Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar ,Hyderabad ,Telangana, INDIA ,500029.
TEL NO :040-48873000
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006649 **Admit Date** : 25-Jun-2026 **Admit Time** : 10:54 PM **UHID** : BAH-00524030

Patient Details :

Patient Name	: Mrs P SAI NITHYA	**Age**	: 33 Y 4 M 22 D
Guardian	: Mr AADITYA SAI KIRAN	**DOB**	: 03-02-1993
Gender	: Female	**Religion**	: Hindu
Occupation	:	**Martial Status**	: Married
Address (H)	: FLAT NO. 307,VAIBHAV KUNCH,LOWER TANKBAND ROAD Gandhi Nagar Hyderabad Telangana INDIA 110005	**Phone No**	: 9908626219/ 9849301139
		E-mail	: aaditya.sai.kiran@gmail.com

Admission Details :

Bed Type : TWIN SHARING **Bed No** : LDR-416 **Ward Name** : 4F -OT

Room No : LDR-416 **Admission Type** : First Visit

Contact Details :

Name	: Mr AADITYA SAI KIRAN	**Relationship**	: W/O
Contact Address	: FLAT NO. 307,VAIBHAV KUNCH,LOWER TANKBAND ROAD Gandhi Nagar Hyderabad Telangana INDIA 110005	**Phone No**	: 9908626219

Signature

Doctor Details :

Doctor Name	: Dr. RAJANI KUMARI	**Specialisation**	: OBSTETRICS AND GYNECOLOGY
Referral Doctor	: Self.	**Phone No**	:
Co-Consultant	:		

Payment Details :

Payment Mode	: DC/CC Card	**Deposit Amount**	: 10000.00
		Payor Name	: GENERALI CENTRAL INSURANCE COMPANY LIMITED

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ACTIVITY RECORD FOR BILLING

BAH-00524030 IP26-00006649
Name : Mrs P SAI NITHYA _____
03-02-1993 33 Y 4 M 22 D (F)
Dr. RAJANI KUMARI

UHID No. : _____ Consultant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
26/6/26	4.50AM	Pre & post	OT	
26/6	6:30AM	OT	Pre & post	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
25/6/26	MST — (1)	7568	
25/6/26	CBP — (1)	20352	
26/6/26	MST — (2)	7570	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
26/6	cardiac monitor	6:30Am		208293	[illegible]
26/6	infusion pump	6:30Am			

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
25/6/26	IV placement	(1)	208251	
26/6/26	Catheterisation	(1)	8283	
26/6/26	PAC	(1)	8282	

ANY OTHER INFORMATION

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.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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Mrs P SAI NITHYA
03-02-1993 33 Y 4 M 22 D (F)
Dr. RAJANI KUMARI

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IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

G2P1L1 prev LSCS @ 37+4 wks c/o mild lower Abd pain.

Obstetric Formula:

Obstetric Hostory:

G1 → Male 3yr / Em LSCS.
G2 → P.P.

Present Pregnancy Record:
- NT scan (N)
Fibroid noted. ① 5.4 × 5.4 Rt lateral wall. FIGO-4
② 4.7 × 4.5 cm, Rt lateral intramural fibroid FIGO-4.

RISK FACTORS:

- TIFFA @
- Inj BETNASOL 4 doses given @ wks.

Fibroid complicating pregnancy.

Height: .... cm
Weight: 66 kg
Allergies: ....
Breast: ☑ Normal ☐ Abnormal
General Examination:

Consciousness:		Pallor:	nil
Icterus:	-	Edema:	
Temp:		PR:	88-90/min
BP:	110/80	DTR:	
CVS:		RS	(N)
Liver/Spleen:		Urine Output:	

LMP: 5/10/2025. EDD: 12/7/2026.
Corrected EDD: 12/07/2026 GA: 37 wks 4d.
Menstrual History: Regular: ☑ Yes ☐ No

Obstetric Examination

Fundal Height: TS.

Ut. Activity: ☐ Relaxed ☑ Mild ☐ Mod ☐ Severe
Liquor: ☑ Adequate ☐ Oligo ☐ Poly
PP: ☑ Cephalic ☐ Breech Others ________
Head Fifths Palpable: 4/5th
FHS: ☑ Normal ☐ Tachy ☐ Brady ☐ Absent

Per Speculum Examination - ND.

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

Vaginal Examination

Cervix: ☑ Long ☐ Partially effaced ☐ Effaced
Os: Closed ✓ ________ Dilated ________
Membranes: ☐ Present ☐ Absent
Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained
Presenting Part: ☑ Vertex ☐ Breech ☐ Others
Sutton: ☑ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2
Pelvis: ☑ Adequate ☐ Doubtful

DIAGNOSIS

G2P1L1. Previous LSCS @ 37 wks 4d / Fibroid complicating pregnancy / Allergic bronchitis with ? False labor for observation & safe confinement.

Docu. No. : RCH /FRM / CLINICAL / 087 (P.T.O)

BAH-00524030 IP26-00006649
Mrs P SAI NITHYA
03-02-1993 33 Y 4 M 22 D (F)
Dr. RAJANI KUMARI

Family History:	Surgical History:
Both parents - HTN, DM,	↓ 1 LSCS.

Medical History:	Medication History:
K/c/o Allergic Bronchitis in pregnancy took on off nebulisation.	ON TAB MONTELUKAST-LC - once daily

Plan of Care: →	Investigations:
- NBM → CTG 3rd hrly. → IV fluid @ 100ml/hr - Inj TRAMADOL im stat - Inj BUSCOPAN im stat. plan - w/f. T pain / leak / SCT. → plan: emergency LSCS if pt gets into labor. ① send CBC ② 2 0 PRBC + 2 0 FFP → to be reserved ③ PAC to be done	(24/3) Hb → 11.7 BG - B+ve. PLT - 2.2 HbA1C - 5.4 HIV, HbsAg, HCV } NR. RPR TIFFA ⓝ RFTS - ⓝ Fetal echo - ⓝ (@ 24 wks) Last scan: (6/6/2026). SLIUG @ 34 wks 6d AFI - 13.2 AC - 43% EFW - 2302 gm. (22%) UAD - ⓝ. Fibroid: ① 4 x 3 x 4 - Ant wall FIGO 4 ② 6.3 x 3.9 x 5.9 cm Ant wall.

Doctor Name: Dr. Swathi. HV.
Signature: Swathi
Date & Time: 26/0/2026 @ 11:30pm

Consultant Name: Dr Rajani Kumari
Signature:
Date & Time:

BAH-00524030 IP26-00006649
Mrs P SAI NITHYA
03-02-1993 33 Y 4 M 22 D (F)
Dr. RAJANI KUMARI

(1)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/06/2026. 3:30AM	S/B Dr Swathi HM	
	+ G2P1 4 prev LSCS @ 37wk 4d, fibroid complicating pregnancy.	
	- c/o pain Abd	
	O/E: P-88 bpm	
	BP > 110/80	
	PA: UTTS.	
	cephal.	
	FHS ⊕ Reg.	
	2/10/10-15"	
	P/V: OS 1cm, Vx at -2, Cx posterior	
	membranes ⊕, no show/ no leak	
	- Explained findings to pt & relatives.	
	plan: Emergency LSCS +/- Myomectomy	
	- Informed consent	
	- Reserve 2 PRBC, 2 FFP	
	- Foleys catheterisation	
	- Shift to OT on call.	
		Swathi / Dr Swathi HM

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/2/2026 9:30 AM	C/S/L @ POD-0	Monitor
		Adv
	Ce Fair Afebrile	
	BP	- NBM
Baby M	PR	- Drugs as charted
	P/A Ut well retracted	- W/F vitals & BPV
	PV: Bleeding WNL	- I/O monitoring (strict)
	I/O	- Inform SR
	( )	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

BAH-00524030 IP26-00006849
Mrs P SAI NITHYA
03-02-1993 33 Y 4 M 22 D (F)
Dr. RAJANI KUMARI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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

(P.T.O)

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CAESAREAN SECTION OPERATIVE NOTES

Surgeon's Name: Dr Rajani / Dr JV Reddy	Date of Delivery: - 26/06/2026.
Assistant Surgeon: - Dr Lavanthi HV.	Time of Delivery: 5:10AM
Anaesthetist's Name: - Dr FAMIR.	Gender of Baby: Female.
Type of Anaesthesia: LA	Weight of Baby: 2.8kg
Neonatologist:	AGPAR Score: 8/10 ; 9/10.
Scrub Nurse: - S/N Sangeetha.	NICU Admission: ☐ Yes ☑ No

Pre-Operative Diagnosis:

☐ Elective ☑ Emergency Indication: .....

Urgency

- ☐ Immediate Threat to life of woman or fetus
- ☐ Maternal or fetal compromise not immediately life threatening
- ☑ No maternal or fetal compromise but needs early delivery
- ☐ Delivery timed to suit woman and staff

Decision time: 30min Knief to rectus: 4mm

CTG Description: Reactive

If there was a delay give the reasons: .....

Surgical Procedure: - Emergency LSCS + Cesarean Myomectomy

Post Operative Diagnosis:

Peri-Operative Complications:

Amount of Blood Loss: - 500ml.	Blood Transfused (in ML):

Name and Number of Surgical Specimen sent for examination:

↓
Fibroid

Examination Findings when Appropriate:

Presentation: ☑ Cephalic ☐ Breech ☐ Other ....
Cervical Dilatation: .... cm

5th Palpable: 4/5th
Fetal Position: ....

Station: ☑ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2
Moulding: ☐ None ☐ + ☐ ++ ☐ +++

Caput: ☐ + ☐ ++ ☐ +++
Meconium: ☐ None ☐ + ☐ ++ ☐ +++

Bladder Catheterized : ☑ Yes ☐ No
Urine: ☑ Clear ☐ Blood Stained

Skin Incision: ☑ Pfannensteil ☐ Transverse ☐ Midline ☐ Other ....

Uterine Incision: ☑ Lower Segment ☐ Classical ☐ Inverted T ☐ J Incision

Previous Scar: ☑ Intact ☐ Thinnedout ☐ Ruptured ☐ No Scar

Incision Through Placenta: ☐ Yes ☑ No

Delivery of head: ☑ Manual ☐ Forceps

(*) Fibroid ~ 6x6cm @ right angle (intramural) just Above @ incision line.

Liquor: ☑ Clear ☐ Meconium: ☐ I ☐ II ☐ III ☐ Blood ☐ Offensive ☐ Not Offensive

Delivery of Placenta: ☐ Manual ☑ CCT .... ☑ Complete ☐ Incomplete ☐ Piecemeal

Cord Appearance: normal ....
Cord around the neck ☐ Yes ☐ No

Appearance of placenta: normal. ....
Cavity explored ☐ Yes ☐ No

Uterus, tubes and ovaries: ☑ Normal ☐ Not Normal
Sterilization: ☐ Yes ☐ No

(*) Myomectomy done
(*) Myoma bed sutured in layers by catgut NO. 1.

Uterine Closure: ☐ One Layer ☑ Two Layers - vicryl No. 1-0. .... Suture

Peritoneal Closure: ☑ Pelvic ☐ Abdominal ☐ None Rapid vicryl NO. 1. .... Suture

Sheath Closure: – vicryl NO. 1. .... Suture

Fat Closure: ☑ Yes ☐ No Rapid vicryl NO. 1 .... Suture

Skin Closure: ☑ Subcuticular ☐ Mattress Rapid vicryl NO. 1 .... Suture

Vagineal Evacuated ☑ Yes ☐ No

Drain: ☐ Yes ☑ No ☐ Remove in .... days ☐ Await instructions

Ctheter ☑ Yes ☐ No ☐ Remove in .... days ☐ Await instructions

Swap & Instruments count correct? ☑ Yes ☐ No ☐ Post-op Antibiotics ☐ Yes ☐ No

Intra-Operative Antibiotics Cover: ☑ Yes ☐ No ☐ Thromboprophylaxis ☐ Yes ☐ No

Post-Operative Notes: – NBM x6hrs

- Iv fluids – 1 0 RL, 1 0 NS @ 100ml/hr
- IV Ab x24hrs
- → Inj TRANEXA 1g iv stat.
- → Foleys – x24hrs.
- → Analgesics → As per Anaesthesia

Doctor Name: Dr Rajni ....
Doctor Signature: (for) [signature] Dr [illegible]

Date & Time: 26/6/2026. @ 6:50AM.

BAH-00524030 IP26-00006649
Mrs P SAI NITHYA
03-02-1993 33 Y 4 M 22 D (F)
Dr. RAJANI KUMARI

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Rajani Kumari
Asst. Surgeon : Dr. J.V. Reddy, Dr Surya
Anaesthetist : Dr. Sumathi
Scrub Nurse : Sr. Sangeetha
Pa... Age : ..... Gender : .....
UHID No. : ..... Surgery Name : .....
Date : 20/6/22 In-time : 5.... Out-time : 6.30...

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 5am

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

Site Marked ☐ Yes ☐ No ☐ NA

Anaesthesia Safety Check Completed ☑ Yes ☐ No

Pulse Oximeter on Patient & Functioning ☑ Yes ☐ No

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

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

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

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

Signature : .....
Name : .....

Before Skin Incision ➤➤

TIME OUT Time: 6:10a

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

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm
- Correct Patient (Check ID Band) ☑ Yes ☐ No
- Correct Site ☑ Yes ☐ No
- Correct Procedure ☑ Yes ☐ No

Anticipated Critical Events

Surgeon Reviews:
- What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? ☐ Yes ☐ No ☐ NA

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

Nursing Team Reviews:
- Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☑ Yes ☐ No ☐ NA
- **Is Essential Imaging Displayed?** ☑ Yes ☐ No ☐ NA
- Power Supply, Earthing, Power Backup and functioning of equipment checked. ☑ Yes ☐ No

Signature : .....
Name : Sangeetha

Before Patient Leaves Operating Room

SIGN OUT Time: 6:30a

Nurse Verbally Confirms with the Team:
- The Name of the Procedure Recorded ☐ Yes ☐ No
- That Instrument, Sponge and Needle Counts are Correct (or Not Applicable) ☐ Yes ☐ No ☐ NA
- The Specimen is Labelled (including patient name) ☐ Yes ☐ No ☐ NA
- Whether there are any Equipment Problems to be addressed ☐ Yes ☐ No ☐ NA

To Surgeon, Anaesthetist and Nurse:
- What are the key concerns for recovery and management of this patient? ☐ Yes ☐ No

Signature : .....
Name : Dr Rajini

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RESULT SHEET

Date	25/6/26					
Time						
Hb	12.7					
PCV	36.7					
RBC	4.32					
WBC	12.06					
N/L						
Platelets	238					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Blood Group. B+ve						
HIV, HbsAg, HCV — NR			2 PRBC Reserve.			
			2 FFP Reserve.			

Culture and Sensitivities : .....

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Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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MEDICATION RECONCILIATION FORM

Drug Allergies: ....nil.. ☐ Not known any Drug Allergies

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

Shifting From: .... 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	Iron. Ca.	1 tab	P/O	OD	25/6	☐ C ☑ DC
2	TAB MONTEK-LC	1 tab	P/O	OD	25/6	☑ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : ....Dr. NAWATHE.NN [signature]....

Date & Time : ....25/6/2026 @ 25....

Nurse Name & Signature: ....[signature]....

Date & Time : ....25/6/26 @ 11:00pm....

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DRUG CHART

Date of Admission: 29/6 Drug Allergies: Nil ☐ 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 .....

BAH-00524030 IP26-00006649
Mrs P SAI NITHYA
03-02-1993 33 Y 4 M 22 D (F)
Dr. RAJANI KUMARI

REGULAR PRESCRIPTIONS

Weight. 66kg Ward. UCF

DRUG : Inj CEFOTAXIM

Dose	Route	Frequency	Start Date
1g	iv	BD	26/6

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

x24 hrs.

Daily Doctor's Endorsement by a Sign

Date / Time 26/6

DRUG : PARACETAMOL

Dose	Route	Frequency	Start Date
1gm	IV	TID	26/6

Name & Signature of the Doctor Starting the Drugs: DINAMIR

Additional Instructions: IV FOR 24 HOURS FOLLOWED BY ORALS

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG : TRAMADOL

Dose	Route	Frequency	Start Date
100 mg	P/O	TID	26/6

Name & Signature of the Doctor Starting the Drugs: DINAMIR

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG : DICLOFENAC

Dose	Route	Frequency	Start Date
50mg	P/O	TID	26/6

Name & Signature of the Doctor Starting the Drugs: DINAMIR

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

BAH-00524030 IP26-00006649
Mrs P SAI NITHYA
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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight ...66Kg... Ward ...LDR...

DRUG : Inj PANTOPRAZOLE

Dose	Route	Frequency	Start Dt.
40mg	IV	OD	26/6

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : INJ. METRONIDAZOLE

Dose	Route	Frequency	Start Dt.
500mg	IV	TID	26/6/26

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

Additional Instructions:
x24hrs.

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

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

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

(P.T.O.)

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight ..66kg.... Ward ......LDR...

DRUG :

Date ▸ Time ▾

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Date ▸ Time ▾

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Date ▸ Time ▾

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Date ▸ Time ▾

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

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

BAH-00524030 IP26-00006649
Mrs P SAI NITHYA
03-02-1993 33 Y 4 M 22 D (F)
Dr. RAJANI KUMARI

Weight. 66 Kgs Ward. LDA

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
25/6.	11:15pm	Inj TRAMADOL	100mg	im		Abu
25/6	11:15pm	Inj NUSCOPAN	40mg	im		Madhavi
25/6/26	11:30pm	Inj ONDENSETRONE	4mg	iv		Abu
25/6/26	11:30pm	Inj PANTOPRAZOLE	40mg	iv		Madhavi
26/6.	4:00AM	Inj PANTOPRAZOLE	40mg	iv		
26/6	4:00AM	Inj METACLOPRAMIDE	10mg	iv		
26/6	5AM.	TRANEXAMIC ACID	1gm	IV		
26/6	630am	DICLOFENAC	100mg	PR		
26/6	630am	TRAMADOL	100mg	PR		

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Mrs P SAI NITHYA
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Dr. RAJANI KUMARI

I.V. FLUIDS CHART

Weight. 66kg Ward. LDR

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
25/6/26	11:30pm		IV	100			26/6		
26/6	5AM	RINGER LACTATE	IV	1000			26/6		
26/6	5AM	RINGER LACTATE	IV	500			26/6		
26/6	530 AM	RINGER LACTATE + 20U OXYTOCIN	IV	150			26/6		
26/6	630 am	RINGER LACTATE + 20U OXYTOCIN	IV	~~75~~					
26/6	7:00 AM			PP					
26/6	8:10 AM								

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

Patient Sticker

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STAT / ONCE ONLY DRUGS

Weight: ..... kgs

Name: .....

Sheet No: .....

DATE	TIME	MEDICATION	DOSAGE & OTHER INSTRUCTIONS	ROUTE	SIGNATURE		
					Doctor	Nurse-1	Nurse-2
26/6/26	9:20 AM						

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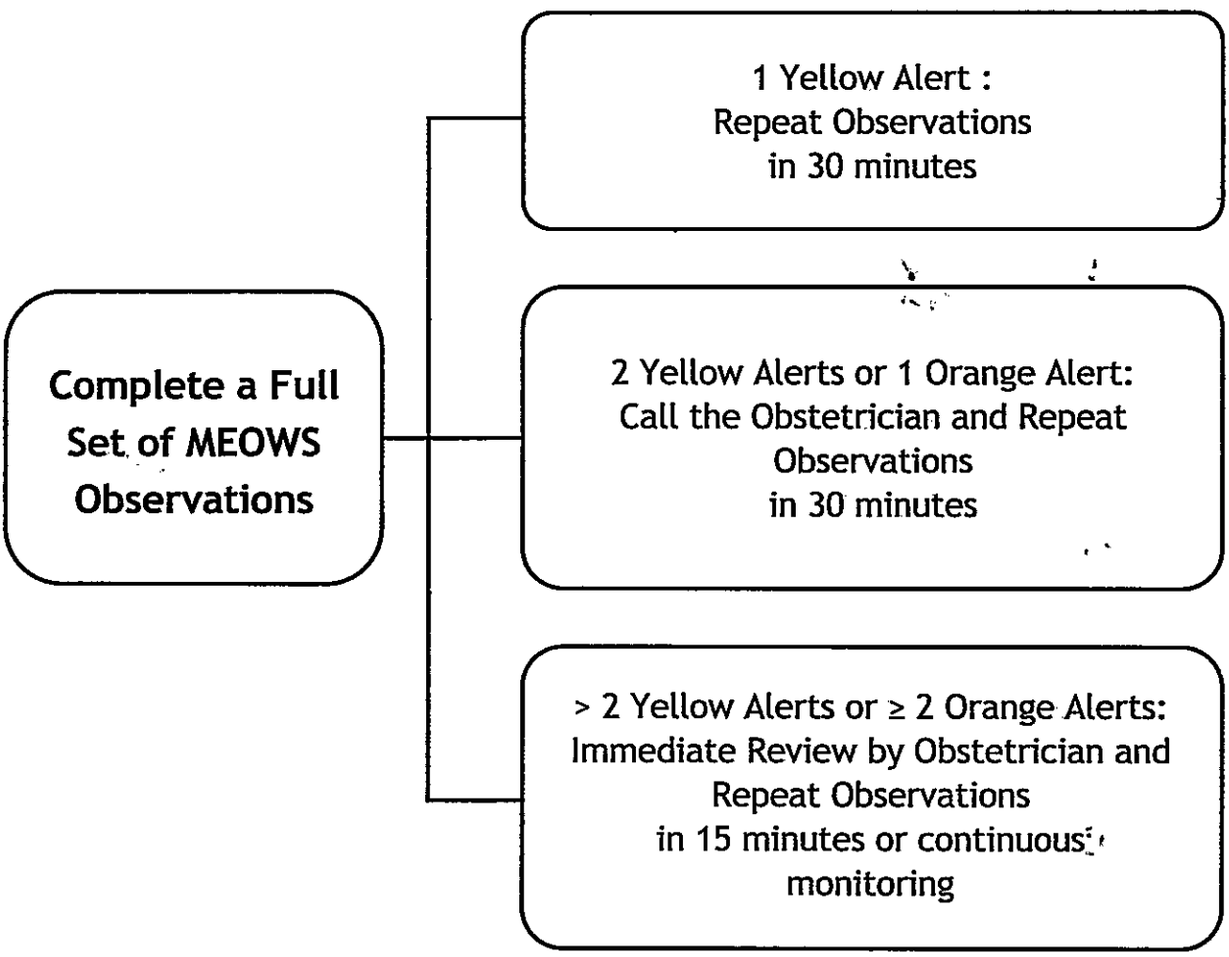
Early Warning Observation Score Chart - Obstetrics

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

25/6/26	Date																								
	Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																								
	21 - 30																								
	11 - 20															20				20				20	20
	0 - 10																								
Saturations	94 - 100 %															99				97				98	99
	< 94 %																								
Administered O_2 (L/min.)																									
Temp°c	40																								
	39																								
	38																								
	37															98.6				98.4				98.6	
	36																								
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90															95				87				93	88
	80																								
	70																								
	60																								
	50																								
	40																								
Systolic Blood Pressue ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140															130				131				132	134
	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70															87				78				99	100
	60																								
	50																								
	40																								
NEURO RESPONSE [✓]	Alert															—				—				—	—
	Voice																								
	Pain																								
	Unresponsive																								
URINE mls / hour	> 30															✓				—				—	—
	< 30																								
Proteinuria	Protein + +																								
	Protein > + +																								
Lochia	Normal																								
	Heavy / Foul																								
Liquor	Clear / Pink																								
	Green																								
TOTAL YELLOW SCORES																0				0				0	0
TOTAL ORANGE SCORES																0				0				0	0
Nurse Initial																h				h				h	h

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score **(MEOWS)**

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		Date																							
26/6/26		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)		> 30																								
		21 - 30																								
		11 - 20																								
		0 - 10																								
Saturations		94 - 100 %																								
		< 94 %																								
Administered O_2 (L/min.)																										
Temp°c		40																								
		39																								
		38																								
		37																								
		36																								
		35																								
		< 35																								
Heart Rate		170																								
		160																								
		150																								
		140																								
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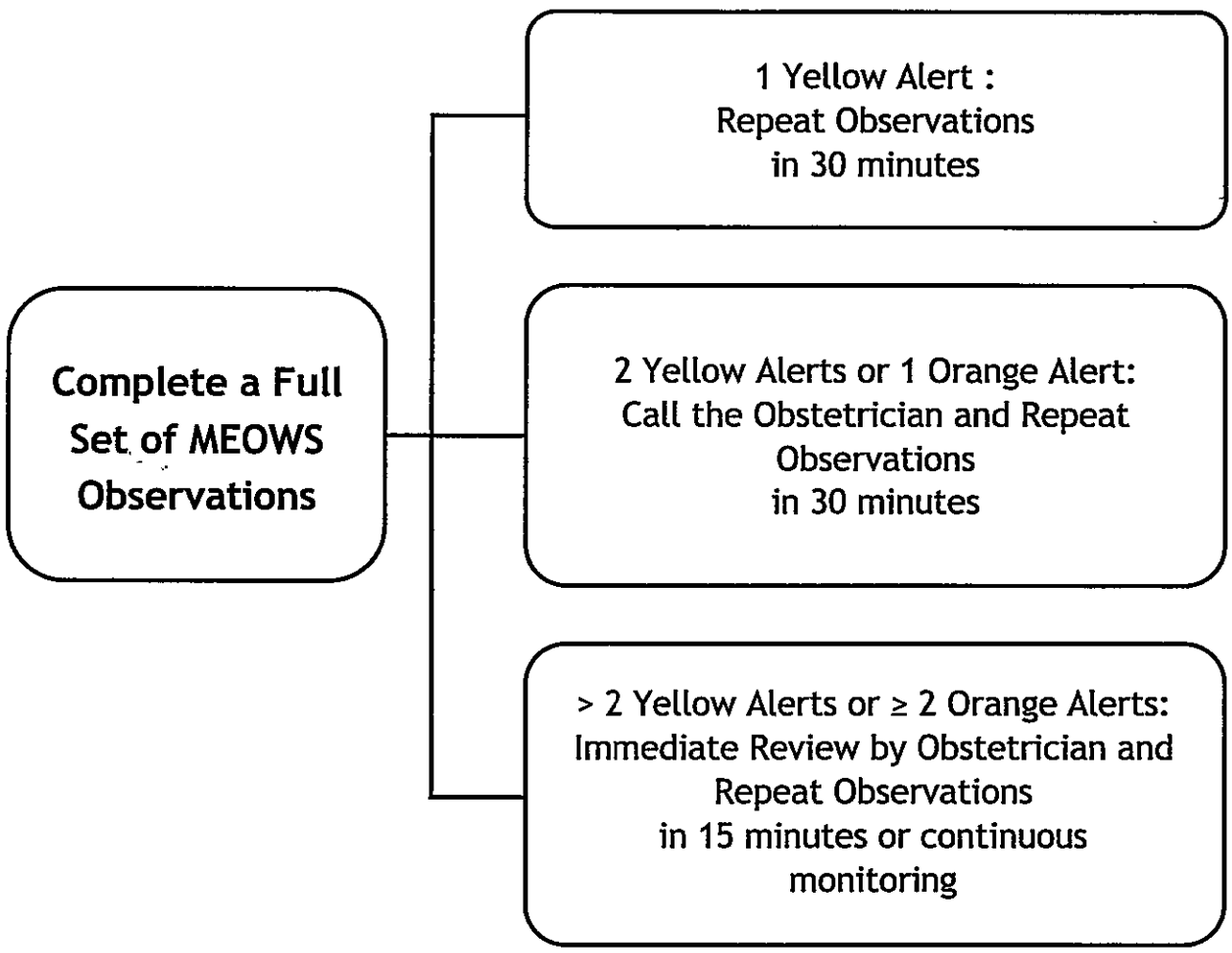
		120																								
		110																								
		100																								
		90																								
		80																								
		70																								
		60																								
		50																								
		40																								
NEURO RESPONSE [✓]		Alert																								
		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																										

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score **(MEOWS)**

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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
20/6	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm	RL	N	100ml						✓		
	12:00 am	RL	B	100ml						✓		
	01:00 am	RL	M	100ml								
Total Intake :		RL 600				**Total Output :**				Passed		
21/6	02:00 am	RL		100ml								
	03:00 am	RL	N	100ml								
	04:00 am	RL		100ml								
	05:00 am	RL	B	100ml								
	06:00 am	RL	M	100ml						100ml		6:50 AM Emp
	07:00 am	RL		100ml								
Total Intake :		RL 600				**Total Output :**				Passed		

Total 24 hrs. Intake		Total 24 hrs. Output	

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Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
26/6/26	08:00 am	RL		100ml							1	
	09:00 am	RL		100ml.							1	
	10:00 am	RL									0	
	11:00 am					NA					1	
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		**Total 24 hrs. Output**	

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FLUID CHART

Sheet No. : .....

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

Date	Time	Intake: Nature of Fluid	Intake: Route			Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

Patient Sticker

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FLUID CHART

Sheet No. : .....

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

		Intakes				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
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Total Intake :						**Total Output :**						
	02:00 pm											
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	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
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	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		**Total 24 hrs. Output**	

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OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 25/6/26 Time of Arrival: 10:45AM Time Seen by Nurse: 10:50AM

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

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

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

3) **Vital Signs:** Temperature: 99°F Pulse: 94 RR: 20 SpO_2: 99% BP: 130/82 Weight: .....

4) **Gestational Criteria:**

Gravida:	G 2	P 1	L 1	A

LMP: 5/10/2025 EDD: 12/7/2026 Gestational Age: 37 weeks

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

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

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

- Location: Lowere abdomen & back pain
- Duration: - Days / Weeks/ Months (Strike out which is not applicable)
- Character: .....
- Frequency: -
- Interventions: .....

6) **Past History:**

a) Surgeries: LSCS

b) Medical: NAD

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

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

9) **Prenatal Medical History:**

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

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

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

Time seen by Doctor: ..... 11:00pm .....

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

Date: ..... 25/6/26 ..... Time: ..... 11:00 .....

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OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 25/6/26

Baseline Information:

Admission From: ☐ ER ☐ OPD ☑ Admission Desk ☐ Others, specify .....

Primary Language: ☑ Telugu ☐ English ☐ Hindi ☐ Others, specify .....

Do you require an interpreter? ☐ Yes ☐ No if Yes specify .....

Source of Information: ☑ Patient ☐ Family ☐ Others, specify .....

Allergies: ☐ Yes ☑ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: .....

If yes , identify .....

Chief Complaints: Lower Abdomen pain

Doctor Notified on Admission: ☑ Yes ☐ No

Name of the Doctor: Dr Swathi

Time Notified: 11:00 pm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
-	-	-

Gynecology Assessment: ☐ Not Applicable

Menstrual History: Regular

Onset of Menarche: .....

Menstrual Cycle: ☑ Regular ☐ Irregular

Last Menstrual Period: .....

Gynecology Surgical History:

Caesarean Section: ☐ No ☑ Yes

Cervical Cerclage: ☑ No ☐ Yes

Ectopic Pregnancy: ☑ No ☐ Yes

Myomectomy: ☑ No ☐ Yes

Others: _____

Gynecological History:

Contraceptives: ☑ No ☐ Yes

Vaginal Discharge: ☑ No ☐ Yes

Post-Coital Bleeding: ☑ No ☐ Yes

Infertility: ☑ No ☐ Yes

If Yes Type: ☐ Primary ☐ Secondary

Obstetric History: G 2 P 1 L 1 A .....

Previous LSCS: 1 yes

Current Medication: ☐ None ☑ Yes, If Yes, Fill the reconciliation form

Family History: ☐ No Abnormalities Detected

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

☐ Liver disease ☐ Other .....

Vital Signs / Measurements: Temp: 97.6f HR: 97 RR: 20

BP: 120/82 Weight: 60kg Height: ..... BMI: .....

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

BAH-00524030 IP26-00006649
Mrs P SAI NITHYA
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PHYSICAL ASSESSMENT

General Appearance: ☐ Healthy ☐ ill looking ☐ Anxious ☐ Agitated ☐ Others: .....

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

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

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

☐ Mobility problem ☐ Walking Problem ☐ No Abnormality Detected

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☐ No Abnormality Detected

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

☐ Under Weight ☐ Diabetes Mellitus ☐ Hyperemesis Gravidarum

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 ..... family members .....

Orientation has been given regarding the following aspects:

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

Infusion Pump : ☐ Yes ☐ No Hand Hygiene Explained: ☐ Yes ☐ No ☐ Others

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

Name of Person Orientation was given to: ..... mrs Sai nithya

Orientation not given Reason: .....

Nurse Signature: .....

Nurse Name: .....

Date & Time: 23/2/26 11pm

BAH-00524030 IP26-00006649
Mrs P SAI NITHYA
03-02-1993 33 Y 4 M 22 D (F)
Dr. RAJANI KUMARI

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CHECKLIST FOR THROMBOPHLEBITIS

25/6/26 2026

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			NA	NA						
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			NA	NA						
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	NA		NA	NA						
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			NA	NR						
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			NA	NR						
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			NA	NR						
		Signature of the Nurse											

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : ..... Name : Monika

Signature of Ward In Charge :

Signature : ..... Name : Kasthuri

Patient Sticker

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3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2										
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		Signature of the Nurse											

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Signature of Shift In Charge :

Signature : ..... Name : .....

Signature of Ward In Charge :

Signature : ..... Name : .....

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	25/6/26 11PM	26/6/26 AM		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				
Secondary Diagnosis (more than one diagnosis)	Yes	15						
	No	0				Low Risk	0 - 24	Standard Fall Precaution
Ambulatory Aid	Furniture	30						
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	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						
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
Mental Status	Forgets limitations	15						
	Oriented to own ability	0						
Total Morse Fall Scale Score:			20	20				
		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

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	No	0						
Secondary Diagnosis (more than one diagnosis)	Yes	15						
	No	0				Low Risk	0 - 24	Standard Fall Precaution
Ambulatory Aid	Furniture	30						
	Crutches, Cane(S), Walker	15						
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IV / Heparin Lock or Saline	Yes	20				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20						
	Weak (uses touch for balance)	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						
Total Morse Fall Scale Score:								
		Signature						

Tick (✓) whichever precaution taken.

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BRADEN 'Q' SCALE

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				Date :	25/6	26/6		
				Time :	11PM	11AM		
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		
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4		
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		
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		
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4		
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	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		
				TOTAL SCORE	28	28		
				Evaluator's Name				

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

Risk Score	Category	Action	Support Surfaces (**Please Note:** Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for **"At Risk"** Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for **"Moderate Risk"** Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for **"High Risk"** Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

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BRADEN 'Q' SCALE

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					Date :			
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PAIN ASSESSMENT FORM

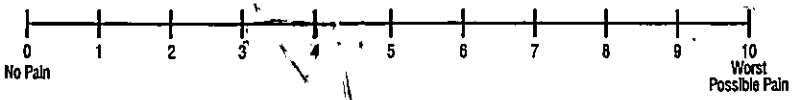
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
25/6/26	11pm	4/10	Lower abdominal pain	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☑ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☐ Yes ☐ No	inj [illegible] / inj Tramadol	
26/6/26	1am	4/10	abdominal pain	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☑ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☐ Yes ☐ No	NA	
26/6/26	4AM	4/10	Abdominal pain	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☑ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☐ Yes ☐ No	NA	
26/6/26	8Am	0/10	None	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA / inj-PCM	
26/6/26	8A	0/8	low abdominal pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

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

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				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
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				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
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				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

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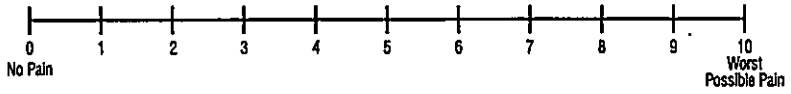
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
   a) At least every 2 hours for the first 24 hours
   b) Then every 4 hours.
   c) Prior to pain pain-relieving intervention.
   d) Within 30 – 60 minutes after pain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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

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

BAH-00524030 IP26-00006649
Mrs P SAI NITHYA
03-02-1993 33 Y 4 M 22 D (F)
Dr. RAJANI KUMARI

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NURSING CARE RECORD

Date: 25/6/26

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							
Afternoon							
Night	8pm	- Assess the patient condition - Plan for Vital & record - Plan for IV fluids - Plan for Medications	8pm	- Assess the patient condition - Maintain Vital - Continue IV fluids - Maintain Medications	- Patient stable	- Vital normal	

Docu. No: RCH /FRM / CLINICAL / 148

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NURSING CARE RECORD

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Date: 26/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am to 2pm	→ Assess the pt condition ← monitor vitals ← maintain I/O	8Am to 2pm	→ Assessed the pt condition → Monitored vitals	→ Now pt is stable	Re-ch vit	
Afternoon							
Night							

Patient Sticker

NURSING CARE RECORD

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Date: .....

Goals

- ☐ Maintain Airway and Oxygenation
- ☐ Relieve Pain & Discomfort
- ☐ Maintain Fluid Balance
- ☐ Improve Activity Tolerance
- ☐ Maintain Good Nutritional Status
- ☐ Maintain Skin Integrity
- ☐ Maintain Personal Hygiene
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- ☐ 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							
Afternoon							
Night							

Patient Sticker

NURSING CARE RECORD

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Date: .....

Goals

- ☐ Maintain Airway and Oxygenation
- ☐ Relieve Pain & Discomfort
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- ☐ 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							
Afternoon							
Night							

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: .... Department: .... Date of Admission: ....

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☑ Not Known If Yes Specify:					
BACKGROUND	Area / Shift Time	25/6/26 8pm - 8am	Mon NG				
	Medical Condition (Any special condition to be noted):	–	–				
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	97.6F	92.				
	Res:	20	26				
	SpO_2:	99%	99%				
	Pulse:	92	92				
	BP:	127/87	110/76				
	Fall Risk Score:	0	–				
	Pain Score:	0/10	–				
Recommendations	Safety Needs:	yes	yes				
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	–	–				
	Special Diet:	☑ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	–	–				
Post Operative Procedure Special Orders:		–	NA				
Handed Over By Name :		Alei	Moni				
Signature :		(signed)	(signed)				
Date:		26/6/26	26/6				
Time:		8:15AM	8pm				
Taken Over By Name :		Moni					
Signature :		(signed)					
Date:		26/6					
Time:		8Am					

Docu. No. : RCH /FRM / CLINICAL / 097

Patient Sticker

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION	Diagnosis:				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
BACKGROUND	Area / Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							

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URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 26/6/26 Date of Removal: .....

Parameters	Date / Shift Time							
	26/6/26							
Need for the Catheter	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hand Hygiene	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Usage of Sterile Equipment	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the Collection bag below the level of bladder	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Check the Tube for Obstruction (Free of Kinking)	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Catheter dated as policy	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Collecting bag is been emptied regularly?	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Maintenance of closed system for the catheter	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing clean and dry?	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the line removed as Policy?	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Performance of Perineal Care	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Onset of New Fever	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Asses for the leakage at the site of insertion	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Nurse	[illegible]							
Signature of the Nurse	[signature]							

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BREAST FEEDING HANDOVER AND ASSESSMENT FORM

1. Breastfeeding initiated?
   - ☑ a. Yes
   - ☐ b. No

2. If No, Reason .....

3. Nipple condition:
   - ☑ a. Nipple well formed
   - ☐ b. Flat nipple
   - ☐ c. Inverted nipple
   - ☐ d. Short nipple

4. Milk flow:
   - ☐ a. Good
   - ☑ b. Drops of colostrums
   - ☐ c. Dry

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

Feeding Positions:
Cross Cradle

Feeding Positions:
Football / Clutch

6. Was the position explained:
   - ☑ a. Yes
   - ☐ b. No

7. For Caesarian mothers:
   - ☑ a. Mother is required sit and feed from the 4th feed
   - ☐ b. Please explain football hold

8. NICU admission:
   - ☐ a. Mother needs to stimulate her breast for 2 min every 2 hours

9. Additional notes: .....

Continuity of Care: Date: 26/6/26

- ↓ Asses the Patient Condition
- ↓ Explained position
- ↓ milk flow DROP of Colostreams
- ↓ and hourly feeding given

Handover given by ..... Handover taken by .....

Signature ..... Signature .....

Date & Time: 26/6/26 @ 8:00 PM Date & Time: .....

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: Mrs. P. Sai Nithya Age: 32y Sex: female UHID.No : BAH - 524030

Date: 25/6 Time: 11pm Proposed Operation: LSCS

Diagnosis: G2P1L1 ō prev. LSCS, fibroid complicating pregnancy

B.P / CRT: 112/65 H.R: 102 Weight: 69 ASA Physical Status: ☐ 1 ☑ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 12.7	Glucose:	Protein:	HIV: NR	X-Ray:
PCV: 36.7	Urea:	Alb:	HBS Ag: NR	ECG:
WBC: 12060	Creat:	Total Bill:	HCV:	2D Echo:
Plate: 2.38	Na:	Dir. Bill:	Blood group: B pos	Stress/Anglo:
PT:	K:	LDH:	T3	Other:
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH	
	Cl -:	SGOT/SGPT:		

Allergies: NKDA.

Medical History: CVS : /

RESP No significant medical history. Diabetes :

CNS : ? Allergic bronchitis → takes MONTEK-LC

Renal : Regular scans - uneventful thrust

Hepatic / GE : /

Others : 2 fibroid - 5×4×5 Cat mall, 1 3×3×2 fundal.

Physical Activity: active, NYHA-I

Past Anaesthetic History: prev. LSCS & SAB 2023

Physical Exam: Coherent

Airway: MP 1 (2) 3 4 Mouth Opening: adq Mentohyoid Distance: 3FB Neck: (N) Teeth: intact.

Lungs : BBE (+) Clear

Heart: S1+S2+ M0.

CNS:

Pregnant: ☑ Yes ☐ No ☐ NA

Venous Access Site : peripheral x2

Spine Exam for regional : Midline

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

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

Plan - SAB +/- EA.

CURRENT MEDICATIONS	DOSAGE
Ecospin stopped	
Fe/Ca/Arg 9.	

Pre-Operative Instructions:

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours; Others 6 Hours — fasting as per protocol.
3. Informed Consent: ☐ Standard ☐ High Risk
4. Post Operative Pain Management: ☐ Discussed with Patient
5. Other Instructions: 2 Prbc / 2 FFP reserve & crossmatch - CBP stat.

Signature: Name: Dr Lavanya Chayath

Docu. No. : RCH /FRM / CLINICAL / 044

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ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No		Fasting Status: okay.	
Physical Status:	☑ Patient Identified	☑ Consent Present	☑ Chart Reviewed

H.R: 10?/m | B.P / CRT: 112/73 mmHg | SpO_2: 96% ERA | R.R: 14/m | Last Feed: >6 hrs.

Pre-OP Diagnosis: G2P1L1 E prev. LSCS. | Operation: LSCS. | Date: 26/6

Surgeon: Dr. RK / Dr GVR / Dr. HSV. | Anaesthesiologist: Dr Samir. | Technician: Aravind.

TIME: 500, 15, 30, 45, 600, 15, 30

N_2O /AIR /O_2 LPM

HALO /SO /SEVO

Drugs:

MEPHENTERMINE 6mg + 6mg iv

TRANEXAMIC ACID 1gm iv

OXYTOCIN 3U + 20U infusion iv

FIO_2 / SaO_2: 97 97

$ETCO_2$

ECG: SR SR

Temperature

Urine Output

Fluids / Blood: RL @ 500ml/hr → ; RL @ 150ml/hr → (OXYTOCIN (20U))

Antibiotic - given.

Suppository: DICLOFENAC 100mg

TRAMADOL 100mg

Blood Loss: ~500ML

NOTES

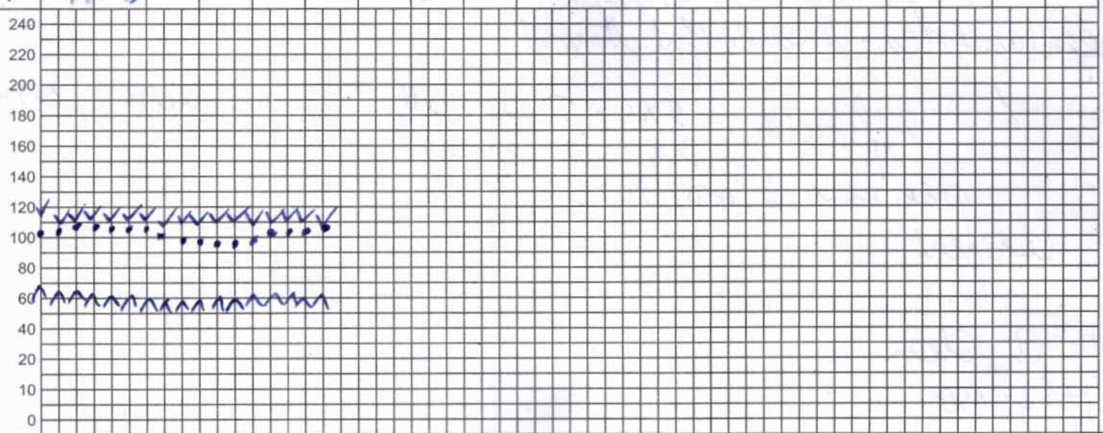
B.P: V Systolic, Λ Diastolic, X Mean, • Heart Rate

Tourniquet on Time

Tourniquet off Time

Throat Pack In

Throat Pack Out



LAB Values: ABG | GRBS | Others

☑ Equipment Checked and Functional	**Temp:**	**Induction**	**Regional:**
☑ BP	☐ HME ☐ Fluid Warmer	☐ IV ☐ Inhal	Extremity Specify:
☐ Cuff Site: (R) UL	☐ Cling Film ☐ OH Warmer	☐ Pre O_2 ☐ RSI	☑ Spinal ☐ Epidural ☐ Caudal
☐ Art Site:	☐ Hugger's ☐ Cotton Wool	☐ Others	Others:
☑ EKG Lead 3 leads	☑ Other sheets	☐ Mask ☐ SGA	Position: sitting
☐ Temp Site	**Times:**	☐ Airway ☐ Oral ☐ Nasal	Site: L3-4
☐ FIO_2 Monitor	Anaes Start: 5AM	ETT# at cm	Needle Size: 27G (P) Depth:
☐ Agent Monitor	OP Start: ↓	☐ Oral ☐ Nasal ☐ Cuff	Parasthesia ☐ Yes ☐ No
☑ Pulse Oximeter	OP End:	☐ Tracheostomy ☐ Topical	Catheter at skin cm
☐ Capnograph	Leave OR: 630am	☐ Drug:	Drug Name & Conc: 10mg BUPIVACAINE (H)
☐ Ventilator	**Anaesthesia:**	☐ Awake ☐ Direct Vision	Bolus: + 25MCG FENTANYL
☐ Nerve Stimulator	☐ GA	☐ Video Laryngoscopy ☐ Stylette / Bougie	Infusion:
Position: Supine	☐ Monitored Anaesthesia Care	☐ Fiberoptic	Block Level: T4 B/L equal to pin prick
☑ Pressure Points Checked	☑ Regional	Blade# Attempts:	Comments:
Eye Care:	**Line (Size & Location)**	Difficulty Why?	Transportation to
☐ Oint	☐ CVP:	☐ **Bilat = BS**	☑ PACU ☐ ICU ☐ Other
☐ Tape	☐ ART:	☐ Semi-Closed Circle	Relaxant Reversed ☐ Yes ☐ No ☑ NA
☐ Padding	☑ IV: 18G (R) UL	☐ Closed Circle	Name of the Doctor: Dr Samir
☑ Awake	☑ IV: 18G (L) UL	☐ Other	Signature of the Doctor: [signature]
	☐ IV:		

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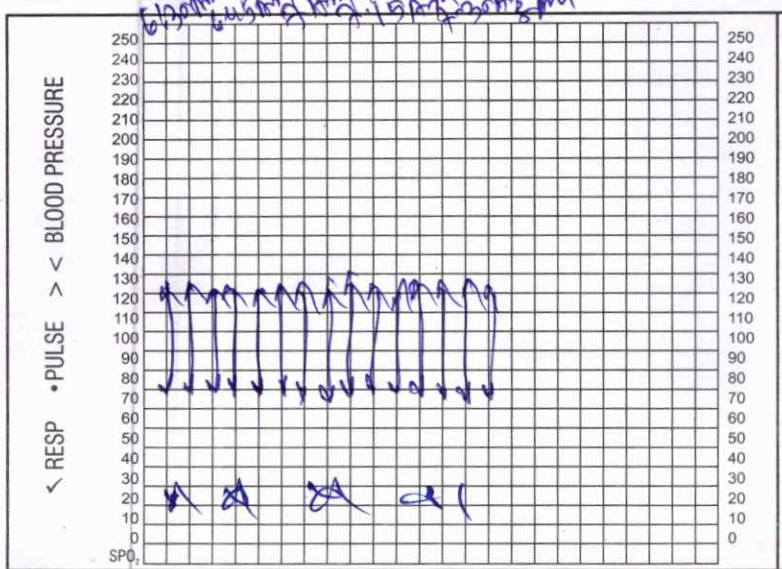
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Mad Shu Time Received : 6:30Pm Time Discharged : .....



IV Cannula Site : Left

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

Vomiting : ☐ Yes ☑ No Drug: Tarziem
NG Tube : ☐ Yes ☑ No
Drain: ☐ Yes ☑ No
Urinary Catheter: ☑ Yes ☐ No
Chest Tube: ☐ Yes ☑ No
Nil Oral ☐ Yes ☑ No
IV Fluids: RL
Oral Feeds: .....

POST ANAESTHESIA SCORE (Modified Aldrete Score)		IN	MINUTES 30	60	90	OUT	SCORING INTERPRETATION
Able to move 4 extremities voluntary or on command = 2 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 0	ACTIVITY	1	1	2	2		A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0	RESPIRATION	2	2	2	2		
BP ± 20 of Pre Anaesthetic leve = 2 BP ± 20-50 of Pre Anaesthetic leve = 1 BP ± 50 of Pre Anaesthetic leve = 0	CIRCULATION	2	2	2	2		
Fully awake = 2 Arousable on calling = 1 Not responding = 0	CONSCIOUSNESS	2	2	2	2		
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0	COLOR	2	2	2	2		
	TOTAL	9	9	10	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
26/6	6:30Pm	0	Normal	
26/6	7:30Pm	0	Normal	

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

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

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

PACU Nurse Name : .....
PACU Nurse Signature: .....
Date & Time: .....

Transferred to Unit by (PACU): .....
Date & Time: .....

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EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : .....

Any other issues :

a) .....

b) .....

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

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

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

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
BAH-00524030 IP26-00006649 Mrs P SAI NITHYA 03-02-1993 33 Y 4 M 23 D (F) Dr. RAJANI KUMARI	25/6/26	26/6/26 @ 6:3am
	Transfer Ordered by Dr. Savir	Reason for Transfer observation
From Unit OT	To Unit PICU Post	Information to Attendant Yes ☐ No ☐
Number of Sheets in Clinical File (38)	Number of Imaging Films (2)	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	RL	(1)
2.		
3.		
4.		
5.		

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

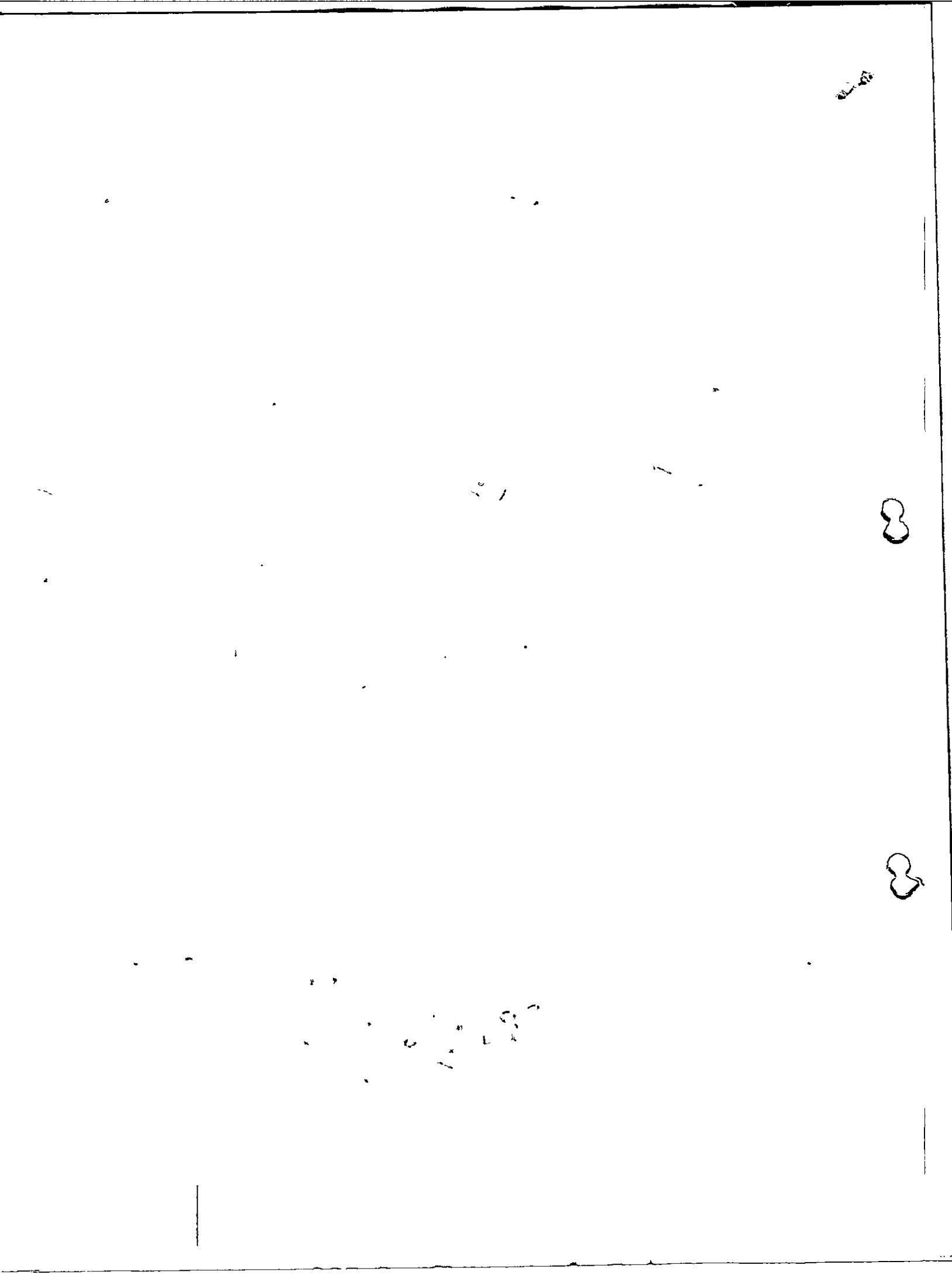
Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sangeetha	DR Swathi

Patient & Clinical Records Received by : 26/6/26 @ 6:00am

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

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
BAH-00524030 IP26-00006649 Mrs P SAI NITHYA 03-02-1993 33 Y 4 M 22 D (F) Dr. RAJANI KUMARI	25/6/26 10:54PM	28/6/26 @ 4:50 AM
	Transfer Ordered by DR Swathi	Reason for Transfer 2SCS
From Unit Pre-post	To Unit OT	Information to Attendant Yes ☐ No ☐
Number of Sheets in Clinical File 35	Number of Imaging Films 8	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.	Blood (2)	
3.		
4.		
5.		

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

DR Rajani Kumari

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sri Naikalli	DR Swathi

Patient & Clinical Records Received by : Sangeetha

Date & Time of Patient Received : 28/6/26 @ 4.50 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

BAH-00524030
Mrs P SAI NITHYA
03-02-1993
Dr. RAJANI KUMARI
IP26-00006649
33 Y 4 M 23 D
(F)

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INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

Patient Name : SAI · NITYA · P Gender: ☐ Male ☑ Female Age : 32 F.

UHID No : BAH-00524030. Date : .....

Instruction:

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

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

CESAREAN MYOMECTOMY.

upon

(Name of the Patient) SAI NITYA · P.

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

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

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

- Excess Bleeding / need of Blood & blood product transfusion. Injury to fetal structures.

My signature on this form indicates that

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

Name of the Doctor who is performing the Surgery / Procedure: Dr. P. V. Reddy / Dr Rajani

Consentee :

Signature : P Nithya

Name : P Nithya

Date & Time : 26/6/26 @ 4:00AM

Witness :

Signature : Madhu

Name : Madhumita

Date & Time : 26/6/26 @ 4AM

Patient Attendant :

Signature : S.P.

Name : Aditya Saikiran P

Relationship with Patient: Husband

Date & Time : 26/6/26 @ 4:00AM

Doctor (who is taking the consent) :

Signature :

Name : DR. NAME

Date & Time : 26/06/2026 @ 4AM

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : SAI NITYA . P. Gender: ☐ Male ☑ Female Age : 32 F.

UHID No : BAH-00524030 Date : 26/6/2026

Instruction:

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

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

EMERGENCY LOWER SEGMENT CESAREAN SECTION +/- MYOMECTOMY. upon P. SAI NITYA (Name of the Patient)

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

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

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

-EXCESS BLEEDING, NEED OF BLOOOD & BLOOD PRODUCTTRANFUSION RISK OF INJURY TO BOWEL, BLADDER OTER VITAL STRUCTURES RISK OF INJURY TO BABY, THRMBOEMBOLISM, WOUND INFECTION.,

My signature on this form indicates that

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

Name of the Doctor who is performing the Surgery / Procedure: Dr Rapini Kumari / Dr B.V Reddy

Consentee :

Signature : Nitya

Name : P. Nithya

Date & Time : 26/6/26 @ 4:00AM

Patient Attendant :

Signature : Aditya

Name : Aaditya Saikiran Pegallapati

Relationship with Patient:

Date & Time : 26/6/26 @ 4:00AM

Witness :

Signature : Madhu

Name : Madhumitha

Date & Time : 26/6/26 @ 4AM

Doctor (who is taking the consent) :

Signature : Swathi

Name : DR SWATHI. M.

Date & Time : 26/6/2026 @ 4 AM

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : Mrs Sai Nithya Age : 32 Gender : Male ☐ Female ☑

UHID NO: BAH-524030 Surgeon Name: Dr. Rajini Kumari

Anaesthesiologist : Dr. Samir Gayath / Dr. Ayesha Sa.

Operative procedure planned : LSCS + myomectomy

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

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

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

☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure

☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma / Renal Tubular Aacidosis

☐ Incapacitating Cronic Obstructive Pulmonary Disease

☑ Others : Bleeding / Need for blood & products

Comments : .....

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

DECLARATION BY PATIENT / GUARDIAN / PROXY

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

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

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

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

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

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

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

- Pregnant : ☑ Yes ☐ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

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

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

Patient / Patient Attendant :

Signature : .....

Name : P Sai Nithya

Relationship with Patient: Self

Date & Time : 26/6/26 @ 4:00 Am

Witness :

Signature : .....

Name : Aadithya Saikiran P

Date & Time : 26/6/26 @ 4:00 AM

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. Jaswin Enayath

Date & Time : 25/6 at 1130am.

26-00002082818

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NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name: Mrs P Sai Nithya	Age: 33Y	Gender: F	
UHID No: BAH-0052403D	IP No: 26-00006669	Date: 26/6/26	Time: 3:49 Am
Diagnosis: Em ISES		(Ward-OT)	

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	100 mcg	01 Amp
2.	Morphine Sulphate Inj. 15mg/Ml	—	—
3.	Remifentanil Hydrochloride Inj. 2MG	—	—
4.	Remifentanil Hydrochloride inj. 1MG	—	—

Doctor Name: Dr SWATHI. HV. Doctor Registration No: TSMC15501

Signature: Swathi

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

IP Registration No: 26-00006649 Date: 26/6/26

Aadhaar No. of the Patient (Optional): .....

1.	Name : Mrs P Sai Nithya	Remarks
2.	Complete postal address (with contact number, if any)	Tankbund Road Gandhi Nagar
3.	Brief description of the illness	Em ISES
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	NO
5.	Details of essential Narcotic drug dispensed	INJ: Fentanyl

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
26/6	INJ: Fentanyl	01		

Dispensed by (Name & ID No.): Sania (018442) M Arvind Kumar (021257) Signature: Sania

Received by (Name & ID No.): ..... Signature: .....

Time: .....

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NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name: Mrs P Sai Nithya		Age: 33Y	Gender: F
UHID No: TAH-00524030	IP No: 26-00006644	Date: 26/6/26	Time: 3:49 Am
Diagnosis: Em LSCS (Ward - CT)			

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	100 mcg	01 Amp
2.	Morphine Sulphate Inj. 15mg/Ml	—	—
3.	Remifentanil Hydrochloride Inj. 2MG	—	—
4.	Remifentanil Hydrochloride inj. 1MG	—	—

Doctor Name: Dr SWATHI.HV. Doctor Registration No: TSMC15501

Signature: [signature]

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

IP Registration No: 26-00006644 **Date:** 26/6/26

Aadhaar No. of the Patient (Optional): ....

1.	**Name :** Mrs P Sai Nithya	**Remarks**
2.	Complete postal address (with contact number, if any)	Tankbund Road Gandhi Nagar
3.	Brief description of the illness	Em LSCS
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	NO
5.	Details of essential Narcotic drug dispensed	INJ: Fentanyl

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
26/6	INJ: Fentanyl	01		

Dispensed by (Name & ID No.): Sania (18442) Signature: Sania

Received by (Name & ID No.): M Arvind Kumar (021257) Signature: AW

Time: ....

Rainbow Children's Hospital

BirthRight

NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name | Age | Gender

UHID No | Date | Time

Diagnosis

PRESCRIPTION DETAILS (Tick only one of the following)

S No	Drug Name	Dosage	Remarks
1	Fentanyl Citrate Inj. 50mcg/Ml		
2	Morphine Sulphate Inj. 15mg/Ml		
3	Pentazocine Hydrochloride Inj. 22mg		
4	Pentazocine Hydrochloride Inj. 11mg		

Doctor Name | Doctor Registration No

Signature

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

IP Registration No: | Date:

Name and Office Patient (Optional)

1	Name	Remarks
2	Complete postal address (with contact number if any)	
3	Brief description of the illness	
4	Whether registered with any other registered medical practitioner / recognized medical institution (if yes, details of the record)	
5	Details of essential Narcotic drug dispensed	

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any

Dispensed by (Name & ID No.) | Signature

Received by (Name & ID No.) | Signature

Time