GUC-00081088 IP18-00036156
Mrs HARINI DEVI R
19-09-1995 30 Y 9 M 6 D (F)
Dr. MATHANGI RAJAGOPALAN

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		25/6/26 at 6AM					
Activity Sheet update by Pharmacy							

ACTIVITY RECORD FOR BILLING

GUC-00081088 IP18-00036156
Mrs HARINI DEVI R
19-09-1995 30 Y 9 M 5 D (F)
Dr. MATHANGI RAJAGOPALAN

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Name: Mrs. Harini Devi

UHID No: 81088 IP No: 36156 Consultant: Dr. Mathangi Dept: LDR

Date of Admission: 24/6/26 Time: Date of Discharge: Time:

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
24/6/26	5:45pm	LDR	7th floor	S/N Abeda 81088

CROSS CONSULTATION VISIT

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
25/6/2026 ✓	CBC	26020091	[signature]

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
24/6	CTH — (1)			(008401)	S. Shalini 01407
24/6/26	CTH - (2)			(008401)	S. Shalini 01407
24/6/26	Infusion Pump	9:10pm	5pm	17176441	01620
24/6/26	CTG (3)			008402	01622
24/6/26	CTG (4)			008408	01620
24/6/26	CTG (5)			008402	01622
24/6/26	CTG (6)			008431	01620

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
24/6/26	IV placement	1	(1716389)	Shalini 04075

ANY OTHER INFORMATION:

Delivery Details:
Normal vaginal Delivery
Date: 24/6/26
Duration: 1 Hour
Time: 11 AM to 12 PM
Dr. Nathangi., Dr. Pavithra

Delivery Sample kit used

Date: 25/6/2026 Time: 5 AM Prepared By: .....

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
S/r. [illegible]			

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DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT

GUC-00081088 IP18-00036156
Mrs HARINI DEVI R
19-09-1995 30 Y 9 M 5 D (F)
Dr. MATHANGI RAJAGOPALAN

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement					
	INTIME	OUT TIME			
Arrangement of File by Nursing		25/6/18 @ 11 PM			
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

GUC-00081088 IP18-00036156
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BED SIDE CHECK LIST FOR NURSES

Date:	20/6/20								
Doctor's Orders	yes								
Carried out or not	yes								
Bed Side									
Structured Handover done	yes								
IV Site	yes								
Central Lines	NA								
Arterial Lines	NA								
Feeding Catheter	NA								
Urinary Catheter	NA								
Skin Care	yes								
Eye Care	yes								
Mouth Care	yes								
Sterillum Bottle, Stethoscope	yes								
Suction Bottle (Should be clean & empty)	NA								
Intubation Tray	no								
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	NA								
Ventilator Tubing,(Any Water, Blood)	NA								
Humidification	NA								
Check all Infusion (Labelling,Correct Preparation)	NA								
Chest Physio & Neb	NA								
Handed Over By Name :	Pooja								
Signature :									
Date & Time:	20/6/20								
Hand Over Taken By Name :									
Signature :									
Date & Time:	20/6/20								

Patient Sticker

Rainbow's Children's Hospital

BirthRight

BED SIDE CHECK LIST FOR NURSES

Date								
Doctor's Orders								
Carried out or not								
Bed Side								
Structured Handover done								
IV Site								
Central Lines								
Arterial Lines								
Feeding Catheter								
Urinary Catheter								
Skin Care								
Eye Care								
Mouth Care								
Sterilizers Bottle, Syringes								
Suction Bottle (Should be exam 5 weekly)								
Intubation Tray								
Emergency Tray Assisted Syringes with Medications (Adrenaline and Atropine) Ambubags of Adrenaline								
Antibiotic Taking (Any Water Based)								
Hydrocortisone								
Check all Infusion (Labelling,Correct Preparation)								
Correct Fluids & Rate								
Has bed Done By Nurse :								
Sign Nurse :								
Date & Time								
Have Done Taken By Nurse :								
Sign Nurse :								
Date : Time:								

Doc. No. : NCH/ PMA / GENERAL / 003

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Guindy

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

ADMISSION SHEET

Registration Details :

Admission No : IP18-00036156 **Admit Date** : 24-Jun-2026 **Admit Time** : 01:56 AM **UHID** : GUC-00081088

Patient Details :

Patient Name	: Mrs HARINI DEVI R		
Guardian	: ROHIN KUMAR G S	**Age**	: 30 Y 9 M 5 D
Gender	: Female	**DOB**	: 19-09-1995
Occupation	:	**Religion**	:
Address (H)	: OLD NO.4, NEW NO. 11, VANIER STREET, WEST SAIDAPET Saidhapet North Chennai Tamil Nadu INDIA 600015	**Martial Status**	:
		Phone No	: 9626643427
		E-mail	: NO@GMAIL.COM

Admission Details :

Bed Type : MICU **Bed No** : MICU 802 **Ward Name** : 8F-OT COMPLEX

Room No : MICU 802 **Admission Type** : First Visit

Contact Details :

Name : ROHIN KUMAR G S

Contact Address : OLD NO.4, NEW NO. 11, VANIER STREET, WEST SAIDAPET Saidhapet North Chennai Tamil Nadu INDIA 600015

Relationship : Husband

Phone No : 9840254818

Signature

Doctor Details :

Doctor Name : Dr. MATHANGI RAJAGOPALAN **Specialisation** : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

Payment Mode : Cash **Deposit Amount** : 7000.00

Payor Name : SELFPAY

Rainbow Children's Hospital
BirthRight Rainbow

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

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Mrs HARINI DEVI R**		
IP No:	**IP18-00036156**	**Age :**	**30 Y 9 M 5 D**
Consultant:	**Dr. MATHANGI RAJAGOPALAN**	**Sex:**	**Female**
		Ward/Bed No:	**8F-OT COMPLEX/MICU 802**

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

Patient, be deemed advisable or necessary.

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

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

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

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

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

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

Signature of Patient/Relative:

Name: ROHAN KUMAR. A.S

Relationship: HUSBAND.

Date: 24/06/26. Time: 01:56AM

Witness Name: P. Thanaraj Sahan

Witness Signature:

Patient Address:

OLD NO.4, NEW NO. 11, VANIER STREET, WEST SAIDAPET Saidhapet
North Chennai Tamil Nadu INDIA
600015

BILLING POLICY

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

DECLARATION

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

Patient Name : ROHIN KUMAR . G.S	UHID Number : 81088
Self/Attendant Name :	Relation : HUSBAND
Self/ Attendant Signature :	Name & Signature of Financial Counselor
Phone Number :	

GUC-00081088 IP18-00036156
Mrs HARINI DEVI R
19-09-1995 30 Y 9 M 5 D (F)
Dr. MATHANGI RAJAGOPALAN

Patient St

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IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints
Pt presented with
% abdomen pain on & off

Obstetric Formula:
Primi

Obstetric Hostory:
G_1 : PP ; OI conception

Present Pregnancy Record:
30/12 NT : 1.9mm ; FTS: low risk
23/2/26: Anomaly scan - R/O ; Pl-Ant SOP: 5-4

RISK FACTORS:
Overt Hypothyroid x2yrs on T.Thyronorm 62.5/75

Height: 158.5 cm
Weight: 85.7 kg
Allergies: Nil
Breast: ☑ Normal ☐ Abnormal
General Examination:
Consciousness: Conscious Pallor: No
Icterus: No Edema: No
Temp: Afebrile PR: 82/min
BP: 120/78 DTR:
CVS: S_1S_2 ⊕ RS NVBS
Liver/Spleen: Urine Output:

LMP: 30/9/25 EDD: 7/7/26
Corrected EDD: GA: 38w1d

Menstrual History: Regular : ☐ Yes ☑ No

Obstetric Examination Marital H: 3yrs ;

Fundal Height: Term ; 2/25"/10'

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

Liquor: ☑ Adequate ☐ Oligo ☐ Poly

PP: ☑ Cephalic ☐ Breech Others _____

Head Fifths Palpable: 3/5 HM

FHS: ☑ Normal ☐ Tachy ☐ Brady ☐ Absent

Per Speculum Examination

Draining: ☐ Present ☑ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination

Cervix: 1.5 cm ☑ Long ☐ Partially effaced ☐ Effaced

Os: Closed _____ Dilated 1 finger

Membranes: ☑ Present ☐ Absent

Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Presenting Part: ☑ Vertex ☐ Breech ☐ Others

Sutton: ☑ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Pelvis: ☑ Adequate ☐ Doubtful

DIAGNOSIS
Primi / 38w1d / Abdomen pain

GUC-00081088 IP18-00036156
Mrs HARINI DEVI R
19-09-1995 30 Y 9 M 5 D (F)
Dr. MATHANGI RAJAGOPALAN

Family History:	Surgical History:
Father - DM | HT	Nil
Medical History: overt Hypothyroid X 2 yrs T. Thyronorm 62.5 | 75 Mcg PCOS	**Medication History:** T. Lnvogen T. Shelcal HD T. Myoga EC T. Thyronorm 62.5 | 75 Mcg
Plan of Care: C/D/W Dr. Mathangi • Admission • CTG • Parks preparation	**Investigations:** CTG

Doctor Name: Dr. Vinitha
Signature: (FOR) 12113
Date & Time: 24/6/26

Consultant Name: Dr. Mathangi
Signature: (FOR) 12113
Date & Time: 24/6/26

GUC-00081088 IP18-00036156
Pat Mrs HARINI DEVI R
19-09-1995 30 Y 9 M 5 D (F)
Dr. MATHANGI RAJAGOPALAN

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RESULT SHEET

Date		10/6					
Time							
Hb		12.4					
PCV		37.7					
RBC		4.27					
WBC		9060					
N/L							
Platelets		2.72					
CRP							
ESR							
PCT							
RBS							
Na							
K							
Cl							
Ca/Mg							
Phosphate							
Urea	9/11/25	8					
Creatinine		0.5					
ALP							
SGPT							
SGOT							
T.Bill/Conj							
T.Protein							
S.Albumin							
S.Globulin							
A/G Ratio							
Uric Acid							
S.Amylase							
Sr.Lipase							
Blood Lactate							
S.Cholesterol							
PT/INR							
APTT							
CSF Protein / Sugar							
Cells							
N/L							

Bl. grp : O positive (oral report)
ICT - Negative

10/6 : FBS : 81
PPBS : 106

TT_4 : 10.7
TT_3 : 165
TSH : 1.12

HIV 1 & 2
HCV
HbsAg
VDRL
— Negative

ECG - Normal sinus rhythm
T wave abnormality

ECHO : Normal
EF : 65 %

(P.T.O)

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : 13/6/26 36w4d .....

X-Ray : Cephalic ; PL - Anterior ; .....

ECHO : AFI : 11 ; EFW : 2607g (29.ile) .....

CT : HC : 5.ile ; Doppler - Normal .....

MRI .....

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

GUC-00081088 IP18-00036156
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Pat

(1)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/6/26 4am	SR Dr. Vinitha Pt reviewed; c/o abdomen pain on & off	
BP: 110/70 PR: 86/min SpO2: 99% RA	O/E: GC fair; Afebrile P/A: UL term; Cephalic; 2/15"/10'; FH good P/v: Cx: 1.5 cm long; OS: 1 finger loose Vx: -2 station PGE2 gel kept intracervically	
12/11/3		Adv: · CTG @ 5am · W/F contractions, Draining/Bleeding P/v · Inform SOS
24/6/2026 8:15AM	C/S/B Dr. Pavithra / Dr. Shreedevi C/I/B Dr. Mathangi To start INJ. SYNTO @ 24 ml/hr	Advice - Liquid diet - To start INT. SYNTO @ 24ml/hr & titrate according
T-(N) PR- 88/min BP- 120/74mmHg CTG - Reactive	O/E Pt GC fair, Afebrile P°/PE° CVS/RS/NAD P/A- uterus @ Term (2C/15"/10') Cephalic FHS - good	- Continuous CTG - W/F contractions - Inform(SOS)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/6/2023	C/S/B Dr. Mathangi	
9:30 Am	P/A - Uterus @ Term	Advice
SYNTO @ 7 2ml/hr	(3C/25"/10')	- Continuous CTG
CTG - Reactive	Cephalic	- Continue INJ. SYNTO
	FHS - good	& titrate accordingly
Bed side USG	P/V Cx - well effaced	- INJ PETHIDINE 50mg +
- LOT	OS - 3cm dilated	INJ. PHENERGAN 25mg IM
- No loop of cord	Membranes - Present	- W/F contractions / Progress
	Vertex @ -2 to -1	- Liquid diet
		- INJ. SUPACEF 1.5g IV (STAT)
	↓ SAP, ARM done clear liquor drained	
	C/S/B Dr. Mamtha	
24/6/23		
11:00 Am	O/E	Advice
	P/A - UI term	- Shift to LABOUR Room
	mod active FC/2E'/10"	- Continuous CTG
CTG - Reactive	cephalic	- Continue INJ. SYNTO
INJ. SYNTO @ 120ml/hr	FHS good	acceleration
		- Position for Labour
	P/V - Cx well effaced	- Encourage active pushing
	OS fully dilated	
	membranes - Absent	
	Vertex @ +1	

Mrs HARINI DEVI R
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(2)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/6/2026	C/S/B Dr. Mathangi	
	A/B Dr. Pavithra / Dr. Shreedevi	
	11:23Am	
	NORMAL VAGINAL DELIVER WITH RIGHT MEDIOLATERAL EPISIOTOMY	
	↓ SAP. Patient in dorsolithotomy position, perineum painted and draped. With good uterine contractions, full cervical dilation good maternal efforts. 2% lignocaine local infiltration given. A right mediolateral episiotomy given during crowning to deliver an alive term girl baby delivered. Baby cried immediately after birth. Delayed Cord clamping done. Cord cut and baby handed over to pediatrician. Cord blood collected for blood grouping and typing. Placenta and membranes delivered intoto. Episiotomy inspected and cutured in layers using rapid vicryl. Hemostasis secured	
	P/A - uterus firm & well contracted	
	P/V - No undue bleeding PV	
	P/R - Rectal mucosa and sphincter tone normal	
	B | Girl	
	A | 24/6/26, 11:23 am	
	B | 6/10, 8/10	
	4 | 2.447 kg	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		Advice
		- Normal diet
		- Plenty of oral fluids
		- Vitals Monitoring
		- follow drug chart
		- CBC c/m 6 Am
		- W/F ↑ Bleeding PV
		- Measure & Inform 1st void
		- Inform (SOS)
		- INJ. TRAPIC 1g IV x 2 doses
	Dr S 22/7	
24/06/2022	C/S/B Dr. AKshitha / Dr. Shreedevi	
4:45PM		
	Pt reviewed, Nil Cb	Advice
PND - D	D/E Pt GC fair, P° / PE°	Afebrile - Normal diet
		- Plenty of oral fluids
T - (N)		- Vitals Monitoring
PR - 84/min	CVS / RS / NAD	- follow drug chart
BP - 120/70 mmHg	P/A - ut well contracted soft	- W/F ↑ Bleeding PV
		- Inform (SOS)
Baby - M/S	L/E - No undue bleeding PV	- CBC C/M 6 Am
B/L - Breast Soft	Epi wound Intact	
voided - 150 ml		
Post void - Bladder collapsed		Shift to ward.
	Dr S 22/7	

GUC-00081088
Mrs HARINI DEVI R IP18-00036156
19-09-1995 30 Y 9 M 5 D
Dr. MATHANGI RAJAGOPALAN (F)

(3)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/6/26	S/B Dr. Mohana / Dr. Dmyalakshmi	
9:40pm		
		pt. reviewed.
PND-0	O/e: pt G/C fair, afebrile	
	PO / PE°	Advice
F-N		= Continue
PR= 80/min	P/A: soft.	same orders.
BP= 118/72 mmHg	Ut. contracted well	- CBC q/m 6am
		- Infoim SOS -
Baby m/ Breasts / soft	L/E: Epi intact	
	BWNL	
voiding freely		
	[signature] 16/12/88	

GUC-00081088 IP18-00036156
Mrs HARINI DEVI R (F)
19-09-1995 30 Y 9 M 5 D
Dr. MATHANGI RAJAGOPALAN

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

CROSS CONSULTATION FORM

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Doctor Name : ..... Date : ..... Time : .....

Diagnosis : .....

Hospital : .....

GUC-00081088 IP18-00036156
Mrs HARINI DEVI R
19-09-1995 30 Y 9 M 6 D (F)
Dr. MATHANGI RAJAGOPALAN

Referred for : ☐ Opinion ☐ C ..... care

Type of Referral :
☐ Emergency
☐ Urgent
☐ Non Urgent

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

Findings and Recommendations : Signature:

25/6/26
PND-1
10.30AM

S/B Physiotherapist

Patient Conscious, Oriented & Afebrile

Assessment

chest B/L Symmetry
Type : Abdominal Thoracic breathing

DVT : Autar Score : No risk.

Functional Assessment :

FIM Score : 7 - independent.

Consultant : Physiotherapist

Name : Sangari T Signature : S T Date & Time : 26/6/26 10:30AM

Advise:

- Deep breathing exercise.
- Pelvic bridging & Tilt.
- Bed mobility exercises.
- posture
- walking.

GUC-00081088 IP18-00036156
Mrs HARINI DEVI R
19-09-1995 30 Y 9 M 5 D (F)
Dr. MATHANGI RAJAGOPALAN

Patient

(1)

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☑ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.
(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: MICU 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	T. THYRONORM	62.5 mcg	P/O	OD		☑C ☐DC
2						☐C ☐DC
3						☐C ☐DC
4						☐C ☐DC
5						☐C ☐DC
6						☐C ☐DC
7						☐C ☐DC
8						☐C ☐DC
9						☐C ☐DC
10						☐C ☐DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : 12113 Dr. Vinitha

Date & Time : 24/6/26

Nurse Name & Signature: S. Shafiné (01407z)

Date & Time : 24/6/26 at 2Am

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

GUC-00081088 IP18-00036156
Mrs HARINI DEVI R
19-09-1995 30 Y 9 M 5 D (F)
Dr. MATHANGI RAJAGOPALAN

(2)

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MEDICATION RECONCILIATION FORM

Drug Allergies: .... ☑ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit. (Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: LDR Shifted to: 7th floor

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T. THYRONORM	62.5mcg	PO	OD	24/6/26 —	☑C ☐DC
2	C. AUGMENTIN	625mg	PO	TDS	24/6/26 at 2pm	☑C ☐DC
3	C. PAN D	40mg	PO	BD	—	☑C ☐DC
4	T. PARACETAMOL	1g	PO	TDS	24/6/26 at 2pm	☑C ☐DC
5	JUSTIN SUPPOSITORY	100mcg	PR	BD	24/6/26 at 11:30pm	☑C ☐DC
6	INJ. TRAPIC	1g	IV	BD	24/6/26 5pm	☑C ☐DC
7						☐C ☐DC
8						☐C ☐DC
9						☐C ☐DC
10						☐C ☐DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Shreedevi [signature] 182217

Date & Time : 24/06/2021

Nurse Name & Signature: S/N Abalya/01880 [signature] 01880

Date & Time : 24/6/26

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

GUC-00081088 IP18-00036156
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19-09-1995 30 Y 9 M 5 D (F)
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DRUG CHART

Date of Admission: 24/6/26 Drug Allergies: ..... ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

NURSES
- Nurses must follow strictly the FIVE RIGHTS before administration of medication.
  1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

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

GUC-00081088 IP18-00036156
Mrs HARINI DEVI R
19-09-1995 30 Y 9 M 5 D (F)
Dr. MATHANGI RAJAGOPALAN

REGULAR PRESCRIPTIONS

Weight. 85.7 kg Ward. LDR

DRUG : C. AUGMENTIN

Dose	Route	Frequency	Start Date
625mg	PO	1-0-1	24/6/21

Name & Signature of the Doctor Starting the Drugs: 182217

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	24/6	25/6
8Am	ES AA	
2pm	SA SP	
10pm	D.K DF	D1 D2

DRUG : C. PAN D

Dose	Route	Frequency	Start Date
40mg	PO	1-0-1	24/6/21

Name & Signature of the Doctor Starting the Drugs: 182217

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	24/6	25/6
7Am	AR PK	
1pm	ES AA	

DRUG : T. PARACETAMOL

Dose	Route	Frequency	Start Date
1g	PO	1-1-1	24/6/21

Name & Signature of the Doctor Starting the Drugs: 182217

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	24/6	25/6
9Am	ES AJS	
2pm	SA SP	
10pm	D.K J.K	

DRUG : JUSTIN SUPPOSITORY

Dose	Route	Frequency	Start Date
100mg	PR	1-0-1	24/6/21

Name & Signature of the Doctor Starting the Drugs: 182217

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	24/6	25/6
9Am	ES NJ	
9pm	D.K JK	

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Mrs HARINI DEVI R
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Dr. MATHANGI RAJAGOPALAN

Weight. 85.700 Ward. LDR

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
24/6/26	4AM	PGE_2 gel	0.5 mg	INTRA CERVICAL	121113	SHO / SS
24/6/26	9.25 AM	INJ. SUPACEF	0.1ml	Id	182217	TJ / MD
24/6/26	10AM	INJ. SUPACEF	1.5g	IV	182217	TJ / MD
24/6/26	10 AM	INJ. PETHIDINE	50mg	Im	182217	TJ / MD
24/6/26	10AM	INJ. PHENERGAN	25mg	Im	182217	TJ / MD
24/6/26	11.25 AM	Inj Synto	10U	Im	182217	TJ / MD
24/6/26	11.30 AM	Inj Trapic	1g	IV	182217	TJ / MD
24/6/26	11.50 AM	Inj Carboprost	250mg	Im	182217	TJ / MD
24/6/26	12pm	T. Misoprostol	600mcg	PR	182217	TJ / MD

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Mrs HARINI DEVI R
19-09-1995 30 Y 9 M 5 D (F)
Dr. MATHANGI RAJAGOPALAN

I.V. FLUIDS CHART

Weight. 85.7kg Ward. CR2

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
24/6	6PM	1 O RL	IV	Maintenance	121113	SD	24/6/26	182217	TJ MD
24/6/26	8AM	INJ. SYNTO 5U IN 500 ml RL	IV	24 ml/hr	182217	TJ MD	24/6/26	182217	TJ MD
24/6/26	11.30 AM	INJ. SYNTO 20 UIN 500 ml RL	IV	125 ml/hr	182217	TJ MD	24/6/26	182217	SA SP

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

GUC-00081088 IP18-00036156
Mrs HARINI DEVI R
19-09-1995 30 Y 9 M 5 D (F)
Dr. MATHANGI RAJAGOPALAN

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STAT / ONCE ONLY DRUGS

Name: Mrs. HARINI Devi

Weight: 85.7kg kgs

Sheet No: (1)

DATE	TIME	MEDICATION	DOSAGE & OTHER INSTRUCTIONS	ROUTE	SIGNATURE		
					Doctor	Nurse-1	Nurse-2
24/6/26	12pm	Justin suppository	100mg	PR	182217	TJ	MD
24/6/26	1pm	Inj metrogyne	0.2mg	IM	182217	TJ	MD

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Dr. MATHANGI RAJAGOPALAN

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Sheet No: 1

REGULAR PRESCRIPTIONS

Weight 85.70 kg Ward LDR

DRUG : INJ. TRAPIC

Dose	Route	Frequency	Start Dt.
1g	IV	0-1-1	24/6/26

Date/Time: 24/6 — 5pm SA / SP; 11pm DR / P.C

Name & Signature of the Doctor Starting the Drugs: 182217

Additional Instructions: X 2 doses

Daily Doctor's Endorsement by a Sign

DRUG : T. THYRONORM

Dose	Route	Frequency	Start Dt.
62.5mcg	PO	1-0-0	25/6/26

Date/Time: 25/6 — 6AM DR / P.C

Name & Signature of the Doctor Starting the Drugs: 182217

Additional Instructions: (Mon - Thursday) Empty stomach

Daily Doctor's Endorsement by a Sign

DRUG : T. THYRONORM

Dose	Route	Frequency	Start Dt.
75mcg	PO	1-0-0	26/6/26

Date/Time: 26/6 — 6AM

Name & Signature of the Doctor Starting the Drugs: 182217

Additional Instructions: (Fri, Sat, Sun) Empty stomach.

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Date/Time:

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

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

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Mrs HARINI DEVI R
19-09-1995 30 Y 9 M 5 D (F)
Dr. MATHANGI RAJAGOPALAN

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REGULAR PRESCRIPTIONS

Sheet No: .... Weight .... Ward ....

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

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

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

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

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

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

GUC-00081088 IP18-00036156
Mrs HARINI DEVI R
19-09-1995 30 Y 9 M 5 D (F)
Dr. MATHANGI RAJAGOPALAN

Patien

(1)

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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	21/6/26																								
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																										
	21 - 30																										
	11 - 20																			20				20			
	0 - 10																										
Saturations	94 - 100 %																			98%				97%			
	< 94 %																										
Administered O_2 (L/min.)																				RA				RA			
Temp°C	40																										
	39																										
	38																										
	37																			98.6F				98.4F			
	36																										
	35																										
	< 35																										
Heart Rate	170																										
	160																										
	150																										
	140																										
	130																										
	120																										
	110																										
	100																										
	90																										
	80																			82/M				88/M			
	70																										
	60																										
	50																										
	40																										
Systolic Blood Pressue ↑	190																										
	180																										
	170																										
	160																										
	150																										
	140																										
	130																										
	120																			120				120			
	110																										
	100																										
	90																										
	80																										
	70																										
	60																										
	50																										
Diastolic Blood Pressure ↓	130																										
	120																										
	110																										
	100																										
	90																										
	80																										
	70																										
	60																										
	50																										
	40																			78				74			
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			
TOTAL ORANGE SCORES																				0				0			
Nurse Initial																				SB				SB			

Docu. No. : RCH /FRM / CLINICAL / 053

GUC-00081088 IP18-00036156
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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																				
2nd/6		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20		20		18		20		21		20				20				20				20			
	0 - 10																									
Saturations	94 - 100 %		99		99%		99%		100		100				97%				98%				97%			
	< 94 %																									
Administered O_2 (L/min.)			RA		RA		RA		RA		RA				RA				RA				RA			
Temp°c	40																									
	39																									
	38														97.6°F				98.0°F				98.3°F			
	37		98.6		98.8		98.6																			
	36								98.0		98.0															
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90		82		80		98		84		80				80bpm				78bpm				80bpm			
	80																									
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressure ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120		116		129				120		118				111				110				112			
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70		72		70		70		70		60				62				60				64			
	60																									
	50																									
	40																									
NEURO RESPONSE [✓]	Alert		✓		✓		✓		✓		✓				✓				✓				✓			
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30		✓		✓		✓		✓		✓				✓				✓				✓			
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal		✓		—		✓		—		—				—				—				✓			
	Heavy / Foul																									
Liquor	Clear / Pink		—		✓		—		✓		—				—				—				✓			
	Green																									
TOTAL YELLOW SCORES			0		0		0		0		0				0				0				0			
TOTAL ORANGE SCORES			0		0		0		0		0				0				0				0			
	Nurse Initial																									

Docu. No. : RCH /FRM / CLINICAL / 053

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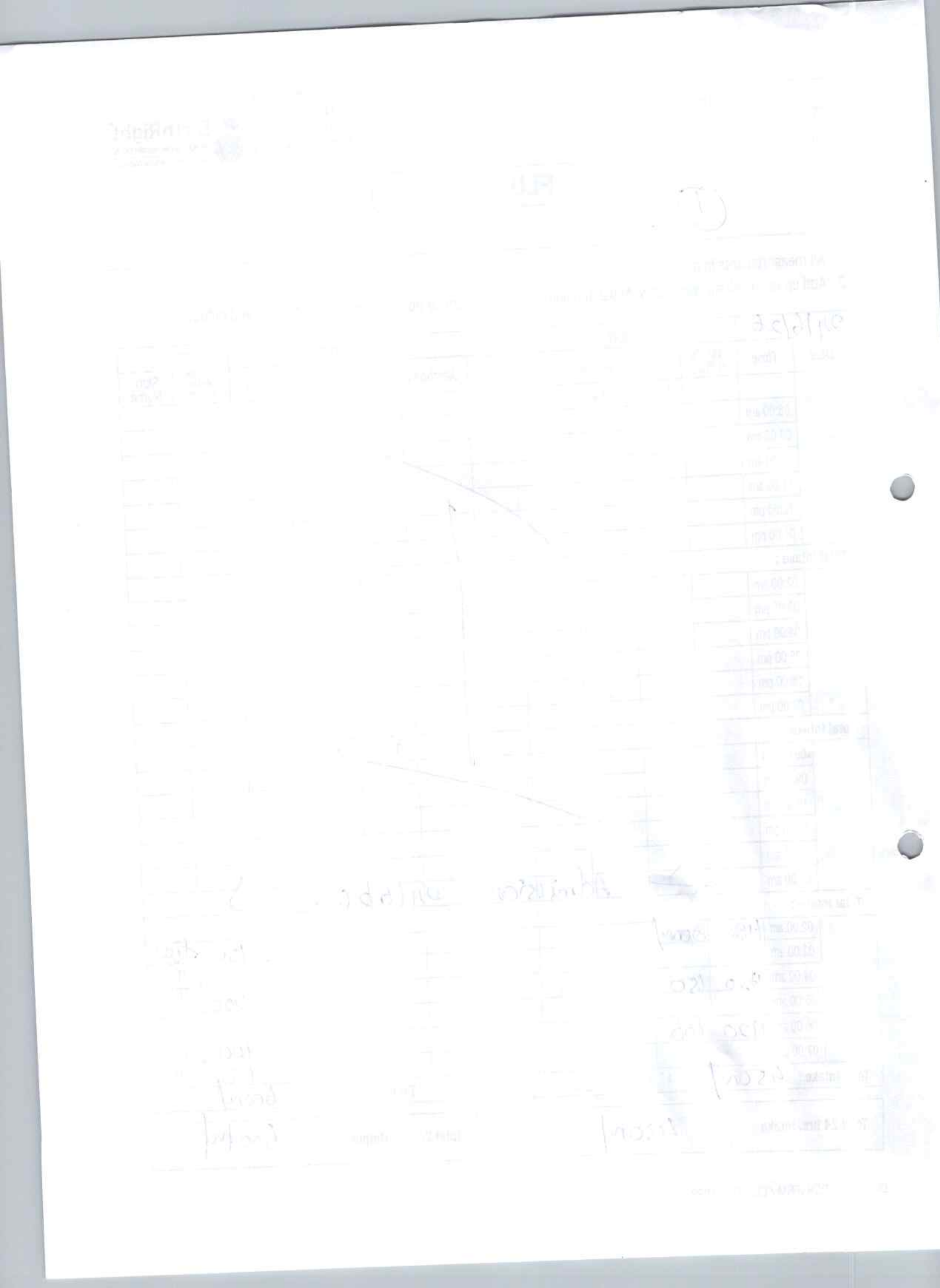
FLUID CHART

Sheet No. : 1

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

24/6/26		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :								Total Output :				
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :								Total Output :				
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am	← Admission 24/6/26 →										
Total Intake :								Total Output :				
	02:00 am	H20	200ml									
	03:00 am									150	Fw	
	04:00 am	H20	150								Fw	
	05:00 am									200	Fw	
	06:00 am	H20	100								Fw	
	07:00 am									100	Fw	
Total Intake :		450ml						Total Output :		150	R	
										600ml		

Total 24 hrs. Intake	450ml	Total 24 hrs. Output	600ml



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FLUID CHART

Sheet No. : (1)

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

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G (SYD)	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombophlebitis Score	Sign. Nurse
24/6	08:00 am	H2O	100	500	24ml							
	09:00 am	H2O	150		48					200	0	Ru
	10:00 am	Juice	100		120					100	0	Ru
	11:00 am	H2O	100		144					150ml	0	Ru
	12:00 pm	H2O	150		125					100	0	Ru
	01:00 pm	H2O	100		125						0	Ru
Total Intake :		1,786ml						Total Output :		550ml	0	Ru
	02:00 pm	H2O	100	125								
	03:00 pm	H2O	100ml	125							0	SA
	04:00 pm	H2O	100								0	SA
	05:00 pm									150	0	SA
	06:00 pm	H2O	100ml								0	SA
	07:00 pm										0	[illegible]
Total Intake :		400ml + 250ml = 650ml								100ml	0	[illegible]
								Total Output :		250ml		
	08:00 pm	H2O	200									
	09:00 pm										0	PL
	10:00 pm									300ml	0	PL
	11:00 pm	H2O	100		Inj. Paracetamol 100ml						0	PL
	12:00 am										0	PL
	01:00 am									300ml	0	PL
Total Intake :		300ml									0	PL
								Total Output :		600ml		
	02:00 am											
	03:00 am	H2O	106							800ml	0	PL
	04:00 am										0	PL
	05:00 am										0	PL
	06:00 am	Milk	150ml								0	PL
	07:00 am	H2O	100				✓			300ml	0	PL
Total Intake :		350ml						Total Output :		600ml		

Total 24 hrs. Intake	3086ml

Total 24 hrs. Output	2000ml

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Mrs HARINI DEVI R
19-09-1995 30 Y 9 M 5 D (F)
Dr. MATHANGI RAJAGOPALAN

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BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NURSING CARE RECORD

Date: 24/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night	9pm	Prevent falls & injury		→ Keep bed in low position & side Rails up → Ensure call bell is within reach → Assist during Ambulation	Ensure safety	Reassessment done	S. Shalini 01407

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- ☐ Maintain Good Nutritional Status
- ☐ Early Ambulation Reduce Anxiety
- ☐ Maintain Skin Integrity
- ☐ Patient & Family Education

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	7:30 Am	Achive acceptable pain control and comfort	8Am	* Assess pain using pain scale * Administer analgesic * Position patient comfortably	Reduced pain to some extend	Reassessment Done	[signature] 6/6/20
Afternoon	3pm	Achieve Acceptable pain control & comfort	3:30 pm	Assess pain using pain scale Administer Analgesic position pt comfortable	reduced pain to same Extend	Reassessment was Done	[signature] 01880
Night	8pm	Assess the patient condition monitor vitals maintain I/O	7Am	Assessed the patient condition monitored vitals maintained I/O chart	Patient is vitals stable	Reassessment done	[signature]

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①

NURSES NOTES

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☑ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
24/6/26		Admission Notes :	
	1³⁰AM	Mrs. Patient got admitted	
		Mrs. Harini Devi. 30yr/Female.	
		under Dr. Mathangi mam patient.	
		patient conscious & oriented.	
		Patient came for Primi 38th day	
		Abdomen pain on & off. patient	
		k/c/o. Hypothyroid on x 2 yrs. Tab.	
		Thyronorm 62.5/75mcg. patient	
		No Allergy Reaction	S. Shalini 0140 hr
		patient vital sign checked	
		& Recorded. vital sign are stable.	
		informed Dr. vinitha mam. she	
		Pv Examination done. Cervix 1.5cm	
		long, Dilated 1 finger.	Shalini 0140 hr
		part preparation done.	
		CTG connected FHR is good	
		patient general condition is fair	
		2 contraction 30 seconds.	
	2²⁵AM	CTG Disconnected informed Dr. vinitha	
		patient general condition is fair	
		patient is sleeping well	
	4AM	S/B Dr. vinitha mam. Pv Examination	
		done. Cervix 1.5cm long, OS 1 finger	
		loose, vertex - 2 station.	Shalini 0140 hr
		Dr. vinitha mam 1/2 Tab PGE2 gel kept	
		intracervically	Shalini 0140 hr

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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Mrs HARINI DEVI R (F)
19-09-1995 30 Y 9 M 5 D
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NURSES NOTES

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☑ No Known Drug Allergies
☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Contineous 24/6/06	
		patient leftsead lateral position	
		changed	
		vital sign checked & Recorded	
		vital sign are stable	
		I/O chart maintain	
		patient Morning care given	
	5Am	CTG connected FHR is good	Shalini 24/06
		New IV line insert 18G. Lt	
		cephallic. — S/N Nivetha	
		IV line pattent, No swelling	
		IVF RL connected	
	6Am	Due Medication given	Shalini 24/06
	7Am	→ Patient take a	
		butter cup brush No other	
		compling	Reg 24/06
	7:30Am	→ Pattient report hand	
		Over to (M) duty staff	Reg 24/06
		Morning Duty	
	7.30Am	Patient care Handing over taken	
		from Night duty staff.	
		monitored vitals and Recorded.	
		Maintained I/O. Patient	
		General condition fair. IV	
		cannula observed. No other	
		complaints. pain assessment	
		Done	24/6/20

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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Mrs HARINI DEVI R (F)
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NURSES NOTES

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☑ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
24/6/20	8AM	Monitored Vitals and Recorded. Maintained I/O. CTG connected, FHR Monitored. Inj-Synto 24ml/hr on connected, No any other complaints	[signature] 01/6/20
	9.30AM	Dr. Mathangi mam done PV Examination Cx well effaced. OS 3cm dilated Membrane - present, vertex at -2 to -1. VISAP ARM done clear liquor drained, CTG on Connect. FHR Monitoring	[signature] 01/6/20
	10AM	Inj. Pethedine 50mg IM, Inj. Phenargan 25mg IM given as per doctor order. Patient dosent have any other complaints after Inj-Supacef 0.1ml ID. Inj-Supacef 1.5g IV given as per doctor order	[signature] 01/6/20
	11AM	CTG connected. FHR monitored Inj. Synto 144ml/hr on connected. watching contractions Pain assessment Done. No other complaints	[signature] 01/6/20
	11.15am	Patient complaints of pressure Dr. Pavithra done PV Examination Cx well effaced, os fully dilated. advised to shift labour room	[signature] 01/6/20

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NURSES NOTES

☑ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
24/6/26	11.23am	Delivery Notes	
		Normal vaginal delivery with RMLE	
		u/SAP patient in dorsolithotomy position,	
		perineum painted and draped with	
		good uterine contractions Cx fully	
		dilated and good maternal efforts	
		2% lignocaine with full cervical	
		dilation and good maternal efforts	
		a right mediolateral episiotomy	
		given. during crowning delivered alive	
		a term girl Baby. Baby care Hand	
		over taken by Dr. Manonmani.	
		Placenta delivered. Inj. synto 10u	
		IM, Inj. synto 20U IV C RL 500ml	
		given. Inj. Trapic 1g IV, given.	
		Episiotomy sutured done. Also	
		Hemostasis achieved. Jultin	
		Suppository 100mg PR / T-Miso 600mg	
		PR kept by Dr. Mathangi mam.	
		Delivery Details	
		B - Alive girl Baby	
		A - 24/6/26 at 11.23AM	
		B - wt - 2.447kg	
		y - 6/10, 8/10	[signature] 24/6/26
	12pm	Monitored vitals and Recorded.	
		Maintained I/O. Patient General	
		condition fair. No other complaints	[signature] 24/6/26

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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Pati

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URSES NOTES

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☐ No Known Drug Allergies
☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
24/6/26	1pm	Dr. pavithra done PV examination Patient have mild bleeding Informed to Dr. mathangi mam advised to give. Dey. Methergine 0.2mg IM given as per doctor order. Uterine massage given. No other complaints	01/8/26
		B - Breast is soft, No enlargement	
		U - Uterus contracted	
		B - Bladder Not yet voided	
		B - Bowel movement present	
		L - Lochia Rubra No foul smelling	
		E - PEEDA Assessment done	
		H - Homan sign Negative	
		E - Emotional status good	01/8/26
	1:30pm	Patient care Handing over given to Evening duty staff	01/8/26
		Evening duty	
	1:30 pm	patient case hand over taken from morning duty staff. Nurse patient was stable conscious & oriented to time present & Pattern minimal of Bleeding IV fluids 125ml/hr ongoing pt vital are stable general condition Plus	01/8/26

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
24/6/26	2pm	B - Breast is soft NO Enlargement	
		U - Uterus was contracted well	
		B - Bowel movement present	
		B - patient is self voiding	
		L - Lochia Rubra present	
		E - REEDA Assessment was done	
		H - Homan Signs negative	
		E - pt Emotional good	[signature]
	4pm	⇒ patient NOT voiding	01858
		minimal of Bleeding Informed	
		to Dr. Akshitha, pre voiding	
		scan was done Advised to	
		Encourage Adequate oralls	[signature]
	4:45	⇒ patient is voiding 150ml	01808
	pm	Informed Dr Akshitha post voiding	
		scan was done Bladder collapsed	
		minimal of Bleeding	[signature]
	5:25pm	⇒ Dr. Saidevi Advised to	01808
		pt shifted to ward patient	
		care hand over given to 7th floor	
		staff nurse	[signature] 01808
		Receiving Notes On 24/6/26	
	5:45pm	patient details handing	
		Over taken from [illegible]	
		patient conscious and Oriented	
		patient urine passed. pv bleeding	
		is Normal. patient tomorrow DIS	

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

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NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
04/6/2[illegible]	5.45pm	plan, tomorrow morning 4/m @ bar CBC. IV line pattern →	[signature]
	6pm	maintain Intake and Output chart. The medication given as per Doctor's order →	[signature]
	7.30pm	Patient details handing over On Night duty staff →	[signature]
		Night duty	
04/6/26	7.30pm	patient details handover taken over from evening to Night duty. patient is IV line Normal diet, urine voided C/m 6Am CBC, tommorrow Discharge plan	→P.Kar[illegible]
	8.00pm	patient Vitals checked and recorded.	→P.Kar[illegible]
	9.00pm	patient due medications given	
		B - Breast is soft diet	
		U - Uterus is contracted well	
		B - Bowel movement present	
		B - urine voided frequently	
		L - Lochia rubra is present	
		E - Reeda Assessment done	
		H - Homan sign's Negative	
		E - Emotional status good.	→P.Kar[illegible]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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☐ No Known Drug Allergies ✓

☐ Drug Allergies .... NIL

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
24/6/26	11.00PM	Patient due medication	
		Inj Taxpic [illegible] given	
		and recorded.	→ [illegible]
25/6/26	12.00AM	patient vitals checked	
		and recorded.	→ [illegible]
	2.00AM	patient is sleeping well,	
		No other complains	→ [illegible]
	4.00AM	patient vitals checked	
		and recorded.	→ [illegible]
	6.00AM	patient due sample	
		CBC collected and send to	
		lab bill raised, intake	
		output chart maintained	→ [illegible]
	7.30AM	patient details has done	
		given to morning duty	
		staff	→ [illegible]

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PHLEBITIS ASSESSMENT

Patient's Name:
MRD No.:
Age :
Sex: ☐ M ☐ F
Consultant:

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19-09-1995 30 Y 9 M 5 D (F)
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CANNULA 1

Date : 24/6/26 Time: 5:30 Am
Location : Lt Cephallic
Size : 18 G
Cannula inserted by : S/N. Niretha

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
24/6/26	5:30 Am	☐Yes ☐No	☐Yes ☐No	observe cannula	[illegible]
	7:30 Am	☐Yes ☐No	☐Yes ☐No	observe cannula	[illegible]
	8AM	☐Yes ☐No	☐Yes ☐No	observe	[illegible]
	10AM	☐Yes ☐No	☐Yes ☐No	observe	[illegible]
	12pm	☐Yes ☐No	☐Yes ☐No	observe	[illegible]
	2PM	☐Yes ☐No	☐Yes ☐No	observe	[illegible]
	4pm	☐Yes ☐No	☐Yes ☐No	observe	[illegible]
	8pm	☐Yes ☐No	☐Yes ☐No	observe	[illegible]
25/6/26	12AM	☐Yes ☐No	☐Yes ☐No	observe	[illegible]
"	4AM	☐Yes ☐No	☐Yes ☐No	observe	[illegible]
"	6Am	☐Yes ☐No	☐Yes ☐No	observe	[illegible]
	8AM	☐Yes ☐No	☐Yes ☐No	observed	[illegible]
	10AM	☐Yes ☐No	☐Yes ☐No	observed	[illegible]
	12pm	☐Yes ☐No	☐Yes ☐No	observed	[illegible]
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

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

CANNULA 2

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

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

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

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

PHLEBITIS ASSESSMENT AND MANAGEMENT RECORD

CANNULA 3

Date : Time:

Location :

Size :

Cannula inserted by :

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		

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

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

Phlebitis score:

CANNULA 4

Date : Time:

Location :

Size :

Cannula inserted by :

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		
		□Yes □No	□Yes □No		

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

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

Phlebitis score:

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

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

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

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time / Score	24/6 N	M 24/6/26 20	E 24/6/26 20
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0	0	0	0
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0	0	0	0
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			0
	None /Bed Rest /Nurse Assist	0	0	0	
IV / Heparin Lock or Saline	Yes	20		20	20
	No	0	0		
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0	0	0	0
Mental Status	Forgets limitations	15			
	Oriented to own ability	0	0	0	0
Total Morse Fall Scale Score:				20	20
		Signature	[signature] 24072	[signature] 01012	[signature] 01808

Fall Risk Grading

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

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

GUC-00081088
Mrs HARINI DEVI R IP18-00036156
19-09-1995 30 Y 9 M 6 D
Dr. MATHANGI RAJAGOPALAN (F)

(2)

Morse Fall Risk Assessment Form

Rainbow® Children's Hospital
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Your Right to a Safe Delivery

Choose Highest Applicable Score from each Category		Date / Time	24/6/26	25/6/26	
		Score	N	M	
History of Falling (immediately or w/in 3 months)	Yes	25	20	20	
	No	0		0	
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0	0	0	
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0	0	0	
IV / Heparin Lock or Saline	Yes	20	20	20	
	No	0	0		
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0	0	0	
Mental Status	Forgets limitations	15			
	Oriented to own ability	0	0	0	
Total Morse Fall Scale Score:			20	20	
		Signature	[signature] 6029	[signature]	

Fall Risk Grading		
Risk Level	**Morse Fall Score (MFS)**	**Action**
Low Risk	0 - 24	Standard Fall Precaution
Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
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Dr. MATHANGI RAJAGOPALAN

BRADEN 'Q' SCALE

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

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

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

Risk Score	Category	Action	Support Surfaces (**Please Note:** Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	⓫ Regular Turning Schedule ⓫ Enable as much activity as possible ⓫ Protect the heels ⓫ Use pressure redistribution surfaces ⓫ Manage moisture, friction and shear ⓫ 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	⓫ Use the Same Protocol as for **"At Risk"** Patients ⓫ 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	⓫ Follow the same protocol as for **"Moderate Risk"** Patients ⓫ In addition to regular turning schedule ⓫ 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	⓫ Use same protocol as for **"High Risk"** Patients ⓫ 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

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BRADEN 'Q' SCALE

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				Date : 25/2			
				Time : 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		
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				TOTAL SCORE	28		
				Evaluator's Name	A		

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

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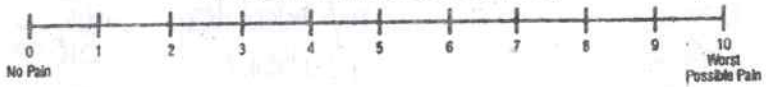
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
24/6	2:30 AM	0/10	Lower Abdomen pain	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☑ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	Comfortable position	Shalini 014072
24/6	6AM	1/10	Lower Abd pain	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☑ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	Comfort position	[illegible] 011176
24/6/26	8AM	1/10	Abdomen	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☑ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	Comfortable position	[illegible] 010792
24/6/26	10AM	2/10	lower abdomen	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☑ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	Breathing Exercise	[illegible] 010792
24/6/26	12PM	1/10	Episiotomy site	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☑ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	Pharmacology therapy	[illegible] 010792
24/6/26	2pm	1/10	Episiotomy site	☑ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☑ Sharp ☐ Dull ☐ Aching ☐ Burning	☑ Increasing ☐ Decreasing	☑ Yes ☐ No	comfortable position	[illegible] 01808
24/6/26	8PM	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	Nil	[illegible] 6070
25/6/26	2AM	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	Nil	[illegible] 60720
25/6/26	8AM	0/10	–	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	Nil	[illegible]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

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

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO_2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO_2 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO_2 less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

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INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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Part - I.

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

Identified Education Needs:

1. Diagnosis — Primi / 38wks
2. Treatment and Care
3. Pain Management
4. Informed Consent
5. Medication / Therapy (safety, effects/ side effect, interactions)
6. Discharge Medication
7. Infection Control Measures
8. Diagnostic Test / Procedures
9. Nutrition / Diet
10. Fall Risk Education
11. Safe use of Medical Equipment / Implantable Devices Safety
12. Patient's / Family Rights
13. Risk / Safety

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
24/6	2pm	enforced consent	Explain about enforced consent (Normal vaginal delivery)	Patient	No learning barriers	Oral	None	Verbalizes understanding	Good	Shalom 01407h

Part - III: CODES

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

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

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

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

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

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OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 24/6/26 Time of Arrival: 1³⁰ Am Time Seen by Nurse: S/N. Shalini 040 ?

1) **Level of Consciousness:** ☑ Conscious ☐ Semi-Conscious ☐ UnConscious

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

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

3) **Vital Signs:** Temperature: 98.6°F Pulse: 82/mt RR: 20/mt SpO₂: 98% BP: 120/78 Weight: 85.7 kg

4) **Gestational Criteria:**

Gravida:	G 1	P —	L —	A —

LMP: 30/9/2025 EDD: 07/07/26 Gestational Age: 38+1 day

Uterine Contraction	☑ Yes	☐ No	☐ NA	Onset 23/6/26	Time	Frequency:
Membrane Rupture	☐ Yes	☑ No	☐ NA	Onset	Time	Fluid Color:
Vaginal bleeding	☐ Yes	☑ No	☐ NA	Onset	Time	Amount:
Pre Eclampsia Symptoms	☐ Yes	☑ No	☐ NA	If Yes specify: Headache / Visual Symptoms / Pain Abdomen / Vomiting		
Good fetal Movement	☑ Yes	☐ No	☐ NA	If No specify:		

5) **Pain Screening:** **Numerical Pain Scale (NPS)**

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

- Location: Lower Abdomen pain
- Duration: 10 mits Days / Weeks/ Months (Strike out which is not applicable)
- Character: Mild
- Frequency: 30 seconds
- Interventions: Comfortable position

6) **Past History:**

a) Surgeries: Nil

b) Medical: Tab. Thyronorm 62.5/75mcg (Hypothyroid x 2 yrs)

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

8) **Current Medications:** ☐ Prenatal Vitamin ☐ None ☐ Others: Overt Hypothyroid x2 yrs

9) **Prenatal Medical History:**

☑ None
☐ Chronic Hypertension
☐ Gestational Hypertension
☐ Diabetes
☐ Gestational Diabetes
☐ Low placenta
☐ Others if yes, specify Overt Hypothyroid x 2yrs! Tab. Thyronorm 62.5

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

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

Time seen by Doctor: DR. vinitha

Nurse Name : S/N. Shalini Gayathri Nurse Signature: S. Shalini Gayathri

Date: 21/6/26 Time: 12 PM

GUC-00081088 IP18-00036156
Mrs HARINI DEVI R
19-09-1995 30 Y 9 M 5 D (F)
Dr. MATHANGI RAJAGOPALAN

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LABOUR AND DELIVERY NURSING ASSESSMENT

Date of Admission: 21/6/26

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 38+1 day
Abdomen pain on & off

Doctor Notified on Admission: ☑ Yes ☐ No

Name of the Doctor: DR. vinitha

Time Notified: 1.30 AM

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Overt Hypothyroid x 2 yrs PCOS	Nil	Nil

Blood Group: O Positive LMP: 30/9/25 EDD: 7/7/26 Gestational age during admission: 38+1 day

Contractions: 2 contraction 30 seconds Vaginal Discharge: —

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

Height: 158.5 Weight: 85.7 kg BMI:

Temp: 98.6 F HR: 82/min RR: 20/min BP: 120/78 SpO_2 98%

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

☑ Hypothyroidism	☐ Rh Incompatibility	☐ Fertility Treatment
☐ Hyperthyroidism	☐ Previous LSCS	☐ Preterm Labour
☐ Hypertension	☐ Gestational Hypertension	☐ Others: (Specify)
☐ Diabetes	☐ Bad Obstetric History	Tab. Thyronorm 62.5/75mcg
☐ Anemia	☐ Obesity (BMI)	
	☐ Twins / Multiple Pregnancy	

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Family History: ☐ No Abnormalities Detected

☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Stroke ☐ Seizures ☐ Kidney disease

☐ Liver disease ☐ Other ..... Father - DM / HTN.

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

Fall Assessment: ☐ Yes ☐ No Score ..... 0 ..... (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore: ☐ Yes ☐ No Score ..... 28 ..... (complete the Braden Q Sheet)

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

☐ Mobility problem ☐ Walking Problem ☑ No Abnormality Detected

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

☑ Overweight ☐ Poor Appetite > 3 Days ☐ Needs Therapeutic Diet.

☐ Under Weight ☐ Diabetes Mellitus ☐ No Abnormality Detected

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

☑ Calm & Cooperative ☐ Restless ☐ Depressed ☐ Agitated ☐ Confused

☐ Others .....

Inform consultant for positive criteria

SOCIAL SCREENING:

1. Marital Status: ☐ Single ☑ Married ☐ Divorced ☐ Widow

2. Special Habits: **Smoker:** ☐ Yes ☑ No **Alcohol Abuse:** ☐ Yes ☑ No **Drug Abuse:** ☐ Yes ☑ No

Social History: Lives With ..... Husband .....

Orientation has been given regarding the following aspects:

Call Bell in Reach : ☑ Yes ☐ No Waste Disposal Explained: ☑ Yes ☐ No

Infusion Pump : ☑ Yes ☐ No Hand hygiene Explained: ☑ Yes ☐ No ☐ Others

Above information given to ..... Patient .....

Name of Person Orientation was given to: ..... Mrs. Harini Devi .....

Orientation not given Reason: ..... - .....

Nurse Signature: ..... S. Shalini .....

Nurse Name: ..... S. Shalini (41072) .....

Date & Time: ..... 24/6/26 at 1339 hrs .....

GUC-00081088 IP18-00036156
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19-09-1995 30 Y 9 M 5 D (F)
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PARTOGRAPH

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LABOUR

Labour: ☐ Spont ☐ IOL-PGE 1 ☑ E2 ☐ Others

Indications for IOL-Accel: ☐ None ☑ Oxytocin

Memb. Repture Type: ☐ SROM ☐ PROM ☑ ARM

Presentation: ☑ Vertex ☐ Breech ☐ Others

INTRA PARTUM COMPLICATION

Maternal: ☑ Nome ☐ Pyrexia ☐ HTN ☐ Others

Liquor: ☑ Adequate ☐ Oligo ☐ Poly ☑ Clear

☐ Blood ☐ Meconium ☐ Cord: .....

Shoulder Dystocia: ☐ Yes ☑ No

DELIVERY DETAILS

Anesthesia: ☑ None ☐ Epidural

Non-epi: ☑ Local ☐ Spinal ☐ General

Del. Type: ☑ SVD ☐ Asst. Breech ☐ Twins

AVD: ☐ Outlet ☐ Low Forceps ☐ Ventouse ☐ Trails of Forceps

Indications: .....

Application, Locking & Traction: .....

Duration of Instrumentation: .....

No. of Pulls: .....

Catherised : ☐ Yes ☑ No

Type: ☐ Fileys ☐ Plain

Perineum : ☐ Intact ☑ Episiotomy ☐ Tear

Suture Material Used: Rapid vicryl

STAGE III

Placenta: ☑ Normal ☐ Abnormal ☐ RP Clots ☑ CCT ☐ Retained ☐ MRP

PPH : ☐ Atomic ☐ Traumatic ☑ None

Lacerations: .....

Cervical: .....

Perineal: Episiotomy

Others: .....

Prophylaxis: (Synocinon) Prostodin

Blood Loss: 350ml

Blood Transfusion: No

Other Details (if any): .....

Ractal Examination: Normal

DURATION OF LABOUR

1st Stage: 6 hours

2nd Stage: 10mins

3rd Stage: 5 mins

Duration of Active Pushing: .....

No. of VE'S: .....

BABY DETAILS

Gender: Girl

Weight: 2.447 kg

APGAR: 6/10, 8/10

Date and Time of Delivery: 24/6/24; 11:23am

LW Doctor: Dr. Mathangi

LW Sister: .....

(P.T.O.)

PARTOGRAPH

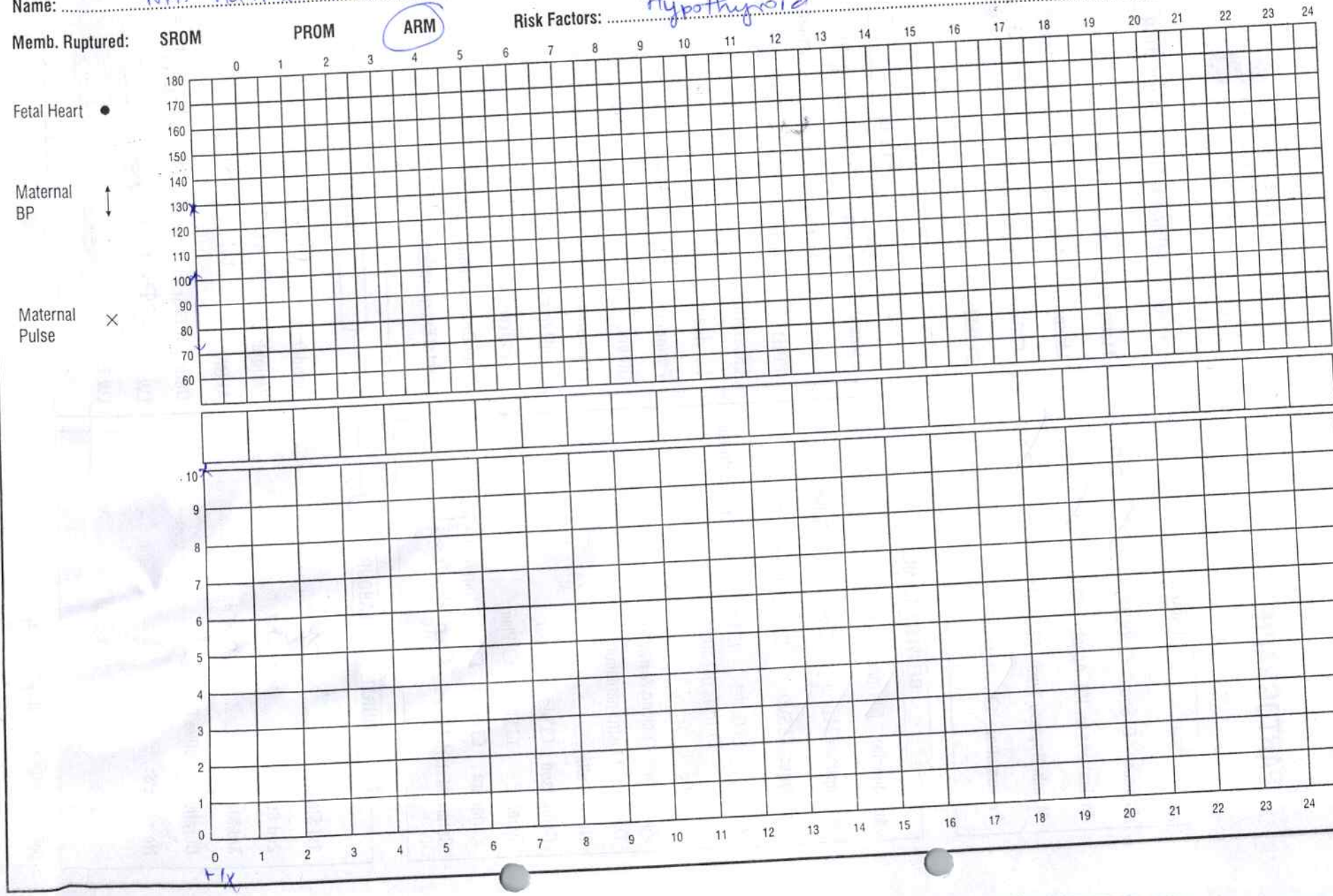
Name: Mrs. Harini Devi

Obstetrics Formula: Primi

Blood Group Type: O-Positive

Memb. Ruptured: SROM PROM ARM

Risk Factors: Hypothyroid




Time
11AM
Signature
Fifths Palpable
0/5
Moulding / Caput
N
N
Amniotic Fluid
C
Position
Cephalic / Breeth
C
Oxytocin
120
ml/hr
Contractions
in 10 mins
5
4
3
2
1
Drugs and
IV Fluids
10
RL
Urinalysis
Test
Amount

Record of Labor:

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management: Time: ..... Signature: .....

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management: Time: ..... Signature: .....

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management: Time: ..... Signature: .....

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management: Time: ..... Signature: .....

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management: Time: ..... Signature: .....

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INDUCTION OF LABOR CONSENT

Name: Mrs. Harini Devi Age: 30yrs Gender: Male ☐ Female ✓

UHID No : 81088 Date: 23/6/26.

You are scheduled for an induction of labor on ..... (date) at 38w 1 d (weeks of gestation).

The reason for your induction is .....

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

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

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

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

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

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

Patient
Signature: R. Hari
Name: R. HARINI DEVI
Date & Time: 24/6/26 at 2AM

Patient Attendant:
Signature:
Name: Rohinkumar
Relationship with Patient: Husband
Date & Time: 24/6/26 at 2AM

Doctor:
Signature: VD 121113
Name: Dr. Vinitha
Date & Time: 24/6/26 2am

Witness
Signature:
Name:
Date & Time:

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INFORMED CONSENT FOR VAGINAL BIRTH

Patient Name : Mrs. Harini Devi UHID No : 81088

Gender: ☐ Male ☑ Female Date : 24/6/26 Time : 2Am

I hereby authorized the performance of the following procedure:

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

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

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

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

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

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

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

Name of the Doctor performing the procedure: .....

Consentee :

Signature : R. Harini

Name : R. HARINI DEVI

Date & Time : 24/6/26 2AM

Witness :

Signature : .....

Name : .....

Date & Time : .....

Patient Attendant :

Signature : .....

Name : Rohin Kumar

Relationship with Patient: Husband

Date & Time : 24/6/26 at 2AM

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. Vinitha

Date & Time : 24/6/26 : 2am

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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:
- [x] 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: 24/6/26

Baby in mothers side
good latching

L	- 2	24/6/26	
A	- 2	C	- 2
T	- 2	A	- 2
C	- 1	T	- 2
H	- 2	C	- 1
	9	H	1
			8

[signature]

Handover given by S/N Tamilselvi 017720

Handover taken by E. Soumiya

Signature S/N [signature] 017720

Signature [signature]

Date & Time:

Date & Time: 24/6/26 5PM

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RISK ASSESSMENT TOOL FOR DEEP VEIN THROMBOSIS

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

Date: 21/6/26

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

(1)

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PATIENT TRANSFER FORM

GUC-00081088 IP18-00036156
Mrs HARINI DEVI R
19-09-1995 30 Y 9 M 5 D (F)
Dr. MATHANGI RAJAGOPALAN

	Date & Time of Admission 24/6/26 at 1:56Am	Date & Time of Transfer Order 24/6/26 at 5:45pm
Treating Consultant Name Dr. Mathangi	Transfer Ordered by Dr. Akshitha	Reason for Transfer observation
From Unit LDR	To Unit 9th floor	Information to Attendant Yes ☐ No ☐
Number of Sheets in Clinical File Whole IP files	Number of Imaging Films CTG - (6)	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	Tab: para 1gram	(9)
2.	C. pan 40mg	(10)
3.	Justine suppoter 100mg	(5)
4.	C. Augmentine	(10)
5.	Inj. Tapic 1gram / NS 100ml	→ (2) (1)

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐
pt shifted to ward

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
SN Ahalya 01808	Dr: Aashitha.

Patient & Clinical Records Received by : [signature]

Date & Time of Patient Received : 24/6/26 @ 5:45P

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

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

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