



SURGERY DETAILS

Date: 28/06/28

Patient Name: Mrs. M. Balamani Date of Birth: 17/06/1988 Age: 38y

Gender: Female Ward: O-T UHID No.: 125303

Date of Surgery: 26/6/28 OT-1 OT-2 OT-3 OT-4 OBG OT-1 OBG OT-2

Name of the Surgery: Elective lower segment Caesarean Section + SA

Time in: 2:45 Pm

Time Out: 3:45 Pm

	NAME	AMOUNT
1. Surgeon	Dr. Srilata Patnaik	O.T charges
2. Anaesthetist	Dr. Brandon	
3. Assistant Surgeon	Dr. Noushreen	
4. OT Technician	Sr. Vaishnavi / Rakesh	
5. Circulating Nurse	Sr. Vanitha / Azad	
6. Assistant Nurse	Sr. Prassana	

Special Equipment: Laparoscopy Bronchoscope Harmonic Morcelator
 C-ARM Cystoscopy Versa Point Liver Cusa
 Neuro Cusa Others

Dr. Noushreen
Signature of the Surgeon

Azad
Signature of Circulating Nurse

Order No: 3090909/08

Order by: *Azad*

Name	Mrs M. BALAMANI	UHID	VIH-00125303
Father/Guardian	Mr SADALA AJAY RATANAM	Age/Gender	38 Y 0 M 9 D/Female
Address	HNO. 12-5-49/1VIAJYAPURI COLONY , TARNAKA, SECUNDERABAD., Lalapet, Hyderabad, Telangana, INDIA, 500017		
IP No	IP-00060490	Admission Date	26-06-2026
Ref Doctor	Self	Discharge Date	28-06-2026

DISCHARGE SUMMARY

Consultant: Dr. SRILATA PATNAIK, CONSULTANT GYNECOLOGIST &
OBSTETRICIAN

Diagnosis: G2P1L1 with 38+1 weeks with previous LSCS with Small
for gestational age baby admitted for Elective Lower
segment cesarean section with bilateral tubectomy.

**ELECTIVE LOWER SEGMENT CESAREAN SECTION WITH BILATERAL
TUBECTOMY DONE UNDER SPINAL ANESTHESIA ON 26.6.2026**

History:

LMP: 2.10.2025

Obstetric formula: G2P1L1

EDD: 9.7.2026

Gestation at admission: 38+1 weeks

Obstetric History:

G1 - Female / 5 years / FTLSCS / NPOL / 3.8kgs / BF X 5YRS / A&H / RCH VKP /
uneventful

G2 - Present pregnancy Spontaneous conception.

Medical History: Nil

Family History: Mother - DM

Name	Mrs M. BALAMANI	UHID	VIH-00125303
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Surgical History: Previous LSCS 6 yrs ago

Allergies: Amoxicillin

Antenatal Details: Mrs. M. BALAMANI was booked to Rainbow Hospital at 8+5 weeks of gestation. She had regular antenatal checkups and investigations as advised. She was on Tablet Ecosprin 150mg OD since 13+2 weeks and stopped at 35+3 weeks. She had history of loose motions at 13+2 weeks and was managed conservatively. She came with complaints of dull abdominal pain since 9:30am on 26.6.2026. She was admitted at 38+1 weeks with previous LSCS with Small for gestational age baby admitted for Elective Lower segment cesarean section with bilateral tubectomy.

Investigations: Enclosed

Blood group: 'O' POSITIVE

Management: Course in hospital: She came with complaints of dull abdominal pain since 9:30am on 26.6.2026, subsided. On examination vitals stable, uterus relaxed.

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: Operative Details:

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. Lower uterine segment thinned out. A lower segment curvilinear incision given on the uterus. Baby delivered with one loop of cord around neck. 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

Name	Mrs M. BALAMANI	UHID
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UH-00125803

prophylaxis with Inj. Taxim 1 gm IV given. Misoprostol 400 mcg given intra cavitory as prophylaxis against postpartum hemorrhage. Uterus closed in layers. Bilateral fallopian tubes identified and ligated using modified pomeroys technique. 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 400 mcg given per rectum as prophylaxis against postpartum hemorrhage. Patient was shifted out of theatre to post operative recovery room.

Delivery Details:

Date: 26.6.2026

Time of Delivery: 2:58:01 pm

Type of Delivery: Elective LSCS

Indication: Previous LSCS

Analgesia: Spinal

Baby Details:

Date: 26.6.2026

Time: 2:58:01pm

Sex: Female

Weight: 2.99kgs

Apgar: 7/10, 9/10

Gestational Age: 38+1 weeks

NICU Admission: No

Post-Operative Notes: Post Operative Period:

She was closely monitored. Her vital signs remained stable. Uterus was well retracted with no postpartum hemorrhage. Breastfeeding initiated. She was shifted to room. Her postoperative period following that was uneventful. On third 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

Name	Mrs M. BALAMANI	UHID	VIH-00125303
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supplemented by written information.

Advice:

1. Tab. Cefuroxime (ceftum) twice daily till 2.7.2026 (9am-9pm) after food.
2. Tab. Calpol 500mg (2tabs) (Paracetamol 500mg) thrice daily till 2.7.2026 (9am-2pm-9pm) after food.
3. Tab. Voveran 50 mg (Diclofenac 50mg) thrice daily till 2.7.2026 (10am-4pm-10pm) after food.
4. Tab. Pantoprazole 40 mg once daily till 2.7.2026 (7am) before food.
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) 1 tablet once daily (2pm) till breastfeeding after food.
7. Nebasulf powder for local application.
8. HPV vaccine after 6 weeks of delivery.

Review after one week on 2.7.2026 at postnatal clinic with prior appointment (This consultation will be charged).

To take appointment for OPD consultation at Rainbow Children's Hospital, just dial one number 1800-2122 (between 8 a.m. to 8 p.m.) (or) log on to www.rainbowhospitals.in

In case of emergency like bleeding, fever - kindly contact 040-42462200. Extension 2220 (Rainbow Hospital, Karkhana).

For Women Who Have Had a Cesarean 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.

Name	Mrs M. BALAMANI	UHID
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- 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 doctorin the language that I understand and I have understood the same.

Name:

Signature:

Relationship:

This summary was explained by:

Summary prepared by: Dr.



Dr. SRILATA PATNAIK
MBBS MD
CONSULTANT GYNECOLOGIST & OBSTETRICIAN

Registrar/Resident/C.M.O

ACTIVE VIH-00125303 IP-00060490
Mrs M. BALAMANI
17-06-1988 38 Y O M 9 D (F)
Dr. SRILATA PATNAIK

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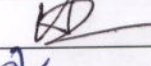
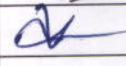
Name: -- 

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

Date of Admission: 26/6/26 Time: 10:53AM Date of Discharge: ----- Time: -----

Room / Bed No: 219 Ward: MICU Suggested Billable bed type: -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
26/6/26	2:32pm	MICU	OT	
26/6/26	4:30 Pm	OT	MICU	
26/6/26	11:20Pm	MICU	Room (105)	

Cross Consultation Visit

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
26/6/26	w placement	(1)	3094759	[Signature]
26/6/26	PAC	(1)	3094760	[Signature]
26/6/26	catheterization	(1)	3094759	[Signature]
<hr/> <i>wegged checked by Lisa 26/6/26 at 10:30pm</i>				

ANY OTHER INFORMATION

Date : _____ Time : _____ Prepared By : _____

Staff Nurse	Shift / Ward <i>W Floor Salford</i>	Billing Assistant	Billing Supervisor
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ERROR LOG

LOCATION: - NICU / PICU / HDU / OT / GENERAL WARD

ICD CODE :-

OBSERVATION: -

DATE :

MRD EXECUTIVE

ADMISSION SHEET

Registration Details :



Admission No : IP-00060490

Admit Date : 26-Jun-2026

Admit Time : 10:53 AM UHID : VIH-00125303

Patient Details :

Patient Name : Mrs M. BALAMANI

Age : 38 Y 0 M 9 D

Guardian : Mr SADALA AJAY RATANAM

DOB : 17-06-1988

Gender : Female

Religion :

Occupation :

Marital Status : Married

Address (H) : HNO. 12-5-49/1VIAJYAPURI COLONY ,
TARNAKA, SECUNDERABAD. Lalapet
Hyderabad Telangana INDIA 500017

Phone No : 9618024077/ 9989449227

E-mail : kumarsjack@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 SADALA AJAY RATANAM

Relationship : W/O

Contact Address : HNO. 12-5-49/1VIAJYAPURI COLONY ,
TARNAKA, SECUNDERABAD. Lalapet
Hyderabad Telangana INDIA 500017

Phone No : 9618024077 / 9381799227

Signature

Doctor Details :

Doctor Name : Dr. SRILATA PATNAIK

Specialisation : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : HERITAGE HEALTH INSURANCE TPA
PVT LTD

VIH-00125303 IP-00060490
 Mrs M. BALAMANI 38 Y O M 9 D (F)
 17-06-1988
 Dr. BRILATA PATNAIK



OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 26/6/26

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: _____ Doctor Notified on Admission: Yes No
pain abdomen Name of the Doctor: Dr. Niklata
 _____ Time Notified: 10:30am

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>nil</u>	<u>prev LSCS</u>	<u>yes.</u>

Gynecology Assessment: <input checked="" type="checkbox"/> Not Applicable	Gynecology Surgical History:	Gynecological History:
Menstrual History: _____ Onset of Menarche: _____ Menstrual Cycle: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular Last Menstrual Period: <u>21/10/25</u>	Caesarean Section: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes Cervical Cerclage: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Ectopic Pregnancy: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Myomectomy: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Others: _____	Contraceptives: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Vaginal Discharge: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Post-Coital Bleeding: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Infertility: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If Yes Type: <input type="checkbox"/> Primary <input type="checkbox"/> Secondary

Obstetric History: G 2 P _____ L 1 A _____

Previous LSCS: prev 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 _____

Vital Signs / Measurements: Temp: 98.6F HR: 82b/m RR: 18b/m
 BP: 122/77 Weight: 85.4kg Height: 158kg BMI: _____

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



PHYSICAL ASSESSMENT

General Appearance: Healthy ill looking Anxious Agitated Others:

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

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

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

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING: 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. Balamani

Name of Person Orientation was given to: Mrs. Balamani

Orientation not given Reason:

Nurse Signature: K. S. Srinivas

Nurse Name: K. Srinivas

Date & Time: 26/6/26 10:35 AM

PATIENT TRANSFER FORM

VIH-00125303
IP-00060490
Mrs M. BALAMANI
17-06-1988 38 Y O M 9 D (F)
Dr. SRILATA PATNAIK



	Date & Time of Admission 26/6/26 at 10:53 AM	Date & Time of Transfer Order 26/6/26 at 2:32 PM
Treating Consultant Name	Transfer Ordered by Dr. Srilata Patnaik	Reason for Transfer E LSCS
From Unit MICU	To Unit OT	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File 35	Number of Imaging Films NST - (1)	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

Shifting Summary / Notes Written by Doctor : Yes No

Dr.

Name & Signature of Person who is Transferring Srs. K. Subashini	Name of Person Ordered Transfer Dr. Srilata Patnaik
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Patient & Clinical Records Received by :
Sri. Jyothi

Date & Time of Patient Received : 26/6/26 @ 2:32 PM

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

VIH-00125303 IP-00060490 Mrs M. BALAMANI 17-06-1988 38 Y O M 9 D (F) Dr. SRILATA PATNAIK 		Date & Time of Admission 26/6/26 at 10:53 AM	Date & Time of Transfer Order 26/6/26 at 2:32 PM
		Transfer Ordered by Dr. Brunda	Reason for Transfer post op care
From Unit O-T	To Unit MICU	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 32	Number of Imaging Films Nil	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.	Nil		
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Dr. Srilata Patnaik			
Name & Signature of Person who is Transferring Azad		Name of Person Ordered Transfer Dr. Brunda	
Patient & Clinical Records Received by :			
Date & Time of Patient Received :			

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

- Unavailable Bed
 Nurse not Available
 Available Bed not ready

PATIENT TRANSFER FORM

VIH-00125303 IP-00060490

Mrs M. BALAMANI
17-06-1988 38 Y O M 9 D (F)
Dr. SRILATA PATNAIK



Date & Time of Admission 26/6/26 @ 10:53 AM	Date & Time of Transfer Order 26/6/26 @ 11:20 PM
Treating Consultant Name	Transfer Ordered by Dr - Nikithe
Reason for Transfer Observation	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
From Unit MICU	To Unit Room (105)
Number of Sheets in Clinical File 38	Number of Imaging Films 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.	Under Pad	1
2.	Sorel	1
3.	Tab:- Paracetamol	1
4.	Tab:- Diclofenac	1
5.	Tab :- Tramadol Tab:- Pantoprazole	1

Shifting Summary / Notes Written by Doctor : Yes No

Name & Signature of Person who is Transferring Sis. Anush	Name of Person Ordered Transfer Dr - Nikithe
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Patient & Clinical Records Received by :
Sd. Bevonika

Date & Time of Patient Received : 26/6/26 @ 11:30 PM

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

Amoxicillin allergy

IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

4/0 pain in abdomen since at 9:30 Am.

Obstetric Formula: G2P1L1
 ML - 6420 NCM

Obstetric History:

G1 - Female / 5420 / FTLSCS / NPOL / 3.85 kg A&H / RCH VKP / unevent / BF - 5420
 G2 - present pregnancy / spontaneous conception
 Present Pregnancy Record: Booked to RCH at 8+5 weeks.

she was on Tab. Eucospin 150 mg since 13+2 wks & stopped at 35+3 wks.

RISK FACTORS:

- H/o loose motions & lower back pain at 13+2 wks, managed conservatively.

prev. LSCS
 SGA baby

Height: 158 cm

Weight: 84.4 kg

Allergies: Amoxicillin allergy

Breast: Normal Abnormal

General Examination: pt is c/c/c

Consciousness: (+) Pallor: (-)

Icterus: (-) Edema: (+)

Temp: Afebrile PR: 100 bpm

BP: 124/77 mmHg DTR: (+)

CVS: S1S2 (+) RS BAE (+)

Liver/Spleen: NAD Urine Output: Adeq.

LMP: 2/10/2025 EDD:

Corrected EDD: 9/7/2026 GA: 38+1 weeks

Menstrual History: Regular: Yes No

Obstetric Examination

Fundal Height: - T61

Ut. Activity: Relaxed Mild Mod Severe

Liquor: Adequate Oligo Poly

PP: Cephalic Breech Others

Head Fifths Palpable:

FHS: Normal Tachy Brady Absent
 146 bpm

Per Speculum Examination Not done

Draining: Present Absent Bleeding

Colour of Liquor: Clear Meconium Blood Stained

Vaginal Examination

Cervix: Long Partially effaced Effaced

Os: Closed Dilated

Membranes: Present Absent

Liquor: Clear Meconium Blood Stained

Presenting Part: Vertex Breech Others

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

Pelvis: Adequate Doubtful

DIAGNOSIS

G2P1L1 with 38+1 weeks with previous LSCS with small for gestational age baby

elective for emergency lower segment cesarean section.

<p>Family History: Mother - DM.</p>	<p>Surgical History: - previous LSCS 6 yrs ago.</p>
<p>Medical History: Nil</p>	<p>Medication History:</p>
<p>Plan of Care: <u>C/I to Dr. Srilata man</u></p> <ul style="list-style-type: none"> - Admission - Consent - PAC - part preparation - FHR monitoring, continuous. - monitor vitals. - Foley's catheterisation. - NBM - Follow drug chart - Inform SOS - Do BT, CT. - NST stat. <p><u>Noted by Subhina</u> 26/6/26 10:30AM</p>	<p>Investigations:</p> <p>BLU: 'O' POSITIVE CBP - 13/6/2026 10.4/10500/20.2L BT - 2:30 sec CT - 4:55 sec ECG - (N)</p> <ul style="list-style-type: none"> • Growth scan 13/6/2026 SLIUF 36+2 wks Cephalic. PL - Ant. right lateral high. AFI - 12.4 cm. AC - 4.1. EFW - 2634 gm. Dopplers - (N) • NT scan 30/12/2025. SLIUF 12+5 wks NT - 1.7 mm • TFFFA scan - 28/2/26 SLIUF 21+2 wks PL - Ant. low lying lower end is 1.5 cm from int. os. CL - 39 mm. No anomalies • usg - early preg. 13/12/25 - Corpus luteal cyst 22 x 19 mm in left ovary <p>FIS - low risk</p>

Doctor Name: Dr. Nikhita

Signature:

Date & Time: 26/6/2026 10:30AM

Consultant Name: Dr. Srilata P.

Signature:

Date & Time: 26/6/2026

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/6/26 4:30 pm	<u>POD-0</u> (Post LSCS)	
P2 L2	o/e pt is d/c eye fair afeb	<u>Adv</u> - NBM - Rest
U/O 600 ml clear, adeq.	BP- 134/88 mmHg PR- 68 bpm S/E NAD PIA soft ut ~ W/R	- No charting - W/F bleeding PV - Monitor Vitals - Follow drug chart - Early Ambulation - Infom 825
Noted by Subhina 4:30 pm 26/6/26	L/E NAB Baby MS BF (+)	<u>Dr Nausheen</u>
26/6/26	<u>POD-0</u> (Post LSCS)	
8:30 pm	o/e pt is d/c Gc - fair afeb.	<u>Adv:</u> - NBM till 10:30 pm - No charting
U/O 900 ml clear, adeq.	BP- 120/84 mmHg PR- 70 bpm S/E - NAD PIA - ut - W/R soft, BS +/-	- W/F bleeding PV - monitor vitals - Follow drug chart - passive ambulation - Infom 825.
Noted by teamah 26/6/26 @ 8:30 pm	L/E - NAB. Baby ← A BF (+) M	<u>Dr. Nikhita</u>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/6/2026 10:30 pm	POD-0 (LSCS) o/e - pt is c/c/c vitals stable PIA - wt - w/R soft, BS (+) L/E - NAB	Adv: - water sips Flb - clear liquids - soft diet at 2:30 AM - monitor vitals - No chasting - Follow drug chart - Inform sas
U/O 1300ml clear, adequate pt. can be shifted to room		
Noted by Karanah 26/6/26 @ 10:30pm		
27/6/2026 8:30 AM	POD-1 (LSCS) o/e - pt is c/c/c GC - fair BP - 102/72 mmHg PR - 75 bpm afebrile S/E - NAD PIA - wt - w/R soft, BS (+) L/E - NAB Baby ← ^A _M BF (+)	Adv: - soft diet - Adeq. Hydration - Ambulation after foleys removal - monitor vitals - No chasting - w/o bleeding pv - Follow drug chart - Inform sas
U/O 2100 ml clear, adeq Remove foleys at 10:30 AM		
Noted by Manasa 27/6		
Dr. Nikkita		



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>27/6/26</u>	<u>POD-1 (Post WCS)</u>	
2 pm	d/e pt is d/c	<u>Adv</u>
<u>P2L2</u>	g/c fair	- <u>Soft diet</u>
	- Afb	- <u>Hydration</u>
	BP- 116/72 mmHg	- <u>Ambulation</u>
Urine not passed	PR- 78 bpm.	- <u>w/ F bleeding PV</u>
	S/E NAD	- <u>Monitor vitals</u>
	P/A soft	- <u>Follow drug chart</u>
	BS ⊕ ut w/ R	- <u>Inform BS</u>
	L/E NAB	
	Baby MS BS ⊕	
<u>27/6/26</u>	<u>POD-1 (Post WCS)</u>	
7 PM	d/e pt is d/c	<u>Adv</u>
<u>P2L2</u>	g/c fair	- <u>soft diet</u>
	Afebrile	- <u>Hydration</u>
	BP- 100/72 mmHg	- <u>Ambulation</u>
Urine Passed	PR- 98 bpm	- <u>w/ F Bleeding PV</u>
Motion Passed	S/E NAD	- <u>Monitor vitals</u>
	P/A soft	- <u>Follow drug chart</u>
	Ut w/ R	- <u>Inform BS</u>
	BS ⊕	
	L/E - NAB	
	Baby mother side BS ⊕	

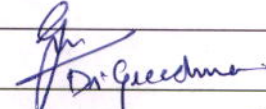
[Signature]
 Dr. Anushka

[Signature]

VIH-00125303 IP-00060490
 Mrs M. BALAMANI
 17-06-1988 38 Y 0 M 9 D (F)
 Dr. SRILATA PATNAIK



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/6/26	POD - 2 (Post Vec)	
7 AM	D/E Pt is c/cle	A/W
	ac-fair	- (N) diet
P/L2	A/cute	- Ambulation
	BP - 115/72 mmHg	- Adequate hydration
Urine Passed	PR - 80 bpm	- W/P Bleeding PV
relaxation Passed	S/E - NAD	- Monitor vitals
	P/A - W/W W/R	- Follows drug chart
	6th RS (+)	- Refer to S/S
Patient can be discharged	L/E - NAB	
	Baby f A, H, RE (+)	
Aseptic agents done	V/E done, No abnormal bleeding	 Dr. Guedema
Wound healthy		Noted by Manisha 27/6/26 @8PM

VIH-00125303
 Mrs M. BALAMANI
 17-06-1988 38 Y O M 9 D (F)
 Dr. SRILATA PATNAIK

IP-00060490

①

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <u>G2P1, 38 weeks & prev LGA</u>		Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known					
	<u>Small for gestational age baby</u>		If Yes Specify:					
BACKGROUND	Surgery / Procedure:		Post OP Day:					
	Date	Shift	<u>26/6/26</u> M	<u>26/6/26</u> E	<u>26/6/26</u> N	<u>26/6/26</u> N	<u>27/6</u> M	<u>27/6</u> E
ASSESSMENT	Medical Condition (Any special condition to be noted):		-	-	<u>acromioclavicular</u>	-	<u>nil</u>	<u>nil</u>
	Diet:		<u>NBM</u>	<u>NBM</u>	<u>acromioclavicular</u> <u>soft diet</u>	<u>soft diet</u>	<u>s.diet</u>	<u>s.diet</u>
RECOMMENDATIONS	Allergy:		<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 checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Ventilation (RA, NP, NIV, VENTI):		<u>RA</u>	<u>R/A</u>	<u>RA</u>	<u>RA</u>	<u>RA</u>	<u>RA</u>
	Tubes/Drains/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 checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Vital Signs:		Temp: <u>98.6F</u>	<u>98.1F</u>	<u>98.1F</u>	<u>98.3F</u>	<u>98.1F</u>	<u>98.4F</u>
			Res: <u>8blm</u>	<u>10blm</u>	<u>7blm</u>	<u>19blm</u>	<u>20blm</u>	<u>25blm</u>
			SpO ₂ : <u>99%</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>	<u>98%</u>	<u>99%</u>
			Pulse: <u>82blm</u>	<u>97blm</u>	<u>99%</u>	<u>82blm</u>	<u>76blm</u>	<u>100blm</u>
			BP: <u>112/70</u>	<u>120/70</u>	<u>130/70</u>	<u>118/77</u>	<u>110/70(80)</u>	<u>118(78)</u>
			LOC: <u>conscious</u>	<u>conscious</u>	<u>conscious</u>	<u>conscious</u>	<u>conscious</u>	<u>conscious</u>
			Fall Risk Score: <u>15</u>	<u>15</u>	<u>15</u>	<u>15</u>	<u>15</u>	<u>15</u>
		Pain Score: <u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	
		Skin Integrity: <u>intact</u>	<u>intact</u>	<u>intact</u>	<u>intact</u>	<u>intact</u>	<u>intact</u>	
		Safety Needs: <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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
		Physiotherapy: <u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>nil</u>	<u>nil</u>	
		Others Specify: <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 checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		Special Diet: <u>NBM</u>	<u>NBM</u>	<u>acromioclavicular</u>	<u>soft diet</u>	<u>s.diet</u>	<u>s.diet</u>	
		Critical Lab Test / Values:	-	-	-	<u>nil</u>	<u>nil</u>	
		Other Special Orders / Medications: <input type="checkbox"/> Yes <input 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 checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		PU Prophylaxis: <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 checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		DVT Prophylaxis: <input type="checkbox"/> Yes <input type="checkbox"/> No	<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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		ADL (Dependent / Non Dependent): <u>dependent</u>	<u>dependent</u>	<u>dependent</u>	<u>dependent</u>	<u>dependent</u>	<u>dependent</u>	
		Post Operative Procedure Special Orders: <u>FHR monitor</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>nil</u>	<u>nil</u>	
		Handed Over By Name: <u>K. Srinivas</u>	<u>Aradhana</u>	<u>Kanaka</u>	<u>Besoniika</u>	<u>Manisha</u>	<u>Manisha</u>	
		Signature / ID: <u>220177</u>	<u>607890</u>	<u>020573</u>	<u>018727</u>	<u>019947</u>	<u>1990505</u>	
		Date: <u>26/6/26</u>	<u>26/6/26</u>	<u>26/6/26</u>	<u>27/6/26</u>	<u>27/6</u>	<u>27/6/26</u>	
		Time: <u>02:30pm</u>	<u>02pm</u>	<u>02:30pm</u>	<u>08AM</u>	<u>02pm</u>	<u>@8pm</u>	
		Taken Over By Name: <u>Br. Anitha</u>	<u>Aradhana</u>	<u>Besoniika</u>	<u>Manisha</u>	<u>Manisha</u>	<u>Besoniika</u>	
		Signature / ID: <u>020264</u>	<u>020573</u>	<u>018727</u>	<u>019947</u>	<u>1990505</u>	<u>018727</u>	
		Date: <u>26/6/26</u>	<u>26/6/26</u>	<u>26/6/26</u>	<u>27/6</u>	<u>27/6/26</u>	<u>27/6/26</u>	
		Time: <u>02:30pm</u>	<u>02pm</u>	<u>11:30am</u>	<u>08AM</u>	<u>@2pm</u>	<u>@8pm</u>	



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <i>G1P1L1 @ 38+1 wks @ previous 2 CS @ small for gestational age baby admitted for @ 2 CS @ bilateral tubectomy</i>		Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known				
	Surgery / Procedure: <i>yes</i>		If Yes Specify: <i>Nil</i>				
BACKGROUND	Date	<i>27/6</i>	<i>28/6</i>				
	Shift	<i>Night</i>	<i>M</i>				
	Medical Condition (Any special condition to be noted):	<i>Nil</i>	<i>Nil</i>				
	Diet:	<i>N. diet</i>	<i>N. diet</i>				
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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	<i>RA</i>	<i>RA</i>				
	Tubes/Drains/Catheter:	<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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	<i>98.6 F</i>	<i>98.3 F</i>			
		Res:	<i>20b/m</i>	<i>20b/m</i>			
		SpO ₂ :	<i>99%</i>	<i>98%</i>			
		Pulse:	<i>79b/m</i>	<i>80b/m</i>			
		BP:	<i>112/70(88)</i>	<i>110/70(80)</i>			
		LOC:	<i>conscious</i>	<i>conscious</i>			
	Fall Risk Score:	<i>0</i>	<i>0</i>				
Pain Score:	<i>0</i>	<i>0</i>					
Skin Integrity	<i>Intact</i>	<i>Intact</i>					
Recommendations	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" 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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Physiotherapy:	<i>Nil</i>	<i>Nil</i>				
	Others Specify:	<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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Diet:	<i>Nil</i>	<i>Nil</i>				
	Critical Lab Test / Values:	<i>Nil</i>	<i>Nil</i>				
	Other Special Orders / Medications:	<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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	PU Prophylaxis:	<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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	DVT Prophylaxis:	<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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
ADL (Dependent / Non Dependent):	<i>dependent</i>	<i>dependent</i>					
Post Operative Procedure Special Orders:		<i>Nil</i>	<i>Nil</i>				
Handed Over By Name :		<i>Beevika</i>	<i>Manoj C</i>				
Signature / ID :		<i>(Signature)</i>	<i>(Signature)</i>				
Date:		<i>28/6/26</i>	<i>28/6</i>				
Time:		<i>2.30 AM</i>	<i>8 AM</i>				
Taken Over By Name :		<i>Manoj C</i>					
Signature / ID :		<i>(Signature)</i>					
Date:		<i>28/6</i>					
Time:		<i>8 AM</i>					

noted by Manoj 28/6 (Signature)

VIH-00125303 IP-00060490
 Mrs M. BALAMANI
 17-06-1988 38 Y O M 9 D (F)
 Dr. SRILATA PATNAIK



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:						
	Surgery / Procedure:	Post OP Day:						
BACKGROUND	Date							
	Shift							
	Medical Condition (Any special condition to be noted):							
	Diet:							
ASSESSMENT	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	
	Ventilation (RA, NP, NIV, VENTI):							
	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 ₂ :						
		Pulse:						
		BP:						
		LOC:						
		Fall Risk Score:						
Pain Score:								
Skin Integrity								
Recommendations	Safety Needs:	<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	
	Physiotherapy:							
	Others Specify:	<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	
	Special Diet:							
	Critical Lab Test / Values:							
	Other Special Orders / Medications:	<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	
	ADL (Dependent / Non Dependent):							
	PU Prophylaxis:	<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	
	DVT Prophylaxis:	<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	
Post Operative Procedure Special Orders:								
Handed Over By Name :								
Signature / ID :								
Date:								
Time:								
Taken Over By Name :								
Signature / ID :								
Date:								
Time:								

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:					
	Surgery / Procedure:	Post OP Day:					
BACKGROUND	Date						
	Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	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
	Ventilation (RA, NP, NIV, VENTI):						
	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 ₂ :					
		Pulse:					
		BP:					
		LOC:					
		Fall Risk Score:					
	Pain Score:						
	Skin Integrity						
Recommendations	Safety Needs:	<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
	Physiotherapy:						
	Others Specify:	<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
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	<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
	ADL (Dependent / Non Dependent):						
	PU Prophylaxis:	<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
	DVT Prophylaxis:	<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
	Post Operative Procedure Special Orders:						
	Handed Over By Name :						
	Signature / ID :						
	Date:						
	Time:						
	Taken Over By Name :						
	Signature / ID :						
	Date:						
	Time:						



NURSING CARE RECORD

Date: 26/6/26

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	11 AM	maintain fluid balance	11 AM	RL 100ml/hr	prevent dehydration	patient well hydrated	[Signature] 26/6/26 10 AM
Afternoon	4 PM	Relieve pain & discomfort	4 PM	Analgesic given	Pain relite	patient calm	[Signature] 26/6/26 7 PM
	6 PM	maintain fluid balance	6 PM	RL 100ml/hr	prevent dehydration	patient well hydrated	
Night	9 PM	Ensure safety	9 PM	To provide side rails	To prevent fall	patient is good	[Signature] 26/6/26 @ 11 PM
		Maintain fluid balance		Maintained input/output chart	To prevent dehydration	patient is stable	



NURSING CARE RECORD

Date: 27/6

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 Nil

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	10 AM	→ Relieve pain & discomfort	10:30 AM	→ Advice the patient to Ambulate	→ TO Reduce pain	→ patient is stable	@
Afternoon	3pm	- Relieve pain & discomfort		- Advice the patient to Ambulate	- TO Reduce pain	- patient is stable	manisha 27/6/26 @ 8pm
Night	11pm	→ Maintain good Nutritional Status		→ To oral Intake is good	→ To Provided soft diet	Patient is stable	Benonika 28/6 @ 8am
	1am	→ Ensure Safety		→ Side rails kept up	→ prevent from fall risk		

Patient Sticker

NURSING CARE RECORD

Date: 28/6

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	9AM	<u>Discharge notes</u> :- doctor		came for rounds and advice for discharge			
Afternoon							
Night							

noted by
 Manasa
 28/6
 @

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
Morning							
Afternoon							
Night							

VIH-00125303
 Mrs M. BALAMANI
 17-06-1988 38 Y 0 M 9 D (F)
 Dr. SRILATA PATNAIK

IP-00060490

BRADEN 'Q' SCALE



					Date:	26/6/2016	26/6/2016	26/6/2016	27/6/2016
					Time:	11 AM	6 PM	10 PM	6 AM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		4	3	3	3
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4	1	3	3
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4	3	3	3
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4	2	4	4
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4	4	3	3
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	3	3
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	1	3	3
					TOTAL SCORE	28	18	22	22
					Evaluator's Name	[Signature]	[Signature]	[Signature]	[Signature]

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

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

VH-00125303 IP-00060490
 Mrs M. BALAMANI
 17-06-1988 38 Y 0 M 10 D (F)
 Dr. SRILATA PATNAIK



BRADEN 'Q' SCALE



Date : 28/6
 Time : 9 AM

Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	3			
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4			
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation. OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4			
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4			
FRICITION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4			
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	3			
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4			
TOTAL SCORE					96			
Evaluator's Name					[Signature]			

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

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



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
26/6/26	11 AM	0	NO Score Pain	<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	comfortable Position	[Signature]
26/6/26	3 PM	0	NO Score Pain.	<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	Comfortable Position	[Signature]
26/6/26	8 PM	1	Back Pain	<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	change comfortable position	[Signature]
27/6	12 AM	0	-	<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	-	Paxonika
27/6	2 AM	0	-	<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	-	Paxonika
27/6	4 AM	6	-	<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	-	Paxonika
27/6	6 AM	0	-	<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	-	Paxonika
27/6	8 AM	0	-	<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	-	Paxonika
28/6	9 AM	0	-	<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	Nil	[Signature]
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Re-assessment Frequency:

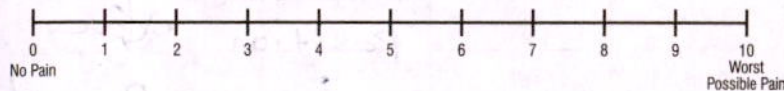
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams 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 0	Pain / Agitation	
	-2	-1		1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Even More 8 Hurts Whole Lot 10 Hurts Worst

/IH-00125303 IP-00060490
 Mrs M. BALAMANI 38 Y 0 M 9 D (F)
 17-06-1988
 Dr. SRILATA PATNAIK

CHECKLIST FOR THROMBOPHLEBITIS

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	26/6/2016 DAY-1			28/6 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	0	0	0	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				<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>						

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 : *manga* Name : *manga*

Signature of Ward In Charge :

Signature : *Chamalakshmi* Name : *Chamalakshmi*

GENERAL CONSENT FOR TREATMENT

Patient Name: Mrs M. BALAMANI Age : 38 Y 0 M 9 D
IP No: IP-00060490 Sex: Female
Consultant: Dr. SRILATA PATNAIK 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: AJAY BAPANAM

Relationship: Husband

Date: 26/06/26

Witness Name: Srinu

Witness Signature: Srinu

Patient Address:

HNO. 12-5-49/1VIAJYAPURI COLONY ,
TARNAKA, SECUNDERABAD. Lalapet
Hyderabad Telangana INDIA 500017

Time: 10-53 AM

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

Patient Name : MRS. M. BALAMANI Gender: Male Female Age : 38 YEARS

UHID No : VH-00125303/ IP-00060490 Date : 26/06/2026

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)

ELECTIVE LOWER SEGMENT CESAREAN SECTION WITH BILATERAL TUBAL LIGATION upon MRS. M. BALAMANI
(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, BOWEL AND BLADDER INJURY, URETERIC INJURY BLOOD AND BLOOD PRODUCTS TRANSFUSION AND ITS ASSOCIATED REACTIONS, INFECTION, POST PARTUM HEMORRHAGE, ADHESIONS, PERMANENT AND IRREVERSIBLE METHOD, <1% CHANCE OF FAILURE, RISK OF ECTOPIC PREGNANCY

My signature on this form indicates that

- I have read and understood the information provided in this form
- 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.
- I have had a chance to ask my surgeon questions.
- I have received all the information I desire concerning the operation or procedure and
- I authorize the consent to the performance of the operation or procedure.

Name of the Doctor who is performing the Surgery / Procedure: DR. SRILATA PATNAIK

Consentee :

Signature : M. Balamani

Name : Mrs. M. Balamani

Date & Time : 26/6/26 10:40am

Patient Attendant :

Signature : [Signature]

Name : S. Ajay Patnam

Relationship with Patient: Husband

Date & Time : 26/6/2026 10:40am

Witness :

Signature :

Name :

Date & Time :

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Adurini

Date & Time : 26/6/26 10:40 am

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE



Patient Name : Mrs. M. Balamani Age : 38y Gender : Male Female

UHID NO: VH-00125303 Surgeon Name: Dr. Srilata Patnaik

Anaesthesiologist : Dr. Madhav

Operative procedure planned : ~~Section~~ Emergency caesarean delivery

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 : 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. M. Balamani the above mentioned operation / Diagnostic / Therapeutic procedures

Emergency caesarean delivery

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 anaesthesiologist 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 : M. Balamani

Name : M. Balamani

Relationship with Patient : self

Date & Time : 26/6/26 11AM

Witness :

Signature : [Signature]

Name : S. Ajay Prakash

Date & Time : 26/6/26 11AM

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Bounda

Date & Time : 26/6/26, 11AM

VIH-00125303 IP-00060490
Mrs M. BALAMANI
17-06-1988 38 Y O M 9 D (F)
Dr. SRILATA PATNAIK



CAESAREAN SECTION OPERATIVE NOTES

Surgeon's Name: DR. SRILATA PATNAIK	Date of Delivery: 26/6/26
Assistant Surgeon: DR. NAUSHEEN	Time of Delivery: 2:58:01 PM
Anaesthetist's Name: DR. BRUNDA	Gender of Baby: female
Type of Anaesthesia: SPINAL	Weight of Baby: 2.99kgs
Neonatologist: DR. SRIKAR	AGPAR Score: 7/10, 9/10
Scrub Nurse: SIS PRASUNA	NICU Admission: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Pre-Operative Diagnosis: G2P14 with 38+1 weeks with previous LSCS with small for gestational age

Elective

Emergency

Indication: previous LSCS

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: Knife to rectus:

CTG Description:

If there was a delay give the reasons:

Surgical Procedure: Elective Lower Segment Caesarean Section

Post Operative Diagnosis:

Peri-Operative Complications:

Amount of Blood Loss: ~ 300ml .

Blood Transfused (in ML):

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

Uterine Incision: Lower Segment Classical Inverted T J Incision

Previous Scar: Intact Thinned out Ruptured No Scar

Incision Through Placenta: Yes No

Delivery of head: Manual Forceps

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

Delivery of Placenta: Manual CCT Complete Incomplete Piecemeal

Cord Appearance: *Normal* Cord around the neck Yes No *1 loop of cord.*

Appearance of placenta: *Normal.* Cavity explored Yes No

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

BK fallopian tubes identified and ligated using Modified Pomeroy technique

Uterine Closure: One Layer Two Layers *Vicryl* Suture

Peritoneal Closure: Pelvic Abdominal None *Vicryl* Suture

Sheath Closure: *Vicryl* Suture

Fat Closure: Yes No *Catgut* Suture

Skin Closure: Subcuticular Mattress *Monocryl* Suture

Vaginal Evacuated Yes No

Drain: Yes No Remove in days Await instructions

Catheter Yes No Remove in *12hrs* days Await instructions

Swaps & Instruments count correct? Yes No Post-op Antibiotics Yes No

Intra-Operative Antibiotics Cover: Yes No Thromboprophylaxis Yes No

Post-Operative Notes: *NBM, Rest, I/O charting, w HF bleeding PV,*
Early Ambulation, Monitor vitals, follow day chart,
Tupur 800.

D. Naushen

Doctor Name: *DR. Srilata Patnaik*


Doctor Signature:

Date & Time: *26/6/26*

SURGICAL SAFETY CHECKLIST

VIH-00125303 IP-0060490
 Mrs M. BALAMANI
 17-06-1988 38 Y O M 9 D (F)
 Dr. SRILATA PATNAIK

Surgeon: Dr. Srilata Patnaik
 Asst. Surgeon: Dr. Nausheen
 Anaesthetist: Dr. Braund
 Scrub Nurse: Dr. Prassanna

Pat: 
 UH: ELSCS
 Age: 38 Gender: F
 Surgery name: ELSCS
 Date: 26/6/26 In-time: 2:45 PM Out-time: 3:50 PM



Before Induction of Anaesthesia >>

SIGN IN	Time: <u>2:80pm</u>
Patient Has Confirmed	
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
Site Marked	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA
Anaesthesia Safety Check Completed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Pulse Oximeter on Patient & Functioning	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Does Patient have a:	
Known Allergy?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Difficult Airway / Aspiration Risk?	
Yes, & Equipment / Assistance Available	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Risk of > 500ml Blood Loss (7ml/kg In Children)?	
Yes, and Adequate Intravenous Access and Fluids Planned	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
Blood Units Reserved	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
Has Antibiotic Prophylaxis been given within the last 60 minutes?	
	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Signature: <u>[Signature]</u>	
Name: <u>Dr. Braund</u>	<u>26/6/26</u>

Before Skin Incision >>

TIME OUT	Time: <u>2:45 PM</u>
Confirm all team members have introduced themselves by Name and Role <input type="checkbox"/> Yes <input type="checkbox"/> No	
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm <u>M. Balamani</u>	
Correct Patient (Check ID Band)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Correct Site	<input type="checkbox"/> Yes <input type="checkbox"/> No
Correct Procedure - <u>ELSCS</u>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Anticipated Critical Events	
Surgeon Reviews:	
What are the Critical or Unexpected Steps, Operative Duration, - <u>1 hour</u>	
Anticipated Blood Loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Anaesthesia Team Reviews:	
Are There Any Patient-specific Concerns?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
Nursing Team Reviews:	
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
Is Essential Imaging Displayed?	
Power Supply, Earthing, Power Backup and functioning of equipment checked.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Signature: <u>[Signature]</u>	
Name: <u>Azad</u>	

Before Patient Leaves Operating Room

SIGN OUT	Time: <u>3:45 PM</u>
Nurse Verbally Confirms with the Team:	
The Name of the Procedure Recorded	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
The Specimen is Labelled (including patient name)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
Whether there are any Equipment Problems to be addressed	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
To Surgeon, Anaesthetist and Nurse:	
What are the key concerns for recovery and management of this patient?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Signature: <u>[Signature]</u>	
Name: <u>Dr. Nausheen</u>	

VIH-00125303 IP-00060490
 Mrs M. BALAMANI
 17-06-1988 38 Y O M 9 D (F)
 Dr. SRILATA PATNAIK



BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date: 26/6/26

To Be Filled In By Assigned Nurse:

Department: ICU Duration of Procedure :

Name of Surgeon: Dr. SriLatha Date of Admission 26/6/26

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

		Staff Signature
1.	Antibiotic given prior to surgery? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Single Dose Antibiotic Or <input checked="" type="checkbox"/> Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of the Antibiotic: <u>Inj. cefotaxim 1gm</u>	
2.	Hair Removal <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes: <input type="checkbox"/> Surgical Clipper Department where Hair Removed: <input checked="" type="checkbox"/> Ward <input type="checkbox"/> Operating Room <input type="checkbox"/> Other:	
3.	Patient's body temperature immediately post operation (Recovery Room) <u>37</u> °C <input type="checkbox"/> Oral Or <input checked="" type="checkbox"/> Axilla (Goal: 36-37°C)	
4.	Name of doctor or staff administering the antibiotic: <u>Dr.</u> Date & Time of antibiotic administration: <u>26/6/26 at</u> Date & Time procedure started: <u>26/6/26 at 2:45 pm</u>	

- 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

OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 26/6/26 Time of Arrival: 10:20AM Time Seen by Nurse: 10:25AM

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: pain in abdomen

3) Vital Signs: Temperature: 98.6F Pulse: 100b/m RR: 18b/m SpO₂: 99% BP: 120/77 Weight: 80.0kg

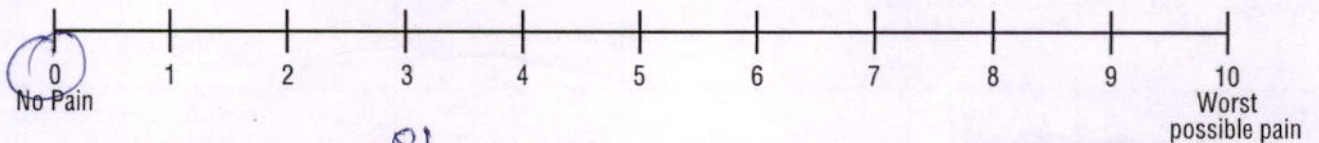
4) Gestational Criteria:

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

LMP: 2/10/25 EDD: 9/7/2026 Gestational Age: 38+1wks

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: Nr. /
- Duration: Nr. / Days / Weeks/ Months (Strike out which is not applicable)
- Character: Nr. /
- Frequency: Nr. /
- Interventions: Nr. /

6) Past History:

- a) Surgeries: prev 2scs
- b) Medical: Nr. /



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

8) Current Medications: Prenatal Vitamin None Others: _____

9) Prenatal Medical History:

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

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

Time seen by Doctor: 10:30 AM

Nurse Name : K. Subasini Nurse Signature: _____

Date: 26/6/26 Time: 10:25 AM

VIH-00125303 IP-00060490

Mrs M. BALAMANI
17-06-1988 38 Y O M 9 D (F)
Dr. SRILATA PATNAIK



①

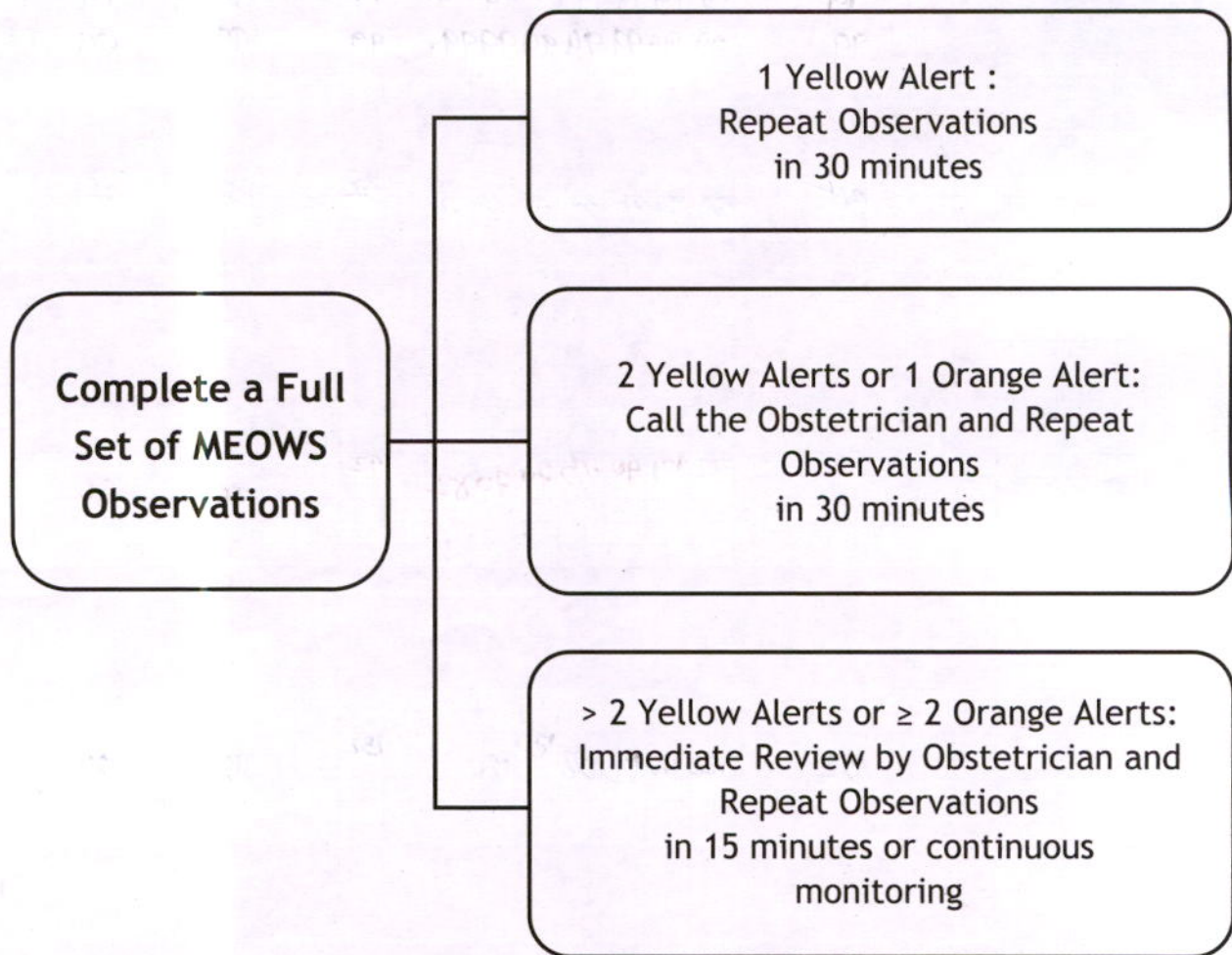


Early warning Observation Score Chart - Obstetrics

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

		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
RESP (write rate in corresp. box)	> 30																								
	21 - 30																								
	11 - 20				11			10	10	14	14	14	14	14	14	14		11	11		11			11	11
	0 - 10																								
Saturations	94 - 100 %				99			99	99	99	99	99	99	99	99	99		99		99			99	99	
	< 94 %																								
Administered O ₂ (L/min.)																									
Temp °C	40																								
	39																								
	38																								
	37																								
	36				36			36	37	36	36	36	36	36	36	36		36		36			36	36	
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90				99			101	101	101	100	95	74	70	82	92		75		80			95	95	
	80																								
	70																								
	60																								
	50																								
40																									
Systolic Blood Pressure ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110				122			120	120	123	123	130	120		132			118		120			112	112	
	100																								
	90																								
	80																								
	70																								
60																									
50																									
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
70				73			60	60	60	62	62	81	76	80			79		82			72	72		
60																									
50																									
40																									
NEURO RESPONSE [✓]	Alert				✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓		✓			✓	✓	
	Voice																								
	Pain																								
	Unresponsive																								
URINE mls / hour	> 30				✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓		✓			✓	✓	
	< 30																								
Proteinuria	Protein ++																								
	Protein > ++																								
Lochia	Normal				NA		NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		NA		NA			NA	NA	
	Heavy / Foul																								
Liquor	Clear / Pink				NA		NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		NA		NA			NA	NA	
	Green																								
TOTAL YELLOW SCORES					0		0	0	0	0	0	0	0	0	0	0		0		0			0	0	
TOTAL ORANGE SCORES					0		0	0	0	0	0	0	0	0	0	0		0		0			0	0	
Nurse Initial					B		B	B	B	B	B	B	B	B	B	B		B		B			B	B	

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

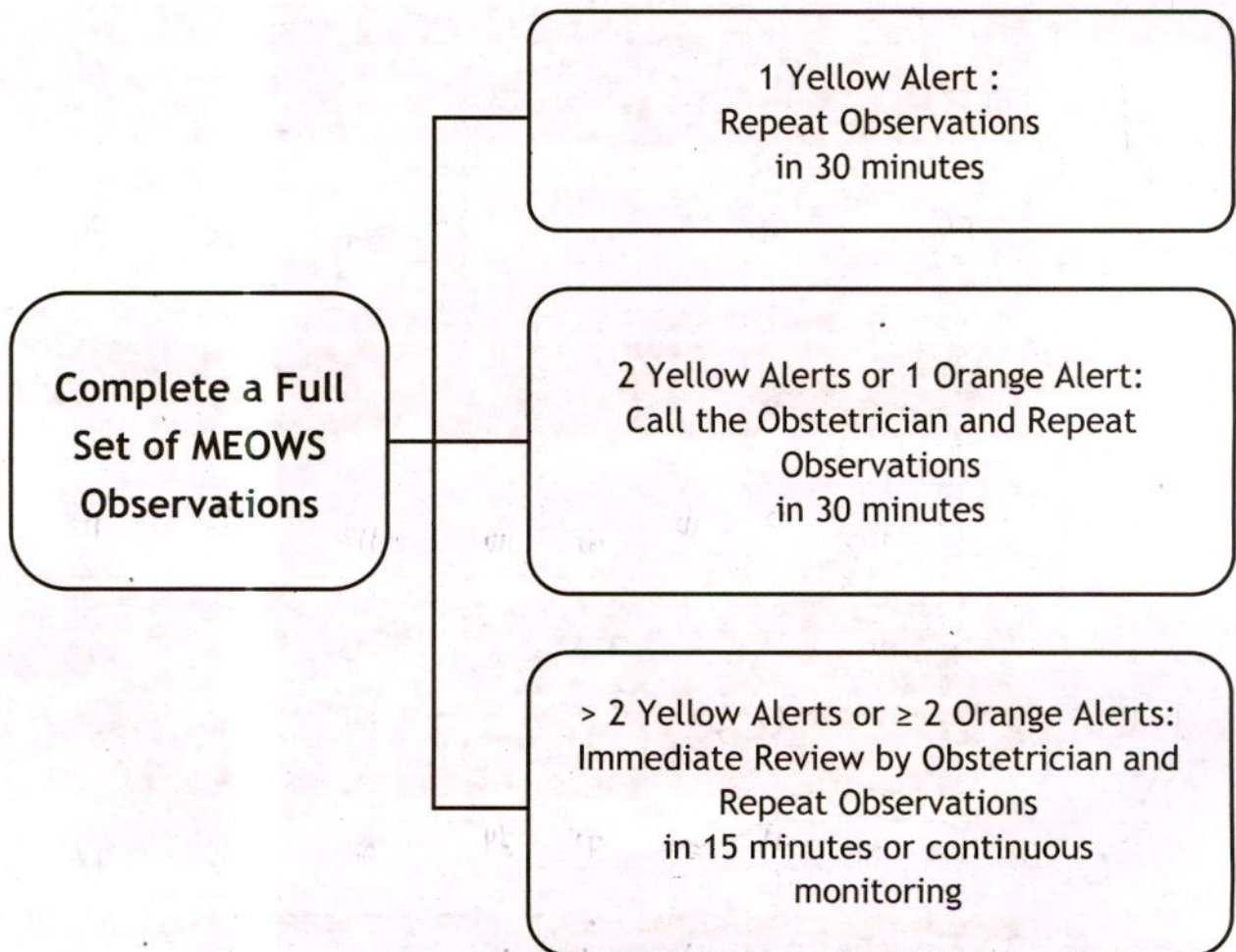


Warning Observation Score Chart - Obstetrics

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

Date																									
		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	18	14	18	19	19	19	19	19	19	19	19	19	19	19	19	19	19	19	18	19	19	19	19
	0 - 10																								
Saturations	94 - 100 %	98	98	97	99	99	98	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	98	98
	< 94 %																								
Administered O ₂ (L/min.)																									
Temp °C	40																								
	39																								
	38																								
	37	37	37	37	37	37	37	37	37	37	37	37	37	37	37	37	37	37	37	37	37	37	37	37	37
	36																								
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90	86	90	88	86	91	91	88	88	88	88	88	88	88	88	88	88	88	88	88	88	88	88	88	88
	80																								
	70																								
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Systolic Blood Pressure	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120	110	112	112	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110
	110																								
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Diastolic Blood Pressure	130																								
	120																								
	110																								
	100																								
	90																								
	80	70	71	71	71	71	71	71	71	71	71	71	71	71	71	71	71	71	71	71	71	71	71	71	71
	70																								
60																									
50																									
40																									
NEURO RESPONSE [✓]	Alert	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	Voice																								
	Pain																								
	Unresponsive																								
URINE ml/s / hour	> 30	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
	< 30	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Proteinuria	Protein ++																								
	Protein > ++																								
Lochia	Normal	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
	Heavy / Foul																								
Liquor	Clear / Pink																								
	Green																								
TOTAL YELLOW SCORES		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
TOTAL ORANGE SCORES		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Nurse Initial		me	me	me	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)



Early Warning Observation Score Chart - Obstetrics

CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGER YELLOW SCORES AT ANY ONE TIME

VIH-00125303 IP-00060490
 Mrs M. BALAMANI
 17-06-1988 38 Y 0 M 10 D (F)
 Name : Date of Birth :
 Dr. SRILATA PATNAIK
 UHID No. : IP No. :



Date		8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (Write rate in corresp. box)	> 30																								
	21- 30																								
	11 - 20		20																						
	0 - 10																								
Saturations	94 - 100%		98																						
	< 94%																								
Administered O ₂ (L/min)																									
Temp °C	40																								
	39																								
	38																								
	37		37																						
	36																								
	35																								
	<35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80		82																						
	70																								
	60																								
	50																								
	40																								
Systolic Blood Pressure	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110		108																						
	100																								
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50																									
Diastolic Blood Pressure	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70		70																						
60																									
50																									
40																									
NEURO RESPONSE [✓]	Alert		✓																						
	Voice																								
	Pain																								
	Unresponsive																								
URINE mis / hour	>30		✓																						
	<30																								
Proteinuria	Protein ++																								
	Protein>++																								
Lochia	Normal		NA																						
	Heavy / Foul																								
Liquor	Clear / Pink		NA																						
	Green																								
TOTAL YELLOW SCORE			0																						
TOTAL ORANGE SCORE			0																						

noted by Manoja 28/6 2:10:00 PM

VIH-00125303 IP-00060490
 Mrs M. BALAMANI
 17-06-1988 38 Y 0 M 9 D (F)
 Dr. SRILATA PATNAIK



FLUID CHART

Sheet No. : 1

26/6/26

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 Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
26/6/26	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am	NBM + RL	500ml								0	26/6/26
	12:00 pm	NBM + RL	100ml						50ml	0		
	01:00 pm	NBM + RL	100ml						50ml	0		
	Total Intake :			250ml			Total Output : 100ml					
26/6/26	02:00 pm											
	03:00 pm	NBM + RL - FF									0	26/6/26
	04:00 pm	NBM + RL + 500ml/hr							600ml	0		
	05:00 pm	NBM + RL	100ml						100ml	0		
	06:00 pm	NBM + RL	100ml						100ml	0		
	07:00 pm	NBM + RL	100ml						100ml	0		
Total Intake :			1300ml			Total Output : 900ml						
26/6	08:00 pm	NBM + RL	100ml						100ml	0	26/6/26	
	09:00 pm	NBM + RL	100ml						100ml	0		
	10:00 pm	H2O + 50ml							50ml	0		
	11:00 pm	H2O + 50ml							50ml	0		
	12:00 am								100ml	0		
	01:00 am								100ml	0		
Total Intake :						Total Output : 500ml						
27/6	02:00 am								100ml	0	27/6/26	
	03:00 am								100ml	0		
	04:00 am								100ml	0		
	05:00 am								100ml	0		
	06:00 am								100ml	0		
	07:00 am								100ml	0		
Total Intake :						Total Output : 600 ml						
Total 24 hrs. Intake						Total 24 hrs. Output					2100 ml	

VH-00125303 IP-00060490
 Mrs M. BALAMANI
 17-05-1988 38 Y 0 M 10 D (F)
 Dr. SRILATA PATNAIK



FLUID CHART

Sheet No. :

27/6/26

- 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							
27/6	08:00 am	Orally + water							100ml		}	Manasa 27/6 2pm
	09:00 am								100ml			
	10:00 am								100ml			
	11:00 am								100ml			
	12:00 pm											
	01:00 pm											
Total Intake :					Total Output : 500ml							
27/6/26	02:00 pm	Orally water									}	Manasa 27/6/26 08pm
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :					Total Output :							
28/6	08:00 pm	Orally water									}	Beenuka 28/6 @1am
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :					Total Output :							
28/6/26	02:00 am	water									}	Beenuka 28/6 @7am
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :					Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

17-06-1988
 Mrs M. SALAMANI IP-00060490
 Dr. SRILATA PATNAIK 38 Y O M 9 D (F)
 D. SRILATA PATNAIK



FLUID CHART

Sheet No. :

28/6/26

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 Thrombo- phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
28/6	08:00 am		Milk									} managed 28/6
	09:00 am		+ water									
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
	Total Intake :						Total Output :					
	02:00 pm											noted by managed 28/6
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											noted by managed 28/6
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											noted by managed 28/6
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						
Total 24 hrs. Intake						Total 24 hrs. Output						

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	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							

VIH-00125303 IP-00060490
 Mrs M. BALAMANI
 17-06-1988 38 Y 0 M 9 D (F)
 Dr. SRILATA PATNAIK



MEDICATION RECONCILIATION FORM

Drug Allergies: Amoxicillin 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	T. IRON	1 TAB	PO	ONCE DAILY		<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
2	T. CALCIUM,	1 TAB	PO	ONCE DAILY		<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : DR. YOGESHWART

Date & Time : 26/6/2026 11 AM

Nurse Name & Signature: K. S. K. Subhasini

Date & Time : 26/6/2026 11 AM



MEDICATION RECONCILIATION FORM

Drug Allergies: Amoxicillin 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: Room (105)

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. PANTOPRAZOLE	40MG	PO	ONCE DAILY		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
2	TAB. PARACETAMOL	1GM	PO	6TH HOURLY		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
3	TAB. DILLOFENAC	50MG	PO	8TH HOURLY		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
4	INF. CEFOTAXIME	1GM	IV	12TH HOURLY		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
5	TAB. TRAMADOL	100MG	IV	8TH HOURLY		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature :  DR. WIKHITA
 Date & Time : 26/6/26 10:30 PM

Nurse Name & Signature: 
 Date & Time : 26/6/26 10:30 PM

Patient Name	I.P. No.	Sheet No.	Wards	Weight (kg)
		①	212/21. ubi	

REGULAR PRESCRIPTIONS

DRUG : INJCEFOTAXIME				Date	26/6														
				Time	11 AM	6:30													
Dose	Route	Frequency	Start Dt.																
1gM	IV	12th HOURS	26/6/26																
Name & Signature of the Doctor starting the Drugs:																			
PR. NAUSHEEN																			
Additional Instructions:																			
FOR 48 hrs.				STOP 28/6/26 7 AM															
Daily Doctor's Endorsement by a Sign.																			

DRUG : T. CEFUROXIME				Date	28/6														
				Time	10 AM														
Dose	Route	Frequency	Start Dt.																
500MG	PO	12th hrs	28/6																
Name & Signature of the Doctor starting the Drugs:																			
Dr. Geeshma																			
Additional Instructions:																			
(T. CEFTUM)																			
Daily Doctor's Endorsement by a Sign.																			

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

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

26/6/26 11 AM 6:30
 28/6/26 10 AM
 28/6/26

Patient Name :	I.P. No.	Sheet No.	Wards	Weight (kg)
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REGULAR PRESCRIPTIONS

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

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

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

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



I.V. FLUIDS CHART

Weight 50.4kg 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
26/6/26	11 AM	RINGER LACTATE	IV	FF	YI	[Signature]	26/6	[Signature]	[Signature]
26/6/26	12 PM	RINGER LACTATE	IV	100ml HR	YI	[Signature]	26/6	B	[Signature]
26/6	3 PM	RINGER LACTATE	IV	FF	B	[Signature]	26/6	B	[Signature]
26/6	2:30 PM	RINGER LACTATE	IV	500ml HR	B	[Signature]	26/6	[Signature]	[Signature]

Signature
VERIFIED BY : Name



Date Time	Nurse Sig.	Dose	Nurse Sig.	Dose	Nurse Sig.	Dose	Nurse Sig.
DRUG :		Dose		Dose		Dose	
		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	
		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Additional Instructions:		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.	

Date Time	Nurse Sig.	Dose	Nurse Sig.	Dose	Nurse Sig.	Dose	Nurse Sig.
VARIABLE DOSE		Dose		Dose		Dose	
		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	
		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Additional Instructions:		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.	

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
26/6/26	10:00 AM	INJ CEFOTAXIME (AFTER TEST DOSE)	1 gm	IV	[Signature]	[Nurses]
26/6/26	12:00 PM	INJ PANTOPRAZOLE	40 mg	IV	[Signature]	[Nurses]
26/6/26	12:00 PM	INJ METOCLOPRAMIDE	10 mg	IV	[Signature]	[Nurses]
26/6/26	2:55 PM	INJ- CARBETOLIN	100 µg	IV	[Signature]	[Nurses]
26/6/26	3:10 PM	INJ. TRANEXAMIC ACID	1 gm	IV	[Signature]	[Nurses]
26/6/26	3:45 PM	SUPP. TRAMADOL	100 mg	PR	[Signature]	[Nurses]
26/6/26	3:45 PM	SUPP. DICLOFENAC	100 mg	PR	[Signature]	[Nurses]
26/6/26	3:45 PM	T. MISOPROSTOL	400 MCG	INTRA CAVITARY	[Signature]	[Nurses]
26/6/26	3:45 PM	T. MISOPROSTOL	400 MCG	PR	[Signature]	[Nurses]

VERIFIED BY : Name Signature

Vaidya

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. 040-42462200, Ext 2000,2001,2002,



PatientName : Mrs M. BALAMANI
Age/Gender : 38 Y 0 M 9 D/ Female
Ward/Bed : N 2F-LABOUR WARD/ LW 219

Inpatient No. : IP-00080480
Admit Date : 26-06-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
BLEEDING TIME/CLOTTING TIME (Specimen : BLOOD)			TEST RESULT STATUS : REPORT AUTHORISED
			Order Date :26-06-2026 11:33
BLEEDING TIME	2 min : 30 sec	min.	1 - 5
CLOTTING TIME	4 min : 55 sec		3 - 7



Dr. SRUJANA SHYAMALA, MD, DNB
 Consultant Pathologist, Reg No : 39356

Name	Mrs M. BALAMANI	UHID	VIH-00125303
Father/Guardian	Mr SADALA AJAY RATANAM	Age/Gender	38 Y 0 M 9 D/Female
Address	HNO. 12-5-49/1VIAJYAPURI COLONY , TARNAKA, SECUNDERABAD., Lalapet, Hyderabad, Telangana, INDIA, 500017		
IP No	IP-00060490	Admission Date	26-06-2026
Ref Doctor	Self	Discharge Date	28-06-2026

DISCHARGE SUMMARY

Consultant: Dr. SRILATA PATNAIK, CONSULTANT GYNECOLOGIST &
OBSTETRICIAN

Diagnosis: G2P1L1 with 38+1 weeks with previous LSCS with Small
for gestational age baby admitted for Elective Lower
segment cesarean section with bilateral tubectomy.

**ELECTIVE LOWER SEGMENT CESAREAN SECTION WITH BILATERAL
TUBECTOMY DONE UNDER SPINAL ANESTHESIA ON 26.6.2026**

History:

LMP: 2.10.2025

Obstetric formula: G2P1L1

EDD: 9.7.2026

Gestation at admission: 38+1 weeks

Obstetric History:

G1 - Female / 5 years / FTLSCS / NPOL / 3.8kgs / BF X 5YRS / A&H / RCH VKP /
uneventful

G2 - Present pregnancy Spontaneous conception.

Medical History: Nil

Family History: Mother - DM

Name	Mrs M. BALAMANI	UHID	VIH-00125303
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Surgical History: Previous LSCS 6 yrs ago

Allergies: Amoxicillin

Antenatal Details: Mrs. M. BALAMANI was booked to Rainbow Hospital at 8+5 weeks of gestation. She had regular antenatal checkups and investigations as advised. She was on Tablet Ecosprin 150mg OD since 13+2 weeks and stopped at 35+3 weeks. She had history of loose motions at 13+2 weeks and was managed conservatively. She came with complaints of dull abdominal pain since 9:30am on 26.6.2026. She was admitted at 38+1 weeks with previous LSCS with Small for gestational age baby admitted for Elective Lower segment cesarean section with bilateral tubectomy.

Investigations: Enclosed

Blood group: 'O' POSITIVE

Management: Course in hospital: She came with complaints of dull abdominal pain since 9:30am on 26.6.2026, subsided. On examination vitals stable, uterus relaxed.

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: Operative Details:

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. Lower uterine segment thinned out. A lower segment curvilinear incision given on the uterus. Baby delivered with one loop of cord around neck. 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

Name	Mrs M. BALAMANI	UHID
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prophylaxis with Inj. Taxim 1 gm IV given. Misoprostol 400 mcg given intra cavitory as prophylaxis against postpartum hemorrhage. Uterus closed in layers. Bilateral fallopian tubes identified and ligated using modified pomeroys technique. 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 400 mcg given per rectum as prophylaxis against postpartum hemorrhage. Patient was shifted out of theatre to post operative recovery room.

Delivery Details:

Date: 26.6.2026

Time of Delivery: 2:58:01 pm

Type of Delivery: Elective LSCS

Indication: Previous LSCS

Analgesia: Spinal

Baby Details:

Date: 26.6.2026

Time: 2:58:01pm

Sex: Female

Weight: 2.99kgs

Apgar: 7/10, 9/10

Gestational Age: 38+1 weeks

NICU Admission: No

Post-Operative Notes: Post Operative Period:

She was closely monitored. Her vital signs remained stable. Uterus was well retracted with no postpartum hemorrhage. Breastfeeding initiated. She was shifted to room. Her postoperative period following that was uneventful. On third 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

Name	Mrs M. BALAMANI	UHID	VIH-00125303
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supplemented by written information.

Advice:

1. Tab. Cefuroxime (ceftum) twice daily till 2.7.2026 (9am-9pm) after food.
2. Tab. Calpol 500mg (2tabs) (Paracetamol 500mg) thrice daily till 2.7.2026 (9am-2pm-9pm) after food.
3. Tab. Voveran 50 mg (Diclofenac 50mg) thrice daily till 2.7.2026 (10am-4pm-10pm) after food.
4. Tab. Pantoprazole 40 mg once daily till 2.7.2026 (7am) before food.
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) 1 tablet once daily (2pm) till breastfeeding after food.
7. Nebasulf powder for local application.
8. HPV vaccine after 6 weeks of delivery.

Review after one week on 2.7.2026 at postnatal clinic with prior appointment (This consultation will be charged).

To take appointment for OPD consultation at Rainbow Children's Hospital, just dial one number 1800-2122 (between 8 a.m. to 8 p.m.) (or) log on to www.rainbowhospitals.in

In case of emergency like bleeding, fever - kindly contact 040-42462200. Extension 2220 (Rainbow Hospital, Karkhana).

For Women Who Have Had a Cesarean 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.

Name	Mrs M. BALAMANI	UHID
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VIP-00125303

- 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 doctorin the language that I understand and I have understood the same.

Name:

Signature:

Relationship:

This summary was explained by:

Summary prepared by: Dr.



Dr. SRILATA PATNAIK
MBBS MD
CONSULTANT GYNECOLOGIST & OBSTETRICIAN

Registrar/Resident/C.M.O