



GUC-00046148 IP18-00036175  
 Mrs PRIYA PARAMESHWARAN  
 30-01-1994 32 Y 4 M 27 D (F)  
 Dr. PRIYADHARSHINI S M



ARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin >		
Activity Sheet update by Nursing		26/6/2020 7:30 PM	<i>[Signature]</i>				
Activity Sheet update by Pharmacy		7:30 PM	<i>[Signature]</i>				

Handwritten text, possibly a signature or date, located in the center of the page.

# ACTIVITY

GUC-00048148 IP18-00036175  
 Mrs PRIYA PARAMESHWARAN  
 30-01-1994 32 Y 4 M 26 D (F)  
 Dr. PRIYADHARSHINI S M

ING



Name: N  
 UHID No: 46143 IP No: 36175 Consultant: Dr. P. Rajakumar Dept: ICU  
 Date of Admission: 24/6/2020 Time: ..... Date of Discharge: ..... Time: .....  
 Room / Bed No: ..... Ward: ..... Suggested Billable bed type: .....

## WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
24/6/20	1 AM	ICU	7th Floor	[Signature]
25/6/2020	6-10 AM	7th Floor (ICU)	MCW	[Signature]
25/6/20	7 PM	ICU	ICU	[Signature]

## CROSS CONSULTATION VISIT

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







DISCHARGE TRACKING SHEET

UHID-

FLOOR-

NAME OF CONSULTANT

GUC-00046148

IP18-00036175

Mrs PRIYA PARAMESHWARAN

30-01-1994

32 Y 4 M 26 D

(F)

Dr. PRIYADHARSHINI S M



ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
	INTIME	OUT TIME			
Discharge Announcement					
Arrangement of File by Nursing		26/6/18 Mishra	<i>[Signature]</i>		
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

10/17

GUC-00046148 IP18-00036175  
 Mrs PRIYA PARAMESHWARAN  
 30-01-1994 32 Y 4 M 26 D (F)  
 PRIYADHARSHINI S M



### BED SIDE CHECK LIST FOR NURSES

Date:	25/10/26								
Doctor's Orders	yes								
Carried out or not	yes								
<b>Bed Side</b>									
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	yes								
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 :	PC								
Signature :	PC								
Date & Time:	25/10/26 8 PM								
Hand Over Taken By Name :	PC								
Signature :	PC								
Date & Time:	26/10/26 8 AM								



ADMISSION SHEET

Registration Details :



Admission No : IP18-00036175 Admit Date : 24-Jun-2026 Admit Time : 10:51 PM UHID : GUC-00046148

Patient Details :

Patient Name : Mrs PRIYA PARAMESHWARAN Age : 32 Y 4 M 25 D  
Guardian : PARAMESHWARAN DOB : 30-01-1994  
Gender : Female Religion :  
Occupation : Martial Status : Married  
Address (H) : 47, 4TH STREET, GANAPATHY NAGAR, Phone No : 8838600253  
MADAPAKKAM Sithalapakkam Kanchipuram E-mail : vfxparama@gmail.com  
Tamil Nadu INDIA 110005

Admission Details :

Bed Type : MICU Bed No : MICU 801 Ward Name : 8F-OT COMPLEX  
Room No : MICU 801 Admission Type : First Visit

Contact Details :

Name : PARAMESHWARAN Relationship : W/O  
Contact Address : 47, 4TH STREET, GANAPATHY NAGAR, Phone No : 8838600253  
MADAPAKKAM Sithalapakkam Kanchipuram  
Tamil Nadu INDIA 110005

*Signature*

Signature

Doctor Details :

Doctor Name : Dr. PRIYADHARSHINI S M Specialisation : OBSTETRICS AND GYNECOLOGY  
Referral Doctor : Dr. Priyadharshini S M Phone No :  
Co-Consultant :

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00  
Payor Name : SELFPAY



**GENERAL CONSENT FOR TREATMENT**

Patient Name: Mrs PRIYA PARAMESHWARAN

Age : 32 Y 4 M 25 D

IP No: IP18-00036175

Sex: Female

Consultant: Dr. PRIYADHARSHINI S M

Ward/Bed No: 8F-OT COMPLEX/MICU 801

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.

(E.g. Drivers Signature: k.p. param...)

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: PARAMESHWARAN

Relationship: Aunt

Date: 24/6/2026

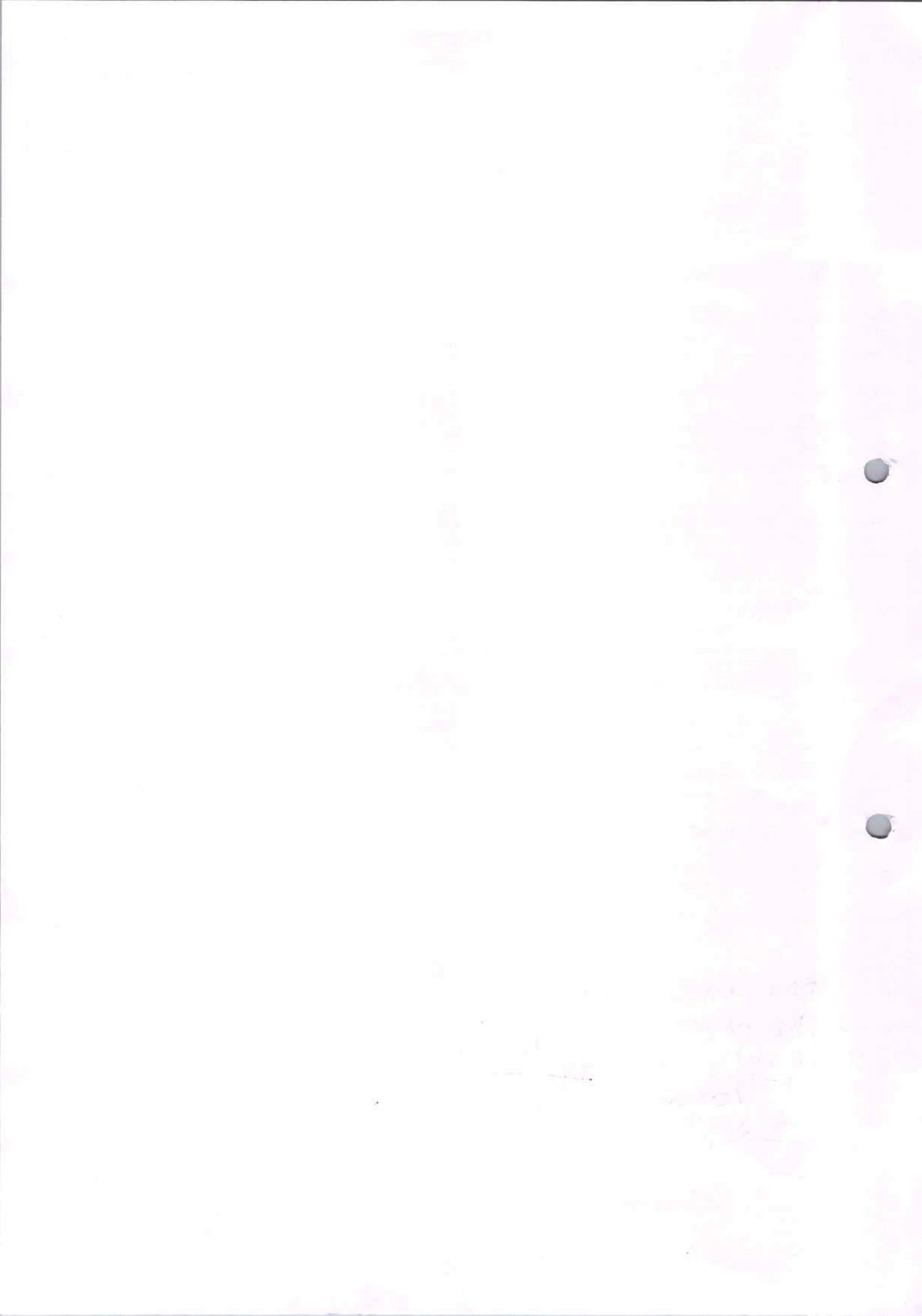
Time: 10:57 AM

Witness Name: P. Thamarai Selvan

Witness Signature: P. Thamarai Selvan

Patient Address:

47, 4TH STREET, GANAPATHY NAGAR,  
MADAPAKKAM Sithalapakkam  
Kanchipuram Tamil Nadu INDIA  
110005

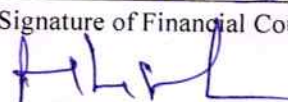


## BILLING POLICY

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

### DECLARATION

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

Patient Name : Mrs. Priya	UHID Number : 46148
Self/Attendant Name : PRAMESHWARAN	Relation : HUSBAND
Self/Attendant Signature : K. J. S. S. Phone Number : 8892573134	Name & Signature of Financial Counselor 



Patient Sticker



# IP ADMISSION SHEET FOR OBSTETRICS

**Presenting Complaints**

Able to PFM well  
 Admitted for IOL

**Obstetric Formula:**

G4 P1 L1 A2

**Obstetric History:**

I - FTNVD, ♀ 3-2kg, 7 years. A & H.  
 II - missed miscarriage - 2024 } MMA  
 III - missed miscarriage - 2025 } taken  
 I - PP, OI conception

**Present Pregnancy Record:**

- Booked & immunised  
 - NT (N)  
 - Anatomy scan (N)

**RISK FACTORS:**

hypothyroid.  
 Fetus - UTDA 2 (RT)  
 OI conception

Height: 164 cm

Weight: 77.6 kg

Allergies: NIL

Breast:  Normal  Abnormal

**General Examination:**

Consciousness: full Pallor: NO  
 Icterus: NO Edema: NO  
 Temp: (N) PR: 88/min  
 BP: 124/74 mmHg DTR: (+)  
 CVS: S1 S2 (+) RS: NAD  
 Liver/Spleen: Slight Urine Output: adequate

LMP: unknown

EDD: 07/07/2026

Corrected EDD:

GA: 38+1 weeks

Menstrual History: Regular:  Yes  No

**Obstetric Examination**

m/s: 8 years, NCM.

Fundal Height: Term

20/15 sec/10 min

Ut. Activity:  Relaxed  Mild  Mod  Severe

Liquor:  Adequate  Oligo  Poly

PP:  Cephalic  Breech Others \_\_\_\_\_

Head Fifths Palpable: 3/5

FHS:  Normal  Tachy  Brady  Absent

**Per Speculum Examination**

Draining:  Present  Absent  Bleeding

Colour of Liquor:  Clear  Meconium  Blood Stained

**Vaginal Examination**

Cervix:  Long  Partially effaced  Effaced

Os: Closed Dilated 2 fingers

Membranes:  Present  Absent

Liquor:  Clear  Meconium  Blood Stained

Presenting Part:  Vertex  Breech  Others

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

Pelvis:  Adequate  Doubtful

**DIAGNOSIS**

G4 P1 L1 A2  
 O positive

Previous vacuum  
 NVD

38+1 weeks  
 OI conception

(RT) renal peliectasis  
 Fetus UTDA 2  
 hypothyroid

Induction of labour (P.T.O)

Patient Sticker

<p>Family History:</p> <p>Both parents - T<sub>2</sub>DM</p>	<p>Surgical History:</p> <p>NIL</p>
<p>Medical History:</p> <p>H/O Hypothyroid preconceptually H/O OI + follicular tracking.</p>	<p>Medication History:</p> <p>Tab. THYRONORM 25mcg OD Tab. ECOSPIRIN 150mg HS-taken</p>
<p>Plan of Care: <u>I/I Dr. Prayadharshini</u></p> <p><u>Advice:</u></p> <ul style="list-style-type: none"> <li>- Admission</li> <li>- parts preparation</li> <li>- secure IV line at 5AM</li> <li>- CTG Q4H; Next 4AM</li> <li>- w/f contractions.</li> <li>* plan: Tab. MISOPROSTOL 50mcg PO STAT at 5AM.</li> <li>- Shift to ward.</li> <li>- w/f T pain abdomen, bleeding, leaking pr.</li> <li>- Inform SOS.</li> </ul>	<p>Investigations:</p> <p>CTG</p>

Doctor Name: Dr. Mohana / Dr. Dnyalakshini

Signature: [Signature]

Date & Time: 24/6/26, 10:45pm

Consultant Name: Dr. Prayadharshini

Signature: [Signature]

Date & Time: 24/6/26, 10:45pm

Patient Sticker

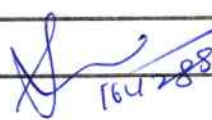
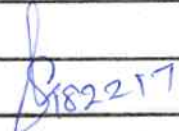
UC-00046148 IP18-00036175  
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 PRIYADHARSHINI S M



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

BirthRight  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

### PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/6/20 5 AM	S/B Dr. Mohana / Dr. Dnyalaksini	
	CTG - Reactive	
38+2 wks	Advice: Tab MISOPROSTOL	SDMGY PO STAT
	- ENEMA STAT	
		 16/6/2020
25/6/20 8:30 AM	C/S/B Dr. Priyadharshini	
	Pt reviewed.	
	Clo Lower Abdominal Pain on & off	
	OLE Pt GC fair, Afebrile	Advice
	P° / PE°	= Liquid diet
CTG - Reactive	LWS	- B start Inj. SYNDO @
	RS NAD	2uml/hr and titrate
	PIA - uterus @ Term	accordingly
	Ct 12" / 10"	- Continuous CTG
	cephalic	- W/F Contractions / Progress
	FHS - good	- INJ. TAXIM 1g IV (ATD) stat
	P/V - Cx - 1.5cm long	
	OS - 3cm dilated	
	BOM @	
	Vertex @ - 3	
	↓ SAP, ARM clear liquor drained.	 18/6/2020





PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/6/26	Vacuum Assisted Vaginal Delivery @ RMLE.	
12:4 PM	D/B Dr. Priyadharsini	
	Assisted by Dr. Vinita / Dr. Shree Devi.	
	<p>↓ SAP, pt in lithotomy position, parts painted &amp; draped. Vertex @ station. Vacuum cup applied @ flexion point. Chignon formed. Head delivered with 2<sup>nd</sup> pull. Baby delivered. Cried immediately after birth. Immediate cord clamping done, cord cut and baby handed over to pediatrician. Left lateral vaginal wall tear of 4-5cm noted apart from episiotomy. Episiotomy - no extension. Skin - superficial tear extending upto anal verge. Sphincter tone intact. Episiotomy sutured in layers followed by left lateral vaginal wall tear and skin. PIR - Rectal mucosa intact; Sphincter tone intact. BwNL</p>	
	B   25/6/2026; 12:4 PM	Adv:
	A   Boy	• Soft diet
	B   3.172 kg	• Ice pack
	Y   7/10, 8/10	• Follow drug chart
		• Tolorm SOS
		• Hb / Pcv c/mbam
	H/P	
	12/11/23	











UC-00046148 IP18-00036175  
Mrs PRIYA PARAMESHWARAN  
0-01-1994 32 Y 4 M 26 D (F)  
r. PRIYADHARSHINI S M

Docu. No. : RCH



# DOCTOR'S SHIFT CHANGE HANDOVER FORM



Date: .....

Department: .....

Shift: .....

S.No	Patient Identification	Diagnosis / Procedure	Clinical Findings Problems	Special Concerns / Investigations / Abnormal Results	Recommendations / Follow up needed	Handing Over Doctor	Receiving Over Doctor

# DOCTOR'S SHIFT CHANGE HANDOVER FORM



Date: .....

Department: .....

Shift: .....

S.No	Patient Identification	Diagnosis / Procedure	Clinical Findings Problems	Special Concerns / Investigations / Abnormal Results	Recommendations / Follow up needed	Handing Over Doctor	Receiving Over Doctor

2UC-00046148 IP18-00036175  
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### RESULT SHEET

Date	3/6					
Time						
Hb	12.2					☐ POSITIVE
PCV	35.3					
RBC						
WBC	7050					
N/L						
Platelets	2.02					HIV HBSAG } NR VDRL }
CRP						
ESR						
PCT						
RBS	3/6					20/2
Na	F-90					TSH-270
K	PP-113					
Cl						OGTT
Ca/Mg						F-71 2hr-116
Phosphate						
Urea						
Creatinine						
ALP						Rubella - Immune
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						EKG } NOT Echo } DONE
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						



JC-00046148 IP18-00036175

PRIYA PARAMESHWARAN

01-1994 32 Y 4 M 26 D (F)

Patil, PRIYADHARSHINI S M



# MEDICATION RECONCILIATION FORM

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

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

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

Shifting From: ICU Shifted to: Ward

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Tab. THYRONORM	25mg	po	OD		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
2						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

\* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Dingalakeshmi S.R

Date & Time: 24/6/20, 11 pm

Nurse Name & Signature: S. Nivetha 1011716

Date & Time: 24/6/20



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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: ..... 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	25mcg	PO	OD		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
2	T. LEFTUM	500mg	PO	BD		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
3	T. PAN	40mg	PO	BD		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
4	T. ZERODOL SP	1Tab	PO	BD		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

\* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Shreedeni  182217

Date & Time: 25/06/2026

Nurse Name & Signature: .....

Date & Time: .....



IC-00046148  
 \* PRIYA PARAMESHWARAN IP18-00036175  
 01-1994 32 Y 4 M 26 D (F)  
 PRIYADHARSHINI S M



# 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 .....



REGULAR PRESCRIPTIONS

Weight: 71.6 ..... Ward: OPD .....

<b>DRUG : Tab. THYRONORM</b>				Date Time	25/6 8:30 AM
Dose 25mg	Route PO	Frequency OD	Start Date 25/6	6 AM P.M. / 8:30 AM	
Name & Signature of the Doctor Starting the Drugs: <i>[Signature]</i> 164288					
Additional Instructions: empty stomach					
Daily Doctor's Endorsement by a Sign					
<b>DRUG : T. CEFTUM</b>				Date Time	25/6 8 AM
Dose 500mg	Route PO	Frequency 1-0-1	Start Date 25/6/24	8 AM / 8:30 AM	
Name & Signature of the Doctor Starting the Drugs: <i>[Signature]</i> 182217					
Additional Instructions: <i>[Signature]</i> 8 PM P.M.					
Daily Doctor's Endorsement by a Sign				DA D2	
<b>DRUG : T. PANTOPRAZOLE</b>				Date Time	25/6 7 AM
Dose 40mg	Route PO	Frequency 1-0-1	Start Date 25/6/24	7 AM / 8:30 AM	
Name & Signature of the Doctor Starting the Drugs: <i>[Signature]</i> 182217					
Additional Instructions: Before food				7 PM SP / 8 PM	
Daily Doctor's Endorsement by a Sign					
<b>DRUG : TAB. ZERODOL SP</b>				Date Time	25/6 9 AM
Dose (1 Tab)	Route PO	Frequency 1-0-1	Start Date 25/6/24	9 AM / 8:30 AM	
Name & Signature of the Doctor Starting the Drugs: <i>[Signature]</i> 182217					
Additional Instructions: 9 PM P.M. / 11 PM P.M.					
Daily Doctor's Endorsement by a Sign					



Weight: 77.6 Ward: 1102

Date Time	Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.	
<b>DRUG :</b>	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route	Dose		Dose		Dose		Dose	
Start Date	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.	

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

**STAT / ONCE ONLY DRUGS**

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
25/6/20	5 AM	T. MISOPROSTOL	50mcg	PO	[Signature]	SP P-R
25/6/20	5:15 AM	ENEMA	100ml	PR	[Signature]	SP P-R
25/6/20	8:30 AM	INJ. TAXIM	0.1ml	Id	[Signature]	SP SA
25/6/20	9 AM	INJ. TAXIM	1g	IV	[Signature]	SP SA
25/6/20	12:41 PM	INJ. SYNTD	10 U	IM	[Signature]	SP SA
25/6/20	12:45 PM	INJ. TRAPIC	1g	IV	[Signature]	SP SA
25/6/20	12:47 PM	INJ. METHERGINE	0.2mg	IV	[Signature]	SP SA
25/6/20	1:10 PM	T. MISOPROSTOL	600 mcg	PR	[Signature]	SP SA
25/6/20	1:10 PM	JUSTIN SUPPOSITORY	100 mcg	PR	[Signature]	SP SA

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







C-00046148 IP18-00036175  
 PRIYA PARAMESHWARAN  
 01-1994 32 Y 4 M 26 D (F)  
 PRIYADHARSHINI S M



①

# Early Warning Observation Score Chart - Obstetrics

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

24/6/2023 <sup>te</sup>		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	①	2	3	④	5	⑥	7	
RESP (write rate in corresp. box)	> 30																										
	21 - 30																										
	11 - 20																										
	0 - 10																										
Saturations	94 - 100 %																										
	< 94 %																										
Administered O <sub>2</sub> (L/min.)																											
Temp °C	40																										
	39																										
	38																										
	37																										
	36																										
	35																										
	< 35																										
Heart Rate	170																										
	160																										
	150																										
	140																										
	130																										
	120																										
	110																										
	100																										
	90																										
	80																										
	70																										
	60																										
	Systolic Blood Pressure ↑	190																									
180																											
170																											
160																											
150																											
140																											
130																											
120																											
110																											
100																											
90																											
Diastolic Blood Pressure ↓		130																									
		120																									
	110																										
	100																										
	90																										
	80																										
	70																										
	60																										
	50																										
	40																										
	NEURO RESPONSE [✓]	Alert																									
		Voice																									
		Pain																									
Unresponsive																											
URINE mls / hour	> 30																										
	< 30																										
Proteinuria	Protein ++																										
	Protein > ++																										
Lochia	Normal																										
	Heavy / Foul																										
Liquor	Clear / Pink																										
	Green																										
TOTAL YELLOW SCORES																											
TOTAL ORANGE SCORES																											
Nurse Initial																											

ADMISSION ON.

20  
 100%  
 10  
 94%  
 20  
 94%  
 20  
 94%

88b  
 78b  
 88b

110  
 100  
 90  
 80  
 70  
 60  
 50  
 40

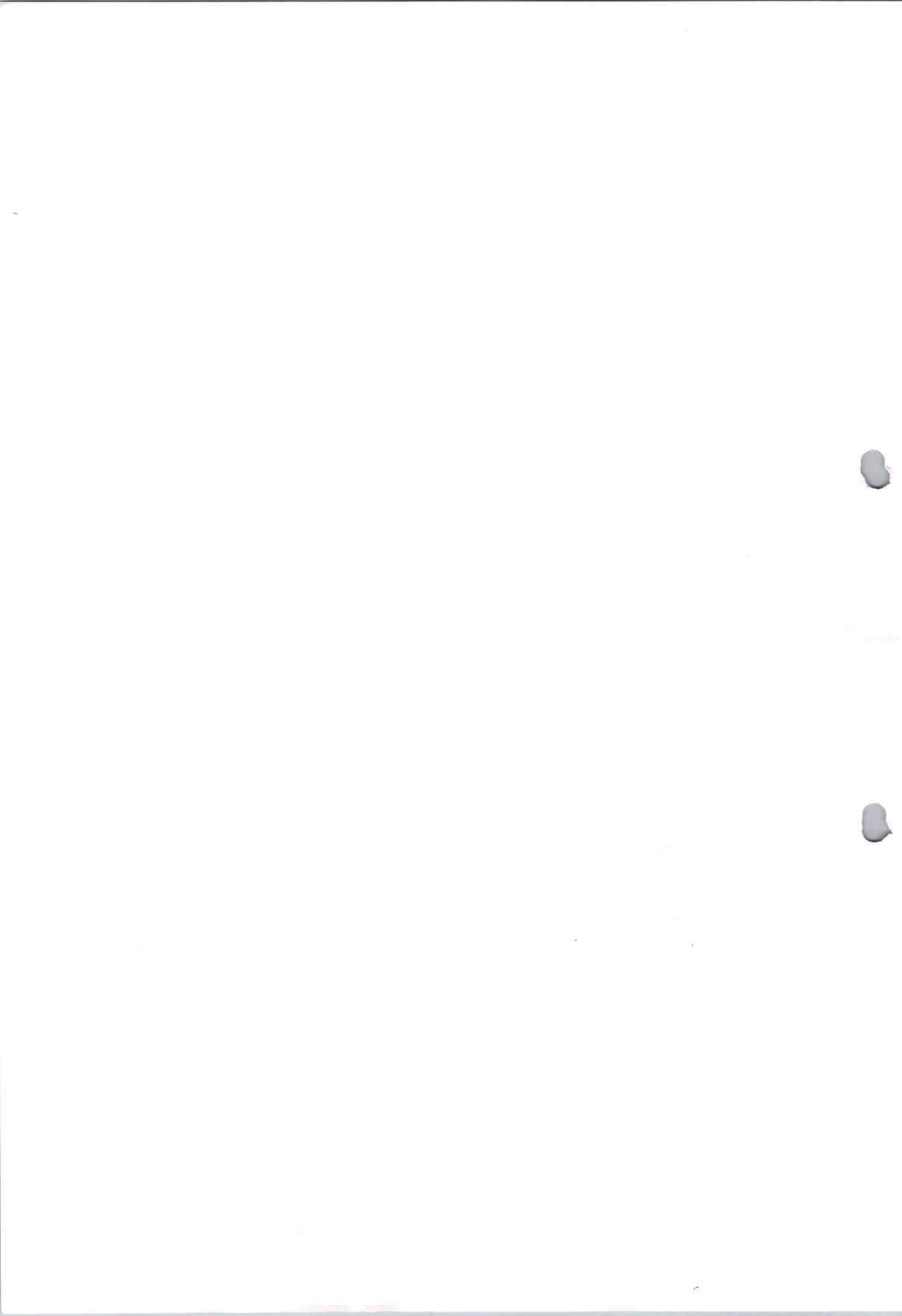


2

# early Warning Observation Score Chart - Obstetrics

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

		Date																									
		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																										
Saturations	11 - 20	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	
	0 - 10																										
Administered O <sub>2</sub> (L/min.)	94 - 100 %	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100		
	< 94 %																										
Temp °C	40																										
	39																										
	38																										
	37	98.8	98.8	98.8	98.8	98.8	98.8	98.8	98.8	98.8	98.8	98.8	98.8	98.8	98.8	98.8	98.8	98.8	98.8	98.8	98.8	98.8	98.8	98.8	98.8		
	36																										
	35																										
	< 35																										
Heart Rate	170																										
	160																										
	150																										
	140																										
	130																										
	120																										
	110																										
	100																										
	90	90	80	80	80	80	80	80	80	80	80	80	80	80	80	80	80	80	80	80	80	80	80	80	80	80	
	80																										
	70																										
	60																										
	50																										
40																											
Systolic Blood Pressure	190																										
	180																										
	170																										
	160																										
	150																										
	140																										
	130																										
	120																										
	110																										
	100	110	115	114	110	114	120	110	116	114	116	114	116	114	116	114	116	114	116	114	116	114	116	114	116	114	
90																											
80																											
70																											
60																											
50																											
40																											
Diastolic Blood Pressure	130																										
	120																										
NEURO RESPONSE [✓]	Alert Voice	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	Pain Unresponsive																										
URINE mls / hour	> 30	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	< 30																										
Proteinuria	Protein ++																										
	Protein > ++																										
Lochia	Normal	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
	Heavy / Foul																										
Liquor	Clear / Pink	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
	Green																										
TOTAL YELLOW SCORES		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
TOTAL ORANGE SCORES		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Nurse Initial		PA	PA	PA	PA	PA	PA	PA	PA	PA	PA	PA	PA	PA	PA	PA	PA	PA	PA	PA	PA	PA	PA	PA	PA		









**FLUID CHART**

Sheet No. : 2

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

Date	Time	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V								N.G
25/6/2022	08:00 am	H <sub>2</sub> O	200ml	24								
	09:00 am			48					100ml	0		
	10:00 am	Tea	200ml	12						0		
	11:00 am			96	12				200	0		
	12:00 pm	H <sub>2</sub> O	200ml	96					200	0		
	01:00 pm				300ml				150	0		
			H <sub>2</sub> O	100ml	125						0	
<b>Total Intake :</b>		1461 ml			<b>Total Output :</b>					650ml		
	02:00 pm	H <sub>2</sub> O	200	125						0		
	03:00 pm	Juice	200ml	125						0		
	04:00 pm			125						0		
	05:00 pm	H <sub>2</sub> O	200ml	12					100	0		
	06:00 pm	H <sub>2</sub> O	150					5:20pm	130	0		
	07:00 pm								300	0		
<b>Total Intake :</b>		1125ml			<b>Total Output :</b>					530ml		
	08:00 pm	H <sub>2</sub> O	100ml							0		
	09:00 pm									0		
	10:00 pm	H <sub>2</sub> O	150ml							0		
	11:00 pm	Tea	200ml						200ml	0		
	12:00 am									0		
	01:00 am									0		
<b>Total Intake :</b>		450ml			<b>Total Output :</b>					350ml		
	02:00 am	H <sub>2</sub> O	100ml						300ml	0		
	03:00 am									0		
	04:00 am	H <sub>2</sub> O	150ml							0		
	05:00 am									0		
	06:00 am									0		
	07:00 am	H <sub>2</sub> O	150ml						350ml	0		
<b>Total Intake :</b>		400ml			<b>Total Output :</b>					650ml		
<b>Total 24 hrs. Intake</b>		3496ml			<b>Total 24 hrs. Output</b>		2280ml					



# FLUID CHART

1. All measurements in ml

2. Add up each column separately every 24 hrs and put on the page below

Date/Time	Type of Fluid	Volume	Intake		Output	Balance
			Oral	IV		
07:00 am	Water	100 ml				
09:00 am	Water	100 ml				
10:00 am	Water	100 ml				
11:00 am	Water	100 ml				
12:00 pm	Water	100 ml				
01:00 pm	Water	100 ml				
02:00 pm	Water	100 ml				
03:00 pm	Water	100 ml				
04:00 pm	Water	100 ml				
05:00 pm	Water	100 ml				
06:00 pm	Water	100 ml				
07:00 pm	Water	100 ml				
08:00 pm	Water	100 ml				
09:00 pm	Water	100 ml				
10:00 pm	Water	100 ml				
11:00 pm	Water	100 ml				
12:00 am	Water	100 ml				
Total Intake:			1200 ml			
Total Output:						
Balance:						



①

# NURSING CARE RECORD

Date: .....

**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				T			
Afternoon				T			
Night	11PM	Achieve acceptable Pain control and Comfort	30 3PM	Assess pain using Pain Scale regularly. → Administer medication as per doctor's orders	Patient vital Sign & etc.	Reassessment done	deepa



# NURSING CARE RECORD

Date: 25/6/2020

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning		Achieve acceptable pain & comfort.		<ul style="list-style-type: none"> <li>- monitor vital signs</li> <li>- Assess the level of pain (pain scale)</li> <li>- provide dimensional therapy</li> </ul>	Reduced pain	Reassessment is done	poor P. P. P.
Afternoon	2pm	Achieve acceptable pain & comfortable.	2:30 pm	<ul style="list-style-type: none"> <li>monitors vital signs</li> <li>Assessed the level of pain (pain scale)</li> <li>provided dimensional therapy</li> </ul>	Reduced Pain	Reassessment is done	poor P. P. P.
Night	8pm	maintain adequate fluid balance of the child	11pm	<ul style="list-style-type: none"> <li>→ Assessed the fluid balance of the child</li> <li>→ monitored vital signs</li> <li>→ maintained I/O chart</li> <li>→ Administered medication as per doctor's order</li> </ul>	<ul style="list-style-type: none"> <li>→ Improving &amp; maintaining adequate fluid balance</li> </ul>	<ul style="list-style-type: none"> <li>Baby was stable</li> <li>Reassessment was done</li> </ul>	P. P. P. 0207149



Patient

**NURSES NOTES**  
 (USE BALL POINT PEN ONLY)

- No Known Drug Allergies
- Drug Allergies *nil*

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
24/6/20	11pm	<p>⇒ Admission notes</p> <p>Mom: Priya 32yrs 17m Under                  Dr. Prayabhishek now. While receiving                  the patient conscious &amp; oriented                  a febrile talking orally &amp; tolerating                  well. Voided freely. @ 6:14 PM 4/2                  38<sup>th</sup> days of conception. For FOL,                  Patient vital signs stable,                  General condition fair</p> <p>⇒ CTG corrected steady FHR                  good. Fetal movement good, General                  Condition fair</p>
24/6/20	12AM	<p>⇒ Under aseptic technique                  Perineal preparation was done Patient                  Co-operated well.</p>
	12 <sup>30</sup> AM	<p>⇒ CTG disconnected                  steady FHR good,</p>
	1 AM	<p>⇒ Patient shifted to                  ward had other 5<sup>th</sup> floor shift</p>
25/6/20	1 AM	<p>Patient moved to                  patient feeling unwell from                  moved to 7th floor. Patient conscious                  &amp; oriented, no W in. Patient plan                  for 2nd morning 4 AM CTG. SAMT mid                  some p/o. worked for contactant</p>

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

**NURSES NOTES**

(USE BALL POINT PEN ONLY)

No Known Drug Allergies

Drug Allergies ..... *nil*

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
25/6/2026	2AM	Patient sleep well. Cautious & Alert no other specific complaints. <i>Dr. Sub</i>
	4AM	Patient vital signs checked and recorded. CTU Connected as per doctor's orders. <i>Dr. Sub</i>
	4:30AM	CTU Report sent to Dr. Mohamman. ph call Adelid to stop CTU. <i>Dr. Sub</i>
	5AM	T. miso 50mg po is given as per doctor's orders. <i>Dr. Sub</i>
	5:15AM	Enema PR is given as per doctor's orders. Dr. Shiyabubshani. man ph call Adelid pt shifted to ward at 6:30AM. <i>Dr. Sub</i>
	6AM	CTU Connected as per doctor's orders. <i>Dr. Sub</i>
	6:30AM	CTU Report sent to Dr. Mohamman. man ph call Adelid shifted to ward. <i>Dr. Sub</i>
	5:45PM	Patient given bath & back scrub solution. as per doctor's orders. <i>Dr. Sub</i>
	6:40PM	Patient admitted to ward. <i>Dr. Sub</i>
25/6/2026	6:40PM	Recovery note - Patient from 5th floor. <i>Dr. Sub</i>

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00046148 IP18-00036175  
 Mrs PRIYA PARAMESHWARAN  
 30-01-1994 32 Y 4 M 26 D (F)  
 Dr. PRIYADHARSHINI S M



2



**NURSES NOTES**  
 (USE BALL POINT PEN ONLY)

- No known Drug Allergies
- Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
1st	25/6	conscious & oriented, afebrile tachycardia-tachypnea orally & tolerating well. Voided freely. => Patient vital signs
	7 AM	Stable. General condition fair & alert
	7:30 AM	=> patient report head ache to morning duty staff
	7:30 AM	pt care hand over taken from night duty staff. pt conscious & oriented. w/ line @ & pattern. pt had normal diet. <i>Srinivasan</i>
	8:10 AM	CTG connected as per doctor order FHR @. pt have 1 contraction in comments for 15 sec. provide comfortable bed position. <i>Srinivasan</i>
	8:30 AM	Dr. Priyadharsini seen for pt did PV examination w/ 1.5cm long, 3cm dilated. membrane @. w/ - 3. ARM done clear liquor draining. Advice to start P.r. synto 200mg order carried out. P.r. synto 50 in 500ml RL 200mg started in infusion. P.r. Pains 0.1u test dose TD given as per doctor order. <i>Srinivasan</i>

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

# NURSES NOTES

(USE BALL POINT PEN ONLY)

 No Known Drug Allergies

 Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
25/6/26	10 AM	pt vital signs checked & recorded. maintain the chart. provide sitting position. pt have 3 contraction in counts for for 20-25 sec. Encourage to take breathing exercise. Dr. Syed is going on infusion. CTG is going FHR ⊕. <sup>POOF</sup> OFF
11.10 AM	12 PM	pt Dr. Priyadharshini / Dr. Vinitha advice to disconnect CTG, syde order carried out. CTG disconnected, Dr. Syed stopped as per doctor's order. Encourage to do squats, walk. <sup>POOF</sup> OFF
	12 pm	pt vital signs checked & recorded. she have 4 contraction in counts for 30 sec. pt do pushing for Dr. Vinitha did per examination as well effaced 8cm dilated. CTG connected FHR ⊕. Dr. Syed syde connected on infusion as per doctor's order. pt shifted to labour room. in low position. <sup>POOF</sup> OFF
	12.41 pm	Dr. Priyadharshini seen the pt did per examination as fully dilated. lithotomy position provided. Encourage to push during contraction next page

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



3



# NURSES NOTES

- No Known Drug Allergies
- Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
25/06/2026		pt is pushing per maternal effort. parts painted, D. box given in perineum. Pmt	
		Episiotomy done. Vacuum applied by Dr. Priya Dharshini. Encourage to push during contraction.	
		Dr. Shoba given fetal support	
		pt is pushing. A single baby delivered vacuum assisted vaginal delivery. Baby cried at birth. cord clamping done.	
		Dr. Manoharan received the baby. pt vital signs checked, seen doc. BP-114/80 HR-80b/m	
		HR-120b/m. Dr. Syro 100ml, Dr. Syro 200 on some 12 12ml/h connected on infusion as per doctor order. pt had bleeding.	
		Dr. Dopic 1gm in low NS given	
		Dr. Metergin 10 given as per doctor order. placenta expelled.	
		Date - 25/06/2026	
		Time - 12-41PM	
		Sex - Boy	
		Weight - 3.172kg	
		APGAR - 7/10, 8/10	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



# NURSES NOTES

No Known Drug Allergies

Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
25/6/20	1.15pm	Pmt episiotomy suture done pt have minimal per. bleeding. Dr. Vinitha assisted for delivery. T. miso 800 mg. Justin suppository kept PIR by Dr. Vinitha.	[Signature]
	2pm	pt vital signs checked & recorded. Encourage to take adequate oral fluid. maintain P/R chart. Breast soft. milk secretion @. TBP given to baby. Baby mother side. B - Breast soft U - uterus contracted B - she is on self voids B - Bowel movement present L - Lochies rubra present E - REEDA assessment done H - Homan sign negative E - pt emotional status good.	[Signature]
	2.30pm	pt had normal diet. P/R: Braden Q, pain assessment nurse full risk assessment done.	[Signature]
	4pm	pt vital signs checked & recorded. provide comfortable bed position. P/R bleeding is minimal. pt voided usual urine	next page

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

(X)

**NURSES NOTES**

- No Known Drug Allergies
- Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
25/6/20		informed to Mr. Parthiv advice to measure next voids urine order carried out.	Pratik
	5:20pm 5:30pm	pt voided 130ml urine informed to Mr. Parthiv Mr. Shreejith. advice to follow drug chart. watch for pt bleeding order carried out.	Pratik
	6pm	pt vital signs checked rechecked. Encourage to take adequate oral fluid. maintain Dro chart. IV line patency. pt bleeding is minimal.	Pratik
	7pm	Mr. Parthiv advice to shift ward follow drug chart. order carried out. pt shifted to ward as per doctor order pt care hand over given to 7th floor staff	Pratik
		<u>Receiving Notes:</u>	
25/6/20	7:10pm	Patient Receiving from LDR to 7th floor. Pt handing over taken from LDR staff. Conscious & Oriented. Patient Bed Side Assessment done. <del>over</del> IV line ⊕ pattern is Normal.	Pratik
	7:30pm	Handover given to Night Duty staff.	

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

Patient Sticker

# NURSES NOTES



- No Known Drug Allergies
- Drug Allergies ..... NOT KNOWN

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
25/06/2028	7:30 PM	Night duty note on 25/6/2028 Patient details taken over from evening duty staff nurse using IPBMR method. on Assessment, patient is conscious, oriented and able, all vital signs assessment done. M line is present and patent, no pain or tenderness. BURSLETTE assessment done B - Breast soft and no engorgement V - uterus is well contracted B - Bowel pattern was normal B - on sleep L - Lochia Rubra is present E - REEDA Assessment done H - Human's sign is negative E - Gravid response was good	R. Jay 02/04/20
	8:15 PM	vitals checked and recorded, all are hemodynamically stable	R. Jay 02/04/20
	10:15 PM	Due medication given as per the drug chart	
	12:00 AM	vitals checked and recorded, all are hemodynamically stable	R. Jay 02/04/20
	4:00 AM	patient vitals checked and recorded.	
	6:00 AM	patient sample Hb, PCV send to lab bill passed	R. Jay 02/04/20

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



### PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
24/6	11pm	0/10	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NO Pain	24/6/2020
25/6/2020	2 AM	1/10	Lower Abdomen	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input checked="" type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Comfortable position	25/6/2020
25/6/2020	6 AM	1/10	Lower Abdomen	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Comfortable position	25/6/2020
25/6/2020	2 AM	1/10	Lower Abdomen	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	comfortable position	25/6/2020
25/6/2020	12 PM	3/10	Lower Abdomen	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Deep breath	25/6/2020
25/6/2020	3 PM	1/10	Episiotomy site	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input checked="" type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input checked="" type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	comfortable position	25/6/2020
25/6/2020	8 PM	1/10	Episiotomy site	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input checked="" type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Provided comfortable position	25/6/2020
26/6/2020	2 PM	1/10	Episiotomy site	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input checked="" type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	comfortable position	26/6/2020
26/6/2020	8 AM	0/10	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Nil	26/6/2020
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

**Re-assessment Frequency:**

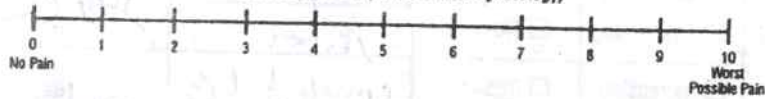
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
  - At least every 2 hours for the first 24 hours
  - Then every 4 hours.
  - Prior to pain-relieving intervention.
  - Within 30 - 60 minutes after pain relief intervention.

# PAIN ASSESSMENT TOOLS

## FACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

## Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1		1	2
<b>Crying Irritability</b>	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
<b>Behavior State</b>	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)
<b>Facial Expression</b>	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
<b>Extremities Tone</b>	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
<b>Vital Signs HR, RR, BP, SaO<sub>2</sub></b>	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 <sub>2</sub> , 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO <sub>2</sub> , less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

## Wong - Baker (Pediatrics) Above 7 Years



GUC-00046148 IP18-00036175  
 Mrs PRIYA PARAMESHWARAN  
 30-01-1994 32 Y 4 M 26 D (F)  
 Dr. PRIYADHARSHINI S M



# Morse Fall Risk Assessment Form

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

Tick (✓) whichever precaution taken.

**Risk Level and Interventions**

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

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

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

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

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

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

1. Name of the project: ...  
 2. Location: ...  
 3. Date: ...

4. Objectives: ...  
 5. Methodology: ...

6. Results: ...

7. Conclusion: ...

8. References: ...

9. Appendix: ...

10. Summary: ...

11. Acknowledgements: ...

### Final Assessment Report



Date: ...  
 Signature: ...

Patient Sticker



# Morse Fall Risk Assessment Form

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

Tick (✓) whichever precaution taken.

**Risk Level and Interventions**

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

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

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

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

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

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

Final Examination

1954

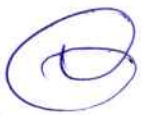
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GUC-00046148 IP18-00036175  
 Mrs PRIYA PARAMESHWARAN  
 30-01-1994 32 Y 4 M 26 D (F)  
 Dr. PRIYADHARSHINI S M



# BRADEN 'Q' SCALE

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

BirthRight  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

		Date: <sup>M</sup> 20/16 <sup>F</sup> 25/16 <sup>N</sup> 25/16						
		Time: 2:16 3 Am 2pm 8pm						
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4
'Activity The degree of physical activity'	1. Bedfast: Confined to bed	2. Chairfast: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	3	3	3
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICITION-SHEAR Friction. Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times.	4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
<b>TOTAL SCORE</b>					27	27	27	27
<b>Evaluator's Name</b>					<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>

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

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

UC-00046148 IP18-00036175  
 M. PRIYA PARAMESHWARAN  
 3-01-1994 32 Y 4 M 26 D (F)  
 R. PRIYADHARSHINI S M



# INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.  
 Patient's / Learner Language: Tamil Patient / Learner Literacy:  Read  Write  Speak Willingness to Learn:  Yes  No Healthcare Literacy:  Yes  No

**Identified Education Needs:**

- |  |  |                                 |  |
|--|--|---------------------------------|--|
| 1. <u>CHP14 A</u><br>Diagnosis <u>33 weeks for</u> | Plan <input checked="" type="checkbox"/> Pain Management             | 6. Discharge Medication         | 10. Fall Risk Education  |
| 2. Treatment and Care <u>for</u>                   | 4. Informed Consent  | 7. Infection Control Measures   | 11. Safe use of Medical Equipment / Implantable Devices Safety |
|  | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 8. Diagnostic Test / Procedures | 12. Patient's / Family Rights                                  |
|  |  | 9. Nutrition / Diet             | 13. Risk / Safety  |

**Part - II**

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
24/6	11pm	yes	Health education given to Patient Pain management	Patient	Learn barrier	Verbal	none	good		[Signature]
25/6	10pm	yes	Explication about breast feeding posture	Parents	NO	none	none	yes	good	[Signature]

**Part - III: CODES**

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

**Learning Barriers:**

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

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

**Mechanism/s to overcome barrier/s:**

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

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

100-2-111-1000-100-100

1. Name: [Handwritten Name]  
 2. Address: [Handwritten Address]  
 3. City: [Handwritten City]  
 4. State: [Handwritten State]  
 5. Zip: [Handwritten Zip]  
 6. Date of Birth: [Handwritten Date]  
 7. Sex: [Handwritten Sex]  
 8. Race: [Handwritten Race]  
 9. Religion: [Handwritten Religion]  
 10. Education: [Handwritten Education]  
 11. Occupation: [Handwritten Occupation]  
 12. Marital Status: [Handwritten Status]  
 13. Number of Children: [Handwritten Number]  
 14. Name of Children: [Handwritten Names]  
 15. Date of Issue: [Handwritten Date]  
 16. Issued By: [Handwritten Name]  
 17. Signature: [Handwritten Signature]  
 18. Title: [Handwritten Title]

Year	Month	Day	Grade	Score	Comments
1952	9	15	1st	85	Good progress
1953	3	10	2nd	78	Needs more practice
1954	7	5	3rd	92	Excellent work
1955	11	20	4th	88	Consistent improvement
1956	5	15	5th	95	Very good
1957	9	10	6th	90	Good
1958	3	5	7th	85	Steady progress
1959	7	15	8th	80	Needs more effort
1960	11	10	9th	75	Below average
1961	5	5	10th	70	Needs significant improvement
1962	9	15	11th	65	Struggling
1963	3	10	12th	60	Needs immediate attention

INTERCOMPARATIVE RECORD

FEDERAL  
 BUREAU OF  
 INVESTIGATION

GUC-00046148 IP18-CC036175  
 Mrs PRIYA PARAMESHWARAN  
 30-01-1994 32 Y 4 M 26 D (F)  
 Dr. PRIYADHARSHINI S M



Patient Sticker



## RISK ASSESSMENT TOOL FOR DEEP VEIN THROMBOSIS

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

Date:.....

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 <sup>+</sup> 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
<b>Total</b>		
<b>Signature of the Nurse</b>		
<b>Action Plan</b>		

## RISK ASSESSMENT FOR VENOUS THROMBOEMBOLISM (VTE)

- ✓ If total score  $\geq 4$  antenatally, consider thromboprophylaxis from the first trimester.
- ✓ If total score 3 antenatally, consider thromboprophylaxis from 28 weeks.
- ✓ If total score  $\geq 2$  postnatally, consider thromboprophylaxis for at least 10 days.
- ✓ If admitted to hospital antenatally consider thromboprophylaxis.
- ✓ If prolonged admission ( $\geq 3$  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.



# OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 24/6/20 Time of Arrival: 11 PM Time Seen by Nurse: 11 PM

1) Level of Consciousness  Conscious  Semi-Conscious  Unconscious

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

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

3) Vital Signs: Temperature: 98.4 F Pulse: 84/ut RR: 24/ut SpO<sub>2</sub>: 100% BP: 101/70 Weight: 74 kg

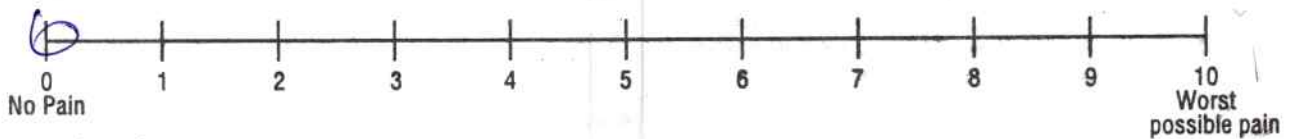
4) Gestational Criteria:

Gravida:	G <u>4</u>	P <u>1</u>	L <u>1</u>	A <u>2</u>
----------	------------	------------	------------	------------

LMP: 1st Dec 2017 EDD: 7.17.2020 Gestational Age: 32 weeks

Uterine Contraction	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> NA	Onset	Time	Frequency:
Membrane Rupture	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> NA	Onset	Time	Fluid Color:
Vaginal bleeding	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> NA	Onset	Time	Amount:
Pre Eclampsia Symptoms	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> NA	If Yes specify: Headache / Visual Symptoms / Pain Abdomen / Vomiting		
Good fetal Movement	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA	If No specify:		

5) Pain Screening: Numerical Pain Scale (NPS)



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

6) Past History:

- a) Surgeries: NIL
- b) Medical: Hypertension

7) Allergy:  Yes  No, If Yes : .....

8) Current Medications:  Prenatal Vitamin  None  Others: Tub. 500mg/isonom 20mg

9) Prenatal Medical History:

- None
- Chronic Hypertension
- Gestational Hypertension
- Diabetes
- Gestational Diabetes
- Low placenta
- Others if yes, specify: Hypothyroid

Triage Category: (Please tick on the category)

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

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

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

OTAS	Level 1 (Resuscitative)	Level 2 (Emergent)	Level 3 (Urgent)	Level 4 (Less Urgent)	Level 5 (Non Urgent)
Level 1 (Resuscitative)	Immediate	≤ 15 minutes	≤ 30 minutes	≤ 60 minutes	≤ 120 minutes (2 Hours)
Re-Assessment	Continuous Nursing Care	Every 15 Minutes	Every 15 Minutes	Every 30 Minutes	Every 60 Minutes
Labour / Fluid	Imminent Birth	Suspected Pre-term Labour / PPROM < 37 Weeks	Signs of Active Labour > 37 weeks	Signs of Early Labour/ SROM > 37 weeks	Discomforts of Pregnancy
Bleeding	Active Vaginal bleeding with/ without abdominal pain	Bleeding associated with cramping (< spotting) < 37 weeks	Bleeding associated with cramping (> spotting) > 37 weeks	Spotting	
Hypertension	Seizure activity	Hypertension > 160/110 and / or headache, visual disturbance, RUQ pain	Mild hypertension > 140/90 with/without associated signs and symptoms		
Fetal Assessment	Abnormal FHR tracing Non-Fetal Movement	Atypical FHR tracing, abnormal dopplers Diseased fetal movement			
Others	<ul style="list-style-type: none"> <li>● Acute onsite severe abdominal pain</li> <li>● Altered level of consciousness</li> <li>● Cord prolapse</li> <li>● Severe respiratory distress</li> <li>● Suspected sepsis</li> </ul>	<ul style="list-style-type: none"> <li>● Major trauma</li> <li>● Shortness of breath</li> <li>● Unplanned and unattended birth</li> </ul>	<ul style="list-style-type: none"> <li>● Abdominal/back pain greater than expected in pregnancy</li> <li>● Flank pain / hematuria</li> <li>● Nausea /vomiting and /or diarrhea with suspected dehydration</li> </ul>	<ul style="list-style-type: none"> <li>● Ongoing assessment from out patient clinic (for hypertension, blood work)</li> <li>● Minor trauma (minor MVC/fall)</li> <li>● Nausea/Vomiting and /or diarrhea</li> <li>● Signs of infection (ie dysuria ,cough, fever, chills)</li> </ul>	<ul style="list-style-type: none"> <li>● Anything that does not seem to pose threat to mother or fetus</li> <li>● Cervical ripening</li> <li>● Out patient placenta previa protocols</li> <li>● Pre-booked visits (ie Rh and progesterone injections, NST</li> <li>● Assessment for version</li> <li>● Rashes</li> </ul>

Time seen by Doctor: 11pm

Nurse Name: B. Nwata Nurse Signature: [Signature]

Date: 2/1/0 Time: 11pm

Patient Sticker

00046148 IP-18-00036175  
PRIYA PARAMESHWARAN (F)  
1-1994 32 Y 4 M 26 D  
PRIYADHARSHINI S M



# LABOUR AND DELIVERY NURSING ASSESSMENT

Date of Admission: 24/6/20

### Baseline Information:

Admission From:  ER  OPD  Admission Desk  Others: specify Door

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: Gravidity 4 P2 B2  
MUO 38 weeks for TOR

Doctor Notified on Admission:  Yes  No

Name of the Doctor: Dr. Divya

Time Notified: 11pm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>Hypothyroid</u>	<u>no</u>	<u>nil</u>

Blood Group: O<sup>+</sup> Pos LMP: entire EDD: 7/7/20 Gestational age during admission: 38 weeks

Contractions: no Vaginal Discharge: no Previous LSCS: nil

Obstetric History: G 4 P 1 L 1 A 2

Height: 164 Weight: 71.6 BMI: 26.7

Temp: 98.7 HR: 84 RR: 24 BP: 110/70 SpO<sub>2</sub>: 100

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

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

Patient Sticker

Family History:  No Abnormalities Detected

- Heart Disease     Hypertension     Diabetes     Stroke     Seizures     Kidney disease  
 Liver disease     Other ..... *Both parents*

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

Fall Assessment:  Yes     No    Score *0/10*    (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore:  Yes     No    Score *27*    (complete the Braden Q Sheet)

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

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

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

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

- Calm & Cooperative     Restless     Depressed     Agitated     Confused  
 Others .....

Inform consultant for positive criteria

SOCIAL SCREENING:

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

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

Orientation has been given regarding the following aspects:

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

Above information given to ..... *Mrs. Bugy*  
Name of Person Orientation was given to: ..... *Mrs. Bugy*  
Orientation not given Reason: .....

Nurse Signature: ..... *[Signature]*

Nurse Name: ..... *[Name]*

Date & Time: ..... *2/16/20*





UC-00046148 IP18-00036175  
Mrs PRIYA PARAMESHWARAN  
0-01-1994 32 Y 4 M 26 D (F)  
Dr. PRIYADHARSHINI S M

Patient St



## BREAST FEEDING HANDOVER AND ASSESSMENT FORM

1. Breastfeeding initiated?

- a. Yes       b. No

2. If No, Reason .....

3. Nipple condition:

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

4. Milk flow:

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

5. Steps for Positioning and attachment:

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



Feeding Positions:  
Cross Cradle



Feeding Positions:  
Football / Clutch

6. Was the position explained:

- a. Yes
- b. No

7. For Caesarian mothers:

- a. Mother is required sit and feed from the 4th feed
- b. Please explain football hold (N/A)

8. NICU admission:

- a. Mother needs to stimulate her breast for 2 min every 2 hours (N/A)

9. Additional notes: .....

Continuity of Care:

Date: 25/6/26

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T - 02

C - 01

H - 01

08

Handover given by ..... *Jojo* .....

Handover taken by ..... *Soupy* .....

Signature ..... *Jojo* .....

Signature ..... *Soupy* .....

Date & Time: ..... 25/6/26 .....

Date & Time: ..... 25/6/26 .....


7.15pm

Patient Sticker



# INDUCTION OF LABOR CONSENT

GUC-00046148 IP18-00036175  
 Mrs PRIYA PARAMESHWARAN  
 30-01-1994 32 Y 4 M 26 D (F)  
 Dr. PRIYADHARSHINI S M



Name: ..... Age: 31 Gender: Male  Female   
 UHID.No : ..... Date: 25/6/26

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

The reason for your induction is .....

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

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

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

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

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

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

Patient  
 Signature: Priya  
 Name: PRIYA G  
 Date & Time: 24/6/26

Patient Attendant:  
 Signature: K. Parameshwaran  
 Name: PARAMESHWARAN  
 Relationship with Patient: HUSBAND  
 Date & Time: 24/6/26

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

Witness  
 Signature: .....  
 Name: .....  
 Date & Time: .....

Handwritten notes at the top left, including a small diagram of a curved line and some illegible text.

Handwritten text in the upper middle section, possibly a title or header.

A block of handwritten text in the middle of the page, appearing to be a list or a set of notes.

Handwritten notes in the lower left quadrant, including some faint diagrams or symbols.

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# INFORMED CONSENT FOR VAGINAL BIRTH

Patient Name : .....  
 Gender:  Male  F

GUC-00046148 IP18-00036175  
 Mrs PRIYA PARAMESHWARAN  
 30-01-1994 32 Y 4 M 26 D (F)  
 Dr. PRIYADHARSHINI S M



UHID No : .....

25/6/20

Time : .....

I hereby authorized the performance of the following procedure:

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

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

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

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

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

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

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

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

Dr. Priyadharsini

**Consentee :**

Signature : *Priya*  
 Name : PRIYA G  
 Date & Time : 24/6/20

**Patient Attendant :**

Signature : *K. Pal*  
 Name : PARAMESHWARAN  
 Relationship with Patient : HUSBAND  
 Date & Time : 24/6/20

**Witness :**

Signature : .....  
 Name : .....  
 Date & Time : .....

Doctor (who is taking the consent) :  
 Signature : *[Signature]*  
 Name : Dr. Priyadharsini  
 Date & Time : 25/6/20

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# PATIENT TRANSFER FORM

IC-00046148 IP18-00036175

PRIYA PARAMESHWARAN  
-01-1994 32 Y 4 M 26 D (F)  
PRIYADHARSHINI S M



①



Date & Time of Admission 24/6/20 at 10:51 PM		Date & Time of Transfer Order 25/6/20 at 1 AM
Treating Consultant Name Dr. Pradyumn Prasad	Transfer Ordered by Dr. Divya	Reason for Transfer Fetus Lethal
From Unit LHR	To Unit J Floor	Information to Attendant Yes <input type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File 70	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant. Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what ?

### Medications / Consumables / Surgicals / Hand over

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

Shifting Summary / Notes Written by Doctor : Yes  No

Name & Signature of Person who is Transferring Dr. Pradyumn Prasad	Name of Person Ordered Transfer Dr. Divya
---	--

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

Date & Time of Patient Received: 25/6/2020 at 1 AM

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

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

1

1. The car starts from rest and accelerates uniformly to a speed of 20 m/s in 4.0 s. What is the acceleration?	20 m/s / 4.0 s = 5.0 m/s <sup>2</sup>
2. A car starts from rest and accelerates uniformly to a speed of 20 m/s in 4.0 s. How far does it travel during this time?	$\frac{1}{2} a t^2 = \frac{1}{2} (5.0 \text{ m/s}^2) (4.0 \text{ s})^2 = 40 \text{ m}$
3. A car starts from rest and accelerates uniformly to a speed of 20 m/s in 4.0 s. What is the average velocity during this time?	$\frac{v_i + v_f}{2} = \frac{0 + 20 \text{ m/s}}{2} = 10 \text{ m/s}$
4. A car starts from rest and accelerates uniformly to a speed of 20 m/s in 4.0 s. What is the displacement during this time?	40 m

5. A car starts from rest and accelerates uniformly to a speed of 20 m/s in 4.0 s. What is the displacement during this time?	40 m
6. A car starts from rest and accelerates uniformly to a speed of 20 m/s in 4.0 s. What is the displacement during this time?	40 m
7. A car starts from rest and accelerates uniformly to a speed of 20 m/s in 4.0 s. What is the displacement during this time?	40 m
8. A car starts from rest and accelerates uniformly to a speed of 20 m/s in 4.0 s. What is the displacement during this time?	40 m
9. A car starts from rest and accelerates uniformly to a speed of 20 m/s in 4.0 s. What is the displacement during this time?	40 m
10. A car starts from rest and accelerates uniformly to a speed of 20 m/s in 4.0 s. What is the displacement during this time?	40 m

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# PATIENT TRANSFER FORM

②



GUC-00046148 IP18-00036175  
 Mrs PRIYA PARAMESHWARAN  
 30-01-1994 32 Y 4 M 26 D (F)  
 Dr. PRIYADHARSHINI S M



Date & Time of Admission 24/6/2026 at 10:55 PM		Date & Time of Transfer Order 25/6/2026 at 6:40 AM
Treating Consultant Name Dr. priyadharsini	Transfer Ordered by Dr. mohana	Reason for Transfer Labour.
From Unit F H Floor (FOL)	To Unit MCCO	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File	Number of Imaging Films CTE → ③	Personal belongings including clinical documents. If any handed over to attendant. Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what ?
Medications / Consumables / Surgicals / Hand over		
Sl.No.	Item Name	Quantity
1.	under pearl	②
2.	box jelly 2 x	①
3.	Scalene 6 1/2	②
4.	T. miso 25 mg	②
5.		
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
Name & Signature of Person who is Transferring Dr. Priyadharsini		Name of Person Ordered Transfer Dr. mohana
Patient & Clinical Records Received by : A. Jay G. K. S.		
Date & Time of Patient Received :		

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

- Unavailable Bed
  Nurse not Available
  Available Bed not ready

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**PATIENT TRANSFER FORM**

(3)



GUC-00046148 IP18-00036175  
 Mrs PRIYA PARAMESHWARAN  
 30-01-1994 32 Y 4 M 26 D (F)  
 Dr. PRIYADHARSHINI S M



Date & Time of Admission <i>24/6/2020 10:15 pm</i>		Date & Time of Transfer Order <i>25/6/2020</i>
Treating Consultant Name <i>Dr. priyadharsini</i>	Transfer Ordered by <i>Dr. parvathy</i>	Reason for Transfer
From Unit <i>LDR</i>	To Unit	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File <i>Whole IP Files</i>	Number of Imaging Films <i>CCY</i>	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.		
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Shifting Summary / Notes Written by Doctor : Yes  No   
*pt shifted toward*

Name & Signature of Person who is Transferring <i>S/N pooja 017776</i>	Name of Person Ordered Transfer <i>Dr. parvathy</i>
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Patient & Clinical Records Received by :  
*Dr. vijay  
@ 7.15 pm*

Date & Time of Patient Received :

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

- Unavailable Bed     
  Nurse not Available     
  Available Bed not ready

PATIENT TRANSFER FORM

1. The transfer is due to a change in patient condition.

2. The transfer is due to a change in patient location.

3. The transfer is due to a change in patient status.

4. The transfer is due to a change in patient care.

5. The transfer is due to a change in patient needs.

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7. The transfer is due to a change in patient safety.

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71. The transfer is due to a change in patient pastimes.

72. The transfer is due to a change in patient recreations.

73. The transfer is due to a change in patient entertainments.

74. The transfer is due to a change in patient amusements.

75. The transfer is due to a change in patient diversions.

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100. The transfer is due to a change in patient diversions.



Docu in RCHERM CLINICAL

UNIVERSITY OF

# PATIENT TRANSFER FORM



GUC-00046148 IP18-00036175

Mrs PRIYA PARAMESHWARAN  
30-01-1994 32 Y 4 M 26 D (F)  
Dr. PRIYADHARSHINI S M



Date & Time of Admission 24/6/26 at 10.51pm		Date & Time of Transfer Order 25/6/26 at 7pm
Treating Consultant Name Dr. Priyadharsini	Transfer Ordered by Dr. Pawlana	Reason for Transfer pt care
From Unit CPR	To Unit 701	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File 70 pp file	Number of Imaging Films CPR 1	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	T. Zerodal	10
2.	T. Pan	10
3.	T. cefixim	10
4.	New mom pad	5
5.	fisher's under pad	10

Shifting Summary / Notes Written by Doctor : Yes  No

Dr. Pawlana

Name & Signature of Person who is Transferring Dr. Priya Parameswaran	Name of Person Ordered Transfer Dr. Pawlana
--	--

Patient & Clinical Records Received by :

Date & Time of Patient Received :

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

- Unavailable Bed                     
  Nurse not Available                     
  Available Bed not ready



GUC-00046148 IP18-00036175  
 Mrs PRIYA PARAMESHWARAN  
 30-01-1994 32 Y 4 M 26 D (F)  
 Dr. PRIYADHARSHINI S M



## BED SIDE CHECK LIST FOR NURSES

Date:	25/6																		
Doctor's Orders	yes																		
Carried out or not	yes																		
<b>Bed Side</b>																			
Structured Handover done	yes																		
IV Site	no																		
Central Lines	no																		
Arterial Lines	no																		
Feeding Catheter	no																		
Urinary Catheter	no																		
Skin Care	yes																		
Eye Care	yes																		
Mouth Care	yes																		
Sterillum Bottle, Stethoscope	yes																		
Suction Bottle (Should be clean & empty)	yes																		
Intubation Tray	no																		
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	no																		
Ventilator Tubing, (Any Water, Blood)	no																		
Humidification	yes																		
Check all Infusion (Labelling, Correct Preparation)	no																		
Chest Physio & Neb	no																		
Handed Over By Name :	[Signature]																		
Signature :	[Signature]																		
Date & Time:	25/6/2018																		
Hand Over Taken By Name :																			
Signature :																			
Date & Time:																			



GUC-00046148 IP18-00036175  
 Mrs PRIYA PARAMESHWARAN  
 30-01-1994 32 Y 4 M 26 D (F)  
 Dr. PRIYADHARSHINI S M

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

BirthRight  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

# PARTOGRAPH

## LABOUR

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

## INTRA PARTUM COMPLICATION

Maternal:  None  Pyrexia  HTN  Others *Hypothyroid*  
 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: *Persistent early deceleration*  
 Application, Locking & Traction: .....  
 Duration of Instrumentation: .....  
 No. of Pulls: .....  
 Catheterised:  Yes  No  
 Type:  Fileys  Plain  
 Perineum:  Intact  Episiotomy  Tear  
 Suture Material Used: *Rapid vinyl, 2-ovicyl*

## STAGE III

Placenta:  Normal  Abnormal  RP Clots  
 CCT  Retained  MRP  
 PPH:  Atomic  Traumatic  None  
 Lacerations: .....  
 Cervical: .....  
 Perineal: *Episiotomy*  
 Others: .....  
 Prophylaxis: *Synocinon* Prostodin  
 Blood Loss: *400ml*  
 Blood Transfusion: *No*  
 Other Details (if any): .....  
 Rectal Examination: *Normal*

## DURATION OF LABOUR

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

## BABY DETAILS

Gender: *Boy*  
 Weight: *3.172 kg*  
 APGAR: *7/10, 8/10*  
 Date and Time of Delivery: *25/06/2026 ; 12:41 PM*  
 LW Doctor: *Dr. Priyadharshini*  
 LW Sister: .....

PARTOGRAPH

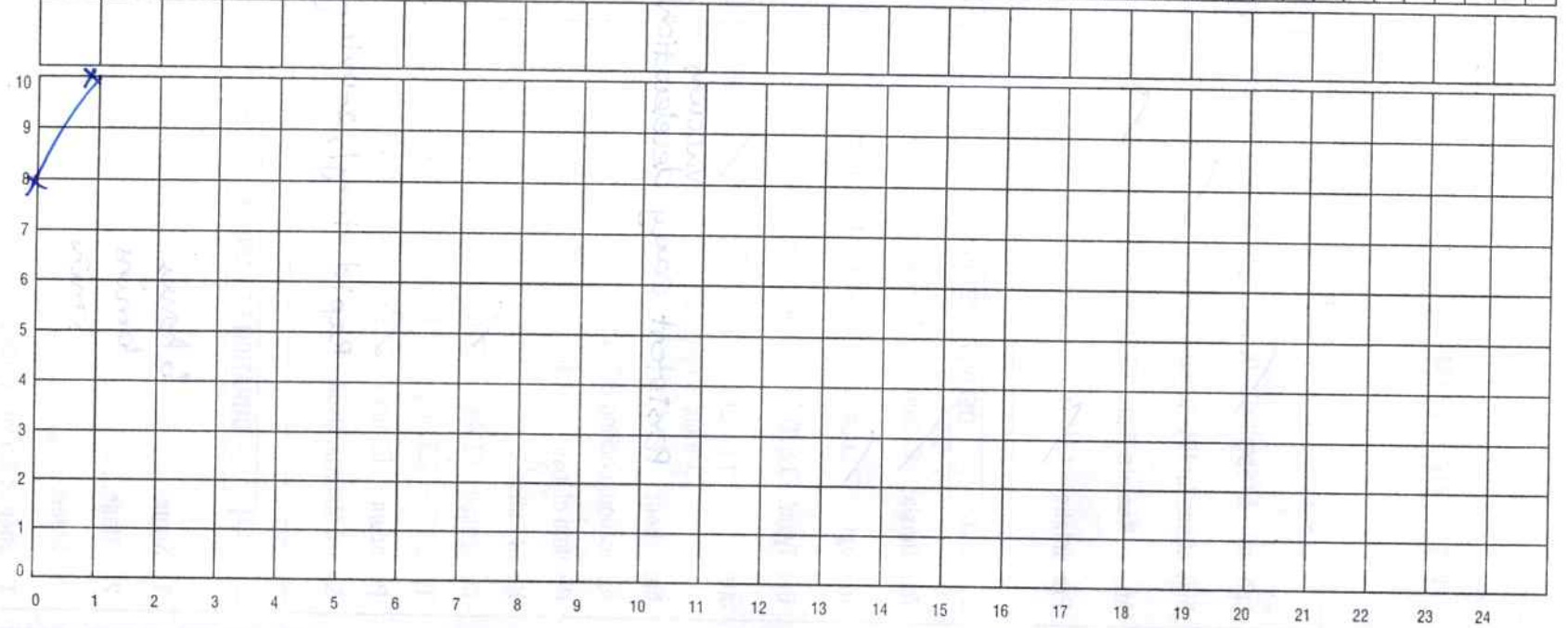
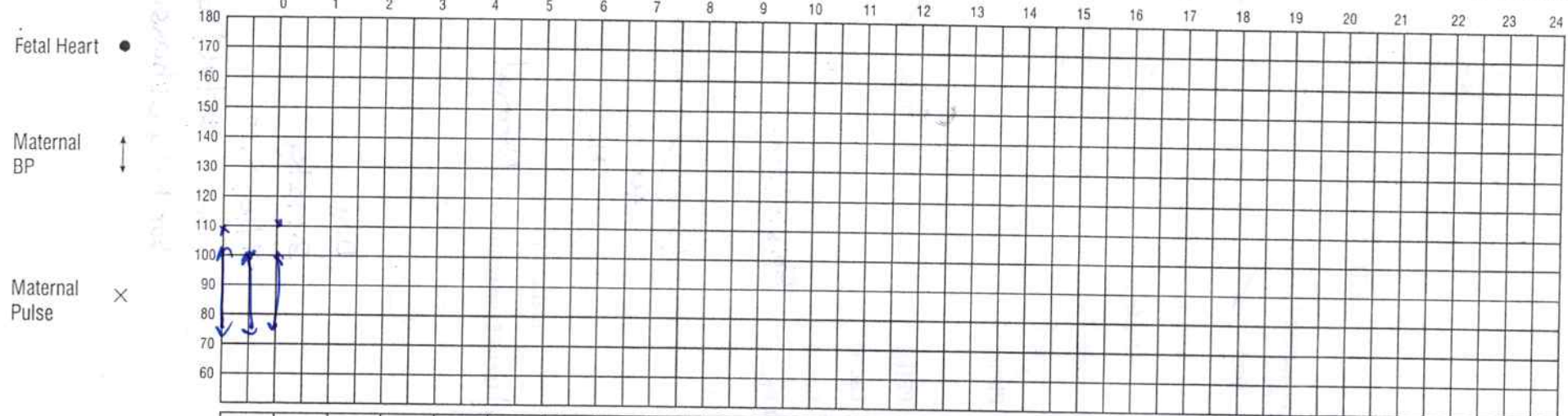
Name: Mrs. Priya

Obstetrics Formula: G4 P1 L4 A1

Blood Group Type: D-POSITIVE

Memb. Ruptured: SROM PROM **ARM**

Risk Factors:





**Record of Labor:**

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

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

---

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

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

---

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

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

---

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

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

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Maternal Condition:

Fetal Condition:


Progress of Labor:

Management:

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

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**INSTRUMENTAL DELIVERY PROFORMA**

<b>Patient Label</b>  GUC-00046148      IP18-00036175 Mrs PRIYA PARAMESHWARAN 30-01-1994      32 Y 4 M 26 D      (F) Dr. PRIYADHARSHINI S M 		OBSTETRICIAN	Dr. Priyadharshini	
		ANAESTHETIST		
		ASSISTANT	Dr. Vinitha	
		DATE	25/06/2024	
		TIME	12:41 pm	
		PLACE	LABOUR WARD	THEATRES
CONSENT VERBAL / WRITTEN	EPISIOTOMY YES / NO	BLADDER EMPTIED? FOLEY IN/OUT NO		
ANALGESIA LOCAL PUDENDAL AMOUNT USED ___ MLS OF ___  EPIDURAL / SPINAL GA	CTG NORMAL / SUSPICIOUS / PATHOLOGICAL Early decelerations (WRITE FULL DETAILS IN MAIN NOTES IF NOT NORMAL CTG)	LIQUOR CLEAR / BLOOD STAINED / MECONIUM  ABDOMINAL FINDINGS 0 / 5 PALPABLE		
<b>VAGINAL EXAMINATION</b>				
NUMBER OF CMs DILATED STATION OF PRESENTING PART	-1 / 0 / +1 / +2 / +3			
POSITION      DOA / LOA / ROA / ROP / LOP / DOP / LOT / ROT				
CAPUT      0      +      ++      +++				
MOULDING      0      +      ++      +++				
<b>INSTRUMENT USED</b>				
Vacuum      KIWI CUP / NEVILLE BARNES / WRIGLEYS / KIELLANDS / SIMPSONS				
MANUAL ROTATION YES / NO	TIME OF APPLICATION 12:40 pm	No. OF TRACTIONS -		
ABANDONED YES / NO (FULL DETAILS IN NOTES)	TIME OF DELIVERY 12:41 pm	LENGTH OF DELIVERY -		

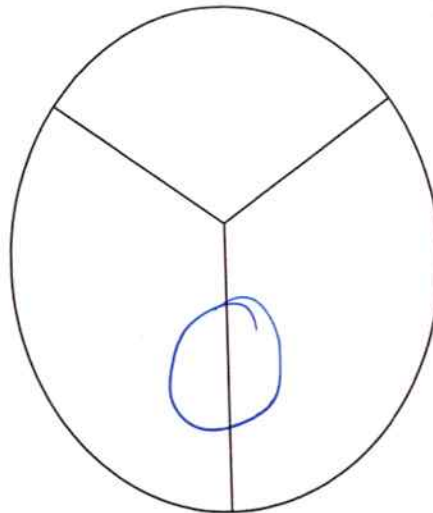
**Rainbow Children's Medicare Limited**

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

For Appointments call: 1800 2122

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

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



EXTENT OF TEAR			
EPISIOTOMY / 1 <sup>ST</sup> degree / 2 <sup>ND</sup> degree / 3A / 3B / 3C / 4 <sup>TH</sup> degree (If 3 <sup>rd</sup> or 4 <sup>th</sup> , please complete proforma)			
SUTURE MATERIAL USED	SUTURE TECHNIQUE	PR	PV
2/0 VICRYL (number.....) 3/0 VICRYL (number.....) OTHER? <i>Rapid vicryl 2-0 vicryl</i>	<u>CONTINUOUS</u> /INTERUPTED SKIN CLOSED? <u>YES</u> /NO	<u>YES</u> / NO	<u>YES</u> / NO
FOLEY CATHETER YES <u>NO</u> REMOVE .....	SWAB COUNT PRE - REPAIR <u>Correct</u> POST - REPAIR <u>Correct</u>	ANTIBIOTICS <u>YES</u> / NO (PRESCRIBE ON DRUG CHART)	ANALGESIA <u>YES</u> / NO (PRESCRIBE ON DRUG CHART)
(SHOULD REMAIN IN SITU FOR MIN OF 12HRS IF REGIONAL BLOCK USED)	PARACETAMOL 1GM PR YES / NO	DICLOFENIC 100MGS PR <u>YES</u> / NO	

**ANTENATAL RECORD**



DR. priyadharshini

Antenatal No: \_\_\_\_\_

Reg.No: \_\_\_\_\_

**PERSONAL DETAILS**

Name: MRS. Priya Age 31 Date of Birth 30/11/1994 Education: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Phone No: \_\_\_\_\_ Mobile: \_\_\_\_\_  
 Husband's Name: \_\_\_\_\_ Age \_\_\_\_\_ Education: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Address: Sithalapakam Kanchipuram, Tamil Nadu  
 Mobile: 8838600253 E-mail Id: \_\_\_\_\_

**IMPORTANT FEATURES**

**SUGGESTED MANAGEMENT**

Gupili A2  
LCB-7yrs

LMP - Not Now

EDD - 7/7/2026

prev 2 early Miscarriage

Baby - UTDA-2

**HISTORY**

Year of Marriage: \_\_\_\_\_ Menstrual History: Previous Periods \_\_\_\_\_ LMP \_\_\_\_\_ EDD \_\_\_\_\_ Corrected EDD \_\_\_\_\_  
 Consanguinity: \_\_\_\_\_ Contraception: \_\_\_\_\_ OBSTETRIC FORMULA: \_\_\_\_\_  
 Gravida \_\_\_\_\_ Para \_\_\_\_\_ Live \_\_\_\_\_ Abortions \_\_\_\_\_

**OBSTETRIC HISTORY**

SL. NO.	DATE OF DELIVERY	GA WEEKS	ANTENATAL DETAILS	MODE OF DELIVERY	BABY	WT	REMARKS
1	2019	term	FRND	vacuum	♀	3.2kg	still
2	2024	→	clinical MC	} medically managed			
3	2025	→	clinical MC				
4	2026	-	FP				

Medical History: hypertension

Family History: Both parents diabetic

Surgical History: nil

Allergies: No drug allergy

## INVESTIGATIONS

### MATERNAL EVALUATION

Blood group & Rh: Wife O +ve Husband Melilla 27/11/77  
 VDRL NR HIV NR HbsAg NR TSH 5.93 GCT (Thy. 25 mcg)  
 ICT

#### ROUTINE INVESTIGATIONS

Date	GA Weeks	Investigations	Report
10/12/85	12.8	Hb - 12.8 WBC - 6.830 RBC - 4.66 MCV - 79.3 PLT - 214 FBS - 75 PPBS - 101 HbA1c - 5.1 ✓ Urea - 26.7	Cocaine - 0.6 pus cells - 3-5

#### SPECIFIC INVESTIGATIONS

Date	GA Weeks	Investigations	Report
20/12	14.2	714	
		FBS - 71	2hr OGTT 116
23/10	12.2	116	
		FBS - 90	PPBS - 103

Tetanus Toxoid: 1<sup>st</sup> dose

2<sup>nd</sup> dose  Booster (also)

### FETAL EVALUATION

#### ULTRASONOGRAPHY

First trimester	29/12	SL scan of 12-13w plac post by (N) Cr-3-occ								
TIFFA	2/12	SL scan of 20-21w plac post by (N) ERW-381g								
Growth scan	Date	GA Weeks	Indication	PP	Wt.	Centile	Growth Velocity	AFI	Placenta	Remarks
	1/5	30	Breech	tb					post.	by (N)
	16/6	37	Cephalic	3.1	58%	AC 67%	(N)	post	Cr 3-occ	
Others										

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

DATE	GA/weeks	TYPE OF TEST	INDICATION	REPORT

Name: \_\_\_\_\_ Corrected EDD: \_\_\_\_\_ Parity: \_\_\_\_\_

SYSTEMIC EXAMINATION

Height: 169      CVS: 3 mms  
 Weight: 62      Respiratory System: \_\_\_\_\_  
 BMI: 23.46 kg      Breasts: S/L      Thyroid: clinically ⊕

ANTENATAL VISITS

Date	Wt	Bp	GA	S-F Ht	Presenting Part	FHS	Liquor	Edema	Review Date
<u>29/12/25</u>	<u>63.1</u>	<u>101/74</u>							
<u>30/1/26</u>	<u>66.6</u>	<u>120/66</u>							
<u>2/2/26</u>	<u>69.1</u>	<u>109/61</u>							
<u>20/3/26</u>	<u>72.2</u>	<u>126/68</u>							
<u>1/5/26</u>	<u>75.2</u>	<u>112/70</u>							
<u>16/5/26</u>	<u>75.4</u>	<u>123/80</u>							
<u>5/6/26</u>	<u>76.8</u>	<u>106/78</u>							
<u>16/6/26</u>	<u>76.5</u>	<u>114/76</u>							
<u>23/6/26</u>	<u>77.6</u>	<u>121/75</u>							

Special Concerns

