Form - A Front

REGISTRATION CARD

(To be filled in capital letters, preferable by the patient)

UHID No._____IPD No._____Date _____

Patient Name :_____Son/Daughter/Wife/Husband of: _____

Age_____Date of Birth_____Gender : M F Aadhar No. _____

Marital Status : ☐ Single ☐ Married ☐ Other Nationality_____Phone No. _____

Address for Correspondence : _____

_____

State_____Pin Code : ☐☐☐☐☐☐ Country_____Mobile _____

Preferred mode of communication : ☐ Phone ☐ Mobile ☐ E- mail ID : _____

Blood Group :_____Rh_____Known Allergy, if any : _____

Person to Notify in case of emergency :

Name :_____Relationship_____Phone No. _____

Patient brought by_____Relationship, if any _____

Mode of Payment : ☐ Cash ☐ Credit Card ☐ Cheque

"I hereby certify that the information provided is accurate to the best of my knowledge."
I consent to undergo medical diagnostic tests, procedures and intervention as may be required. Management is not responsible for loss or any personal items while are in.....

PTO

Form A - Back

Patient Name :_____DOA_____

BED No._____Date & Time_____UHID No._____IPD No. _____

Estimate / Daily Expenses Form

Estimate Amount of Procedure Package :

Procedure Name :

Package Inclusions :- 1. Procedure Charge Yes/No

2. Room Charge For..... Days Yes/No

3. Indoor Medicine Yes/No

4. Any Other Service

Note : Any other thing other than package inclusion will be chargeable.

Dr. Sign. Patient Sign. Attendant Sign.

Daily Expenses form Other than Package

Date	Admission Fees	Room/Bed/ ICU Charge	Doctor Visit	X-Ray/ ECG	Oxygen	Procedure Operation	Other	Total

Case Sheet for Labor Patients

Patient's Name : _____ UHID : _____

Diagnosis : _____ Age : _____

Presenting Complaints - **Amenorrhoea of..... Months**

C/O Pain in abdomen	☐	C/O Bleeding/Leaking P/V	☐
Fetal Movements	☐	Fever	☐
Foul smelling discharge	☐	Breathlessness at rest/Exertion	☐
Palpitations	☐	Weakness/Tiredness	☐
Headache	☐	Vomiting	☐
Seizure/Fits	☐	Blurred Vision	☐

Obstetric History - G P L A

Menstrual History - LMP **EDD**

Previous menstural cycles - regular/irregular

Medical/Surgical History

Family History

General Examination :

1. **Weight**
2. **Height**
3. **Pulse**
4. **BP**
5. **Temperature**
6. **Pallor**
7. **Jaundice**
8. **Oedema**

Investigation : 1. CBC .....

2. HIV - .....

3. VDRL .....

4. Urine Albumin (If B.P. more than 140/90) .....

Form B-1 Back

Systemic Examination

- RS-
- CVS

Abdominal Examination

- Fundal Height - for Gestation age
- Presentation -
- FHR Per minute
- Contractions per minute
- Engagement of Presenting Part

P/V Examination (done under all aspetic precautions - 4 hourly or SOS)

- Cervical Dilatation -
- Effacement -
- Presenting Part -
- Membranes - Present/absent
- Station -
- Bleeding/Show
- Liquour - Clear/meconium stained/Blood Stained
- Caput/Moulding -

PLAN OF CARE -

Delivery Notes :

- P/A examination to rule out second baby .....
- Injection Oxytocin 10 IU IM given, AMTSL done.....
- Placenta & membranes checked, found complete.....
- Uterus well contracted, No PPH.....

Post Partum Notes - (For Mother) :

1.	Pulse	2.	BP
3.	Temperature	4.	P/A to check uterus (contracted)
5.	Bleeding P/V	6.	Lochia
7.	Breast	8.	Calf Tenderness/Redness/Swelling

COUNSELLING done on
Exclusive breast feeding & Post Partum Contraceptive methods.....

Baby Notes :

Foot Print of Baby

Date & time of Delivery .....

- Mode of Delivery - Vaginal/LSCS
- Sex-
- Weight -
- Cry/Breathing -
- Outcome of Delivery -
- APGAR at 5 min-
- Maturity - Full term/Preterm/Postdated
- Congenital anomaly -
- Resuscitation -
- Amniotic fluid colour-

Duration of Rupture of Membranes -

- Inj. Vit K-
- Time of starting Breast Feeding -

Newborn Examination

- Assess feeding of baby
- Baby temp
- Respiration
- Cord Stump
- Colour of Skin-Jaundice/Cynosis/Pallor

In case of Referral :

Reason for referral : .....

Referred to Place & time.....

SIGNATURE OF DOCTOR

Form B-2 Back

POST PARTUM RECORD

FOR MOTHER	15 MINS	30 MINS	1 HOUR	2 HOUR
BLEEDING (0 +++)				
UTERUS - HARD/ROUND :				
B/P				
TEMPERATURE :				
PULSE :				
URINE VOIDED :				
VULVA :				
NEW BORN :				
BREATHING :				
TEMPERATURE :				
CORD STUMP :				
NEWBORN ABNORMAL SIGNS (LIST) :				

FEEDING OBESERVED FEEDING WELL DIFFICULTY

COMMENTS

MOTHER : TREATMENT GIVEN

NEW BORN : TREATMENT GIVEN

ADVISE AND COUNSEL

MOTHER

- ☐ Postpartum care and hygiene
- ☐ Nutrition
- ☐ Birth Spacing and family planning
- ☐ Danger signs
- ☐ Follow-up Visits
- ☐ Advise on Postpartum stress management

BABY

- ☐ Exclusive breast feeding
- ☐ Hygiene, cord care and warmth
- ☐ Special advice in low birth weight
- ☐ Danger signs
- ☐ Follow-up visits

PREVENTIVE MEASURES

FOR MOTHER

- ☐ Iron/Folate
- ☐ Mebendazole
- ☐ ART

FOR BABY

- ☐ Risk of bacterial infection and treatment
- ☐ BCG, OPV-0, Hep-0
- ☐ RPR result and treatment
- ☐ TB test result and prophylaxis
- ☐ ART