



aid  
fc



Name	Mrs NITYA CHENNURI	UHID	BAH-00550709
Father/Guardian	Mr prashanth reddy bhagirathi	Age/Gender	29 Y 6 M 7 D/ Female
Address	NIZAMABAD, Nizamabad, Nizamabad, Telangana, INDIA, 110005		
IP No	IP26-00006547	Admission Date	09-06-2026
Ref Doctor	Self.		
Discharge Date	12.06.2026		

### DISCHARGE SUMMARY

**Consultant:**  
**Dr. RAJANI KUMARI**  
MD (OBGYN)

**Diagnosis: G3A2 WITH 38 WEEKS WITH RECURRENT PREGNANCY LOSS WITH CEPHALOPELVIC DISPROPORTION WITH H/O RENAL CALCULUS FOR ELECTIVE LOWER SEGMENT CAESAREAN SECTION**

**ELECTIVE LOWER SEGMENT CAESAREAN SECTION DONE ON 09.06.2026**

**History:**

LMP: 09.09.2025  
EDD: 26.06.2026  
38weeks

Obstetric formula: G3A2  
Gestation at admission:

**Obstetric History:**

- G1 - 2023 - Missed miscarriage, SERPC at 6 weeks.
- G2 - 2024 - Missed miscarriage, MERPC at 5 weeks.
- G3 - Present pregnancy, Spontaneous conception.

**Medical History:** K/c/o renal calculus (Spontaneously expuled in April-2026), H/O recurrent UTI

**Surgical History:** SERPC-2023

**Allergies** : Nil

**Family History** : Mother-DM

Name	Mrs NITYA CHENNURI	UHID	BAH-00550709
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**Antenatal Details:**

Mrs NITYA CHENNURI was booked to Rainbow hospital at 7<sup>+3</sup> weeks of gestation. She had regular antenatal checkups and investigations as advised. NT scan was normal. FTS low risk. NIPS low risk. TIFFA was normal. Fetal echo normal. Fetal surveillance done by serial growth scans. Scan done on (02.06.2026) at 37 weeks weeks showed single live intrauterine fetus with cephalic presentation, AFI: 15.6cm EFW: 2893 (37%) AC: 24% placenta: posterior high with Doppler normal She was admitted at 38 weeks for Elective LSCS.

**Investigations:** Enclosed.

Blood group: "B" Positive

**Management: Course in hospital:**

At admission on clinical examination the vitals were stable, uterus was relaxed. Fetal well being was confirmed by an admission NST which was found to be reactive. She was prepared for elective C- section with indwelling Foley's catheter and IV canula under aseptic conditions. Written informed consent for surgery taken. Preanesthetic check up done. Anesthetic premedication (IV Pantop and Perinorm) given. Antibiotic prophylaxis with Inj. Taxim 1 gm IV given. Patient shifted to theatre.

**Surgery Notes:**

Under spinal anesthesia she was painted and draped as per hospital protocol. Abdomen opened in layers. The parietal and visceral peritoneum carefully opened after identifying the urachus. Bladder was reflected. A Lower segment curvilinear incision given on the uterus. Baby delivered. Cord clamped and cut and cord blood collected for blood grouping and Rh typing. Baby handed over to pediatrician. Placenta delivered with controlled cord traction. Antibiotic prophylaxis with Inj. Taxim 1 gm IV given. Uterus closed in layers. Hemostasis secured. Instruments and swab count checked. Rectus sheath closed. Skin closed with subcuticular sutures. Wound dressing done. Vagina cleaned with Betadine solution after expelling clots. Misoprostol 600 mcg given per rectum as prophylaxis against Postpartum hemorrhage. Patient was shifted out of theatre to post operative recovery room.

**\*LUS highly vascular**

**\*Single loop of cord around neck**

**\*True knot present**

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- \*Left uterine artery ligation done
- \*Left ovary adherent to posterior surface of uterus
- \*Posterior surface - endometriotic patch present

#### Delivery Details:

Date : 09.06.2026  
Time of Delivery : 01:45pm  
Type of Delivery : Elective Lower segment caesarean section  
Indication : CPD with RPL  
Anaesthesia : Spinal

#### Baby Details:

Date : 09.06.2026  
Time : 01:45pm  
Sex : Male  
Weight : 3.080kg  
Apgar : 8,9  
Gestational Age 38 weeks  
NICU Admission: No

#### Post-Operative Notes:

She was closely monitored. Her vital signs remained stable. Uterus was well retracted with no postpartum hemorrhage. Breast feeding initiated. She was shifted to room. Thromboprophylaxis given. Her postoperative period following that was uneventful. On second postoperative day dressing was changed. On inspection wound was healthy. Her general condition was satisfactory and she was found to be fit for discharge. Wound care and medications were explained to patient supplemented by written information. She was given the postpartum book for further reference.

#### Advice:

1. Tab. Taxim O 200mg twice daily till 15.06.2026 (9am-9pm) after food.
2. Tab. Calpol (Paracetamol 500mg) 2 tablets thrice daily till 13.06.2026 (8am-2pm-10pm) after food.
3. Tab. Voveran (Diclofenac-50mg) 1 tablet thrice daily till 13.06.2026 (9am-3pm-11pm) after food.
4. Tab. Pantodac (Pantoprazole - 40mg) 1 tablet twice daily till 15.06.2026 (7am-7pm) before food.

Name Mrs NITYA CHENNURI UHID BAH-00550709  
IP No IP26-00006547 Admission Date 09-06-2026

5. Tab. Livogen (Elemental Iron - 50mg, folic acid 1.5mg) once daily (7am) for three months before breakfast.
6. Tab. Shelcal (Elemental Calcium 500mg, vitamin D3 250 IU) once daily (2pm) till breast feeding after food.
7. Inj.Enoxaparin 40mg(Clexane) subcutaneously over thigh once daily(8am) till 12.06.2026
8. Nebasulf Powder for local application.

Home Blood pressure monitoring to be done **twice daily** for **two weeks**. Report to emergency if **BP >140/90mmHg**, presence of headache, vomitings, blurred vision, reduced urine output, epigastric pain, seizures.

\* Suggest **PAP smear** and **HPV Vaccine** after **6 weeks**; Please discuss with your treating doctor regarding **HPV vaccination**.

Review with **Dr. RAJANI KUMARI** after **2 week** on **25.06.2026** at Rainbow Children's Hospital with prior appointment (**Review consultation will be charged**).

#### **For Women Who Have Had a Caesarean Section Care of the wound:**

- 1.You can bath and shower.
- 2.The wound can get wet during a bath or shower. Dry it thoroughly and gently by dabbing with a gauze piece. Do not rub the wound.
- 3.This gauze piece needs to be discarded after one use.
- 4.Prior to touching the wound clean hands thoroughly with Microshield solution and allow them to air dry or use disposable paper napkins.
- 5.Apply Nebasulf or Neomycin dusting powder on the wound after it is dry.
- 6.Do not touch the wound with unwashed hands.

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, immunization and safe parenting, when and how to obtain emergency care etc also have been explained by doctor .....in a language that I can understand and I acknowledge.

Patient/ Attender

In case of emergency like bleeding, fever please refer to postpartum book for further details - Chapter II page 6 kindly contact 9154865045 at Rainbow

Name	Mrs NITYA CHENNURI	UHID	BAH-00550709
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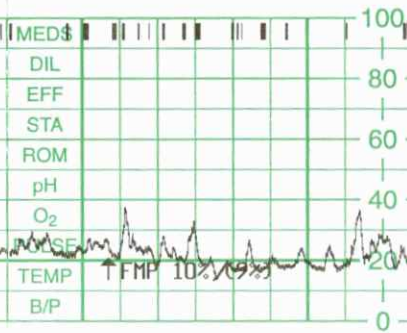
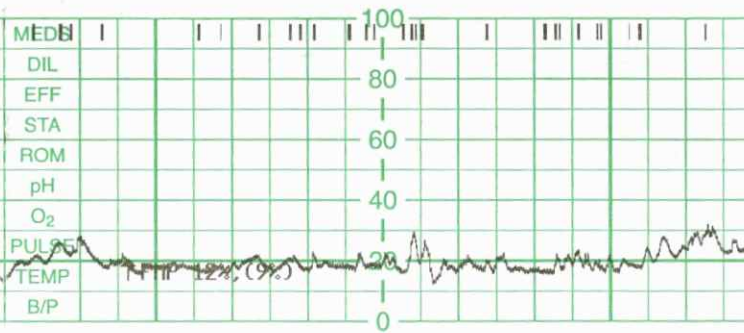
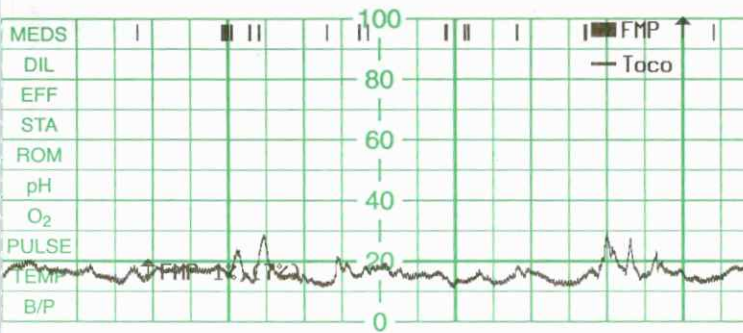
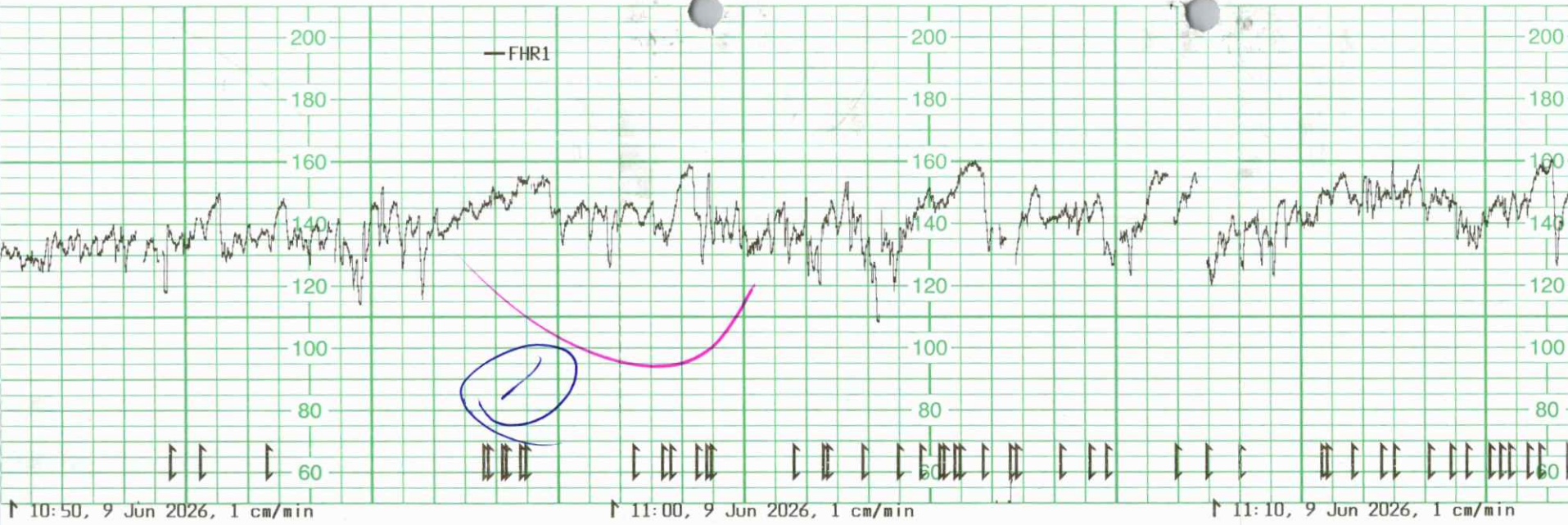
Children's Hospital just dial one toll free number - 18002122. You can also take appointments at any time by going online to our website [www.rainbowhospitals.in](http://www.rainbowhospitals.in)

  
Registrar/Resident/C.M.O

Consultant:  
**Dr. RAJANI KUMARI**  
MD (OBGYN)



Mrs Nitya, Pooja  
 11:15:58, 9 Jun 2026, 1 cm/min  
 Selftest: OK, Fu-Rev: B 01.05, Pr-Rev: A 01.11, INT RT 14  
 Product: MZ024 DE53023795 G:02:Z1, DB: A:04:24, Toco DE67823237 L: 01.05




L: 01.05: FHR1 DE67567418  
 PHILIPS



**ACTIVITY RECORD FOR BILLING**

Name : **BAH-00550709 IP26-00006547**  
**Mrs NITYA CHENNURI**  
**02-12-1996 29 Y 6 M 7 D (F)**  
**Dr. RAJANI KUMARI**

UHID No. :  Consultant: \_\_\_\_\_ Dept : \_\_\_\_\_

Date of Admission: \_\_\_\_\_ Time : \_\_\_\_\_ Date of Discharge : \_\_\_\_\_ Time: \_\_\_\_\_

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

**WARD TRANSFERS**

Date	Time	From	To	Signature of Nurse
9/6/26	1:10 PM	Pre - post	OT	<i>[Signature]</i>
9/6/26	9:30 PM	OT	pre - post	<i>[Signature]</i>
9/6/26	9 PM	Pre & post	Floor	<i>[Signature]</i>

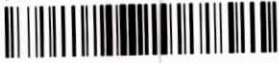
**Cross Consultation Visit**

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









# IP ADMISSION SHEET FOR OBSTETRICS

**Presenting Complaints**

Come for ELUS

Obstetric Formula:  $G_3A_2$

**Obstetric History:**

- 1 - missed AB<sup>o</sup> (Ap) x 3 (M/RPC → <sup>Gelus</sup> SRRPC)
- 2 - missed AB / May 24 / M/RPC
- 3 - PP. Spont (Brighter color)

**Present Pregnancy Record:**

M7 - (A) NIPS CR  
 FIS CR  
 TIRPA (A)

**RISK FACTORS:**

Height: ..... cm

Weight: ..... kg

Allergies: ..... Ammonia (hives)

Breast:  Normal  Abnormal

General Examination: Fair

Consciousness: (+) Pallor: (-)

Icterus: (-) Edema: (-)

Temp: Afebrile PR:

BP: DTR: (+)

CVS: RS BAP (+)

Liver/Spleen: MAS Urine Output: Adeq

LMP: 9/9/2015

EDD:

Corrected EDD: 20/6/2016  
 19/6/2016

GA: 37<sup>W5</sup> wks.

Menstrual History: Regular:  Yes  No

**Obstetric Examination**

Fundal Height: Term

Ut. Activity:  Relaxed  Mild  Mod  Severe

Liquor:  Adequate  Oligo  Poly

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

Head Fifths Palpable: \_\_\_\_\_

FHS:  Normal  Tachy  Brady  Absent

**Per Speculum Examination** not done

Draining:  Present  Absent  Bleeding

Colour of Liquor:  Clear  Meconium  Blood Stained

**Vaginal Examination** not done

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

Androd Pelvis / Narrow Subpubic Area (-)

**DIAGNOSIS**

$G_3A_2$  / 39 wks / RPL / CPD / Hb<sub>o</sub> / Renal calculus  
 for ELUS



<p>Family History:</p> <p>Mother - DM</p>	<p>Surgical History:</p> <p>SBRPC (2023)</p>
<p>Medical History:</p> <p>R/O /s R/O renal calculus (Passel Ap/26)<sup>Sp.</sup> H/O Recurrent UTI</p>	<p>Medication History:</p> <p>7. Iron (Calw)</p>
<p>Plan of Care:</p> <ul style="list-style-type: none"> <li>- NBM</li> <li>- Admission NST</li> <li>- Pains papaw</li> <li>- Informed consent</li> <li>- Oxyg as charted</li> <li>- Infant Pediatrician } Anesthesiologist</li> <li>- Foley's catheterization</li> <li>- Shift to OT on call</li> <li>- collect CBP</li> </ul>	<p>Investigations:</p> <p><u>B (+ve) (Positive)</u></p> <p>HIV trbony VDRL HCV } NR</p> <p><u>CBC (7/6/2023)</u> Hb - 12.2 WBC - 9.34 Plt - 205</p> <p><u>USG (2/6/2023)</u> SLPI 37wk / N PL- PH AFI - 15.6cm Edo - 2893g (34%) AC - 247 VAD - (2)</p>

Doctor Name: D. Mamshe

Signature: [Signature]

Date & Time: 9/1/2023 @ 10:00 Am.

Consultant Name: Dr. Rajani Kumari

Signature: [Signature]

Date & Time: 9/1/2023 @ 10:00 Am.



**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
9/6/26 2:45pm	<p style="text-align: center;"><u>C/S/B Dr. Veena</u></p> <p>POD-0 / Et-LSCS + (F) ut artery ligation</p>	<p style="text-align: center;"><u>Adv</u></p>
<p>Baby @ 4:15</p>	<p>Pt is stable, No clo          o/e AC fair          BP- 121/80          PR- 87          SpO<sub>2</sub>- 100% on RA.          P/A- Ut well retracted          BS (F)          L/C- BWNL          u/b 100 cc (or empty)</p>	<ul style="list-style-type: none"> <li>- NBM for 4-6 hours</li> <li>- Vital monitoring</li> <li>- I/O charting</li> <li>- w/o excessive bleeding</li> <li>- ENF's, Analgesics &amp;</li> <li>- Thromboprophylaxis as per AXON</li> <li>- Foley's removal @ 6am</li> <li>- IV Abx for 24 hours</li> <li>- Inform SOS</li> </ul>
9/6/26	<p style="text-align: center;"><u>C/S/B Dr. Dna</u></p>	<p style="text-align: center;"><u>Adv</u></p>
<p>8:30am</p> <p>Baby &amp; Mother</p> <p>Pt can be shifted to room</p>	<p>POD-0 Et-LSCS          AC fair Afebrile          BP: 130/70 mmHg          PR: 106/min          SpO<sub>2</sub>: 100% on RA          P/A- uterus Retracted          BS (F) well          L/C BWNL          u/b- 100ml          50ml/hr.</p>	<ul style="list-style-type: none"> <li>- Oral sips allowed</li> <li>- Drugs as charted</li> <li>- urine I/O charting</li> <li>- w/o excessive bleeding</li> <li>- IV fluids.</li> <li>- Analgesics &amp; thromboprophylaxis as per AXON.</li> <li>- Foley's removal at 6AM tomorrow.</li> <li>- Inform SOS</li> </ul>

*[Handwritten signature]*



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>10/6/26</u>	<u>C/S/B Dr. Dug</u>	
7:30 AM	POD-1	Adv
Baby & Mother	C/C Fair, Afebrile BP!	Soft diet Drugs as charted
passed flatus	PR 84% P/A uterus retracted well	Adequate hydration Monitor vitals
	UE NAB	w/ft bloody PV Inform SOS BP monitoring 2nd hour
	<u>C/S/B Dr. Rajani kumari / Dr Veera</u>	
<u>10/6/26</u>		
12:30 PM	POD-1	Adv
FL ✓ U ✓ SX ✓	Pt is stable Nocto o/e GC - fair, Afebrile Vitals - stable	Soft diet Drugs as charted
	P/A - Ut well retracted MS ⊕	Ambulation 3rd hourly Adequate hydration
	UC - Bw NL Blc Breasts - Soft, MS ⊕	Dulcolax @ npt. (If didn't pass stool) Vitals monitoring.
		Inform SOS.
		C. Coofare 26hr BD BP 2 <sup>nd</sup> hourly monitoring. N.B. maheshwari



**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
10/6/2016	CS1b Dr Mansha	
7pm		
		Ad
	GC - far Afebrile	Soft Diet / Adeq Hydration
	vitals stable	Drops as chart
	P/A ut well retained	Monitor vitals
U✓	BS ⊕	Ambulation
F✓	LGE Bloody urine. ⊕	DULCOPAR SUPPOSITORY ⊕ P/R
Sx	No Complaints	@ 10pm (10pm) Tonight
		Infirm sus
		N. B. maheshwari
		M Dman
11/6/2016	CS1b Dr Mansha	
7am	POO 2	
		Ad
	GC far Afebrile	Regular Diet / Adeq Hydration
	vitals stable	Drops as chart
Bmy	P/A ut well retained	w/ vitals & SR
	BS ⊕	Ambulation
	Pv Bloody urine	Infirm sus
U✓	No Complaints	Noted by Riya @ 7am
SV		11/6/2016
		M Dman

BAH-00550709 IP26-00006547  
 Mrs NITYA CHENNURI  
 02-12-1996 29 Y 6 M 7 D (F)  
 Dr. RAJANI KUMARI



# DRUG CHART

Date of Admission: 9/1/2020 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)

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

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

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

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



REGULAR PRESCRIPTIONS

Weight. 75kg Ward. 2DT

Verified by Dr. Dhakshayani

DRUG : <u>IN CEFOTAXIME</u>				Date Time	<u>9/6</u>	<u>10/6</u>
Dose	Route	Frequency	Start Date			
<u>1g</u>	<u>IV</u>	<u>3D</u>	<u>9/6</u>			
Name & Signature of the Doctor Starting the Drugs:				<u>9am</u>	<u>X</u>	<u>STOP</u>
Additional Instructions: (A/D)				<u>10pm</u>	<u>X</u>	<u>STOP</u>
				<u>12pm</u>	<u>X</u>	<u>STOP</u>
Daily Doctor's Endorsement by a Sign				<u>6</u>	<u>✓</u>	

DRUG : <u>PARACETAMOL</u>				Date Time	<u>9/6</u>	<u>10/6</u>
Dose	Route	Frequency	Start Date			
<u>1gm</u>	<u>IV</u>	<u>TID</u>	<u>9/6</u>			
Name & Signature of the Doctor Starting the Drugs:				<u>8am</u>	<u>X</u>	<u>STOP</u>
Additional Instructions: <u>N FOR 24 HOURS FOLLOWED BY ORAL</u>				<u>9pm</u>	<u>X</u>	<u>STOP</u>
				<u>10pm</u>	<u>X</u>	<u>STOP</u>
Daily Doctor's Endorsement by a Sign				<u>6</u>	<u>✓</u>	

DRUG : <u>DICLOFENAC</u>				Date Time	<u>9/6</u>	<u>10/6</u>
Dose	Route	Frequency	Start Date			
<u>50mg</u>	<u>P/O</u>	<u>TID</u>	<u>9/6</u>			
Name & Signature of the Doctor Starting the Drugs:				<u>7am</u>	<u>X</u>	<u>STOP</u>
Additional Instructions:				<u>3pm</u>	<u>X</u>	<u>STOP</u>
				<u>11pm</u>	<u>X</u>	<u>STOP</u>
Daily Doctor's Endorsement by a Sign				<u>6</u>	<u>✓</u>	

DRUG : <u>TRAMADOL</u>				Date Time	<u>9/6</u>	<u>10/6</u>
Dose	Route	Frequency	Start Date			
<u>100mg</u>	<u>P/O</u>	<u>TID</u>	<u>9/6</u>			
Name & Signature of the Doctor Starting the Drugs:				<u>8am</u>	<u>X</u>	<u>STOP</u>
Additional Instructions:				<u>4pm</u>	<u>X</u>	<u>STOP</u>
				<u>12pm</u>	<u>X</u>	<u>STOP</u>
Daily Doctor's Endorsement by a Sign				<u>6</u>	<u>✓</u>	



Sheet No: .....

**REGULAR PRESCRIPTIONS**

Weight 10kg Ward .....

<b>DRUG : ENOXAPARIN</b>				Date/Time	10/6 11/6/26
Dose	Route	Frequency	Start Dt.		
400	S/C	OD	10/6	8 AM	
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions: <u>APRIL OB/GYN CONSULTATION.</u>					
Daily Doctor's Endorsement by a Sign					
<b>DRUG : PANTOPRAZOLE</b>				Date/Time	10/6 11/6/26
Dose	Route	Frequency	Start Dt.		
40mg	P/O	OD	9/6/16		
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
<b>DRUG : CEFIXIME</b>				Date/Time	
Dose	Route	Frequency	Start Dt.		
200mg	P/O	BD			
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
<b>DRUG : PARACETAMOL</b>				Date/Time	10/6 11/6/26
Dose	Route	Frequency	Start Dt.		
1g	P/O	TID	10/6/26	6 AM	
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

Verified by Dr. Dhakshayani



Sheet No: .....

**REGULAR PRESCRIPTIONS**

Weight 7.5 kgs Ward .....

<b>DRUG :</b> P. CEFEXIME				Date Time	11/6																
Dose	Route	Frequency	Start Dt.																		
200mg	P/O	BD	10/6/26	10AM																	
Name & Signature of the Doctor Starting the Drugs:				[Signature]																	
Additional Instructions:				10PM																	
Additional Instructions:				<u>At 10AM</u>																	
<b>Daily Doctor's Endorsement by a Sign</b>				1																	
<b>DRUG :</b> C. LACTARE				Date Time	10/6	11/6/26															
Dose	Route	Frequency	Start Dt.																		
2tabs	P/O	BD	10/6/26	12PM																	
Name & Signature of the Doctor Starting the Drugs:				[Signature]																	
Additional Instructions:				12PM																	
Additional Instructions:				[Signature]																	
<b>Daily Doctor's Endorsement by a Sign</b>				2																	
<b>DRUG :</b>				Date Time																	
Dose	Route	Frequency	Start Dt.																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
<b>Daily Doctor's Endorsement by a Sign</b>																					
<b>DRUG :</b>				Date Time																	
Dose	Route	Frequency	Start Dt.																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
<b>Daily Doctor's Endorsement by a Sign</b>																					

Verified by Dr. Dhakshayami

Verified by Dr. Dhakshayami

Signature  
VERIFIED BY: Name



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
		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
		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
9/6	12:30pm	IN PANTOPRAZOLE	40mg	IV	[Signature]	[Nurses]
9/6	12:30pm	IN METOCLOPRAMIDE	10mg	IV	[Signature]	[Nurses]
9/6	200pm	DICLOFENAC	100mg	PR	[Signature]	[Nurses]
9/6	2pm	TRAMADOL	100mg	PR	[Signature]	[Nurses]
9/6	2pm	METHELGINE	0.2mg	IV	[Signature]	[Nurses]
9/6	2pm	ONDANSETRON	4mg	IV	[Signature]	[Nurses]
9/6	2pm	3mg TRANEXAMIC ACID	1gm	IV	[Signature]	[Nurses]
9/6	8pm	3mg LASIX (FUROSEMIDE)	5mg	IV	[Signature]	[Nurses]
9/6	10:30pm	DULEOLAX SUPPOSITORIES	20mg	P/R	[Signature]	[Nurses]

Signature  
VERIFIED BY: Name

Verified by  
Dr. Divyashrayani



I.V. FLUIDS CHART

Weight: Alex Ward: 201

Signature  
VERIFIED BY: Name

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
9/6	9:30 AM	RINGER LACTATE	IV	100 ml/hr	<u>A</u>	<u>Alex</u> <u>Alex</u>	9/6	<u>hi</u>	<u>A</u> <u>Alex</u>
9/6	130 PM	RINGER LACTATE + 6U OXYTOCIN	IV	200	<u>m</u>	<u>A</u> <u>Alex</u>	9/6	<u>n</u>	<u>Alex</u> <u>Alex</u>
9/6	4 PM	RINGER LACTATE	IV	FF	<u>R</u>	<u>ck</u> <u>Alex</u>	9/6	<u>A</u>	<u>Alex</u> <u>Alex</u>
9/6	6 PM	RINGER LACTATE	IV	FF	<u>n</u>	<u>A</u> <u>Alex</u>	9/6	<u>n</u>	<u>Alex</u> <u>Alex</u>
9/6	9 PM	RINGER LACTATE	IV	100ml	<u>n</u>	<u>A</u> <u>Alex</u>	10/6	<u>n</u>	<u>Alex</u> <u>Alex</u>
		<u>stop</u>							
		<u>M. Dhanalakshmi</u>							

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Mrs NITYA CHENNURI  
02-12-1996 29 Y 6 M 7 D (F)  
Dr. RAJANI KUMARI



210

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

BirthRight  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

### RESULT SHEET

Date	7/6/20.				
Time					
Hb	12.2				
PCV					
RBC					
WBC	9.34				
N/L					
Platelets	207				
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 grouping 'B' +ve						
HIV } HCV } NR VDRL } HbsAg }						

Culture and Sensitivities : .....

.....

.....

.....

Radiology :      USG : .....

                    X-Ray : .....

                    ECHO : .....

                    CT : .....

                    MRI : .....

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









# FLUID CHART

Sheet No. : 11

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
9/16/26	08:00 am											
	09:00 am											
	10:00 am	RL		100ml								
	11:00 am	RL	H	100ml								
	12:00 pm	RL	R	100ml								
	01:00 pm	RL	m	100ml								
<b>Total Intake :</b>			Taken			<b>Total Output :</b>						
9/16/26	02:00 pm	RL		100					100ml			
	03:00 pm	RL		100								
	04:00 pm	RL		100					50			
	05:00 pm	RL		100								
	06:00 pm	RL		100								
	07:00 pm	RL	DRP		100					100ml		
<b>Total Intake :</b>			Taken			<b>Total Output :</b>						
9/16/26	08:00 pm	RL	H2O	100ml					200ml			
	09:00 pm	RL		100ml								
	10:00 pm	RL		100ml								
	11:00 pm	RL		100ml								
	12:00 am	RL		100ml								
	01:00 am	RL		100ml								
<b>Total Intake :</b>			Taken			<b>Total Output :</b>						
10/16/26	02:00 am	RL		100ml								
	03:00 am	RL		100ml								
	04:00 am	RL		100ml								
	05:00 am	RL	H2O	100ml								
	06:00 am	RL		100ml								
	07:00 am	RL		10ml					1000ml			
<b>Total Intake :</b>			Taken			<b>Total Output :</b>						

**Total 24 hrs. Intake**

**Total 24 hrs. Output**

BAH-00550709 IP26-00006547  
 Mrs NITYA CHENNURI  
 02-12-1996 29 Y 6 M 7 D (F)  
 Dr. RAJANI KUMARI



# FLUID CHART

Sheet No. : .....

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

		Intake				Output					IV Site Thrombophlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
10/6/26	08:00 am		Salli			/						
	09:00 am					/		NA				
	10:00 am	o	+		NA	/	o					
	11:00 am		H2O			/						
	12:00 pm					/						
	01:00 pm					/						
<b>Total Intake :</b> Taken					<b>Total Output :</b> U-1 M-							
10/6/26	02:00 pm					/						
	03:00 pm					/						
	04:00 pm		Kachidi			/						
	05:00 pm					/		NA				
	06:00 pm					/						
	07:00 pm					/						
<b>Total Intake :</b>					<b>Total Output :</b>							
10/6/26	08:00 pm					/						
	09:00 pm		VPma			/						
	10:00 pm		+			/						
	11:00 pm	o	H2O			/						
	12:00 am					/						
	01:00 am					/						
<b>Total Intake :</b> Taken					<b>Total Output :</b> U-2 M-1							
10/6/26	02:00 am					/						
	03:00 am					/						
	04:00 am		H2O			/						
	05:00 am	o				/						
	06:00 am		H2O			/						
	07:00 am					/						
<b>Total Intake :</b> Taken					<b>Total Output :</b> U- M-							

**Total 24 hrs. Intake**

**Total 24 hrs. Output**

BAH-00550709 IP26-00006547  
 Patient Mrs NITYA CHENNURI  
 02-12-1996 29 Y 6 M 8 D (F)  
 Dr. RAJANI KUMARI



# FLUID CHART

Sheet No. : .....

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

		Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine				
			Mouth	I.V	N.G								
11/02/20	08:00 am												
	09:00 am												
	10:00 am	o	SBW								o	(Signature)	
	11:00 am												
	12:00 pm		H <sub>2</sub> O										
	01:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							

**Total 24 hrs. Intake**

**Total 24 hrs. Output**

Patient Sticker



# 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	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							

<b>Total 24 hrs. Intake</b>	
-----------------------------	--

<b>Total 24 hrs. Output</b>	
-----------------------------	--



# NURSING CARE RECORD

Date: 9/6/26

- 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	8AM	→ Assess the pt condition	8AM	→ Assessed the pt condition	I/O chart maintained	patient is stable	Sri
	To	→ plan for vitals → plan for I/O chart	To	→ vital are checked & recorded → I/O chart maintained			
	2PM	→ plan for DB plan	2PM	→ IV placement done			
Afternoon	9PM	→ Assess the pt condition	9PM	→ Assessed pt condition	patient is stable	vital's is normal	Aashu
		→ check the vital's		→ checked vital's & recorded			
		→ I/O chart maintain		→ maintained I/O chart			
8PM	→ plan for Medication	8PM	→ given Medication as per doctor's order				
Night	8PM	→ Assess pt condition	8PM	→ Assessed pt condition	Patient is stable	Re-checked vitals	Sri
	to	→ monitor the vitals	to	→ monitored vitals			
		→ maintain I/O chart		→ maintained I/O chart			
8AM	→ Drugs per chart	8AM	→ Drugs as per chart				

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 Mrs NITYA CHENNURI  
 02-12-1996 29 Y 6 M 7 D (F)  
 Dr. RAJANI KUMARI



# NURSING CARE RECORD

Date: 10/6/26

- 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	8Am ↓ 2pm	- Assess the pt condition - Monitor vitals - Maintain I/O Chart - medication Give as per drug chart	8Am ↓ 2pm	- Assessed the pt condition - monitored vitals - maintain I/O Chart - medication Give as per drug chart	pt is stable	Re checked vitals	manisha
Afternoon	2pm ↓ 8pm	→ plan soft diet → monitor the vitals → plan Ambulation 3rd h. → drugs give as per drug chart.	2pm ↓ 8pm	→ planned soft diet. → monitored the vitals. → planned Ambulation 3rd h. → drugs given as per drug chart.	→ pt is stable now.	→ Re assessed the vitals	(Signature)
Night	8pm ↓ 8Am	→ Assess the pt condition → Check the vital sign → Maintain the I/O Chart → Administer medication as per Doctor's advice.	8pm ↓ 8Am	→ Assess the patient condition → check the vital sign → Maintain the I/O Chart. → Administer medication as per Doctor's advice.	→ patient is stable now	→ Re assessed the vitals	(Signature)



# NURSING CARE RECORD



Date: 11/6/26

**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	8AM    2pm	→ Assess the pt condition. → monitor the vitals. → plan dress dressing today. → drugs give as per drug chart.	8AM    2pm	→ Assessed the pt condition. → monitored the vitals. → planned closed dressing Today. → drugs given as per drug chart.	→ pt is stable now	→ Re-assessed the vitals.	
Afternoon							
Night							

Patient Sticker

# NURSING CARE RECORD



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
- 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
<b>Morning</b>							
<b>Afternoon</b>							
<b>Night</b>							



## NURSING SHIFT HAND OVER FORM - WARD

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

SITUATION	Diagnosis: <span style="font-size: 1.2em; color: blue;">LSCS</span>		Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: .....					
BACKGROUND	Area	Shift Time	9/16 8AM	9/16 8-2	9/16/26 N1	10/6/26 MS	10/6/26 N1	11/6/26 MC
	Medical Condition (Any special condition to be noted):		NA	-	-	-	-	-
ASSESSMENT	Allergy:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Tubes/Drains/Catheter:		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:		Temp: 98.0	Temp: 98.1	Temp: 98.2	Temp: 98.6 F	Temp: 98.6 F	Temp: 98.1 F
			Res: 20	Res: 20	Res: 22	Res: 26b	Res: 26b	Res: 26b
			SpO <sub>2</sub> : 99%	SpO <sub>2</sub> : 98%	SpO <sub>2</sub> : 99%	SpO <sub>2</sub> : 99%	SpO <sub>2</sub> : 98%	SpO <sub>2</sub> : 99%
			Pulse: 87	Pulse: 100	Pulse: 88	Pulse: 96b	Pulse: 92b	Pulse: 80b
			BP: 110/75	BP: 120/80	BP: 130/82	BP: 121/84	BP: 112/85	BP: 110/75
RECOMMENDATIONS	Safety Needs:		NA	-	yes	-	yes	yg.
	Physiotherapy		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Others Specify:		NA	-	-	-	-	-
	Special Diet:		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Other Special Orders / Medications:		NA	-	-	-	-	-
Post Operative Procedure Special Orders:		NA	-	-	-	-	-	
Handed Over By Name :		Sivaltha	Anusha	Anusha	Seshu	Suman	mahi	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		9/16/26	9/16/26	10/6/26	10/6/26	10/6/26	11/6/26	
Time:		3PM	8PM	8AM	2PM	8AM	2PM	
Taken Over By Name :		Anusha	Madhu	Seshu	mahi	mahi		
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]		
Date:		9/16/26	9/16/26	10/6/26	10/6/26	11/6/26		
Time:		2PM	8PM	8AM	8PM	8AM		

BAH-00650709 IP26-00066547  
 Mrs NITYA CHENNURI  
 02-12-1995 29 Y 6 M 8 D (F)  
 Dr. RAJANI KUMARI



## NURSING SHIFT HAND OVER FORM - WARD

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

<b>SITUATION</b>	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: .....					
<b>BACKGROUND</b>	Area						
	Shift Time						
	Medical Condition (Any special condition to be noted):						
<b>ASSESSMENT</b>	Allergy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Vital Signs:	Temp:					
		Res:					
		SpO <sub>2</sub> :					
		Pulse:					
		BP:					
	Fall Risk Score:						
	Pain Score:						
<b>Recommendations</b>	Safety Needs:						
	Physiotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Others Specify:						
	Special Diet:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Other Special Orders / Medications:						
	Post Operative Procedure Special Orders:						
	Handed Over By Name :						
	Signature :						
	Date:						
	Time:						
	Taken Over By Name :						
	Signature :						
	Date:						
	Time:						



## Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	9/6	9/6	10/6	Fall Risk Grading		
		Score	8 AM	5 <sub>2</sub>	M <sub>6</sub>	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						
Secondary Diagnosis (more than one diagnosis)	Yes	15				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
Ambulatory Aid	Furniture	30				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0	0	0			
IV / Heparin Lock or Saline	Yes	20	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						
	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:			20	20	20			
		Signature	Li	AD	CB			

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



## CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	9/16 DAY-1			10/16 DAY-2			14/16 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	-		-	-	-	-			
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	NA	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	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	-		NA	NA	NA	NA			
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	-		NA	NA	NA	NA			
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	NA	-		NA	NA	NA	NA			
Signature of the Nurse				Si	AS		AS	AS	SS	MS			

**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 : Si Name : Sjantha

Signature of Ward In Charge :

Signature : K Name : Kalshuri

Patient Sticker



## CHECKLIST FOR THROMBOPHLEBITIS

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										
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										
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2										
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										
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										
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5										
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 of Ward In Charge :

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

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



## PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
9/6/26	9AM	0	NA	<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	NA	Li
9/6/26	3PM	0	NA	<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	NA	Ⓚ
9/6	8PM	0	NA	<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	NA	Ⓚ
10/6/26	12pm	0/10	NA	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input checked="" type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	Ⓚ
10/6/26	6pm	0/10	NA	<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	NA	Ⓚ
10/6/26	10pm	0/10	NA	<input checked="" type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input checked="" type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	Ⓚ
10/6/26	8AM	0/10	NA	<input checked="" type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input checked="" type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	Ⓚ
11/6/26	12pm	0/10	NA	<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	NA	Ⓚ
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

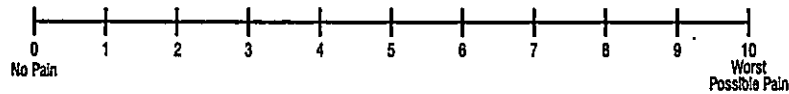
**Re-assessment Frequency:**  
 1. Every eight hours for all hospitalized patients.  
 2. For post-surgical patients, patients with chronic pain, patient with severe pain:  
 a) At least every 2 hours for the first 24 hours      b) Then every 4 hours.  
 c) Prior to pain pain-relieving intervention.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

# PAIN ASSESSMENT TOOLS

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

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



BAH-00550709

IP26-00006547

Mrs NITYA CHENNURI

02-12-1996

29 Y 6 M 7 D (F)

Dr. RAJANI KUMARI



## 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 :	9/6	9/6	10/6/26	10/6
					Time :	RAM	E2	Mc	Sw
Mobility	<b>1. Completely immobile:</b> Does not make even slight changes in body or extremity position without assistance.	<b>2. Very limited:</b> Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	<b>3. Slightly limited:</b> Makes frequent through slight changes in body or extremity position independently.	<b>4. No limitations:</b> Makes major and frequent changes in position without assistance.	4	4	4	4	
"Activity The degree of physical activity"	<b>1. Bedfast :</b> Confined to bed	<b>2. Chairfast :</b> Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.*	<b>3. Walks occasionally:</b> Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	<b>4. All patients too young to ambulate; OR walks frequently:</b> Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	3	
Sensory Perception	<b>1. Completely limited:</b> 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.	<b>2. Very limited:</b> 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.	<b>3. Slightly limited:</b> 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.	<b>4. No impairment:</b> 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	<b>1. Constantly moist:</b> Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	<b>2. Very moist:</b> Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	<b>3. Occasionally moist:</b> Skin is occasionally moist, requiring linen change every 12 hours.	<b>4. Rarely moist:</b> Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	3	
<b>FRICION-SHEAR</b> <b>Friction</b> Occurs when Skin moves against support surfaces <b>Shear</b> Occurs when skin and adjacent bony surface slide across one another	<b>1. Significant problem:</b> Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	<b>2. Problem:</b> 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.	<b>3. Potential problem:</b> 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.	<b>4. No apparent problem:</b> 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	<b>1. Very Poor:</b> 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.	<b>2. Inadequate:</b> 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.	<b>3. Adequate:</b> 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.	<b>4. Excellent:</b> 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	<b>1. Extremely compromised:</b> Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	<b>2. Compromised:</b> Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	<b>3. Adequate:</b> Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	<b>4. Excellent:</b> Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	
<b>TOTAL SCORE</b>					28	28	28	26	
<b>Evaluator's Name</b>					Fj	↓	0	27	

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

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

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

# OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 9/6/26 Time of Arrival: 9:45 AM Time Seen by Nurse: 9:50 AM

1) Level of Consciousness:  Conscious  Semi-Conscious  Unconscious

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

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

3) Vital Signs: Temperature: 98.6 Pulse: 85 RR: 20 SpO<sub>2</sub>: 99.7 BP: 110/75 Weight: .....

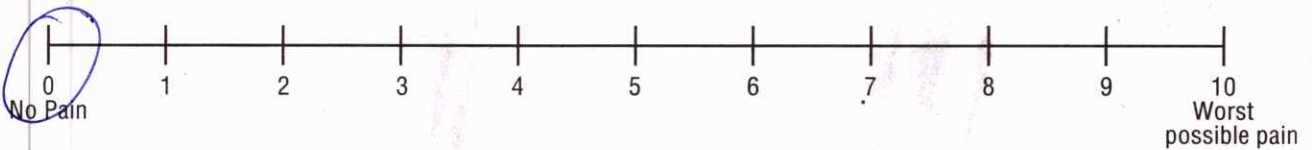
4) Gestational Criteria:

Gravida:	G <u>3</u>	P	L	A <u>2</u>
----------	------------	---	---	------------

LMP: 9/9/25 EDD: 9/6/26 Gestational Age: 39 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: .....
- Duration: ..... Days / Weeks/ Months (Strike out which is not applicable)
- Character: .....
- Frequency: .....
- Interventions: Spit

6) Past History:

- a) Surgeries: 1 2011
- b) Medical: .....



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 / PPRM < 37 Weeks	Signs of Active Labour > 37 weeks	Signs of Early Labour/ SRM > 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: ..... 10:00 AM

Nurse Name : ..... Sialha Nurse Signature: ..... [Signature]

Date: 8/6/26 Time: 11:00 AM



## LABOUR AND DELIVERY NURSING ASSESSMENT

Date of Admission: 9/6

**Baseline Information:**

Admission From:  ER  OPD  Admission Desk  Others: specify .....

Primary Language:  Telugu  English  Hindi  Others

Do you require an interpreter?  Yes  No

Source of Information:  Patient  Family  Others

Personal belonging if any:  Jewelry  Nose Ring  Bangles  Anklets  Finger Ring  Bracelets  
 handed over to .....

**Allergies:**  Yes  No  Medications  Blood Transfusion  Food  Other: .....  
 If yes, identify .....

**Chief Complaints:** ..... Doctor Notified on Admission:  Yes  No  
EL - LSCS Name of the Doctor: Dr. Naveena  
 Time Notified: 10:00 AM

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

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

**Blood Group:** B +ve LMP: 9/1/15 EDD: 19/6/16 Gestational age during admission: 39.6 wks  
 Contractions: NO Vaginal Discharge: NO

**Obstetric History:** G 3 P 1 L 1 A 2 Previous LSCS NO  
 Height: ..... Weight: 2 BMI: .....  
 Temp: 98.8 HR: 87 RR: 20 BP: 110/75 SpO<sub>2</sub>: 99%

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

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



Family history:  No Abnormalities Detected

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

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

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

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

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

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

Inform consultant for positive criteria

**NUTRITIONAL SCREENING:**

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

Inform consultant for positive criteria

**PSYCHOLOGICAL SCREENING:**

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

Inform consultant for positive criteria

**SOCIAL SCREENING:**

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

Social History: Lives With ..... Hubbard .....

**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. nitya .....

Orientation not given Reason: .....

Nurse Signature: ..... Sri Sruatha .....

Nurse Name: .....

Date & Time: 9/6/26 @ .....

BAH-00550709 IP26-00006547  
Mrs NITYA CHENNURI  
02-12-1996 29 Y 6 M 7 D (F)  
Dr. RAJANI KUMARI

## 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:

NO

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

9. Additional notes: .....

Continuity of Care:

Date: 9/6/2026

→ Assessed pt condition  
 → check the vital's  
 → No chest maintained

Handover given by ..... Amylia E-.....

Handover taken by ..... Madhunya.....

Signature ..... [Signature] .....

Signature ..... [Signature] .....

Date & Time: 9/6/2026 @ 7pm .....

Date & Time: 9/6/26 @ 2M .....



## URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 8/6.....

Date of Removal: 10/6/26 6:00 AM.....

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



## CAESAREAN SECTION OPERATIVE NOTES

Surgeon's Name: <i>Dr Rajani Kumari</i>	Date of Delivery: <i>9/6/2020</i>
Assistant Surgeon: <i>Dr Swathi HV / Dr Manu</i>	Time of Delivery: <i>01:45 pm</i>
Anaesthetist's Name: <i>Dr Samir / Dr Ayesha</i>	Gender of Baby: <i>male</i>
Type of Anaesthesia: <i>Spinal</i>	Weight of Baby: <i>3.080 kg</i>
Neonatologist: <i>Dr Anushe</i>	AGPAR Score: <i>8, 9</i>
Scrub Nurse: <i>Archana</i>	NICU Admission: <input type="checkbox"/> Yes <input type="checkbox"/> No

Pre-Operative Diagnosis: *G3P2 / 39w / RPL / CPD / H10 Renal calculus*

Elective       Emergency      Indication: *CPD & RPL*

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: *NA*      Knife to rectus: *3mm*

CTG Description: *Reactive*

If there was a delay give the reasons: *no delay*

Surgical Procedure: *Elective CS*

Post Operative Diagnosis: *ADP-0*

Peri-Operative Complications: *—*

Amount of Blood Loss: <i>~150-200cc</i>	Blood Transfused (in ML): <i>—</i>
---	------------------------------------

Name and Number of Surgical Specimen sent for examination:

*—*

**Examination Findings when Appropriate:**

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

Skin Incision:  Pfannenstiel  Transverse  Midline  Other ..... LUS highly vascular  
Uterine Incision:  Lower Segment  Classical  Inverted T  J Incision ..... Single loop of cord  
Previous Scar:  Intact  Thinned out  Ruptured  No Scar ..... True knot  
Incision Through Placenta:  Yes  No - left uterine artery ligation done  
Delivery of head:  Manual  Forceps - left ovary adherent to post surface of uterus. Post  
Liquor:  Clear  Meconium:  I  II  III  Blood  Offensive  Not Offensive Surgeon  
Delivery of Placenta:  Manual  CCT .....  Complete  Incomplete  Piecemeal made  
Cord Appearance: ..... Normal ..... True knot ..... Cord around the neck  Yes  No - Loop Endometrial  
Appearance of placenta: ..... Normal ..... Cavity explored  Yes  No Patch  
Uterus, tubes and ovaries:  Normal  Not Normal Sterilization:  Yes  No  
*Left ovary adherent to post surface of uterus*

Uterine Closure:  One Layer  Two Layers ..... Vicryl no 1-0 ..... Suture  
Peritoneal Closure:  Pelvic  Abdominal  None ..... Rapid vicryl 2-0 ..... Suture  
Sheath Closure: ..... Vicryl no 1-0 ..... Suture  
Fat Closure:  Yes  No ..... Rapid vicryl 2-0 ..... Suture  
Skin Closure:  Subcuticular  Mattress ..... Rapid vicryl 2-0 ..... Suture  
Vaginal Evacuated  Yes  No  
Drain:  Yes  No  Remove in ..... days  Await instructions  
Catheter  Yes  No  Remove in ..... days  Await instructions  
Swap & Instruments count correct?  Yes  No  Post-op Antibiotics  Yes  No  
Intra-Operative Antibiotics Cover:  Yes  No  Thromboprophylaxis  Yes  No

Post-Operative Notes: .....  
..... NBM x 4-6 hrs  
..... Wgts as checked  
..... vitals 9 BPV (exams)  
..... No mortality  
..... Foley removed @ 6am clm  
..... labem 52

Doctor Name: *D Rajan Kumar*  
Date & Time: .....

Doctor Signature: *[Signature]*

# SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Rajani Kumari  
 Asst. Surgeon : Dr. Manisha, Dr. Sudeep  
 Anaesthetist : Dr. Samir, Dr. Aysha  
 Scrub Nurse : Sr. Archana

Patient Name : Mrs NITYA CHENNURI  
 UHID No. : 02-12-1998  
 Date : 9/6/25

BAH-00550709 IP26-00006547  
 Mrs NITYA CHENNURI  
 02-12-1998 29 Y 6 M 7 D (F)  
 Dr. RAJANI KUMARI

Gender : F  
FLSCC  
 -time : .....



## Before Induction of Anaesthesia >>

SIGN IN	Time: <u>1pm</u>
<b>Patient Has Confirmed</b>	
Identity	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Site	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Procedure	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Consent	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Site Marked</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA
<b>Anaesthesia Safety Check Completed</b>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Pulse Oximeter on Patient &amp; Functioning</b>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Does Patient have a:</b>	
Known Allergy?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>Difficult Airway / Aspiration Risk?</b>	
Yes, & Equipment / Assistance Available	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>Risk of &gt; 500ml Blood Loss (7ml/kg In Children)?</b>	
Yes, and Adequate Intravenous Access and Fluids Planned	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Blood Units Reserved	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
<b>Has Antibiotic Prophylaxis been given within the last 60 minutes?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA
Signature : <u>[Signature]</u>	
Name : .....	

## Before Skin Incision >>

TIME OUT	Time: <u>1:34pm</u>
<b>Confirm all team members have introduced themselves by Name and Role</b>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Surgeon, Anaesthesia Professional and Nurse Verbally Confirm</b>	
Correct Patient (Check ID Band)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Correct Site	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Correct Procedure	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Anticipated Critical Events</b>	
<b>Surgeon Reviews:</b>	
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss?	<u>bleeding</u> <u>1hr</u> <u>500ml</u> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
<b>Anaesthesia Team Reviews:</b>	
Are There Any Patient-specific Concerns?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
<b>Nursing Team Reviews:</b>	
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
<b>Is Essential Imaging Displayed?</b>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Signature : <u>[Signature]</u>	
Name : <u>Puja</u>	

## Before Patient Leaves Operating Room

SIGN OUT	Time: .....
<b>Nurse Verbally Confirms with the Team:</b>	
The Name of the Procedure Recorded	<input type="checkbox"/> Yes <input type="checkbox"/> No
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
The Specimen is Labelled (including patient name)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Whether there are any Equipment Problems to be addressed	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
<b>To Surgeon, Anaesthetist and Nurse:</b>	
What are the key concerns for recovery and management of this patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Signature : <u>[Signature]</u>	
Name : .....	

# PATIENT TRANSFER FORM



BAH-00550709 IP26-00006547

Mrs NITYA CHENNURI  
02-12-1996 29 Y 6 M 7 D (F)  
Dr. RAJANI KUMARI



Date & Time of Admission <i>9/6/26 @ 9:58am</i>		Date & Time of Transfer Order <i>09-06-26 @ 2:30 PM</i>
Treating Consultant Name	Transfer Ordered by <i>Dr. Sanir</i>	Reason for Transfer <i>observation</i>
From Unit <i>OT -</i>	To Unit <i>Pre - Post</i>	Information to Attendant Yes <input type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File	Number of Imaging Films <i>-</i>	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what ?
Medications / Consumables / Surgicals / Hand over		
Sl.No.	Item Name	Quantity
1.	<i>RL</i>	<i>1</i>
2.		
3.		
4.		
5.		
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>		
Name & Signature of Person who is Transferring <i>Sr. Natasha</i>		Name of Person Ordered Transfer <i>Dr. Sanir</i>
Patient & Clinical Records Received by : <i>Anusha Ch</i>		
Date & Time of Patient Received : <i>09-06-26 @ 2:30 PM</i>		

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

# CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

Patient Name : Mrs. NITHYA CHENNURI Age : 29 Gender : Male  Female

UHID NO: BAH 550709 Surgeon Name: Dr. RAJANI KUMAR

Anaesthesiologist : Dr. SAMIR / Dr. AYESHA

Operative procedure planned : ELECTIVE LOWER SEGMENT CESAREAN SECTION

## PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

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

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

- Heart disease       Hypertension       Diabetes mellitus       Renal failure  
 Hepatic disorders       Shock       Multiple organ failure       Polytrauma / Renal Tubular Acidosis  
 Incapacitating Chronic Obstructive Pulmonary Disease  
 Others : Hypotension, Bleeding

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 Mrs. NITHYA CHENNURI the above mentioned operation / Diagnostic / Therapeutic procedures ELECTIVE LOWER SEGMENT CESAREAN SECTION

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 : [Signature]  
Name : NITYA CHENNURI  
Relationship with Patient : self  
Date & Time : 9/6/26 @ 10:15 AM


**Witness :**

Signature : [Signature]  
Name : PRASHANTH REDDY BHAKIRTHI  
Date & Time : 9/6/26 @ 10:15 AM

**Doctor (who is taking the consent) :**

Signature : [Signature]  
Name : Dr. Sr. Aysha  
Date & Time : 09/06/26, 10:15 AM

# PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00550709 IP26-00006547 Mrs NITYA CHENNURI 29 Y 6 M 7 D (F) 02-12-1996 Dr. RAJANI KUMARI		Date & Time of Admission 9/6/2026 @ 9:58 AM	Date & Time of Transfer Order 9/6/2026 @ 9 PM
		Transfer Ordered by Dr. DUA	Reason for Transfer observation
From Unit pre & post	To Unit 210	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 32	Number of Imaging Films NST - 1	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	pl	500ml	
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Anisha		Name of Person Ordered Transfer Dr. DUA	
Patient & Clinical Records Received by : Anantha			
Date & Time of Patient Received : 9/6/26 9pm			

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



# NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 10/6/26 Time: 10 am

Origin: Indian Height: 1.52m Weight: 75kg BMI:  ~ 26 kg/m<sup>2</sup>  
 ~ 28 kg/m<sup>2</sup>  
 ~ 30 kg/m<sup>2</sup>  
Food Allergies: No f A 32 kg/m<sup>2</sup>

Diagnosis: LSCS

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

### Diet Advised:

Liquid Diet – ORS/ Coconut Water / Butter Milk / Barley Water / Soups

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

Soft Diet – Soft Rice, Dal and Vegetable Curries Soft Cooked, Curd

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

Patient's / Attendant's

Signature: Nitya

Name: \_\_\_\_\_

Date & Time: 10/6/26 ; 10 am

Dietician's

Signature: Sobiya


Name: Syeda Sobiya Zahoor

Date & Time: 10/6/26 ; 10 am



# PATIENT TRANSFER FORM



Patient Name & UHID No.  BAH-00550709 IP26-00006547 Mrs NITYA CHENNURI 02-12-1996 29 Y 6 M 7 D (F) Dr. RAJANI KUMARI 		Date & Time of Admission  9/6/25 @ 9:58 AM	Date & Time of Transfer Order  9/6/26 @ 9:20 AM
		Transfer Ordered by  DR. Naveena	Reason for Transfer  GL-LSCS
From Unit  Pre - post	To Unit  OT	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File  30	Number of Imaging Films  - 1 -	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.	RL - 500 ml	1	
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring  Sis. Abhishek		Name of Person Ordered Transfer  DR Naveena	
Patient & Clinical Records Received by :  Arbana			
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

**Department of Anaesthesiology**  
**PRE-ANAESTHETIC EVALUATION**



Name: Mrs. Nitya Chennuri Age: 29 yr. Sex: Female UHID.No: BAH-00550109.

Date: 02/06/20 Time: 11:30 AM Proposed Operation: ELECTIVE CAESAREAN SECTION  
(#20pm) 1-2pm

Diagnosis: G3P0A2 <sup>37w</sup> weeks GA c Renal calculus

B.P / CRT: 120/74 H.R: 82/m Weight: 75 ASA Physical Status:  1  2  3  4  5

**Laboratory Data:**

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

Allergies: NKA

**Medical History:** CVS :

RESP: H/O BA<sup>+</sup> No exacerbations recently Diabetes :

CNS :

Renal: Renal Calculi<sup>+</sup>

Hepatic / GE: Regular - ANCS - Physical Activity: active<sup>+</sup>, NYHA-I.

Others: -

Past Anaesthetic History: prev. D9C + TIVA.

**Physical Exam:**

Airway: MP 1 (2) 3 4 Mouth Opening: ada Mentohyoid Distance: 3cm Neck: (N) Teeth: intact

Lungs: clear

Heart:

CNS:

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

Anaesthetic Plan:  MAC  REGIONAL  GA-ETT  LMA

Peri-Operative Plan Explained to the Patient:  Yes  No

CURRENT MEDICATIONS	DOSAGE
<u>CLEXANE 40mg</u>	<u>(stopped 2 weeks ago)</u>
<u>ECOSPRIN 75mg</u>	<u>(stopped)</u>

**Pre-Operative Instructions:**

- DVT Prophylaxis :
  - Water / ORS 2 Hours
  - Others 6 Hours
- NIL ORAL
- Informed Consent:  Standard  High Risk
- Post Operative Pain Management:  Discussed with Patient
- Other Instructions: trace csp.

Signature: [Signature] Name: Dr. Ranj



# ANAESTHESIA CHART



## Pre Induction Assessment:

Change in Patient Condition:  Yes  No Fasting Status: Adequate

Physical Status:  Patient Identified  Consent Present  Chart Reviewed

H.R: 98/min B.P / CRT: 148/86 mmHg SpO<sub>2</sub>: \_\_\_\_\_ R.R: 22/min Last Feed: → Ghs

Pre-OP Diagnosis: C2 Polio A2 C3-7+6 wks / EBOT Operation: ELECTIVE DSCS Date: 09/12/16

Surgeon: Dr. Rajani, Dr. Swathi Anaesthesiologist: Dr. Sami Technician: Swathi

TIME	13:15	13:25	13:35	13:45	14:00																
N <sub>2</sub> O / AIR / O <sub>2</sub> LPM																					
HALO / SO / SEVO																					
Drugs:																					
<u>4g OXYTOCIN 3IU IV + 6U infusion</u>																					
<u>1mg METHYLLINE 0.2mg IV</u>																					
<u>4g TRANEXAMIC ACID 1gm IV</u>																					
FIO <sub>2</sub> (SaO <sub>2</sub> )	<u>100</u>	<u>100</u>	<u>100</u>	<u>100</u>	<u>100</u>	<u>100</u>															
ETCO <sub>2</sub>																					
ECG	<u>SR</u>	<u>SR</u>	<u>SR</u>	<u>SR</u>	<u>SR</u>	<u>SR</u>															
Temperature																					
Urine Output																					
Fluids Blood																					
B.P																					
V Systolic																					
A Diastolic																					
X Mean																					
• Heart Rate																					
Tourniquet on Time																					
Tourniquet off Time																					
Throat Pack In																					
Throat Pack Out																					

Antibiotic  
 Given  
 Suppository  
 D ICLOFENAC 100mg  
 TRANDOL 100mg  
 Blood Loss

LAB Values

ABG

GRBS

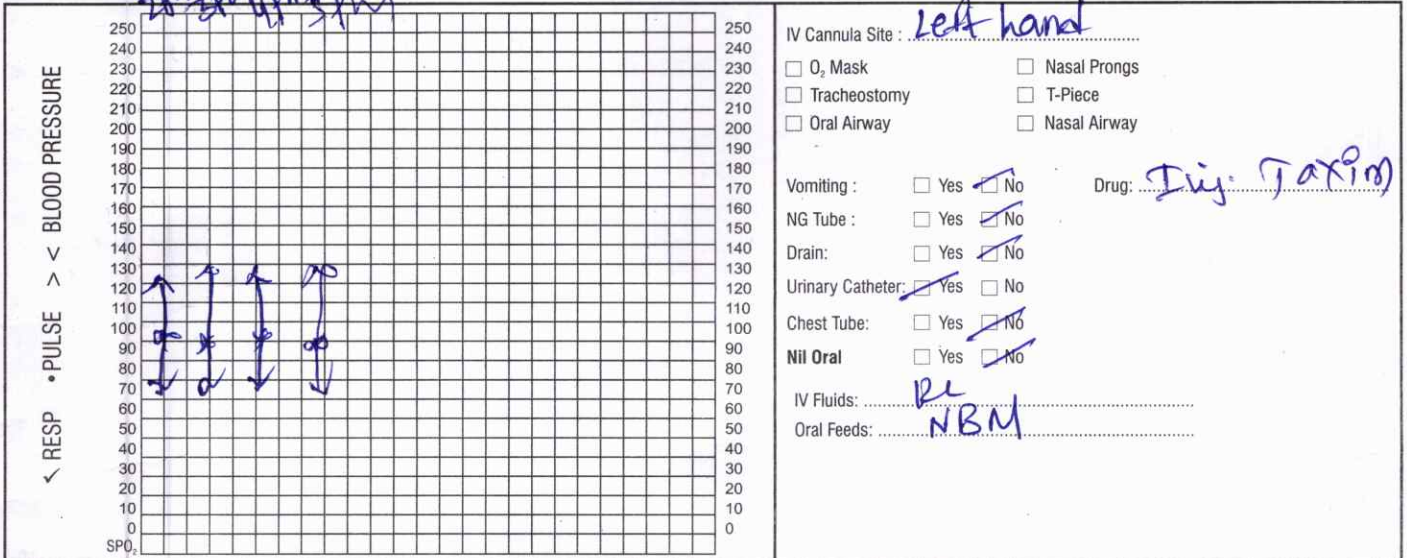
Others

<input checked="" type="checkbox"/> Equipment Checked and Functional <input checked="" type="checkbox"/> BP <u>RUL</u> <input type="checkbox"/> Cuff Site: _____ <input type="checkbox"/> Art Site: _____ <input checked="" type="checkbox"/> EKG Lead <u>3lead</u> <input type="checkbox"/> Temp Site <input type="checkbox"/> FIO <sub>2</sub> Monitor <input type="checkbox"/> Agent Monitor <input type="checkbox"/> Pulse Oximeter <input type="checkbox"/> Capnograph <input type="checkbox"/> Ventilator <input type="checkbox"/> Nerve Stimulator  Position: <u>Supine</u> <input type="checkbox"/> Pressure Points Checked  Eye Care: <input type="checkbox"/> Oint <input type="checkbox"/> Tape <input type="checkbox"/> Padding <input checked="" type="checkbox"/> Awake	<b>Temp:</b> <input type="checkbox"/> HME <input type="checkbox"/> Fluid Warmer <input type="checkbox"/> Cling Film <input type="checkbox"/> OH Warmer <input type="checkbox"/> Huggers <input type="checkbox"/> Cotton Wool <input type="checkbox"/> Other <u>Sheets</u>  <b>Times:</b> Anaes Start: <u>1:15 pm</u> OP Start: _____ OP End: _____ Leave OR: <u>2:15 pm</u>  <b>Anaesthesia:</b> <input type="checkbox"/> GA <input type="checkbox"/> Monitored Anaesthesia Care <input type="checkbox"/> Regional  <b>Line (Size &amp; Location)</b> <input type="checkbox"/> CVP: _____ <input type="checkbox"/> ART: _____ <input checked="" type="checkbox"/> IV: <u>18G @ UL</u> <input type="checkbox"/> IV: _____ <input type="checkbox"/> IV: _____	<b>Induction</b> <input checked="" type="checkbox"/> IV <input type="checkbox"/> Inhal <input type="checkbox"/> Pre O <sub>2</sub> <input type="checkbox"/> RSI <input type="checkbox"/> Others  <input type="checkbox"/> Mask <input type="checkbox"/> SGA <input type="checkbox"/> Airway <input type="checkbox"/> Oral <input type="checkbox"/> Nasal ETT# _____ at _____ cm <input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Cuff <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Topical <input type="checkbox"/> Drug: _____  <input type="checkbox"/> Awake <input type="checkbox"/> Direct Vision <input type="checkbox"/> Video Laryngoscopy <input type="checkbox"/> Stylette / Bougie <input type="checkbox"/> Fiberoptic Blade# _____ Attempts: _____ Difficulty Why? _____  <input type="checkbox"/> Bilat = BS <input type="checkbox"/> Semi-Closed Circle <input type="checkbox"/> Closed Circle <input type="checkbox"/> Other	<b>Regional:</b> Extremity _____ Specify: _____ <input checked="" type="checkbox"/> Spinal <input type="checkbox"/> Epidural <input type="checkbox"/> Caudal Others: _____ Position: <u>sitting</u> Site: <u>L3-4</u> Needle Size: <u>25G @</u> Depth: _____ Parathesia <input type="checkbox"/> Yes <input type="checkbox"/> No Catheter at skin _____ cm Drug Name & Conc: <u>10mg BUPIVACAINE (H)</u> Bolus: <u>+25mcg PENTANOL</u> Infusion: _____ Block Level: <u>T4-L1 equal to lid.</u> Comments: _____  Transportation to <input checked="" type="checkbox"/> PACU <input type="checkbox"/> ICU <input type="checkbox"/> Other Relaxant Reversed <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA Name of the Doctor: <u>Dr Sami</u> Signature of the Doctor: _____
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POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: Anusha Time Received: 2:20 pm Time Discharged: .....



POST ANAESTHESIA SCORE (Modified Aldrete Score)	IN	MINUTES			OUT	SCORING INTERPRETATION
		30	60	90		
Able to move 4 extremities voluntary or on command = 2 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 0	ACTIVITY	01	02	02	02	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	02	02	02	02	
BP ± 20 of Pre Anaesthetic level = 2 BP ± 20-50 of Pre Anaesthetic level = 1 BP ± 50 of Pre Anaesthetic level = 0	CIRCULATION	02	02	02	02	
Fully awake = 2 Arousable on calling = 1 Not responding = 0	CONSCIOUSNESS	02	02	02	02	
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0	COLOR	02	02	02	02	
TOTAL		9	10	10	10	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
9/6	2pm	0'	Normal	Anusha
9/6	4pm	0'	Normal	
9/6	5pm	0'	Normal	
9/6	9pm	0/10	NA	

Pain Tool Used:  N PASS  FLACC  Wong Baker  NPS

Reassessment Frequency:

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

Anaesthesiologist Name: Dr. SK. Aysha

Anaesthesiologist Signature: [Signature]

Date & Time: .....

PACU Nurse Name: Anusha

PACU Nurse Signature: [Signature]

Date & Time: 9/6/2026

Transferred to Unit by (PACU): 210

Date & Time: 9/6/2026



# INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE



Patient Name : Ms Nitya Chennur Gender:  Male  Female Age : 29y

UHID No : BAH-00550709 Date : 9 June 2016

**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)

ELECTIVE LOWER SEGMENT CESAREAN SECTION  
upon  
(Name of the Patient) Ms Nitya

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.

Bleedy, infection, Inadvertent injury to Bowel, Bladder or Blood vessel, Chances of Blood transfusion

**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: D. Rajani Keman

**Consentee :**  
Signature : [Signature]

Name : Ms Nitya Chennur

Date & Time : 09/06/2016 @ 10:30am

**Patient Attendant :**  
Signature : [Signature]

Name : PRASHANTH REDDY BHAGIRTHI

Relationship with Patient: Husband

Date & Time : 9 June 2016 @ 10:30 AM

**Witness :**  
Signature : [Signature]

Name : Alabi

Date & Time : 9/6/2016 @ 10:30 AM

**Doctor (who is taking the consent) :**  
Signature : [Signature]

Name : Dr Manu M.

Date & Time : 9/6/2016 @ 10:30am

26-0000205302

### NARCOTIC PRESCRIPTION FORM (PATIENT COPY)

Patient Name: Mrs. Nitya Chennuri	Age: 29y	Gender: Female	
UHID No: 0117-00550709	IP No: JP26-00006547	Date: 9/6/26	
Diagnosis: LSCS	word-OT		
PRESCRIPTION DETAILS (Tick only one of the following)			
S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/ML	100mcg	1 Amp
2.	Morphine Sulphate Inj. 15mg/ML	/	/
3.	Remifentanyl Hydrochloride Inj. 2MG	/	/
4.	Remifentanyl Hydrochloride inj. 1MG	/	/
Doctor Name: Dr. SK. AYESHA		Doctor Registration No: TSMC/FMR/07725	
Signature: <i>Aysha</i>			

### NARCOTIC DISPENSING FORM APPENDIX 4 – FORM NO. 3E

(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: JP26-00006547 Date: 9/6/26

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

1.	Name: Mrs. Nitya Chennuri	Remarks		
2.	Complete postal address (with contact number, if any)	Nizamabad Nizamabad Telangana 500005		
3.	Brief description of the illness	LSCS		
4.	Whether registered with any other registered medical practitioner / recognized medical institution ( If yes, details of the recorded)	no		
5.	Details of essential Narcotic drug dispensed	Fentanyl		
Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
9/6/26	Fentanyl	01 Amp	<i>Bashanth</i>	

Dispensed by (Name & ID No.): Sarika (021442) Signature: Sarika

Received by (Name & ID No.): Sarawathi (021006) Signature: *St*

Time: .....