Rainbow® Children's Hospital
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BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery.

ACTIVITY VIH-00202411 IP-00060236
Mrs K VENKATA HIMAJA
04-05-1998 28 Y 1 M 1 D (F)
Dr. BHAVANA K

Name: ----------

UHID No : - --------- Consultant : ---------- Dept : ----------

Date of Admission : 5/6/26 ------ Time : 7:25 Am ---- Date of Discharge : ---------- Time: ----------

Room / Bed No : ------22X---- Ward : MICU ---------- Suggested Billable bed type : ----------

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
5/6/26	9:7 Am	MICU	OT	
5/6/26	10:00 AM	OT	MICU	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
5/6/26	CBP.	V126019386	[signature]
	Chart checked by G Sharma 5/6/26 at 11am		

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
~~5/6/26~~	~~Respiration Pressure~~	~~8:30am~~			
5/6/26	Cardiac Monitor	10 am	11.40 am	3087083	
	Cross checked		by	A Shamini	5/6/26 at 11.40am

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
5/6/26	IV placement	1	3087086	[illegible]
5/6/26	PAC	1	3087085	[illegible]
~~5/6/26~~				
	Clown checked by		L Shamini	5/6/26 at 11 45 Am

ANY OTHER INFORMATION

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Secunderabad

H.No.3-7-222/223,Sy.No.51 to 54,Opp.Karkhana P S,Karkhana Main Road,Kakaguda, Karkhana ,Hyderabad ,Telangana, INDIA ,500009.
TEL NO :040-42462200, Ext 2000,2001,2002
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP-00060236 **Admit Date** : 05-Jun-2026 **Admit Time** : 07:25 AM **UHID** : VIH-00202411

Patient Details :

Patient Name	: Mrs K VENKATA HIMAJA	**Age**	: 28 Y 1 M 1 D
Guardian	: Mr P KRANTHI KUMAR	**DOB**	: 04-05-1998
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 203 nakshatra block, gk's festoon, Sainikpuri Sainikpuri Hyderabad Telangana INDIA 500094	**Phone No**	: 9573705324/ 8309036505
		E-mail	: kranthi.p7398@gmail.com

Admission Details :

Bed Type : MICU **Bed No** : LW 219 **Ward Name** : N 2F-LABOUR WARD

Room No : LW 219 **Admission Type** : First Visit

Contact Details :

Name : Mr P KRANTHI KUMAR **Relationship** : W/O

Contact Address : **Phone No** : 9573705324

Signature

Doctor Details :

Doctor Name : Dr. BHAVANA K **Specialisation** : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

Payment Mode : Cash **Deposit Amount** : 0.00

Payor Name : SELFPAY

VIH-00202411 IP-00060236
Mrs K VENKATA HIMAJA
04-05-1998 28 Y 1 M 1 D (F)
Dr. BHAVANA K

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ETRICS / GYNECOLOGY
NURSING INITIAL ASSESSMENT FORM

Date of Admission: 5/6/26

Baseline Information:

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

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

Do you require an interpreter? ☐ Yes ☑ No if Yes specify —

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

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

If yes, identify —

Chief Complaints: cervical cerclage

Doctor Notified on Admission: ☑ Yes ☐ No

Name of the Doctor: Dr. Nikhola

Time Notified: 7:30AM

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

Past Medical History	Past Surgical History	Previous Hospital Admission
H/o sciatica Right leg not on Rx	Nil	Nil

Gynecology Assessment: ☑ Not Applicable

Menstrual History: .....

Onset of Menarche: .....

Menstrual Cycle: ☐ Regular ☐ Irregular

Last Menstrual Period: .....

Gynecology Surgical History:

Caesarean Section: ☑ No ☐ Yes

Cervical Cerclage: ☑ No ☐ Yes

Ectopic Pregnancy: ☑ No ☐ Yes

Myomectomy: ☑ No ☐ Yes

Others: _____

Gynecological History:

Contraceptives: ☑ No ☐ Yes

Vaginal Discharge: ☑ No ☐ Yes

Post-Coital Bleeding: ☑ No ☐ Yes

Infertility: ☑ No ☐ Yes

If Yes Type: ☐ Primary ☐ Secondary

Obstetric History: G — P Primi L — A —

Previous LSCS: —

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

Family History: ☑ No Abnormalities Detected

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

☐ Liver disease ☐ Other Mother - DM, Father - HTN, DM

Vital Signs / Measurements: Temp: 98.6°F HR: 82b/m RR: 19b/m

BP: 121/76mmHg Weight: 57 kg Height: 150 cm BMI: .....

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

Oscare.

(P.T.O.)

VIH-00202411 IP-00060236
Mrs K VENKATA HIMAJA
04-05-1998 28 Y 1 M 1 D (F)
Dr. BHAVANA K

PHYSICAL ASSESSMENT

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

Fall Assessment: ☐ Yes ☑ No Score ..15.. (complete the Morse Fall Risk Assessment Sheet)

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

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

☐ Mobility problem ☐ Walking Problem ☑ No Abnormality Detected

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☑ No Abnormality Detected

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

☐ Under Weight ☐ Diabetes Mellitus ☐ Hyperemesis Gravidarum

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

☐ Others .....

Inform consultant for positive criteria

SOCIAL SCREENING:

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

Social History: Lives With ..family..

Orientation has been given regarding the following aspects:

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

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

Above information given to ..mrs. Himaja..

Name of Person Orientation was given to: ..mrs. Himaja..

Orientation not given Reason: ~

Nurse Signature: ..K Ri..

Nurse Name: ..K. Sukanya..

Date & Time: ..5/6/26 7:35AM..

PATIENT TRANSFER FORM

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VIH-00202411 IP-00060236
Mrs K VENKATA HIMAJA
04-05-1998 28 Y 1 M 1 D (F)
Dr. BHAVANA K

	Date & Time of Admission	Date & Time of Transfer Order
	5/6/26 at 7:25Am	5/6/26 at 9:7 Am
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
	Dr. Ashwini	cervical cerclage
From Unit	**To Unit**	**Information to Attendant**
MICU	OT	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
35	Nil	Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Dr. Ashwini

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
SPS. Prathyusha	Dr. Ashwini

Patient & Clinical Records Received by : Sr. Vanitha

Date & Time of Patient Received : 5/6/26 @ 9:07Am

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

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

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
VIH-00202411 IP-00060236 Mrs K VENKATA HIMAJA 04-05-1998 28 Y 1 M 1 D Dr. BHAVANA K	05/06/26 @7:25 AM	05/06/26 @ 10 AM.
	Transfer Ordered by Dr. Madhav	Reason for Transfer Post-OP Care
From Unit OT	To Unit MICU	Information to Attendant Yes ☐ No ☐
Number of Sheets in Clinical File 38	Number of Imaging Films — NIL —	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Dr. Ashwini

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sr. Manimala	Dr. Madhav

Patient & Clinical Records Received by : Prathyusha

Date & Time of Patient Received : 5/6/26 @ 10AM

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

VIH-00202411 IP-00060236
Mrs K VENKATA HIMAJA
04-05-1998 28 Y 1 M 1 D (F)
Dr. BHAVANA K

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IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

LMP: 1/12/2025. EDD:

Corrected EDD: 11/09/2026. GA: 26 wks.

Obstetric Formula: Primigravida.
ML - 1½ yr. NCM.

Menstrual History: Regular : ☑ Yes ☐ No

Obstetric Hostory:
G1 - present pregnancy / spontaneous conception.

Obstetric Examination

Fundal Height: - 26 wks.

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

Present Pregnancy Record: Booked to RCH since conception. H/O spotting PV at 17+5 weeks & 23+6 weeks, managed conservatively. She is on Tab. Ecospin 150 mg OD since 12+5 weeks.

Liquor: ☐ Adequate ☐ Oligo ☐ Poly

PP: ☐ Cephalic ☐ Breech Others _____

Head Fifths Palpable: _____

FHS: ☑ Normal ☐ Tachy ☐ Brady ☐ Absent
134 bpm.

RISK FACTORS:
- short cervix (26 mm)

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

Height: 150 cm
Weight: 57.20 kg
Allergies: Nil
Breast: ☑ Normal ☐ Abnormal
General Examination: pt is c/c/c
Consciousness: ⊕ Pallor: ⊖
Icterus: ⊖ Edema:
Temp: Afebrile PR: 99 bpm
BP: 122/70 DTR: ⊕
CVS: S1S2⊕ RS BAE⊕
Liver/Spleen: NAD Urine Output: Adeq

DIAGNOSIS

Primigravida with 26 weeks with Rh negative pregnancy with fibroid uterus with anemia.
with short cervix for cervical cerclage.

VIH-00202411 IP-00060236
Mrs K VENKATA HIMAJA
04-05-1998 28 Y 1 M 1 D (F)
Dr. BHAVANA K

Family History:

Mother - DM.
Father - HTN; DM.

Surgical History:

Nil

Medical History:

H/o sciatica - Right leg not on Rx.

Medication History:

Tab. Ecospsin 150 mg OD.

Plan of Care:

c/I to Dr. Bhavana mam

- Admission
- Consent
- PAC
- past preparation
- NBM
- FHR monitoring
- monitor vitals.
- Follow drug chart
- Inform SOS.
- send CBP.

noted by Suhasini
5/6/26. 7:30AM

Investigations:

BG: 'B' NEGATIVE
HBG: 'O' POSITIVE
ICT - Negative (24/2/26)

HIV
HBSAg
HCV
VDRL
} NR.

5/6/26 -
CBP - 10/13000/2.87L

- NT scan
26/02/2026.
SLIUF
11+6 wks.
NT - 1.9 mm.
Intramural fibroid in post. wall 18×12 mm.

- TIFFA scan -
30/4/2026.
SLIUF
20+4 wks.
PL- Aut. high.
CL - 30 mm.
screen positive for preeclampsia.
No anomalies.
FTS

- cervical length assessment -
4/6/26
SLIUF
25+6 wks.
PL- Aut. high.
AF- LP - 3.6 cm
CL- 26 mm.

- cervical length assessment
21/05/2026.
SLIUF
23+6 wks.
PL - Aut. lower end is 2.5 cm from int. os.
CL - 29.5 mm.
Funnelling ⊖

Doctor Name: Dr. Nikhita
Signature: NR
Date & Time: 5/6/2026 7:30Am.

Consultant Name: Dr. Bhavana
Signature:
Date & Time: 5/6/2026.

VIH-00202411 IP-00060236
Mrs K VENKATA HIMAJA
04-05-1998 28 Y 1 M 1 D (F)
Dr. BHAVANA K

NURSING CARE RECORD

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Date: 5/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night	7 Pm	Ensure safety	7 Am	provided side Rails	Prevent fall	Patient good	5/6/26 7 Am

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Mrs K VENKATA HIMAJA
04-05-1998 28 Y 1 M 1 D (F)
Dr. BHAVANA K

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NURSING CARE RECORD

Date: 5.6.26

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	10am	maintain fluid Balance	10Am	Encourage to take Oral fluids	To prevent dehydration	Patient was dehydrated	[illegible] @ 10Am 5/6/26
Afternoon							
Night							

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Mrs K VENKATA HIMAJA
04-05-1998 28 Y 1 M 1 D (F)
Dr. BHAVANA K

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/6/26 10:00 Am	POD-0 (Post cerclage)	
	O/E- pt is c/c/c	Adv:
	GC- Fair.	- NBM for 2 hours
	BP- 110/72 mmHg	- monitor vitals
	PR- 94 bpm.	- FHR monitoring
	S/E- NAD.	- Rest
	P/A- ut ~ 26 wks.	- Follow drug chart.
	relaxed.	- Inform SOS.
	FHR (+) 140 bpm.	
	L/E- NAB.	
	(Bhavana)	Dr. Nikhita
		Noted by prathusha @ 10
5/6/2026 12 PM	POD 0 (cerclage) O/E.	Adv
	Pt is c/c/c.	- sips of water f/b clear liquid f/b soft diet.
	GC fair	- Monitor vitals
	BP- 109/70 mmHg	- FHR Monitoring
	PR- 98 bpm	- Follow drug chart
	S/E- NAD.	- Rest
pt can be discharged	P/A- UH ~ 26 wks	- Inform SOS
	Relaxed	
	FHR (+) 150 bpm	
	L/E- NAB	
		Dr. Yogeshwari
	Noted by Prathusha @ 12pm	

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OGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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TEL NO :040-42462200, Ext 2000,2001,2002
WEB : https://rainbowhospitals.in

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Mrs K VENKATA HIMAJA**	**Age :**	**28 Y 1 M 1 D**
IP No:	**IP-00060236**	**Sex:**	**Female**
Consultant:	**Dr. BHAVANA K**	**Ward/Bed No:**	**N 2F-LABOUR WARD/LW 219**

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

Patient, be deemed advisable or necessary.

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

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

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

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

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

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

Signature of Patient/Relative:

Name: P.K RAMTHI KUMAR
Relationship: Husband.
Date: 05/06/26 Time: 07.25 AM
Witness Name:
Witness Signature:

Patient Address:
203 nakshatra block, gk's festoon,
Sainikpuri Sainikpuri Hyderabad
Telangana INDIA 500094

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date: 5/6/26

To Be Filled In By Assigned Nurse:

Department: MICU Duration of Procedure : 40 mins

Name of Surgeon: Dr. Bhavana Date of Admission : 5/6/26

Bundle Care Criteria: (Tick (√) if done)

		Staff Signature
1.	Antibiotic given prior to surgery? ☑ Yes ☐ No ☐ Single Dose Antibiotic Or ☑ Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision? ☐ Yes ☐ No Name of the Antibiotic: Inj: cefotaxime 1gm	
2.	Hair Removal ☑ Yes ☐ No If Yes: ☐ Surgical Clipper Department where Hair Removed: ☑ Ward ☐ Operating Room ☐ Other: ..... Skin preparation done (cleanse surgical area with antiseptic agent)? ☑ Yes ☐ No	
3.	Patient's body temperature immediately post operation (Recovery Room) 36 °C ☐ Oral Or ☐ Axilla (Goal: 36-37°C)	
4.	Name of doctor or staff administering the antibiotic: K. Sukanya Date & Time of antibiotic administration: 5/6/26 at 8:50 Am Date & Time procedure started: 5/6/26 9C 20 Am	

- Ensure form is filled in completely by assigned staff whenever patient had surgery
- If any bundle care criteria has not been observed or unmet, assigned staff must inform infection control nurse for management
- All forms (Bundle care and when required SSI form) are completed properly
- Forms must always be kept in Infection Control folder in respective department

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : MRS. K. VENKATA HIMAJA Gender: ☐ Male ☑ Female Age : 28 Y

UHID No : VIH - 00202411 / 60236. Date : 5/6/2026.

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

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

CERVICAL CERCLAGE

upon MRS. K. VENKATA HIMAJA

(Name of the Patient)

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

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

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

BLEEDING, INFECTION, CHANCES OF RUPTURE OF MEMBRANES, CHANCES OF SPONTANEOUS MISCARRIAGE, CHANCES OF PRETERM LABOUR.

My signature on this form indicates that

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

Name of the Doctor who is performing the Surgery / Procedure: DR. BHAVANA K.

Consentee :

Signature : K.V.

Name : MRS. K. VENKATA HIMAJA

Date & Time : 5/6/2026. 7:15 AM.

Patient Attendant :

Signature :

Name : P. Kranthi Kumar

Relationship with Patient: Husband

Date & Time : 5/6/2026. 7:15 AM

Witness :

Signature :

Name : K. Ashwini

Date & Time : 5/6/26 7:15 AM

Doctor (who is taking the consent) :

Signature :

Name : Dr. Ashwini

Date & Time : 5/6/2026. 7:15 AM.

VIH-00202411 IP-00060236
Mrs K VENKATA HIMAJA
04-05-1998 28 Y 1 M 1 D (F)
Dr. BHAVANA K

Ref. No. : F / HW / CON / ANES / 02

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CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MAC

Patient Name : K. VENKATA HIMAJA Age : 28yr

Gender : M ☐ F ☑ - IP No : ..... Consultant : Dr. Bhavana

Ward / Bed No. : ..... Anaesthesiologist : Dr. Madhav.

Operative procedure planned : Cervical cerclage

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

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

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

☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure

☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma / RTA

☐ Incapacitating COPD ☐ Others : .....

Comments : Bleeding

- 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 K. VENKATA HIMAJA the above mentioned operation / Diagnostic / Therapeutic procedures Cervical cerclage

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

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for 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, CVP line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

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

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

- Pregnant: ☑ Yes ☐ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

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

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

Patient / Patient Attendant :
Signature : .....
Name : K. Venkata Himaja
Relationship with Patient: Self
Date & Time : .....

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

Doctor (who is taking the consent) :
Signature : .....
Name : Dr. P. Madhav.
Date & Time : 05/06/24

VIH-00202411 IP-00060236
Mrs K VENKATA HIMAJA
04-05-1998 28 Y 1 M 1 D (F)
Dr. BHAVANA K

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Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATIO

Name: Venkata Himaja Age: 28yr Sex: F UHID.No : VIH00202411

Date: 05/06/26 Time: 08:40AM Proposed Operation: Cervical Cerclage.

Diagnosis: Primi ? Cervical incompetence

B.P / CRT: 121/76 H.R: 96/min Weight: 57.2kgs ASA Physical Status: ☐1 ☑2 ☐3 ☐4 ☐5

Laboratory Data:

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

Allergies: NKDA.

Medical History: CVS : (-)

RESP : Diabetes : (-)

CNS :

Renal :

Hepatic / GE : Physical Activity: Good.

Others :

Past Anaesthetic History: Not Significant.

Physical Exam:

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

Lungs : BAE(+) clear.

Heart: S_1(+) S_2(+)

CNS: NAD

Pregnant: ☑Yes ☐No ☐NA Venous Access Site : (+) Spine Exam for regional (N)

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours; → Others 6 Hours
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☑ Discussed with Patient
5. Other Instructions:

Signature: Name: Dr P Madhav

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

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ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No | Fasting Status: Adequate

Physical Status: ☑ Patient Identified | ☑ Consent Present | ☑ Chart Reviewed

H.R: 110/min | B.P / CRT: 110/73 | SpO_2: 100 % | R.R: 17/min | Last Feed: > 6hrs

Pre-OP Diagnosis: Primi c cervical incompetence Operation: Cervical cerclage Date: 05/06/21

Surgeon: Dr. Bhavana / Dr. Archana Anaesthesiologist: Dr. Madhav Technician: Vaishnavi

TIME	9:15	9:30	(10)
N_2O /AIR /O_2 LPM			
HALO /SO /SEVO			
Drugs:			
FIO$_2$ / SaO$_2$	100	100	100
ETCO$_2$			
ECG	NSR	NSR	NSR
Temperature			
Urine Output			

Antibiotic

Suppository

Blood Loss

NOTES

Fluids / Blood

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

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

240 220 200 180 160 140 120 100 80 60 40 20 10 0

LAB Values: ABG | GRBS | Others

- ☑ Equipment Checked and Functional
- ☑ BP
- ☑ Cuff Site: LUL
- ☐ Art Site:
- ☑ EKG Lead 3 leads
- ☐ Temp Site
- ☐ FIO_2 Monitor
- ☐ Agent Monitor
- ☑ Pulse Oximeter
- ☐ Capnograph
- ☐ Ventilator
- ☐ Nerve Stimulator

Position: Supine

☑ Pressure Points Checked

Eye Care:
- ☐ Oint
- ☐ Tape
- ☐ Padding
- ☑ Awake

Temp:
- ☐ HME ☐ Fluid Warmer
- ☐ Cling Film ☐ OH Warmer
- ☐ Hugger's ☐ Cotton Wool
- ☐ Other

Times:
- Anaes Start: 09:20AM
- OP Start:
- OP End:
- Leave OR: 10:00 AM

Anaesthesia:
- ☐ GA
- ☐ Monitored Anaesthesia Care
- ☑ Regional

Line (Size & Location)
- ☐ CVP:
- ☐ ART:
- ☑ IV: 18G RW
- ☐ IV:
- ☐ IV:

Induction
- ☐ IV ☐ Inhal
- ☐ Pre O_2 ☐ RSI
- ☐ Others

- ☐ Mask ☐ SGA
- ☐ Airway ☐ Oral ☐ Nasal
  ETT# ..... at ..... cm
- ☐ Oral ☐ Nasal ☐ Cuff
- ☐ Tracheostomy ☐ Topical
- ☐ Drug:

- ☐ Awake ☐ Direct Vision
- ☐ Video Laryngoscopy ☐ Stylette / Bougie
- ☐ Fiberoptic

Blade# ..... Attempts: .....
Difficulty Why? .....

- ☐ **Bilat = BS**
- ☐ Semi-Closed Circle
- ☐ Closed Circle
- ☐ Other

Regional:
Extremity Specify: .....
☑ Spinal ☐ Epidural ☐ Caudal
Others: .....
Position: Sitting
Site: L3-4
Needle Size: 25G(W) Depth: .....
Parasthesia ☐ Yes ☑ No
Catheter at skin ..... cm
Drug Name & Conc: 2ml 0.5%
Bolus: Bupivacaine
Infusion: .....
Block Level: T6
Comments: .....

Transportation to
☑ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☑ NA

Name of the Doctor: .....
Signature of the Doctor: Dr Madhav

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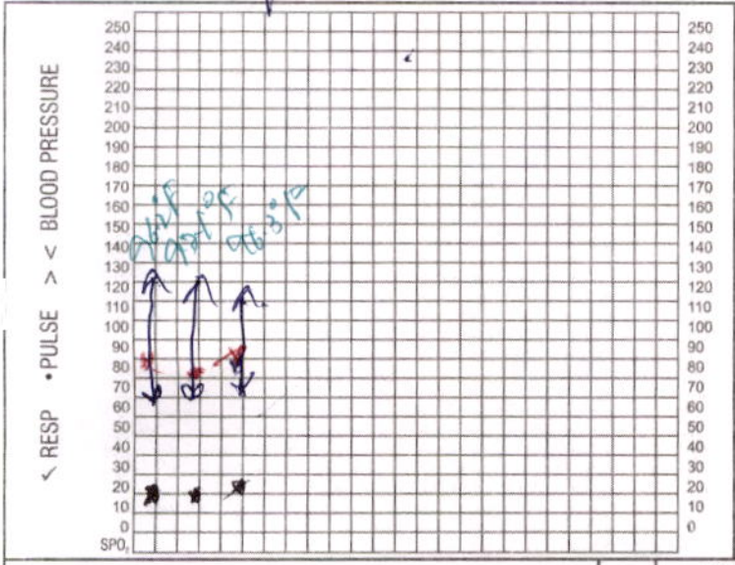
PACU RECORD

Received in PACU by : prathyusha Time Received : 11 Am Time Discharged : 12 pm



IV Cannula Site : observed for Cannula

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

Vomiting : ☐ Yes ☑ No Drugs as per doctors order

NG Tube : ☐ Yes ☑ No

Drain: ☐ Yes ☐ No

Urinary Catheter: ☐ Yes ☐ No

Chest Tube: ☐ Yes ☐ No

Nil Oral ☐ Yes ☐ No

IV Fluids: .....

Oral Feeds: .....

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
5/6/26	11Am	Score 0		

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

Anaesthesiologist Name : Dr. Madhavi

Anaesthesiologist Signature: .....

Date & Time: .....

PACU Nurse Name : Prathyusha

PACU Nurse Signature: .....

Date & Time: 5/6/26 @ 11Am

Reassessment Frequency:

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

Transferred to Unit by (PACU): Prathyusha

Date & Time: 12pm

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EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : .....

Any other issues :

a) .....

b) .....

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

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

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

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

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SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Bhavana K
Asst. Surgeon : Dr. Ashini
Anaesthetist : Dr. Madhav
Scrub Nurse : Sr. Ruby P

Age : 28yr Gender : Female
UHID No. : Surgery Name : Cervical cerclage
Date : 05/06/20 In-time : 9:20AM Out-time : 10:00AM

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 09:00Am

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

Site Marked ☐ Yes ☐ No ☑ NA

Anaesthesia Safety Check Completed ☑ Yes ☐ No

Pulse Oximeter on Patient & Functioning ☑ Yes ☐ No

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

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

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

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

Signature : Dr P Madhav 05/06/20
Name :

Before Skin Incision ➤➤

TIME OUT Time: 9:20AM

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

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm → Mrs K. Venkata Himaja
- Correct Patient (Check ID Band) ☑ Yes ☐ No
- Correct Site Cervix ☑ Yes ☐ No
- Correct Procedure → cerclage ☑ Yes ☐ No

Anticipated Critical Events

Surgeon Reviews:
- What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? 1/2 an hr Bleeding 10-15 ML ☑ Yes ☐ No ☐ NA

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

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

Signature :
Name : Manimala

Before Patient Leaves Operating Room

SIGN OUT Time: 10:00AM

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

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

Signature :
Name : Dr Ashini

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OPERATION NOTES

Surgeon : Dr. Bhavana K	Asst. Surgeon : Dr. Ashwin
Pre-Operative Diagnosis:	
Surgical Procedure : Cervical cerclage ↓ SA	
Indications for Surgery :	
Date : 05/06/26	Start Time : 9:20AM / End Time : 10:00AM
Post Operative Diagnosis:	
Peri-Operative Complications:	
Amount of Blood Loss: - 10 ml	Blood Transfused (in ML)
Name and Number of Surgical Specimen sent for examination:	
Operation Notes:	

- under strict aseptic conditions, under SA patient kept in lithotomy position
- Parts painted & draped.

- Anterior & posterior vaginal walls retracted c̄ Sims speculum
- Anterior lip of cervix held c̄ babcock forceps

Intra-op finding - cervix was pulled up to left side.

- Cervical cerclage done c̄ Mc donald stitch using silk.
- Knot placed anteriorly
- Hemostasis checked & ensured

Adv - NBM x 2 hrs
W/F bleeding PV
Monitor vitals
follow drug chart
inform SOS

A/ Dr Ashwini

Name of the Surgeon: Dr. Bhavana K.

Signature of the Surgeon: ....

Date & Time: 9:50 am 5/8/26

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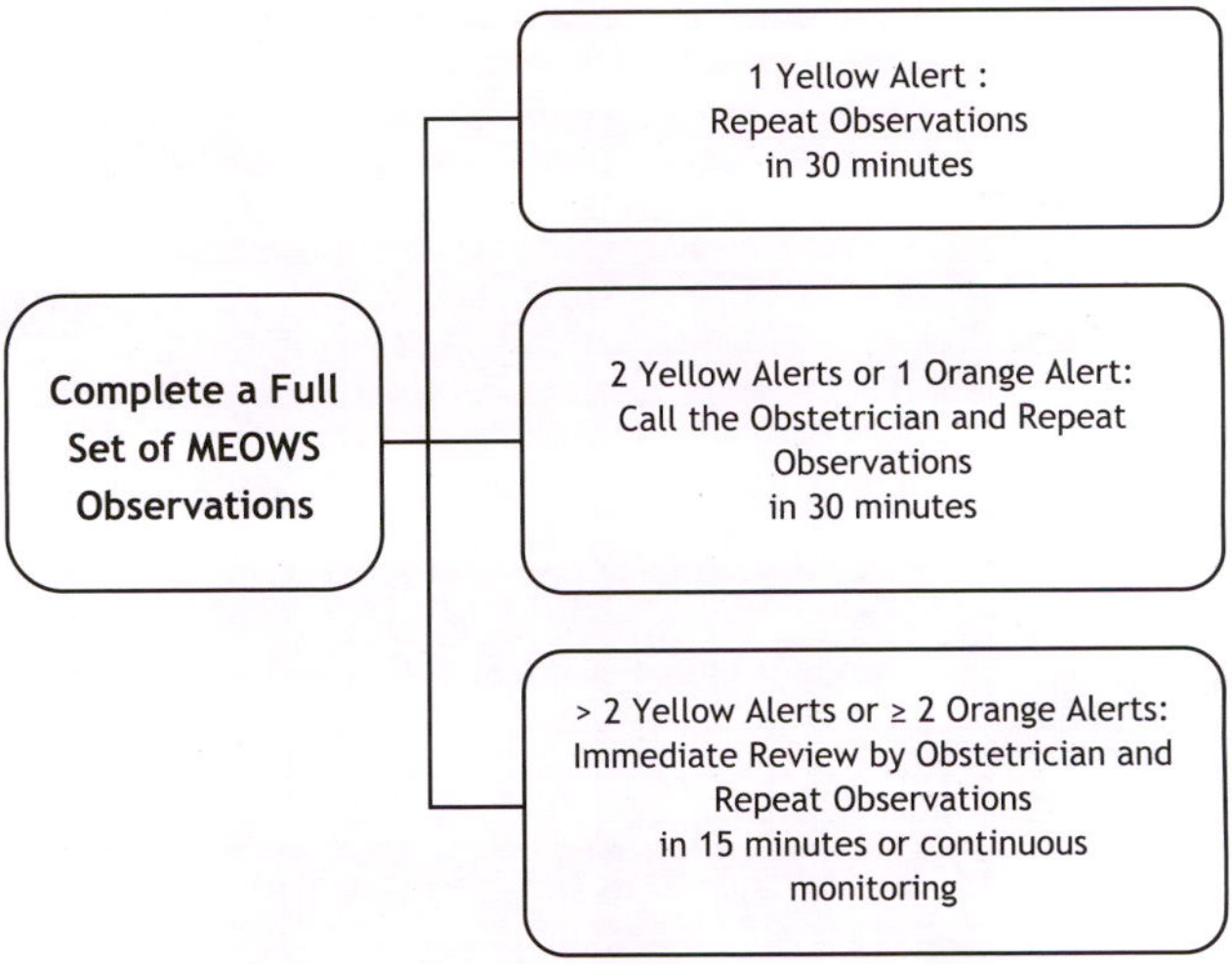
Early Warning Observation Score Chart - Obstetrics

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

5/6/26.	Date																								
	Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																								
	21 - 30																								
	11 - 20																								19
	0 - 10																								
Saturations	94 - 100 %																								99
	< 94 %																								
Administered O_2 (L/min.)																									
Temp°c	40																								
	39																								
	38																								
	37																								
	36																								36
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80																								80
	70																								
	60																								
	50																								
	40																								
Systolic Blood Pressure ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120																								121
	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70																								70
	60																								
	50																								
	40																								
NEURO RESPONSE [✓]	Alert																								✓
	Voice																								
	Pain																								
	Unresponsive																								
URINE mls / hour	> 30																								✓
	< 30																								
Proteinuria	Protein + +																								
	Protein > + +																								
Lochia	Normal																								NA
	Heavy / Foul																								
Liquor	Clear / Pink																								NA
	Green																								
TOTAL YELLOW SCORES																									0
TOTAL ORANGE SCORES																									0
Nurse Initial																									

Obstetrics and Gynaecology Early Warning Signs



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

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FLUID CHART

Sheet No. : 1

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
5/6/26	06:00 am											
	07:00 am	NBM + RL		500ml						✓	0	
Total Intake :		500ml				**Total Output :**				passed		

Total 24 hrs. Intake	500ml

Total 24 hrs. Output	passed

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MEDICATION RECONCILIATION FORM

Drug Allergies: Nil ☑ Not known any Drug Allergies

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

Shifting From: MICU Shifted to: OT

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	TAB. IRON	1 TAB	PO	ONCE DAILY		☑C ☐DC
2	TAB. CALCIUM	1 TAB	PO	ONCE DAILY		☑C ☐DC
3	TAB. FOLIC ACID.	1 TAB	PO	ONCE DAILY		☑C ☐DC
4	TAB. ECOSPRIN	150 MG	PO	ONCE DAILY		☐C ☑DC
5						☐C ☐DC
6						☐C ☐DC
7						☐C ☐DC
8						☐C ☐DC
9						☐C ☐DC
10						☐C ☐DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : DR. NIKHITA.

Date & Time : 5/6/2026 7:45 AM.

Nurse Name & Signature: K. Suhasini

Date & Time : 5/6/26 at 7:45 Am

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DRUG CHART

Date of Admission: 5/01/2026. Drug Allergies: Nil ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

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

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

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

Sign

VERIFIED BY : Name

VIH-00202411 IP-00060236
Mrs K VENKATA HIMAJA
04-05-1998 28 Y 1 M 1 D (F)
Dr. BHAVANA K

REGULAR PRESCRIPTIONS

Weight. 57kg...... Ward. MICU.....................

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

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

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

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

VIH-00202411 IP-00060236
Mrs K VENKATA HIMAJA
04-05-1998 28 Y 1 M 1 D (F)
Dr. BHAVANA K

Weight 57 kg Ward. MICU.

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
5/6	9:00 AM	INJ. CEFOTAXIME [AFTER TEST DOSE]	1 GM	IV		
5/6	8:20 AM	INJ. PANTOPRAZOLE	40 MG	IV		
5/6	8:20 AM	INJ. METOCLOPRAMIDE	10 MG	IV		
5/6	8:40 AM	INJ. HYDROXYPROGESTERONE	500 MG	IM		

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

VIH-00202411 IP-00060236
Mrs K VENKATA HIMAJA
04-05-1998 28 Y 1 M 1 D (F)
Dr. BHAVANA K

I.V. FLUIDS CHART

Weight. 57kg Ward. micu

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
5/6	8.30PM	RINGER LACTATE	IV	F/F					
5/6	9PM	RINGER LACTATE	IV	100 ML/HR			05/06		
05/06	09:40 AM	RINGER LACTATE	IV	600 ml/hr					

Signature .....

VERIFIED BY : Name .....

10520|V|26

YH-00202411

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

ANTENATAL RECORD

Antenatal No: Mrs. Himaja

Consultant: Dr Bhavana.

Reg. No:

PERSONAL DETAILS

Name: Mrs. Sahitya Age: 27 Date of Birth: 04/05/1998 Education: post-graduate

Occupation: Self employeed Phone No: 8309036505 Mobile: 9573705324

Husband's Name: P. Kranthi Kumar Age: 27 Education: B.Tech Occupation: Software Engg

Address: 203, Nakshatra Block, Gk's festoon, Sainikpuri 500094

Mobile: 9573705324 E-mail Id: kranthi.p7398@gmail.com

IMPORTANT FEATURES	SUGGESTED MANAGEMENT
Primi RH Negative Screen +ve PE Fibroid. 18 mm. Anti-D	Corrected EDD 12/9/2026 Ref by Dr. Preetham Dr. Hariram, Star Hospital on Ecospirin

HISTORY

Year of Marriage: 11/24 Y

Menstrual History : Previous Periods: Regular.

Consanguinity: NCM

Contraception:

LMP 1/12/25 EDD Corrected EDD

OBSTETRIC FORMULA:

Gravida 1 Para Live Abortions

OBSTETRIC HISTORY

SL. NO.	DATE OF DELIVERY	GA WEEKS	ANTENATAL DETAILS	MODE OF DELIVERY	BABY	WT	REMARKS
	G1 - PP - spont conception Booked to RCH ∵ conception						

Medical History : H/O sciatica - Right leg not on Rx

Family History: mother - DM, father - HTN

Surgical History : Nil.

Allergies: Nil.

INVESTIGATIONS

MATERNAL EVALUATION

Blood group & Rh: Wife B NEGATIVE Husband ICT Neg

VDRL NR HIV NR HbSAg NR TSH 1.61 (24/2) GCT

ROUTINE INVESTIGATIONS HCV - NR SPECIFIC INVESTIGATIONS

Date	GA Weeks	Investigations	Report
24/2/26 -			
Sr creat - 0.39			
TSH - 1.61			
HBA1C - 4.9			
CUE - Pus cells - 2-3			
Blood - Trace			
CBP - 12.1/11200/2.62L			
HPLC - (N)			

Date	GA Weeks	Investigations	Report

Tetanus Toxoid: 1st dose ✓ T.T 2nd dose

FETAL EVALUATION

ULTRASONOGRAPHY

3/3/26 First Trimester	NT scan: 11+6 weeks CL - 30mm, Intramural fibroid SLIUF NT - 1.90mm. Post wall - 18x12mm. Screen +ve - PE
TIFFA	

Growth scan	Date	GA Weeks	Indication	PP	Wt.	Centile	Growth Velocity	AFI	Placenta	Remarks

Others	

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

DATE	GA/Weeks	TYPE OF TEST	INDICATION	REPORT
				FTS - low risk HPLC - (N)

Name: _____ Corrected EDD: _____ Parity _____

SYSTEMIC EXAMINATION

Height _____ CVS _____

Weight: _____ Respiratory System: _____

BMI: _____ Breasts: _____ Thyroid: _____

ANTENATAL VISITS

Date	Wt	BP	GA	S-F Ht	PresentingPart	FHS	Liquor	Edema	Review Date

Special Concerns Belly fat

ANTENATAL ADMISSION

DOA	DOD	GA Weeks	Complaint	Management	Advice

BRIEF DELIVERY NOTES

Gestational age _____ Date & time of delivery: _____

Type of labour: Spontaneous

Induction: Indication _____

Method - PGE1 ☐ PGE2 ☐

Mode of delivery: SVD ☐ AVD ☐ Vacuum ☐ Forceps ☐

Indication: _____

Caesarean section: Emergency ☐ Elective ☐

Indication: _____

SALIENT FEATURES:

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

Postpartum Period: _____

_____

_____