

[Signature]
26/05/2026

SPE-0001/032 IPZ-00006/02
Mrs SOUMYASREE MAHAPATRO
10-05-1993 33 Y 0 M 16 D (F)
Dr. SHREEJA KARAN



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NBOW HOSPITALS
ght to a Safe Delivery

ACTIVITY RECORD FOR BILLING

Cash: Credit:

Name: Mrs. Soumyasree Mahapatro Age: 33 Gender: Female
 UHID No: Spb-12012 IP No: 6002 Consultant: Dr. Shreeja Dept: ORS & Erythrology
 Date of Admission: 26/05/26 Time: 09:28am Date of Discharge: 26/5/26 Time: 3pm
 Room / Bed No: JVF-2 Ward: 3F Room Bed No: JVF 2 Ward: 3F

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
26/5/26	9:28am	Admission	Recovery	<i>[Signature]</i>
26/5/26	10am	Recovery	JVF-OT-01	<i>[Signature]</i>
26/5/26	10:30am	JVF-OT-01	Recovery	<i>[Signature]</i>
26/5/26	3pm	Recovery	Discharged	<i>[Signature]</i>
Updated on				

DOCTORS VISITS

Consultants	Date		Date		Date		Date		Date		Date		Date		Date	
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
1 <u>Dr. Shreeja</u>																
2																
3																
4																
5																
6																

DISCHARGE SUMMARY

Name	Mrs SOUMYASREE MAHAPATRO	UHID	SPB-00017012
Father/Guardian	Mr SATYA SWARUP DWIBEDI	Age/Gender	33 Y 0 M 16 D/Female
Address	SARJAPUR BANGALORE, Dommasandra, Bangalore, Karnataka, INDIA, 562125		
IP No	IP27-00006752	Admission Date	26-05-2026
Ref Doctor	Others	Discharge Date	26-05-2026

Consultants : Dr. Shreeja Karan
MS, DNB, FRM(RGUHS), MRCOG(UK)
RJS 2014 0000037 KTK

Diagnosis: Secondary infertility / Poor Ovarian reserve/ Previous failed IUI

Procedure- OPU under GA on 26.05.2026

History: Secondary Infertility came for OPU. She received COS for 9 days and came for Oocyte retrieval and ICSI.

Menstrual History:- LMP- 16.05.2026
Previous cycles: Regular

Obstetric History:A1- Failed Early IUP

Medical History: None

Family History: H/O Asthma

Surgical History: None

Allergies : None

Stimulation protocol:

Antagonist Protocol

Rainbow Children's Medicare Limited

For Appointments call: 1800 2122 or SMS "RWCH" to 57575



Marathahalli:

Survey No. 8/5,
Marathahalli-KR Puram, Outer Ring Road
Doddanekundi, Bengaluru - 560 037.
Ph: 1800 2122



Bannerghatta Road:

No 178/1 & 178/2,
Opposite Janardhan Towers,
Bilekahalli, Bengaluru - 560 076.
Ph: 080-66902200



Hebbal:

No.247/248/288/100
Byatarayanapura Village,
Yelahanka Hobli, Bengaluru - 560 092.
Ph: 1800 2122

Sarjapur Road :

Sy No. 3/3, 3/4, Ambalipura Village
Varthur Hobli, Sarjapur Road
Bengaluru - 560 103.
Ph: 080 6957 9999

Registered Office: 8-2-120/103/1, Survey No. 403, Road No. 2, Banjara Hills, Hyderabad - 500034, Telangana.

Name	Mrs SOUMYASREE MAHAPATRO	UHID	SPB-00017012
IP No	IP27-00006752	Admission Date	26-05-2026

Inj Gonadotropin Releasing Hormone (GnRH) agonist (Gonadorelin) 150 + Inj Humog HP 150 + Asprorelis 0.25 mg X 9 days
Trigger- Inj Decapeptyl 0.1mg+ Inj Ovitrelle 250mcg

Investigations: Enclosed.

Surgery Notes:

Under GA Patient given lithotomy position
Parts painted with NS and draped
Transvaginal USG guided oocyte retrieval done
Oocyte aspiration needle - > Single lumen
Total Follicles- 08
Follicles aspirated-08
Oocyte retrieved-08
No POD collection noted at end of the procedure
Minimal PV bleeding Noted
Procedure uneventful
Blood loss minimal

Post-Operative Notes: Postoperative period: patient is comfortable and vitals stable.

Advice on discharge:

1. Tab Pan 40mg 1-0-1 BF X 3 days
2. Tab Dolo 650mg 1-1-1 for 3 days
3. Syp Digene 5ml sos

Review with Dr. Shreeja Karan in OBG OPD on 29.05.2026 with prior appointment.

In case of emergency (pain abdomen, bleeding), Kindly contact 9620688818/9620688814.

To take appointment for OPD consultation at Rainbow Children's

Rainbow Children's Medicare Limited

For Appointments call: 1800 2122 or SMS "RWCH" to 57575

Marathahalli:
Survey No. 8/5,
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hospital Contact 18002122 .

Discharge Summary Prepared by Dr. Shreeja Karan

Discharge Summary explained to patient , Nurse Name & Signature

Shreeja

Dr. Shreeja Karan
MS, DNB, FRM(RGUHS), MRCOG(UK)
RJS 2014 0000037 KTK

Patient Signature: _____

Rainbow Children's Medicare Limited

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Registered Office: 8-2-120/103/1 Survey No. 403 Road No. 2 Banjara Hills, Hyderabad - 500034, Telangana.

CONSENT FORM FOR ANAESTHESIA



Patient Name : Soumyashree Age : 324 Gender : Male Female

UHID NO : _____ Surgeon Name : Dr. Geeta

Anaesthesiologist : Dr. Hanjirasa Operative procedure planned : OPU

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 can be achieved by infusing weak solutions of local anaesthetics 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 / Road Traffic Accident
- Incapacitating Chronic Obstructive Pulmonary Disease
- Others : _____

DECLARATION BY PATIENT / GUARDIAN / PROXY

Bronchospasm, Laryngospasm / PRE

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

I authorize and give consent for anaesthesia (Regional / General Anesthesia / Monitored Anesthesia Care as considered appropriate by the anaesthesia 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 and 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 anaesthesia. Drowsiness, PONV

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, Nausea and Vomits.

I authorize the anaesthesia 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.

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

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

It has been explained all my queries in the language understood by me.

Signature of Patient / Patient Attendant :

Signature : Soumyashree Manjunath

Name : SOUMYASHREE

Relationship with Patient : Self

Date & Time : 26/5/26

Signature of Doctor (who is taking the consent) :

Signature : Chp

No. : RCH / FRM / CLINICAL / 021

Witness :

Signature : Satya Swamy Dribedi

Name : Satya Swamy Dribedi

Date & Time : _____

Name : Dr. Hanjirasa

Date & Time : 26/5/26. 10:10am

Dr. Sanjana
Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

MT: Odisha.



Name: Sanjana choudhary Age: 32y Sex: F UHID.No: _____

Date: 24/1/24 Time: 9:00am Proposed Operation: Vacuum pickup

Diagnosis: Primary infertility

B.P./CRT: 107/68 H.R: 70bpm Weight: 87.9kg ASA Physical Status: 1 2 3 4 5

Hgb: 13.7
PCV: 41.7
WBC: 10.90
Plate: 223
PT: _____
PTE: _____
INR: _____

Laboratory Data:

Glucose: 89 Protein: _____ HIV: _____ X-Ray: _____
Urea: _____ Alb: _____ HBS Ag: _____ ECG: _____
Creat: _____ Total Bill: _____ HCV: _____ 2D Echo: _____
Na: _____ Dir. Bill: _____ Blood group: A+ve Stress/Anglo: _____
K: _____ LDH: _____ (Report +) Other: _____
Ca++: _____ Alk phos: _____ T4: _____ HbA1c: 6.0%
Mg++: _____ Amylase: _____ TSH: 2.750
Cl-: _____ SGOT/SGPT: _____

Allergies: NKDA.

Medical History: CVS: No active symptoms.

RESP: no Bronchial Asthma - uses Inhaler ses (last und zynago).

CNS: ↳ New admitted for exacerbation.

Renal: 9 Physical Activity: > 4 METs.

Hepatic / GE: NPI

Past Anaesthetic History: NPI

Physical Exam: P I C C L E.

Airway: MP 1 2 3 4 Mouth Opening: > 3FB Mentohyoid Distance: > 3FB Neck: Short Teeth: Duched

Lungs: B/L NVBS

Heart: S1, S2 ⊕

CNS: HMF ⊕ Venous Access Site: Good Spine Exam for regional: Medlene ⊕

Pregnant: Yes No NA

Anaesthetic Plan: MAC REGIONAL GA-ETT LMA Mask

Peri-Operative Plan Explained to the Patient: Yes No

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

- DVT Prophylaxis:
- NIL ORAL $\left\{ \begin{array}{l} \text{Water / ORS 2 Hours} \\ \text{Others 6 Hours} \end{array} \right.$ coconut water, solids, milk, pulpy juices.
- Informed Consent: Standard High Risk
- Post Operative Pain Management: Discussed with Patient
- Other Instructions: Save Sample.

Signature: [Signature] Name: Dr Sanjana

ANAESTHESIA CHART

Patient Sticker

Pre Induction Assessment: Yes No

Change in Patient Condition: Yes No

Physical Status: Patient Identified Consent Present Chart Reviewed

Fasting Status: **Adequate**

H.R.: **90 bpm** B.P./CRT: **120/90** SpO₂: **100%** R.R.: **16 cpm** Last Feet: _____ Date: _____

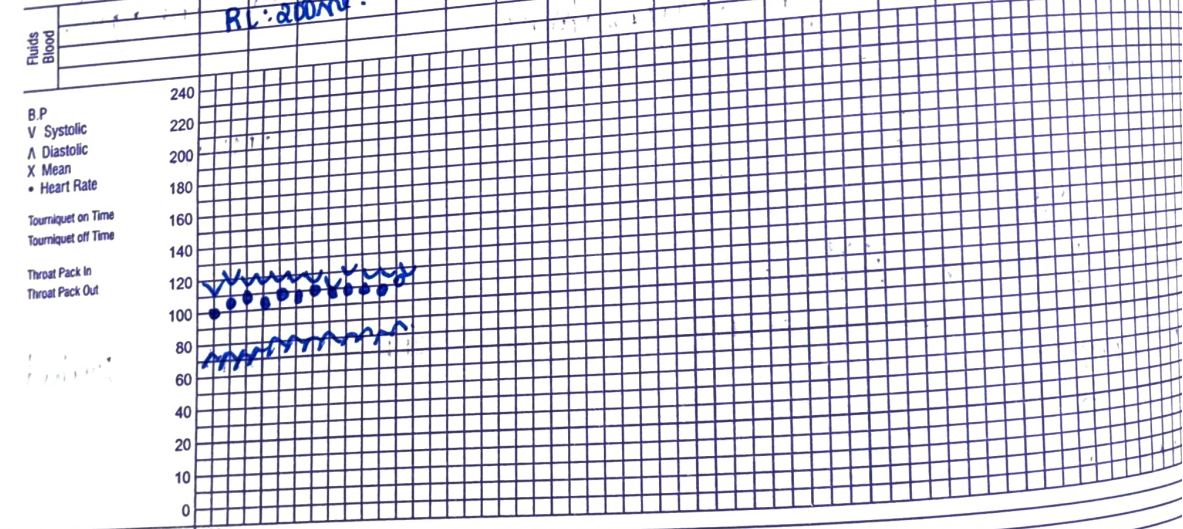
Pre-OP Diagnosis: **Primary infertility**

Surgeon: **Dr. Sreeja** Anaesthesiologist: **Dr. Harinad** Technician: **Dr. Ruchitha**

TIME	N ₂ O/AIR (%)	HALO (SEVO)	Drugs
10:30	2%		
10:45			
11			

Drugs:

- 10 Midazolam 2mg
- 10 Ketamine 40mg
- 10 Propofol 60mg
- 10 Dexamethasone 8mg
- 10 Hydrocortisone 100mg
- 10 PCT 5mg
- 10 Propofol 100+40mg



LAB Values

ABG

GRBS

Others

Equipment Checked and Functional

BP

Cuff Site: _____

Art Site: _____

EKG Lead

Temp Site

FIO₂ Monitor

Agent Monitor

Pulse Oximeter

Capnograph

Ventilator

Nerve Stimulator

Position: **Lithotomy**

Pressure Points Checked

Eye Care:

Oint

Tape

Padding

Awake

Temp:

HME Fluid Warmer

Cling Film OH Warmer

Hugger's Cotton Wool

Other: **Blanket**

Times:

Anaes Start: **10:30am**

OP Start: **10:35 am**

OP End: **10:50 am**

Leave OR: **11:05 am**

Anaesthesia:

GA Monitored Anaesthesia Care Regional

Line (Size & Location)

CVP

ART: **20G Chane**

IV

IV

Induction

IV Inhal

Pre O₂ RSI

Others

Mask SGA **No 3 Ambu**

Airway Oral Nasal

ETT# _____ at _____ cm

Oral Nasal Cuff

Tracheostomy Topical

Drug: _____

Awake Direct Vision

Video Laryngoscopy Stylette / Bougie

Fiberoptic

Blade# _____ Attempts: _____

Difficulty Why? _____

Bilat = BS

Semi-Closed Circle

Closed Circle

Other

Regional: Spinal Epidural

Extremity _____

Others: _____

Position: _____

Site: _____

Needle Size: _____

Parasthesia Yes No

Catheter at skin _____

Drug Name & Conc: _____

Bolus: _____

Infusion: _____

Block Level: _____

Comments: _____

Transportation to PACU ICU

Relaxant Reversed Yes No

Name of the Doctor: _____

Signature of the Doctor: _____

ANESTHESIA CARE UNIT RECORD

Time Received

Time Discharged

250	IV Cannula Site	<i>SOU/Chone</i>
245	ETT, Mask	<input type="checkbox"/> Nasal Prongs
240	<input type="checkbox"/> Tracheostomy	<input type="checkbox"/> I-Piece
235	<input type="checkbox"/> Oral Airway	<input type="checkbox"/> Nasal Airway
180	Vomiting	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Drug
160	NG Tube	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
140	Drain	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
130	Urinary Catheter	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
110	Chest Tube	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
90	Nil Oral	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
80	IV Fluids:	<i>RA @ 100 ml/hr</i>
60	Oral Feeds:	<i>MONITOR VITALS NO FURTHER ORDER</i>

POST ANAESTHESIA SCORE (Modified Aldrete Score)	IN	MINUTES			OUT	SCORING INTERPRETATION
		30	60	90		
1. Patient awake & oriented to person 2. Patient awake & oriented to environment 3. Patient awake & oriented to environment 4. Patient awake & oriented to environment 5. Patient awake & oriented to environment 6. Patient awake & oriented to environment 7. Patient awake & oriented to environment 8. Patient awake & oriented to environment 9. Patient awake & oriented to environment 10. Patient awake & oriented to environment	1					A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician
ACTIVITY	2					
RESPIRATION	2					
CIRCULATION	2					
CONSCIOUSNESS	1					
COLOR	2					
TOTAL	8					

PAIN ASSESSMENT AND MANAGEMENT FORM				Signature
Site	Time	Pain Score	Intervention	

Reassessment Frequency:

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

Transferred to Unit by (PACU)
Date & Time

DR. R. J. ...
26 / 1 / 20

Rainbow Children's Hospital - Sarjapur

3/2, 2nd floor, Sarjapur - Marathahalli Rd, opp. to 3m car care, Bellandur, Bengaluru, Karnataka 560102 Her
Layout ,Bangalore ,Karnataka, INDIA ,560102.

WEB : <https://rainbowhospitals.in>

ADMISSION SHEET



Admission Details :

Admission No : IP27-00006752

Admit Date : 26-May-2026

Admit Time : 09:24 AM UHID : SPB-00017012

Personal Details :

Mr Name

Gender

Address

City (H)

Mrs SOUMYASREE MAHAPATRO

Mr SATYA SWARUP DWIBEDI

Female

SARJAPUR BANGALORE Dommasandra
Bangalore Karnataka INDIA 562125

Age

DOB

Religion

Martial Status

Phone No

E-mail

: 33 Y 0 M 16 D

: 10-05-1993

:

:

: 7978855989/

: MOHAPATRASOUMYA82@gmail.com

Admission Details :

Type : DAY CARE

Bed No : IVF -1

Bed No : IVF -1

Admission Type : First Visit

Ward Name : 3F - IVF RECOVERY

Contact Details :

Contact Name : Mr SATYA SWARUP DWIBEDI

Contact Address : SARJAPUR BANGALORE Dommasandra
Bangalore Karnataka INDIA 562125

Relationship : Husband

Phone No :


Signature

Physician Details :

Physician Name : Dr. SHREEJA KARAN

Specialty : Others

Consultant :

Specialisation : INFERTILITY

Phone No :

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : SELFPAY

GENERAL CONSENT FOR TREATMENT

Mrs **SOUMYASREE MAHAPATRO**
 IP27-00006752
 Dr. **SHREEJA KARAN**

Age : 33 Y 0 M 16 D
 Sex: Female
 Ward/Bed No: 3F - IVF RECOVERY/IVF -1

I, 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, surgical procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient's best interest, to 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 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.

By my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, surgery, 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 the 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, damage or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital of 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 equipment and monitors the whole process as per evidence based guidelines".

I do not allow use of medication brought from outside by the patient. 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. In case of failing the submission, I will pay 200/- Rs.
 Patient Signature: *[Signature]*

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

Signature of Patient/Relative:

Name: **Mr. SATHYA SWARUP DWIBEDI**
 Relationship: **husband**
 Date: **24/05/2026**
 Signature: *[Signature]*

Time:

Patient Address:
 SARJAPUR BANGALORE Dommasandra
 Bangalore Karnataka INDIA 562125

ESTIMATION SHEET

ADMISSION NUMBER: SPB - 000/2012
PATIENT NAME: Mrs. Savya Sura
ROOM CATEGORY: JVF-2
DATE: 21/05/2026
CASH/CREDIT: _____
ROOM CHARGES: 3F.
REMARKS: For OJUM Pickup: 1,20,000 Package

- Room Charges inclusive of Bed, Nursing, Consultation Charges, Duty Doctor Charges & Services Treatment Monitoring Management Charges, Diet Charges.
- All other charges, like Diet, Investigations, primary Consultant, IP or OP Procedures, Equipment, Cross Consultations, Blood/ Blood Products, Implants, Ward Consumables, Infection Preventive Measure Charges, Pharmacy and Consumables will be charged extra.
- 5% GST Charges applicable on Bed Charges from 18.07.2022 as per the GST Council.
- Admission will be made according to the ward category chosen by the patient. charges will be applicable as per bed category. Please cross check the room eligibility and tariff as per their Insurance Company policy terms and conditions.
- If the patient is shifted to the ICU, the attendant should vacate the room. If the attender occupies the room, it will be charged as per dual occupancy.
- The time it takes for cash discharge is a minimum 3-4 hrs. and in the case of insurance, it will take a minimum 6-7 hrs.
- Bed charges will be calculated based on 12PM to 12PM Checkout.
- Daily wise payment to be done on the day wise approximate bill.

DECLARATION

Mrs. Savya Sura Dussade have attended the Financial Counselling desk & understood the expected costs & other conditions applicable. In this case, the TPA/Insurance Company rejects the claim for no whatsoever reasons at any point of time after discharge. I promise to settle the claim with the hospital as per Hospital Cash Tariff.

Name, Relation, Sign., Ph. No. of Patient/Attendant	Name & Signature of Financial Counselor
<u>Mrs. Savya Sura Dussade</u>	