky, bloated, jaundiced, other = 1 Cyanotic = 0	COLOR	2				
TOTAL		9/10				

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
			<u>WPO on PCA with WPC (wand) & Ryle's & PCA for IV</u>	

Pain Tool Used: N PASS FLACC Wong Baker NPS

Anaesthesiologist Name: _____
 Anaesthesiologist Signature: [Signature]
 Date & Time: _____
 PACU Nurse Name: Thamshya
 PACU Nurse Signature: [Signature]
 *Date & Time: 25/6/26 @ 3:30pm

Reassessment Frequency:

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

Transferred to Unit by (PACU): [Signature]
 Date & Time: 25/6/26 @ 3:30pm



CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MAC

Patient Name: **GUC-00079451** IP18-00036178 Age :
 Gender: M Mrs **SNEHALI KOUSHIK** (F) Consultant :
 04-04-1988 38 Y 2 M 21 D
 Dr. **PRIVADHARSHINI S M**
 Ward / Bed / Room No.  anaesthesiologist: *Dr. Mohan*
 Operative procedure planned: *Emergency L.S.S*

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 anaesthetics 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 : *HYPOTENSION / BRADYCARDIA / P.O.N.V*

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

I authorize and give consent for anaesthesia (Regional / General Anesthesia / Monitored anaesthesia 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 anaesthesia.

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 : Selati
Name :
Relationship with Patient:
Date & Time :

Witness :

Signature : [Signature]
Name :
Date & Time :

Doctor (who is taking the consent) :

Signature : [Signature]
Name : 101348
Dr. A.S.H. [Signature]
Date & Time : 25/6/26 3PM

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



Name: GUC-00079451 IP18-00036178 Age: Sex: UHID.No:

Date: 04-04-1988 38 Y 2 M 21 D (F) Proposed Operation:
 Mrs SNEHALI KOUSHIK
 Dr. PRIYADHARSHINI S M

Diagnosis: 

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

Laboratory Data:

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

Allergies:

Medical History: CVS :

RESP : Diabetes :

CNS :

Renal :

Hepatic / GE : Physical Activity:

Others :

Past Anaesthetic History:

Physical Exam:

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

Lungs :

Heart:

CNS:

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

Signature: Name:

Patient Sticker

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Time Received : Time Discharged :

250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 SPO ₂	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	IV Cannula Site : <input type="checkbox"/> O ₂ Mask <input type="checkbox"/> Nasal Prongs <input type="checkbox"/> Tracheostomy <input type="checkbox"/> T-Piece <input type="checkbox"/> Oral Airway <input type="checkbox"/> Nasal Airway
		Vomiting : <input type="checkbox"/> Yes <input type="checkbox"/> No Drug: NG Tube : <input type="checkbox"/> Yes <input type="checkbox"/> No Drain: <input type="checkbox"/> Yes <input type="checkbox"/> No Urinary Catheter: <input type="checkbox"/> Yes <input type="checkbox"/> No Chest Tube: <input type="checkbox"/> Yes <input type="checkbox"/> No Nil Oral <input type="checkbox"/> Yes <input type="checkbox"/> No IV Fluids: Oral Feeds:

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 ACTIVITY					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:	
Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0 RESPIRATION						
BP \pm 20 of Pre Anaesthetic level = 2 BP \pm 20-50 of Pre Anaesthetic level = 1 BP \pm 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 :

Anaesthesiologist Signature:

Date & Time:

PACU Nurse Name :

PACU Nurse Signature:

Date & Time:

Transferred to Unit by (PACU):

Date & Time:

RCH 2D

ANTENATAL RECORD



DR. Priyadarshini

Antenatal No: _____

Reg. No: _____

PERSONAL DETAILS

Name: **MRS. Snehali Koushik** Age **37** Date of Birth **1/1/1988** Education: _____

Occupation: _____ Phone No: _____ Mobile: _____

Husband's Name: _____ Age _____ Education: _____ Occupation: _____

Address: **10 Peranathan colony West Mambalam Chennai, Tamil Nadu**

Mobile: **9358734049** E-mail Id: _____

IMPORTANT FEATURES

SUGGESTED MANAGEMENT

Mdx 2 1/2 yrs
NCM
Cervical erosion

LMP - 3/10/2025
EDD - 10/1/2026

HISTORY

Year of Marriage: _____ Menstrual History: Previous Periods _____

Consanguinity: _____ Contraception: _____

LMP _____ EDD _____ Corrected EDD _____

OBSTETRIC FORMULA:

Gravida _____ Para _____ Live _____ Abortions _____

OBSTETRIC HISTORY

Sl. NO.	DATE OF DELIVERY	GA WEEKS	ANTENATAL DETAILS	MODE OF DELIVERY	BABY	WT	REMARKS

Medical History: **Nd**

Family History: **father diabetic**

Surgical History: **Nd**

Allergies: **Nd**

INVESTIGATIONS

MATERNAL EVALUATION

Blood group & Rh: Wife **A₁ +ve** Husband **AB Neg** ICT
 VDRL **NR** HIV **NR** HbsAg **NR** TSH **1.23** GCT

ROUTINE INVESTIGATIONS

Date	GA Weeks	Investigations	Report
01/11/21		Hb - 13.1	29/11
		RBC - 4.64	
		PCV - 37	
		MCV - 79	26/12
		PLT - 434	
		WBC - 9.08	
		pus cells - 2-4	29/13
		Estreptinino - 0.57	
		RBS - 97 HBAC >	
		Urea - 12	10/4

SPECIFIC INVESTIGATIONS

Date	GA Weeks	Investigations	Report
		Urea creat - No protein	
		Urea creat - No protein	
		Hb - 10.2 PCV - 32.3	
		plate 3 2 Juv fBS - 76	
		2 hrs diff - 140	
		fBS - 19	
		PPBS 8 mm	

Tetanus Toxoid: 1st dose **Td Vac (2/1/26)** 2nd dose **Bermin** ✓

FETAL EVALUATION

ULTRASONOGRAPHY

Date	GA Weeks	Indication	PP	Wt.	Centile	Growth Velocity	AFI	Placenta	Remarks
02/10/21		SL 20w 4 13cm							plac post Ca-2.8 UTA PE (N) NIFT LP
26/02		SL 20w 4 20-21w							plac post UTA PE (N)
17/4	28	BRGECU		1.2	357	AC 287	(N)	post	Ca 20cm UTA PE (N)
15/5	32	Cepelic		1.9	547			post	Ca 20cm UTA PE (N)
13/6	36	Cepelic		2.66	321	AC 321	(N)	post	Ca - 17cm
Others									

Were any Prenatal diagnostics done- Yes No If yes, please specify the details below:

DATE	GA/weeks	TYPE OF TEST	INDICATION	REPORT
		Ech Echo	Jan 17/21	

Name: _____ Corrected EDD: _____ Parity _____

SYSTEMIC EXAMINATION

Height: 140.80
 Weight: 44 kg
 BMI: 22

CVS: } normal
 Respiratory System: }
 Breasts: 3/4 L Thyroid: clear

ANTENATAL VISITS

Date	Wt	Bp	GA	S-F Ht	Presenting Part	FHS	Liquor	Edema	Review Date
2/11/25	42.9	95/60							
5/12/25	42.2	96/60							
16/12/25	41.3	88/56							
2/1/26	40.9	96/64							
8/1/26	40.7	93/59							
27/1/26	41.5	102/60							
12/2/26	42.1	98/54							
24/2/26	42.7	102/59							
16/3/26	42.8	86/60							
27/3/26	43	85/59							
17/4/26	44.1	99/68							
25/4/26	45	94/68							
15/5/26	45.7	92/62							
19/6/26	46.8	100/65							
24/6/26	47.7	101/72							

Special Concerns

ANTENATAL ADMISSION

DOA	DOD	GA Weeks	Complaint	Management	Advice

BRIEF DELIVERY NOTES

Gestaional age: _____ Date&time of delivery: _____

Type of labour: Spontaneous

Induction:- Indication _____

Method - PGE1 PGE2

Mode of delivery: SVD AVD Vacuum Forceps

Induction: _____

Caesarean section: Emergency Elective

Indication: _____

SALIENT FEATURES:

Baby details: Girl Boy Wt: _____ Apgar score: _____

Postpartum Period: _____

IP18-00036178

GLIC-00079451
Mrs SNEHALI Koushik
04-04-1988 38 Y 2 M 21 D (F)
Dr. PRIYADHARSHINI S M



BirthRight
IV RAINBOW HOSPITALS
Your Right to a Safe Delivery

PRE - OPERATIVE CHECK LIST

Patient's Name : MRS. Snehali Koushik Date: 25/6/2026
 Blood Group : A +ve UHID : 7945 Age : 38 Gender : M F
 Planned Surgery : Eme Surgeon : Dr. Priyadharshini S M
 Anesthetist : Dr. Mahesh Date & Time of Operation : 25/6/2026

Tick Appropriate Boxes
To be filled by Nurse Incharge / Senior Nurse :

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

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

Billing Clearance taken

Billing Executive Name : M. Sankhona babu

Billing Executive Signature : [Signature]

Date & Time : 25-06-2026 16:07

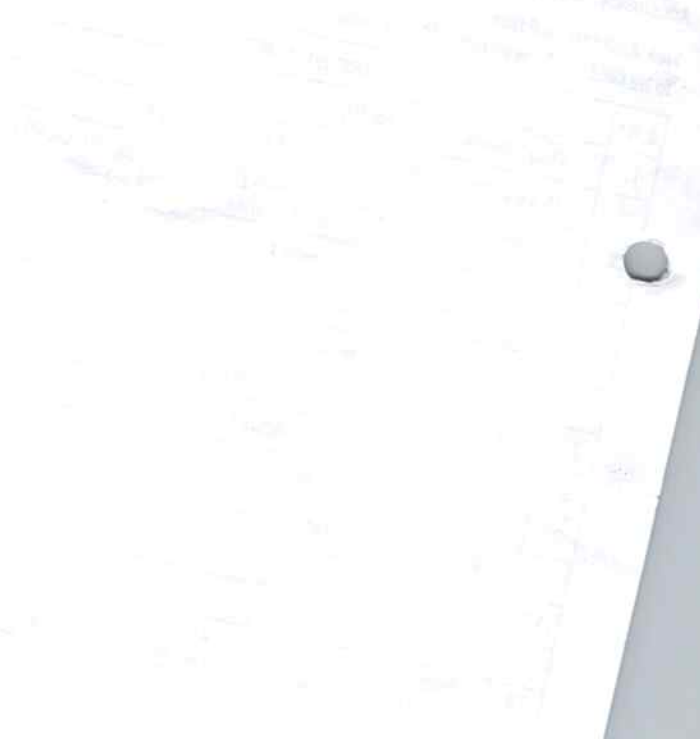
Nurse In-Charge Name : D. Sobhen

Signature of Nurse In-Charge : [Signature]

Date & Time : 25/6/2026

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

Handwritten notes at the top of the page, including the word "Bacteria" and other illegible text.



Handwritten notes at the bottom of the page, including the word "Fungi" and other illegible text.

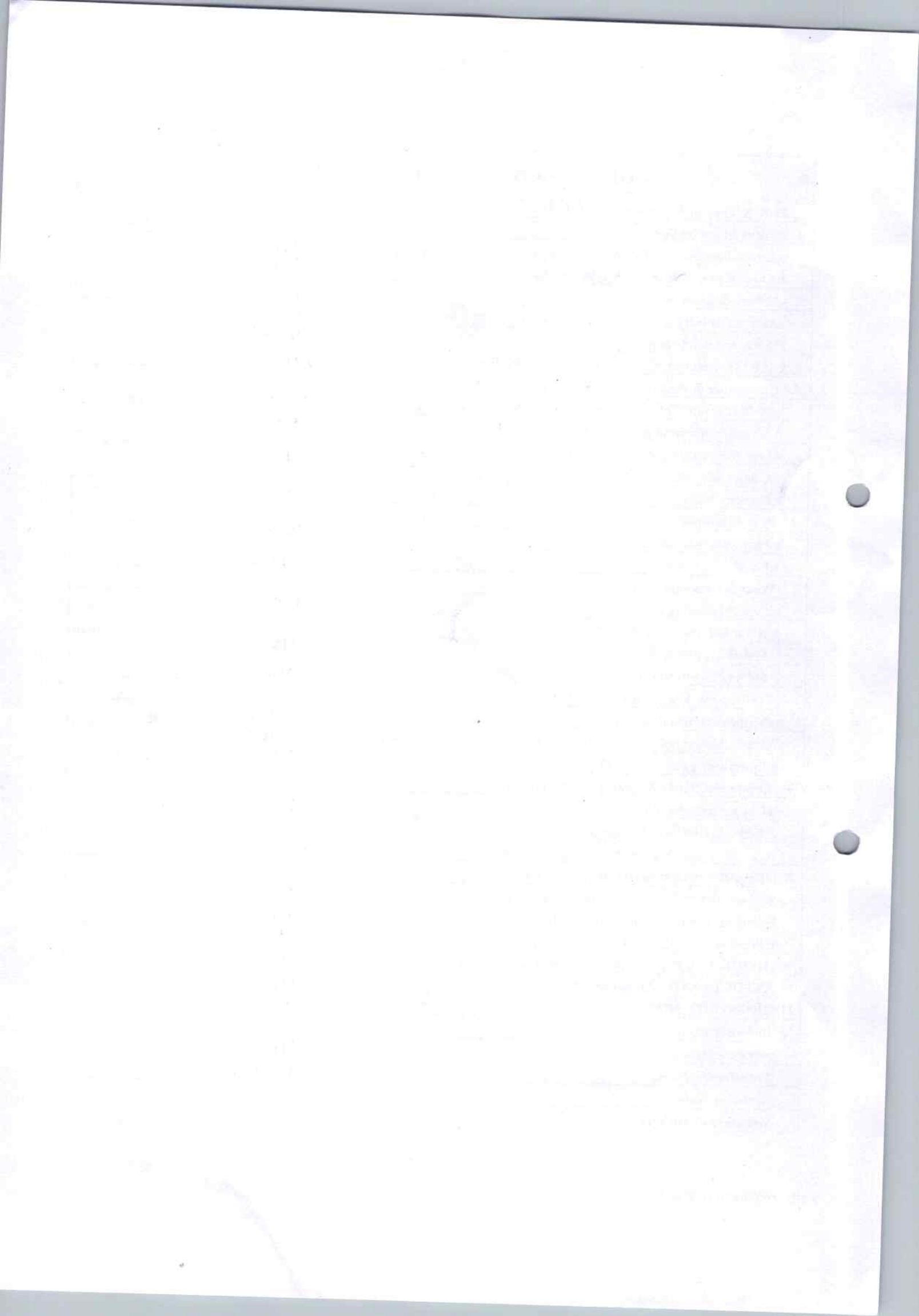


PATIENT TRANSFER NURSING HANDOVER CHECKLIST

Date & Time of Transfer: LDR

TRANSFERRED TO: OT

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



GUC-00079451 IP18-00036178
 Mrs SNEHALI KOUSHIK
 04-04-1988 38 Y 2 M 21 D (F)
 Dr. PRIYADHARSHINI S M

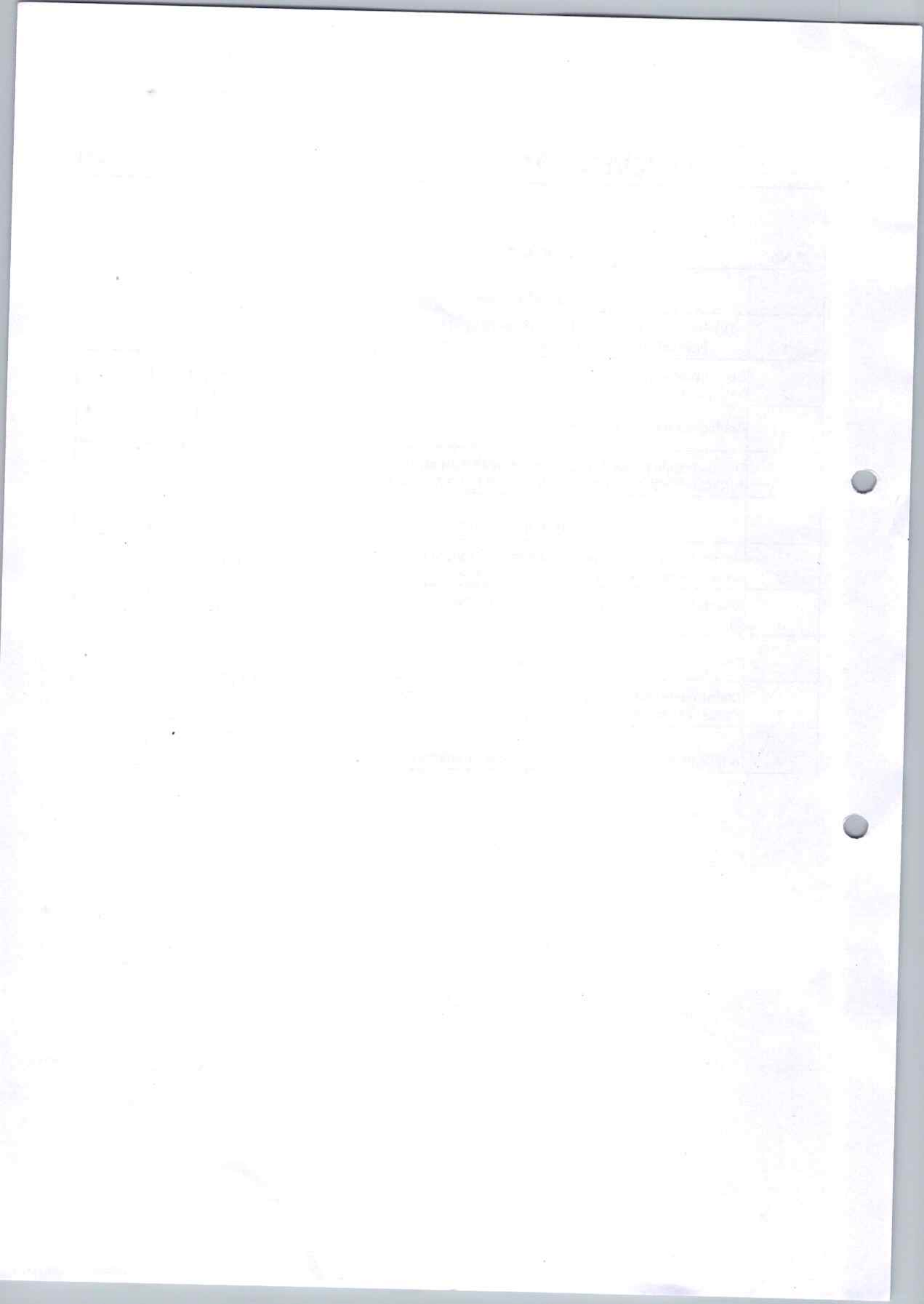


Rainbow
 Children's
 Hospital

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to Safe Delivery

SSI PREVENTION CHECKLIST

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



Patient Sticker

LABOUR AND DELIVERY NURSING ASSESSMENT

Date of Admission: 25/6/20

Baseline Information:

Admission From: ER OPD Admission Desk Others: specify LDR

Primary Language: Telugu English Hindi Others Tamil

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: Pain in abdomen after Elderly Doctor Notified on Admission: Yes No
Pain for 2 Name of the Doctor: Dr. Mahan
 Time Notified: 6 AM

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>Fibroid uterus</u>	<u>Cervical cerclage 2018</u>	

Blood Group: B+ A1 post LMP: 3/10/20 EDD: 10/7/20 Gestational age during admission: 37th wks

Contractions: 4-4 Vaginal Discharge: N/L

Obstetric History: G 1 P 1 L 1 A 1 Previous LSCS 1

Height: 140 Weight: 47.7 BMI: _____
 Temp: 98.4 HR: 84 RR: 24 BP: 110/70 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 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 Further

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

Fall Assessment: Yes No Score 10 (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore: Yes No Score 27 (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

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. SNEHALI

Name of Person Orientation was given to: Mrs. SNEHALI

Orientation not given Reason:

Nurse Signature: [Signature]

Nurse Name: Mrs. S. N. SNEHALI

Date & Time: 25/6/20



ASSESSMENT FORM

Date: 25/6/26 Time of Arrival: 6 AM Time Seen by Nurse: Dr. Nivetha

1) Level of Consciousness: Conscious Semi-Conscious Unconscious

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

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

3) Vital Signs: Temperature: Pulse: RR: SpO₂: BP: Weight:

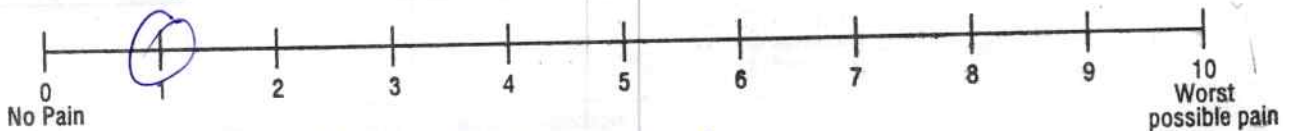
4) Gestational Criteria:

Gravida:	G <u>1</u>	P <u>-</u>	L <u>-</u>	A <u>-</u>
----------	------------	------------	------------	------------

LMP: 3/10/2025 EDD: 10/07/2026 Gestational Age: 37+6 day

Uterine Contraction	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA	Onset <u>since morning</u>	Time <u>5 AM</u>	Frequency: <u>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)



- ⑩ Location: Lower Abdomen Pain
- ⑩ Duration: 10 sec. Days / Weeks/ Months (Strike out which is not applicable)
- ⑩ Character: cramping
- ⑩ Frequency: 2 contractions
- ⑩ Interventions: comfortable position

6) Past History:

- a) Surgeries: Cervical excoriation at 20+5 wks
- b) Medical: Fibroid uterus

Patient Sticker

7) Allergy: Yes No, If Yes :

8) Current Medications: Prenatal Vitamin None Others:

9) Prenatal Medical History:
 None Gestational Diabetes
 Chronic Hypertension Low placenta
 Gestational Hypertension 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 / PPRM < 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: Dr. Dirys

Nurse Name: Shirley Nivette Nurse Signature: Shirley Nivette

Date: 25/6/21 Time: 6am

PATIENT TRANSFER FORM



GUC-00079451 IP18-00036178
 Mrs SNEHALI Koushik
 04-04-1988 38 Y 2 M 21 D (F)
 Dr. PRIYADHARSHINI S M



Date & Time of Admission <i>25/6/26 @ 5:46 AM</i>		Date & Time of Transfer Order <i>25/6/26 @ 3:30 PM</i>
Treating Consultant Name <i>Dr. priyadharshini</i>	Transfer Ordered by <i>Dr. mohan .</i>	Reason for Transfer <i>For Further Management</i>
From Unit <i>OT</i>	To Unit <i>MW</i>	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File <i>1 IP file</i>	Number of Imaging Films <i>-</i>	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.		
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes No

Name & Signature of Person who is Transferring <i>[Signature]</i> 6078911	Name of Person Ordered Transfer <i>Dr. mohan .</i>
---------------------------------------------------------------------------------	-------------------------------------------------------

Patient & Clinical Records Received by :

[Signature]

Date & Time of Patient Received :

25/6/2026 at 3:30 pm

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

- Unavailable Bed Nurse not Available Available Bed not ready



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:

Continuity of Care:

Date: 25/6/2026

L - 2

A - 2

T - 2

C - 2

H - 1

I

Handover given by D. Schelwein

Handover taken by Paula

Signature [Signature]

Signature [Signature]

Date & Time: 25/6/2026

Date & Time: 26/6/2026

PATIENT TRANSFER FORM



GUC-00079451 IP18-00036178

Mrs SNEHALI KOUSHIK
04-04-1988 38 Y 2 M 21 D (F)
Dr. PRIYADHARSHINI S M



Date & Time of Admission <i>25/6/2026 at 5.45 AM</i>		Date & Time of Transfer Order <i>25/6/2026 at 2.20 PM</i>
Treating Consultant Name <i>Dr. Prityadharshini</i>	Transfer Ordered by <i>Dr. Prityadharshini</i>	Reason for Transfer <i>also EMP use</i>
From Unit <i>UR</i>	To Unit <i>OT</i>	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File <i>2</i>	Number of Imaging Films <i>CTM (8)</i>	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.		
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes No

Name & Signature of Person who is Transferring <i>S/M Sobelner</i>	Name of Person Ordered Transfer <i>Dr. Prityadharshini</i>
-----------------------------------------------------------------------	---------------------------------------------------------------

Patient & Clinical Records Received by :
[Signature]
601291

Date & Time of Patient Received :

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

Unavailable Bed
 Nurse not Available
 Available Bed not ready

PATIENT ID: GUC-00079451 IP18-00036178

DRM

Mrs SNEHALI KOUSHIK 38 Y 2 M 21 D (F)
04-04-1988
Dr. PRIYADHARSHINI S M



Date & Time of Admission 25/6/26 at 5:45 AM		Date & Time of Transfer Order 26/6/26 at 12 AM
Treating Consultant Name Dr. Prasadharshini	Transfer Ordered by Dr. Akshitha	Reason for Transfer further treatment
From Unit NICU	To Unit 7th floor	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File op file	Number of Imaging Films CTH (8)	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.		
2.		
3.		
4.		
5.		
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>		
Name & Signature of Person who is Transferring Shalini		Name of Person Ordered Transfer Dr. Akshitha
Patient & Clinical Records Received by : [Signature]		
Date & Time of Patient Received : 26/6/26 at 12:30 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

From Date: 4-10-12
 To Date: 4-10-12
 Patient Name: [Handwritten Name]
 Referring Physician: [Handwritten Name]
 Receiving Physician: [Handwritten Name]
 Reason for Transfer: [Handwritten Text]

Sl. No.	Medication	Dose	Frequency
1.			
2.			
3.			
4.			
5.			

Signature of Referring Physician: [Signature]
 Signature of Receiving Physician: [Signature]
 Date & Time of Patient Received: [Handwritten Date/Time]
 Patient's Clinical Record Received by: [Handwritten Name]

GUC-00079451 IP18-00036178
Mrs SNEHAJI Koushik
04-04-1988 38 Y 2 M 22 D (F)
Dr. PRIYADHARSHINI S M



NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 26/06/2026

Time: 3:30 PM

Origin: _____

Height: 140.8 cm

Weight: 47.7 kg

BMI: ~ 26 kg/m²
 ~ 28 kg/m²
 ~ 30 kg/m²

Food Allergies: _____

Diagnosis: EMERGENCY LSCS

Type of Diet: Liquid Soft Normal Diabetic
 Vegetarian Non-Vegetarian Vegan

Diet Advised:

Liquid Diet – ORS/ Coconut Water / Butter Milk / Barley Water / Soups (2)

Normal Diet – Rice, Rotis, Dal and Soft Cooked Vegetables and Curd (1)

Soft Diet – Soft Rice, Dal and Vegetable Curries Soft Cooked, Curd (3)

Diabetic Diet – Brown Rice / Oats/ Dahlia/ Rotis, Dal and Vegetables and Curd (Avoid Roots / Tubers)

Patient's / Attendant's

Signature: Snehali

Name: Snehali Koushik

Date & Time: 26/6/2026 / 3 PM

Dietician's

Signature: A. Sadigra (018236)

Name: A. Sadigra Ferber

Date & Time: 26/06/26 / 3 PM

DIETARY NOTES

Date	Time	Notes	Sign
25/06/26	8:45 AM	<ul style="list-style-type: none"> - Patient is on Normal Diet. - Patient is stable. Oral is good. - Advised to take well-balanced diet. -> Followed by plenty of oral fluids. -> Liquid diet for further orders. - Advised to take water, soups - coconut water, fruit juices (etc.) 	A.P. (018336)
	3:30 PM	<ul style="list-style-type: none"> EM-15CS -> done NPO x 3 hours. 	A.P. (018336)
26/6/26	9:30 AM	<ul style="list-style-type: none"> - Patient is on soft diet - Patient is stable. Oral is better. - Advised to take soft to digest foods like Poha, soft rice, mashed - well cooked vegetables and salad (etc.) - Consume small frequent meals. - Include carbohydrate foods for milk reaction - Jaggery, fenugreek and oats. <p>PPAR Values - Energy - 1600 kcal. Protein - 17-19 g/dl.</p>	A.P. (018336)