Patient Sticker

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SURGERY DETAILS

MAH-00371748 IP5-00176067
Mrs VENKATA NAVEENA POCHA
01-04-1995 31 Y 3 M 6 D (F)
Dr. SUDHARANI BAIRRAJU

Date : 07/07/26

P..... Date of Birth: 01/04/1995 Age: 31y

G..... Ward : IVF OT UHID No.: MAH-00371748

Date of Surgery: 07/07/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : frozen Embryo Transfer

Time in : 10.15 AM Time Out : 11:15 Am

		NAME	AMOUNT
1.	Surgeon	Dr. Sudharani. B	
2.	Anaesthetist		
3.	Assistant Surgeon	Dr. Akhila.	
4.	OT Technician		
5.	Circulating Nurse		
6.	Assistant Nurse	Swaroop	

Special Equipment:
☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☑ Others ultrasound guidline
R265-033674

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 5-000 96 91 585 / 585 Order by: Swaroop

Docu. No. : RCHBH/FRM/GENERAL/114

MAH-00371748 IP5-00176067
Mrs VENKATA NAVEENA POCHA
01-04-1995 31 Y 3 M 6 D (F)
Dr. SUDHARANI BAIRRAJU

FET

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CONSUMABLES OF OT

Circulating staff :..... Technician : ..... Date : 07/7/23448 Time : 11 AM

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			Major Pack			Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : A / P / N						Suction Catheter		
HME filter : A / P / N						Feeding Tube		
Syringes : 10 cc						Vaccum Suction Set		
05 cc			Gloves			Surgical Gloves		
02 cc						Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade			Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL			Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml			Koochies					
			Ointments					
			Suction Catheter			Mother gown	01	01
Fentanyl			Cap, Mask	3/3	3/3	Proto gown	01	01
Morphine			Gauze Pack			NIS room	01	01
Ketamine			Mop Pack			Tramadol	01	01
Propofol			Steristrip			Inner gloves 6½	01	01
Rocuronium			Underpad	01	01	Inner gl 7	01	01
Glycopyrolate			Draw sheet	02	02	foot cover	02	02
Myopyrolate			Abgel			Ec Syes	01	01
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
			Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set					
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution					
			Microshield					
			Cotton Balls					
			Latex Gloves					
			Ramdione Scrub					
			Saral					

Surgeon Dr. Sudharani B Anaesthesiologist Nurse Swaroop OT Technician

Order No. : 5-000 9691 583/589 Ordered by : Swaroop

Doc. No. : RCHBH/ FRM / GENERAL / 125

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ACTIVITY RECORD FOR BILLING

Name :_____

UHID No. : MAH-00371748 IP5-00176067
Mrs VENKATA NAVEENA POCHA
01-04-1995 31 Y 3 M 6 D (F)
Dr. SUDHARANI BAIRRAJU

_____Consultant: _____ Dept : _____

Date of Adn _____Date of Discharge : _____ Time: _____

Room / Bed No : _____Ward : _____ Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
07/7/26	10:50Am	Gyne Recovy	IVF-OT	Swaroopa.
07/7/26	11:15AM	IVF-OT	Gyne Rem	Swaroopa
07/7/26	01 pm	Gyne Rem	Billing	Swaroopa.

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
07/7/26	Cardiac Monitor	10 Am	10:15 Am	5-000968158	Swaroop.
07/7/26	Ultrasound Machine	11 Am	11:10 Am	R265-03367	Swaroop.

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Banjara Hills

8-2-120/103/1,2,3,4 and 5,Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad ,Telangana, India ,500034.
TEL NO :+91-40-4466 5555
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176067 **Admit Date** : 07-Jul-2026 **Admit Time** : 09:51 AM **UHID** : MAH-00371748

Patient Details :

Patient Name	: Mrs VENKATA NAVEENA POCHA	**Age**	: 31 Y 3 M 6 D
Guardian	: Mr MALLU DASARATHARAMI REDDY	**DOB**	: 01-04-1995
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Married
Address (H)	: FLAT NO G3, MEGA SRI APTS, RD NO 7, ANAJANEYA NAGAR, MOOSAPET Bharat Nagar colony Hyderabad Telangana INDIA 500018	**Phone No**	: 7730054476
		E-mail	: na@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : POST OP 409 **Ward Name** : 4F-OT COMPLEX

Room No : POST OP 409 **Admission Type** : First Visit

Contact Details :

Name : Mr MALLU DASARATHARAMI REDDY **Relationship** : Husband

Contact Address : FLAT NO G3, MEGA SRI APTS, RD NO 7, ANAJANEYA NAGAR, MOOSAPET Bharat Nagar colony Hyderabad Telangana INDIA 500018 **Phone No** : / 7730054476

Signature

Doctor Details :

Doctor Name : Dr. SUDHARANI BAIRRAJU **Specialisation** : INFERTILITY

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash **Payor Name** : SELFPAY

MAH-00371748 IP5-00176067
Mrs VENKATA NAVEENA POCHA
01-04-1995 31 Y 3 M 6 D (F)
Dr. SUDHARANI BAIRRAJU

BirthRight™ FERTILITY BY RAINBOW HOSPITALS

OUTPATIENT NURSING ASSESSMENT FORM

Date: 07/07/26 Time: 10Am

Chief Complaint: –

Allergies: ☐ Yes ☐ No ☐ Medications ☐ Blood Transfusion ☐ Food ☑ Not Known

If yes , identify –

Vital Signs : Temperature: 98.6°F Pulse: 72b/min Respiratory Rate 18/min

BP 113/73mmHg SpO_2 100% Weight 56.8kg Height ..... BMI 21.9

Pain Screening: ☐ Yes ☐ No If Yes, Pain Score: ..... Pain Tool Used: ☐ Wong Baker ☑ NPS

RISK FOR FALL:

History of Falling: within past 3 months ☐ Yes ☑ No

Ambulatory Aids:

- Wheelchair ☐ Yes ☑ No
- Crutches / Cane / Walker ☐ Yes ☑ No
- Uses furniture for support ☐ Yes ☑ No

Gait/Transferring:

- Bedrest / immobile ☐ Yes ☑ No
- Weak ☐ Yes ☑ No
- Impaired ☐ Yes ☐ No

Mental Status:

- Forgets limitations ☐ Yes ☑ No
- Vulnerable Patient ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

- ☐ Escort while ambulating
- ☐ Assist Patient
- ☐ Educate patient and family on fall precautions/prevention

Functional Screening:

☑ Normal Activity of Daily Living

If there is abnormal ADL check one of the following

- ☐ Mobility Problems
- ☐ Dressing Problems
- ☐ Others .....

Inform consultant for positive criteria

Nutritional Screening: ☑ No Abnormalities Detected

- ☐ Abnormal BMI
- ☐ Appetite Problem
- ☐ Loss of Weight Observed in the past 3 Months
- ☐ Others .....

Inform consultant for positive criteria

Psycho-Social-Economic-Spiritual Screening: ☑ No Significant Findings

☐ Single ☑ Married ☐ Lives Alone ☐ Lives with family ☐ Lives with friends ☐ Abnormal behaviour

Inform the physician about any unusal concerns about patients Psychological / Social Status: Nil

Inform the physician about any spiritual needs, if applicable

Nurse Signature: .....

Nurse Name: Swaroop

Date & Time: 07/7/26 at 10Am

MAH-00371748 IP5-00176067
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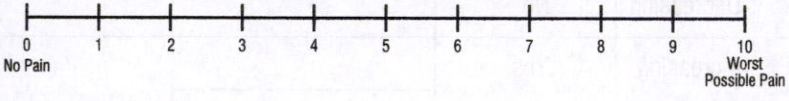
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
07/7/26.	10Am	0	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	— Nil —	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

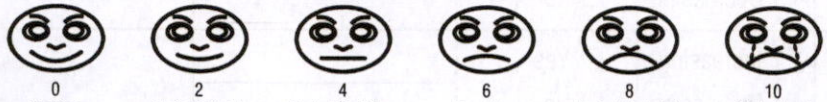
Re-assessment Frequency:
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
   a) At least every 2 hours for the first 24 hours
   b) Then every 4 hours.
   c) Prior to pain pain-relieving intervention.
   d) Within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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years



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 of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	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, SaO_2	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

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Dr. SUDHARANI BAIRRAJU

MULTI-DISCIPLINARY PLAN OF CARE FORM

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Diagnosis: Primary Unexplained Subfertility-A

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
07/7/26	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☑ Modified ☐ Per-Op ☐ Post Op	patient came for frozen embryo transfer	frozen embryo transfer and complicatn	frozen embryo transfer.		☑ Nursing ☐ Others:
07/7/26 10:50Am	☐ Medical ☑ Nursing ☐ Others:	☐ Initial ☐ Modified ☑ Per-Op ☐ Post Op	Patient has come for frozen Embryo transfer.	Vitals checked Informed doctor	Shifted patient to OT upon doctor orders.		☐ Medical ☐ Others:
07/7/26	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Monitor vitals	Page discharge	discharge medications.		☐ Medical ☑ Nursing ☐ Others:
07/7/26 11:20Am	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Procedure has done under ultrasound guidle, under aseptic precautions	Advised rest to Patient for 30- 45 mins	Explained about discharge medicatio as per doctor Prescription		☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	07/7/26 10:10Am			Fall Risk Grading		
		Score						
History of Falling (immediately or w/in 3 months)	Yes	25				Risk Level	Morse Fall Score (MFS)	Action
	No	0	0					
Secondary Diagnosis (more than one diagnosis)	Yes	15						
	No	0	0					
Ambulatory Aid	Furniture	30				Low Risk ✓	0 - 24	Standard Fall Precaution
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0					
IV / Heparin Lock or Saline	Yes	20				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0	0					
GAIT / Transferring	Impaired	20						
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0	0			High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
Mental Status	Forgets limitations	15						
	Oriented to own ability	0	0					
Total Morse Fall Scale Score:			0					
		Signature	AS					

Tick (✓) whichever precaution taken.

Risk Level and Interventions

Low Risk (0 – 24) (Standard Falls Precautions)

- ☑ Ensure patients use their prescribed eye glasses if any, in the hospital
- ☑ Use chairs with arm rests
- ☑ Use safety straps on stretchers and wheelchairs while transporting patients

Moderate Risk (25-50) Apply all low risk intervention and

- ☐ Assist and/or supervise ambulation. Reinforce to always call for assistance
- ☐ Hourly safety check
- ☐ Assess patient after visitors, leave to ensure safety measures in place

High Risk (≥ 51) Apply all low and moderate risk interventions, and.

- ☐ Initiate constant observation by healthcare provider as appropriate to patient's needs

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MAH-00371748 IP5-00176067
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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... NKDA ..... ☑ 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: ..... Shifted to: .....

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	Inj PACID	100 mg	IM	OD		☐C ☐DC
2	T. ESTABET	2mg	PO	TID		☐C ☐DC
3	T. ECOSPRIN	150 mg	PO	OD		☐C ☐DC
4	T. MEDROL	16mg	PO	OD		☐C ☐DC
5	T FOLIC ACID	5mg	PO	OD		☐C ☐DC
6						☐C ☐DC
7						☐C ☐DC
8						☐C ☐DC
9						☐C ☐DC
10						☐C ☐DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Anilab

Date & Time : 7/7/26 @ 10:30Am

Nurse Name & Signature: Swaroopa L B

Date & Time : 07/7/26 at 10:30Am

MAH-00371748 IP5-00176067
Mrs VENKATA NAVEENA POCHA
01-04-1995 31 Y 3 M 6 D (F)
Dr. SUDHARANI BAIRRAJU

Patient

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/7/26	Patient came for frozen embryo transfer. Vitals Stable PR – BP – SpO – 100% RR – 16 cpm	Plan Shift to OT for ET AG.
7/7/26.	patient. Stable Discharge medications explained.	Plan — can be discharged. Ale

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

FORM-6

CONSENT FORM FOR ASSISTED REPRODUCTIVE TECHNOLOGY PROCEDURE

BirthRight™ FERTILITY BY RAINBOW HOSPITALS

Patient Name: Mrs S.V. Nlaveena Pocha Age 31y UHID No. MAH-00371748

I/We have requested the clinic Birthright fertility By Rainbow Hospital (name and address of clinic) to provide us with treatment services to help us bear a child.

We understand and accept (as applicable) that:

1. The drugs that are used to stimulate the ovaries for ovulation induction have temporary side- effects like nausea, headaches and abdominal bloating. Only in a small proportion of cases, a condition called ovarian hyperstimulation occurs where there is an exaggerated ovarian response. Such cases can be identified ahead of time but only to a limited extent. Further, at times the ovarian response is poor or absent in spite of using a high dose of drugs. Under these circumstances, the treatment cycle will be cancelled.
2. There is no guarantee that:
   (i) The oocytes will be retrieved in all cases.
   (ii) The oocytes will be fertilized.
   (iii) Even if there were fertilization, the resulting embryos would be of suitable quality to be transferred.

   All these unforeseen situations will result in the cancellation of any treatment.
3. I/ We fully consent to these procedures and to the administration of such drugs and anesthetics as may be necessary. We also consent to any other operative measures, which may be found to be necessary in the course of the treatment.
4. I/ We have been told of the risks of ultrasound directed follicle aspiration.
5. I/ We are aware that we are free to withdraw or vary the terms of this consent until the gametes and/ or embryos have been used in accordance with my/ our wishes. I am aware that this will have to be a written request.
6. There is no certainty that a pregnancy will result from these procedures even in cases where good quality embryos are transferred.
7. If a clinical pregnancy does result from assisted conception treatment, I/ we understand there is an accepted risk of multiple pregnancy, an ectopic pregnancy or of a miscarriage. I/ We understand that as in natural conception, there is a small risk of fetal abnormality.
8. Medical and scientific staff can give no assurance that any pregnancy will result in the delivery of a normal living child.
9. The uncertainty of the outcome of the procedure has been fully explained to me/ us.

   I/ We fully understand the risks of treatment including;
   (i) It is not possible to guarantee that a follicle will develop in a given cycle and that occasionally cycles have to be abandoned before egg retrieval.
   (ii) There is a risk that spontaneous ovulation can happen prior to/or during the egg retrieval.
   (iii) An egg is not always recovered from a follicle at the time of egg retrieval.
   (iv) Any eggs may be collected and fertilization of any collected eggs will occur.
   (v) Is a risk that the cycle will be abandoned before Embryo Transfer if there is failure of fertilization, abnormal fertilization or failure of the embryo to cleave (divide).
   (vi) A pregnancy may result from treatment.
   (vii) Treatment may be abandoned at any time if there are problems in the laboratory or with the culture system.

BirthRight Fertility by
Rainbow Hospitals, Banjara Hills
8-2-120/103/1, Survey No. 403, Road No. 2,
Banjara Hills, Hyderabad, Telangana-500 034.

10. I/ We have been fully informed of all that is involved with the In Vitro Fertilization / Intracytoplasmic Sperm Injection technique and have been advised regarding the chances of success, the possibility of multiple pregnancy occurring and other possible complications of treatment by the doctor. I/ We have also received information relating to treatment by these techniques in order to assist us to become more fully aware of what is involved.

Informed Consent:

The above information has been read out and explained to me in own language (in the event that it is necessary), and it has been explained to me that this form has the authority of a legal document. We have had the opportunity to ask questions, all of which have been answered to my satisfaction.

Unreservedly and in my full sense I hereby give my fully informed and non-coerced consent to undergo any or all of the aspects of treatment as noted above by any means as deemed appropriate by the professional team of BirthRight Fertility by Rainbow Hospitals. We understand that we will become the legal parents of any resulting child and the child will have all the normal legal rights on us. With our signatures, we certify that we understand the implication of these procedures.

The degree of procedure proposed has been explained to me and my spouse in detail including the complications and the associated mortality and morbidity. The benefits and risks of this procedure have been explained to me. I have also been told about the alternatives available for this procedure including the advantages and disadvantages of the alternative.

Wife / Woman Name: P.V. Naveena

Signature: Naveena

Date & Time: 07/7/26 10Amy

Husband Name: M. Dasaratha Rami Reddy

Signature: M. Dr

Date & Time: 07/07/2026 10Am

Endorsement by the ART Clinic:

I/we have personally explained to P.V. Naveena and M. Dasaratha Rami Reddy the details and implications of his / her / their signing this consent / approval form, and made sure to the extent humanly possible that he / she / they understand these details and implications.

This consent would hold good for all the cycles performed at the clinic.

Wife / Woman Name: P.V. Naveena

Signature: Naveena

Date & Time: 07/7/26 10Amy

Husband Name: M. Dasaratha Rami Reddy

Signature: M. Dr

Date & Time: 07/07/2026 10Am

Name, Address and Signature : [signature]

of the Witness from the clinic [illegible]

Date & Time: 07/7/26 10:10Amy

Name of the ART Clinic: BirthRight Fertility by Rainbow Hospitals, Banjara Hills

Address: 8-2-120/103/1, Survey No. 403, Road No. 2, Banjara Hills, Hyderabad, Telangana-500 034

Date & Time : 07/7/26 at 10:15Amy

Name of the Doctor: Dr. Sudheerani B

Signature: B Sudheerani

Date & Time: 07/7/26 at 10:05Am

CONSENT FORM FOR FROZEN EMBRYO TRANSFER

BirthRight™ FERTILITY BY RAINBOW HOSPITALS

Patient Name: Pocha Venkata Naveena Age: 31 UHID No: MAH-00371748

We consent for the transfer of our cryopreserved embryos into my uterus with or without anaesthesia. The Embryos are obtained from

- ☑ Self Gametes
- ☐ Donor Oocytes
- ☐ Donor Sperm
- ☐ Donor Gametes

BirthRight Fertility by
Rainbow Hospitals, Banjara Hills
8-2-120/103/1, Survey No. 403, Road No. 2,
Banjara Hills, Hyderabad, Telangana-500 034.

We understand that

1. There is no certainty that a pregnancy will result from this procedure even in cases where good quality embryos are placed.
2. The pregnancy achieved may not always result in the delivery of a full term/normal living child.
3. There are inherent risks of unexpected complications with any medical procedure. I shall not hold the doctors, employees, management of the hospital liable should any such event arise during the procedure.

I have been given a suitable opportunity to take part in counselling about the implications of the proposed treatment. The type of anaesthetic proposed (general/regional/sedation) has been discussed in terms which I have understood.

Informed Consent:

The above information has been read out and explained to me in my own language (in the event that it is necessary) and it has been explained to me that this form has the authority of a legal document.

Unreservedly and in my full sense I hereby give my fully informed and non-coerced consent to undergo any or all of the aspects of treatment as noted above by means as deemed appropriate by the professional team of BirthRight Fertility By Rainbow Hospitals. We understand that we will become legal parents of any resulting child and the child will have all the normal legal rights on us. With our signatures, we certify that we understand the implication of these procedures.

The degree of procedure proposed has been explained to me and my relatives in detail including the complications and the associated mortality and morbidity. The benefits and risks of this procedure have been explained to me. I have also been told about the alternatives available for this procedure including the advantages and disadvantages of the alternatives.

Patient Name: Pocha Venkata Naveena
Signature: Naveena
Date & Time: 7/07/2026 10Amp

Spouse Name: M. Dasaratha Rami Reddy
Signature: M. Dh
Date & Time: 07/07/26 10Amp

Endorsement by Assisted Reproductive Technology Clinic:

As the member of BirthRight Fertility by Rainbow Hospitals professional team, I have made sure that the patient understands the implications of the above and has had an opportunity to clarify all her/their queries.

Name of the Doctor: Dr. Sudharani B
Signature: B Sudharani
Date & Time: 07/7/26 at 10:05Amp

Mrs VENKATA NAVEENA POCHA
01-04-1995 31 Y 3 M 6 D (F)
Dr. SUDHARANI BAIRRAJU

LIST

Surgeon : Dr. Sudharani B
Asst. Surgeon : Dr. Akhila.
Anaesthetist :
Scrub Nurse : Swaroopa.

Patient Name : MRS V. Naveena Age : 31y Gender : F
UHID No. : MAH-003717 US Surgery Name : PET
Date : 07/7/26 In-time : 11 AM Out-time : 11:20 AM

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Before Induction of Anaesthesia ➤➤

SIGN IN Time:

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

Site Marked ☐Yes ☐No ☐NA

Anaesthesia Safety Check Completed ☐Yes ☐No

Pulse Oximeter on Patient & Functioning ☐Yes ☐No

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

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

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

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

Signature :

Name :

Before Skin Incision ➤➤

TIME OUT Time: 11:07 AM

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

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm
- Correct Patient (Check ID Band) ☑Yes ☐No
- Correct Site ☑Yes ☐No
- Correct Procedure PET ☑Yes ☐No

Anticipated Critical Events

Surgeon Reviews:
- What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? Difficult Teams 5-7 mins 0- ☐Yes ☐No ☐NA

Anaesthesia Team Reviews:

Are There Any Patient-specific Concerns? ☐Yes ☑No ☐NA

Nursing Team Reviews:

Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☑Yes ☐No ☐NA

Is Essential Imaging Displayed? ☐Yes ☐No ☑NA

Power Supply, Earthing, Power Backup and functioning of equipment checked. ☑Yes ☐No

Signature :

Name : Swaroopa.

Before Patient Leaves Operating Room

SIGN OUT Time: 11:15 Am.

Nurse Verbally Confirms with the Team:

The Name of the Procedure Recorded ☑Yes ☐No

That Instrument, Sponge and Needle Counts are Correct (or Not Applicable) ☑Yes ☐No ☐NA

The Specimen is Labelled (including patient name) ☑Yes ☐No ☐NA

Whether there are any Equipment Problems to be addressed ☐Yes ☐No ☑NA

To Surgeon, Anaesthetist and Nurse:

What are the key concerns for recovery and management of this patient? ☐Yes ☑No

Signature : B Sudharani

Name : Dr. Sudharani B

MAH-00371748 IP5-00176067
Mrs VENKATA NAVEENA POCHA
01-04-1995 31 Y 3 M 6 D (F)
Dr. SUDHARANI BAIRRAJU

Patient

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NURSES NOTES

☑ No Known Drug Allergies
☐ Drug Allergies ..... NKDA .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
07/7/26	10Am	Pre-procedure Notes: Mrs. V. Naveena Pocha patient has come for Frozen Embryo Transfer procedure. Patient file taken. Identification of patient has done by patient full name, UHID Number and procedure Name - Given Sterile gown, headcap & face mask to the patient. placed ID Band. vitals checked informed doctor, Rbs per doctor's Orders shifted patient to OT with full bladder. Swaroop 018426
07/7/26	11:Am	Intra-procedure Notes:- Once again patient identification has done by patient full Name, UHID Number & procedure Name and positioned patient into Lithotomy. Time out done. under aceptic precautions & under ultrasound guidlie procedure has done. Swaroop 018426
07/7/26	11:25Am	Post-procedure Notes: Shifted patient to observation to take rest for 30-45 mins

NOTE: DO NOT WRITE OUTSIDE THE MARGINS

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NURSES NOTES

☑ No Known Drug Allergies
☐ Drug Allergies ..... NKDA .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		Patient has No Complaints As per doctor prescription. patient discharged. Explaid about post procedu Medication accordg to doctors prescription
04/2/26.	11:45AM	Post - procedu Vital Temp - 98.6°F BP - 117/71 MHg Pulse - 70/min Resp - 18/m SpO2 - 99% P/A - Soft

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

(P.T.O)

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POST PROCEDURE CARE PLAN

Date & Time: 07/7/26 11 AM

Patient Name: V Naveena Pocha Age: 31y UHID No: MAH-0037.17cs

Procedure Done: frozen embryo transfer

Post Procedure Diagnosis: FET done

Post-Operative Monitoring Parameters / Frequency: —

Special Patient Positioning and Requirements: —

Nutritional Instructions: Normal diet.

When to Start Mobilization: —

Special Referrals: —

The new order for all required medications documented in the doctor order/medication sheet: ☑ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up: β hCG after 12 days
Luteal support

Name of the Doctor: Dr. Sudharani

Signature: for Dr. Sudharani

Date & Time: 7/7/26 @ 11 am.

Note: Plan of care will be readjusted if necessary

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BRADEN 'Q' SCALE

				Date :		07/7/26		
				Time :		01pm		
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		
"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		
FRICTION-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.		4		
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		28		
				Evaluator's Name		S		

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	• 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	• 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	• 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	• 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

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RY PATIENT / FAMILY EDUCATION RECORD

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Telugu ..... Patient / Learner Literacy : ☐ Read ☐ Write ☐ Speak Willingness to Learn : ☐ Yes ☐ No Healthcare Literacy : ☐ Yes ☐ No

Identified Education Needs :

1. Diagnosis
2. Treatment and Care Plan
3. Pain Management
4. Informed Consent
5. Medication / Trerapy (safety, effects/side effect, interactions)
6. Discharge Medication
7. Infection Control Measures
8. Diagnostic Test / Procedures
9. Nutrition / Diet
10. Fall Risk Education
11. Safe use of Medical Equipment / Implantable Devices Safety
12. Patient's Family Rights
13. Risk / Safety
14. Activity / Exercise
15. Social Rehabilitation Needs
16. Special Discharge / Follow-up Education / Coping Skills
17. Others.....

Part - II

Date	Time	Need Indentified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barries	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
07/7/16	1	4	Informed Consent	PT	1	P, O	1	1	Nil	
07/7/16	12pm	5, 9	Explaid about discharge medicati as per doctor orely	pts	1	O, P	1	1	Nil	
7/7		6	Discharge medication	PT	1	P O	1	1	Nil	

Part - III : CODES

Who was taught : PT : Patient F : Father M : Mother S : Spouse Sn : Son D : Daughter C : Caregiver O : Other (Specify).....

Learning Barriers :
1. No Learning Barries
2. Physical Impairment
3. Emotional Barries
4. Language Barrier
5. Educational Level
6. Desire / Motivate to Learn
7. Impaired Thought Process / Cognitive limitations
8. Responsibilities at Home
9. Cultural Difference
10. Financial Difficulties
11. Beliefs and Values
12. Impaired Vision / or Hearing
13. Cultural / Religion Practice
14. Others (Specify) .....

Teaching Tools Used : A : Audio D : Demonstration V : Video O : Oral P : Printed

Mechanism/s to overcome barrier/s :
1. None
2. Obtain translator
3. Reassurance & Support
4. Teach Family / others
5. Respect values & beliefs
6. Respect Cultural / Religion Preference
7. Other, Specify.....

Understanding : 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review

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DISCHARGE PLANNING FORM

Nationality: Indian

NOTES: * To be completed by a NURSE within (24) hours of admission.

1. Anticipated Date of Discharge: as per doctor ords

2. Destination Post Discharge: ☑ Home

   Family Members Notified (Person Contacted)

   ☐ Transfer

   Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☑ Self Care ☐ Family Home Care ☐ Home Professional Assistance

   ☐ Needs Assistance In:

			Remarks
☐ Medication	☐ Yes	☑ No	
☐ Bathing	☐ Yes	☑ No	
☐ Eating	☐ Yes	☑ No	not required
☐ Walking	☐ Yes	☑ No	
☐ Dressing	☐ Yes	☑ No	
☐ Toileting	☐ Yes	☑ No	

4. Nutritional Plan:

   ☐ Dietary Instruction Discussed with the:

   ☑ Patient ☐ Family Member ☐ Others: .....

5. Discharge Planning Discussed with the:

   ☑ Patient ☑ Family Member ☐ Others: .....

6. Patient/Family Educational Plan:

   ☑ Educational Topic/s: To take adequate oral liquids

   ☐ Patient's Educational Topic/s discussed with the:

   ☑ Patient ☐ Family Member ☐ Others: .....

Nurse Signature: .....

Nurse Name: Swaroop

Date and Time: 07/7/16 at 12:30 pm