BAH-00611929 IP5-00176192
Mrs HAFSA FATIMA
07-05-1997 29 Y 2 M 3 D (F)
Dr. SUDHARANI BAIRRAJU

Patient Sticker

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SURGERY DETAILS

Date : 10/7/26.

Patient Name: Hafsa fatima Date of Birth: 8/5/1997 Age: 29 yr

Gender: F Ward : IVF OT UHID No.: BAH-00611929

Date of Surgery: 10/7/26 ☐ OT -1 ☐ ~~OT -2~~ ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Oocyte retrieval

Time in : 09/07/26 09:00 AM Time Out : 09:30 AM

	NAME	AMOUNT
1. Surgeon	: Dr Sudharani B	
2. Anaesthetist	: Dr. Tejaswini	
3. Assistant Surgeon	: Dr Akhila	
4. OT Technician	: Br. N. Ravi	
5. Circulating Nurse	: Sr Swaroopa	
6. Assistant Nurse	: Sr Malli	

Special Equipment: ☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☑ Others under ultra sound guidance

L265-034212.

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 5-0009695846/846 Order by: Swaroopa

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

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Oocyte Retrieval

CONSUMABLES OF OT

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Technician : N. Ravi Date : 10/7/26 Time : 9AM

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	3	3				Suction Catheter		
HME filter : A / P / N						Feeding Tube		
Syringes : 10 cc	2	2				Vaccum Suction Set		
05 cc			Gloves			Surgical Gloves		
02 cc	2	2				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					
PMO line	1	1	Ointments					
			Suction Catheter			Mother gown	01	01
Fentanyl	1	1	Cap, Mask	5/5	5/5	proto gowns	02	02
Morphine			Gauze Pack			NS 100ml	01	01
Ketamine			Mop Pack			Teanso fix	01	01
Propofol	2	2	Steristrip			Inj. Augmentin 1.2g	01	01
Rocuronium			Underpad	01	01	D-water	02	02
Glycopyrolate			Draw sheet	02	02	10cc Syringe	01	01
Myopyrolate			Abgel			Inter fix	01	01
Ondansetron			Foleys catheter			RL 500ml	01	01
Pencan 25g/ Spinal Needle 22			Urobag			Hip leggings	01	01
Bupivacaine 0.25%			Chest Drainage Catheter			Thee way Ext	01	01
Bupivacaine 0.25%(Heavy)			Romodrain bag			Allesorb	01	01
Antibiotics			Bandage			camera cover	01	01
Midazolam	1	1	Tegaderm			foot cover	01	01
Suppositories			Ioban			Ensure bs	01	01
Anamol : 80mg / 250mg / 170 mg			Double J Stent			Ensure 7	01	01
Supridol : 100mg			Vaccum Suction set					
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution					
O2 nasal prong O2	1	1	Microshield					
			Cotton Balls					
			Latex Gloves					
			Ramdione Scrub					
			Saral					

Surgeon Dr. Sudhakar Anaesthesiologist Dr. Tejaswini Nurse Swaroop OT Technician

Order No. : 5-0009 6958 02/743 Ordered by : Swaroop

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

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 : IP5-00176192 **Admit Date** : 10-Jul-2026 **Admit Time** : 08:10 AM **UHID** : BAH-00611929

Patient Details :

Patient Name	: Mrs HAFSA FATIMA	**Age**	: 29 Y 2 M 3 D
Guardian	: Mr FEROZ KHAN	**DOB**	: 07-05-1997
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Married
Address (H)	: H NO:30/30 BESIDE SRAVANI HOSPITAL Rein Bazar Hyderabad Telangana INDIA 500023	**Phone No**	: 9483367777/ 9966966662
		E-mail	: nomaildi@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : RC 407 **Ward Name** : 4F-GYN RECOVERY

Room No : RC 407 **Admission Type** : First Visit

Contact Details :

Name : Mr FEROZ KHAN **Relationship** : Husband

Contact Address : H NO:30/30 BESIDE SRAVANI HOSPITAL Rein Bazar Hyderabad Telangana INDIA 500023 **Phone No** : 9483367777 / 9966966662

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

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ACTIVITY RECORD FOR BILLING

Name :_____

UHID No : IP No : _____Consultant: _____ Dept : _____

BAH-00611929 IP5-00176192
Mrs HAFSA FATIMA
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Dr. SUDHARANI BAIRRAJU

Date of A _____Date of Discharge : _____ Time: _____

Room / E _____ Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
10/4/26	8:55Am	Gynae recovery	IVF OT	
10/4/26	9:35Am	IVF OT	Gynae recovery	
10/4/26	12pm	Gyny Re.	IVF OT	

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
10/7	Monitor	8:15AM	12pm	5-0009695 844	8
10/7	Ultra Sound	9:00	9:25AM	R265-034212	8

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
10/7/26	IV Cannulation	01	5-0009695 846	
	PAC	OP Basis		

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

BAH-00611929 IP5-00176192
Mrs HAFSA FATIMA
07-05-1997 29 Y 2 M 3 D (F)
Dr. SUDHARANI BAIRRAJU

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OUTPATIENT NURSING ASSESSMENT FORM

Date: 10/7/26 Time: 8:30am

Chief Complaint: —

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

If yes , identify —

Vital Signs : Temperature: 98.4°F Pulse: 88b/m Respiratory Rate 18b/m

BP 92/58mmHg SpO_2 99% Weight 55 Height 1.52 BMI 24.1

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: Sugarupa

Date & Time: 10/7/26 8:30am

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PAIN ASSESSMENT FORM

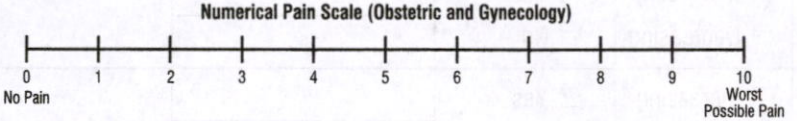
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
10/7/26	8:15AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	– –	[signature]
10/7/26	8:55AM	01	Abdomen	☐ Continuous ☑ Intermittent	☐ Acute ☑ Chronic	☐ Sharp ☑ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	Comfortable position –	[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		

Re-assessment Frequency:

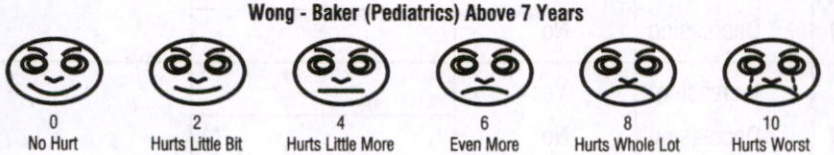
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
   a) At least every 2 hours for the first 24 hours
   b) Then every 4 hours.
   c) Prior to pain pain-relieving intervention.
   d) Within 30 – 60 minutes after pain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

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D Primary Subfertility with Male factor

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
10/7/26 8:15AM	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	patient came for oocyte retrieval	Oocyte retrival cont complications	Oocyte retrieval & anesthesia		☐ Nursing ☐ Others:
10/7/26 8:20AM	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	patient came for Oocyte retrival	IV cannula placed	Shifted to OT for Oocyte retrival		☐ Medical ☐ Others:
10/7/26 9:35AM	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	patient c/o monitor vitals w/o bleeding P/V	Safe discharge	Discharge medications		☐ Medical ☐ Nursing ☐ Others:
10/7/26 09:36AM	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	procedure done without any complications	Advised 2 hours rest	discharged accordingly patient Clarified and explained medications		☐ 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	10/1/26 8:30AM			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	20			Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	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:			20					
		Signature						

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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Patient St Dr. SUDHARANI BAIRRAJU

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MEDICATION RECONCILIATION FORM

Drug Allergies: DKA ☐ 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						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr Ruhila

Date & Time : 10/7/24 @ 8:25Am

Nurse Name & Signature: Swarupa

Date & Time : 10/7/24 @ 8:30Am

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/26. 8:20 Am	patient came for oocyte retrieval.	plan.
	PR – 70b/m	– NPO
	BP – 92/60mmHg	– PAC
	RR – 12/min	– Shift to OT
	SpO_2 – 99%	
	CVS } NAD RS	
		[signature]
		[signature] 9.35 am 10/7/26
10/7/26 2 pm	pt stable	plan
	Discharge medications explained.	can be discharged.
		[signature]

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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DRUG CHART

Date of Admission: 10/7/26 Drug Allergies: NKDA ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

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

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

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

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

Patient Sticker

REGULAR PRESCRIPTIONS Weight. .... Ward. ....

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

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

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

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

BAH-00611929 IP5-00176192
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07-05-1997 29 Y 2 M 3 D (F)
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Weight. 55kg Ward. SURG I

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
10/7/26	8:30AM	Inj AUGMENTIN	1.2g	IV		BHAGYA MY

BAH-00611929 IP5-00176192
Mrs HAFSA FATIMA
07-05-1997 29 Y 2 M 3 D (F)
Dr. SUDHARANI BAIRRAJU

I.V. FLUIDS CHART

Weight. 55kg Ward. IVFOT

		osition 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
10/7/26	8:30AM	RINGER LACTATE	IV	150ml/hr			10/7/26		

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

FORM-6

CONSENT FORM FOR ASSISTED REPRODUCTIVE TECHNOLOGY PROCEDURE

BirthRight™ FERTILITY BY RAINBOW HOSPITALS

Patient Name: Mrs. Hafsa Fatima Age 29y UHID No. BAH-00611929.

I/We have requested the clinic Birthright fertility By Rainbow Hospitals. (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.

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

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.

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: Hafsa fatima. Husband Name: Feroz khan.

Signature: Hafs Signature:

Date & Time: 29/6/26 @ 3pm Date & Time: 29/6/26 @ 3pm

Endorsement by the ART Clinic:

I/we have personally explained to Hafsa fatima and Feroz khan. 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: Hafsa fatima. Husband Name: Feroz khan.

Signature: Hafs Signature:

Date & Time: 29/6/26 @ 3pm Date & Time: 29/6/26 @ 3pm

Name, Address and Signature :

of the Witness from the clinic BirthRight fertility by rainbow hospitals

Date & Time: 29/6/26 @ 3pm

Name of the ART Clinic: BirthRight Fertility by Rainbow Hospitals, Banjara Hills Name of the Doctor: Dr. Sudhasani. B

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

Date & Time : 29/6/26 @ 3pm Date & Time: 29/6/26 @ 3:10 pm

FORM-12

CONSENT FORM FOR OOCYTE RETRIEVAL / EMBRYO TRANSFER

BirthRight™ FERTILITY BY RAINBOW HOSPITALS

Patient Name: Hafsa Fatima Age: 29y UHID No: BAH-00611929

Address: Birthright fertility by rainbow hospitals

Name & Address of the ART Clinic: Birthright fitility

I / We have asked the clinic named above to provide us with treatment services to help us to bear a child.

I / We consent to:

a) Being prepared for oocyte retrieval by the administration of hormones and other drugs.

b) The retrieval of oocyte(s) from my ovaries under ultrasound guidance / Laparoscopy and under Anaesthesia

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

I / We understand that:

I / We had a full discussion with Dr Sudharani B about the above procedures and the risks and complications involved and I have been given oral and written information about them I understand and accept that the drugs that are used to stimulate the ovaries to raise oocytes 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.

I / We consent that I/we shall be the legal parent(s) of the child and the child will have all the legal rights on me, in case of anonymous gamete / embryo donation.

I / We 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.

Wife / Woman Name: Hafsa Fatima

Signature:

Date & Time: 20/7/26 @ 8:45 am

Husband Name: MD Feroz Khan

Signature:

Date & Time: 20/7/26 @ 8:45 am

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. We have had the Opportunity to ask questions, all of which have been answer to our 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 means as deemed appropriate by the professional team of BirthRight Fertility by Rainbow hospital. 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 surgery 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 alternatives.

Wife / Woman Name: Hafsa Fatima
Signature:
Date & Time: 10/7/26 @ 8:45 am

Husband Name: MD Feroz Khan
Signature:
Date & Time: 10/7/26 @ 8:45 am

Endorsement by the ART Clinic:

I/ we have personally explained to Hafsa Fatima and MD Feroz Khan the details and implications of her signing this consent / approval form, and made sure to the extent humanly possible that she understands these details and implications.

Wife / Woman Name: Hafsa Fatima
Signature:
Date & Time: 10/7/26 @ 8:45 am

Name, Address and Signature:
of the Witness from the clinic Butterfield
Date & Time: 10/7/26 @ 8:45 am

Name of the Doctor: Dr Sudhavani B
Signature:
Date & Time: 10/7/26 @ 8:45 am

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

Consent of the Husband (As and If applicable)

As the Husband / Partner I consent to the course of the treatment outlined above. I understand that I will become the legal parent of the any resulting child, and that the child will have all the normal legal rights on me.

Husband Name: MD Feroz Khan
Address: Hyderabad
Signature:
Date & Time: 10/7/26 @ 8:45 am

Name, Address and Signature:
of the Witness from the clinic Butterfield
Date & Time: 10/7/26 @ 8:45 am

Name of the Doctor: Dr Sudhavani B
Signature :
Date & Time : 10/7/26 @ 8:45 am

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

Patient Sticker

BAH-00611929 IP5-00176192
Mrs HAFSA FATIMA
07-05-1997 29 Y 2 M 3 D (F)
Dr. SUDHARANI BAIRRAJU

Rainbow® Children's Hospital
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Your Right to a Safe Delivery

CONSENT FOR ANAESTHESIA

Authorization By: ☑ Patient ☐ Patient Attendant

Operative Procedure: Oocyte Retrieval

Anaesthesiologist: Dr Sudharani Surgeon: Dr. Sudharani

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 ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders
☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease
☐ Others Nil

Declaration by Patient Attendant

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team
  ☐ Regional Anaesthesia ☐ General Anaesthesia ☐ Monitored Anaesthesia Care
- 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, allergic reactions, headaches, variations in blood pressure, nausea and vomiting.
- I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Access, arterial line, use of suppositories and or nerve blocks for pain relief, changing from regional to general anaesthesia etc) which are considered necessary by them during the course of surgery.
- I also 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 if need arises.
- I acknowledge that the anaesthesiologist have informed me about the anaesthetic procedure, risk, benefits and alternative treatments.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / ~~Patient Attendant~~:
Signature: Hafsa
Name: HAFSA FATIMA
Relationship with patient: Self
Date & Time: 3/7/26 11 AM

Witness:
Signature:
Name: MD. Feroz Khan
Date & Time: 3/7/26, 11 AM
Husband

Doctor (who is taking consent):
Signature: Sudharani Name: Dr Sudharani Date 3/7/26 Time: 11 AM

Patient Sticker

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Your Right to a Safe Delivery

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స: .....

అనస్థీషియా వైద్యుడు: ..... శస్త్రచికిత్స నిపుణుడు: .....

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

సాధారణ అనస్థీషియా అనేది శస్త్రచికిత్స ముందు రోగిని పూర్తిగా అపస్మారక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్రావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు.

రీజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్కోటిక్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై రిస్క్స్:

క్రింద పేర్కొన్న వైద్య సమస్యల కారణంగా ఉండే అధిక ప్రమాదాల గురించి వైద్యులు నాకు వివరంగా చెప్పారు. నాకు ఉన్న సందేహాలను నేను అడిగాను మరియు అవి నివృత్తి చేయబడ్డాయి.

☐ హృదయ వ్యాధి ☐ రక్తపోటు ☐ మధుమేహం ☐ మూత్రపిండాల వైఫల్యం ☐ బహుళ అవయవ వైఫల్యం

☐ కాలేయ సమస్యలు ☐ షాక్ ☐ ఊబకాయం ☐ దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)

☐ ఇతరవి: .....

రోగి / రోగి అటెండెంట్

- అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
  ☐ రీజనల్ అనస్థీషియా ☐ జనరల్ అనస్థీషియా ☐ మానిటర్డ్ అనస్థీషియా కేర్
- అనస్థీషియా ఉపయోగంలో అప్పుడప్పుడూ జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. వీటిలో ఇంజెక్షన్ ఇచ్చిన చోట నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అలెర్జీ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెనస్ యాక్సెస్, ఆర్టీరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, రీజనల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందానికి నేను అనుమతి ఇస్తున్నాను.
- శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న వైద్యుల బృందానికి కూడా నేను అనుమతి ఇస్తున్నాను.
- అనస్థీషియా విధానం, ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయ చికిత్సల గురించి అనస్థీషియా వైద్యులు నాకు వివరించినట్లు నేను అంగీకరిస్తున్నాను.
- పై సమాచారం అంతా నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో వాటికి సమాధానాలు ఇచ్చారు. ఈ అనుమతి నేను పూర్తిగా స్పష్టమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం: .....

పేరు: .....

రోగితో సంబంధం: .....

తేదీ & సమయం: .....

సాక్షి:

సంతకం: .....

పేరు: .....

తేదీ & సమయం: .....

డాక్టర్ :

సంతకం: ..... పేరు: ..... తేదీ & సమయం: .....

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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

BirthRight BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

Name: HAFSA FATIMA Age: 29y Sex: F UHID.No :

Date: 3/7/26. Time: 11 AM Proposed Operation: Oocyte Retrieval.

Diagnosis: For IVF.

B.P / CRT: 120/78 H.R: Weight: 55kg ASA Physical Status: ☑1 ☐2 ☐3 ☐4 ☐5

Laboratory Data: HbA1c 5.3

Hgb: 12.1	Glucose:	Protein:	HIV:	X-Ray:
PCV: 36.9	Urea:	Alb:	HBS Ag: NR	ECG:
WBC: 7000	Creat:	Total Bill:	HCV:	2D Echo:
Plate: 2.56	Na:	Dir. Bill:	Blood group: A +ve	Stress/Anglo:
PT:	K:	LDH:	T3	Other:
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH 3.145	
	Cl -:	SGOT/SGPT:		

Allergies: —

Medical History: CVS :

RESP : Diabetes : —

CNS :

Renal : NAD.

Hepatic / GE : Physical Activity: Active.

Others :

Past Anaesthetic History: ↓ Colonoscopy for lower GI Scopy ↓ MAC ē deng ; US

Physical Exam:

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

Lungs : Clear

Heart: S1S2

CNS: NAD

Pregnant: ☐ Yes ☐ No ☑ NA LMP - 28/6. Venous Access Site : (+) Spine Exam for regional : (N)

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

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

Signature: Name: Dr Sunidhara

BAH-00611929 IP5-00176192
Mrs HAFSA FATIMA
07-05-1997 29 Y 2 M 3 D (F)
Dr. SUDHARANI BAIRRAJU

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition:	☐ Yes ☑ No	Fasting Status: confirmed	
Physical Status:	☑ Patient Identified	☑ Consent Present	☑ Chart Reviewed

H.R: 80/min | B.P / CRT: 115/70mmHg | SpO_2: 100% | R.R: 20/min | Last Feed: >6hrs

Pre-OP Diagnosis: IVF Treatment. Operation: OOcyte Retrieval Date: 10/7/26

Surgeon: Dr. Sudha Rani Anaesthesiologist: Dr. Tejaswini Technician: Ravi

TIME	9am	9:30am.
N_2O /AIR /O_2 LPM		
HALO /SO /SEVO		
Drugs:		
MIDAZOLAM	1mg	
FENTANYL	100mcg.	
PROPOFOL Infusion	33mg/hr.	
FIO_2 / SaO_2	100 100	
$ETCO_2$	40 40	
ECG	SR SR	
Temperature		
Urine Output		
Fluids / Blood	RINGER LACTATE 300ml.	

Antibiotic

Suppository

Blood Loss

NOTES

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

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

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

LAB Values: ABG | GRBS | Others

☑ Equipment Checked and Functional
☑ BP
☑ Cuff Site: .....
☐ Art Site: .....
☐ EKG Lead
☐ Temp Site
☐ FIO_2 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

Times:
Anaes Start: 9Am
OP Start: .....
OP End: .....
Leave OR: 9:30Am.

Anaesthesia:
☐ GA
☑ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP: .....
☐ ART: .....
☑ IV: 20G R UL.
☐ IV: .....
☐ IV: .....

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

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

☐ Awake ☐ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# ..... Attempts: .....
Difficulty Why? .....

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

Regional:
Extremity Specify: .....
☐ Spinal ☐ Epidural ☐ Caudal
Others: .....
Position: .....
Site: .....
Needle Size ..... Depth: .....
Parasthesia ☐ Yes ☐ No
Catheter at skin ..... cm
Drug Name & Conc: .....
Bolus: .....
Infusion: .....
Block Level: .....
Comments: .....

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

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

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Patient

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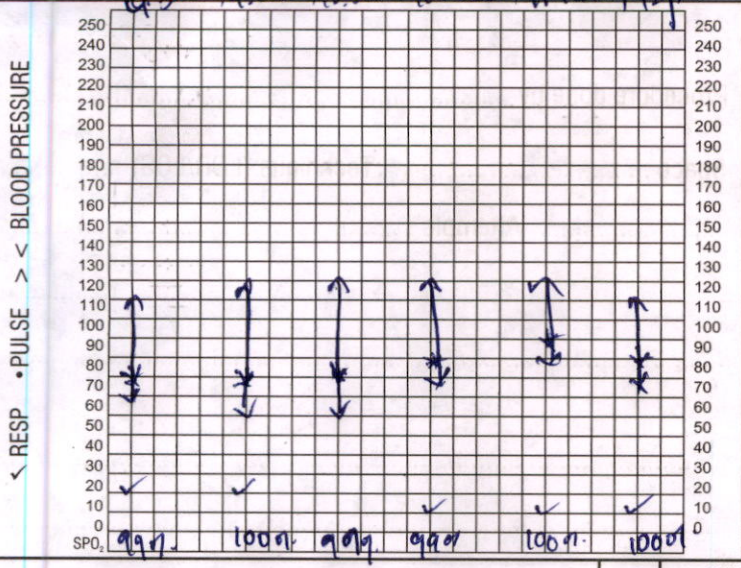
POST-ANAES[illegible]RD

Received in PACU by : Bis. Swaroop Time Received : 9:35Am Time Discharged : 12pm

9:35AM 9:50AM 10:5AM 10:15AM 11:15AM 12pm



IV Cannula Site : Rt hand

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

Vomiting : ☐ Yes ☑ No Drug: .....
NG Tube : ☐ Yes ☑ No
Drain: ☐ Yes ☐ No
Urinary Catheter: ☐ Yes ☑ No
Chest Tube: ☐ Yes ☑ No
Nil Oral ☑ Yes ☐ No

IV Fluids: 10 RL on/flow
Oral Feeds: Allow

POST ANAESTHESIA SCORE
(Modified Aldrete Score)

		IN	MINUTES 30	60	90	OUT
Able to move 4 extremities voluntary or on command = 2 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 0	ACTIVITY	1	2	2	2	2
Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0	RESPIRATION	2	2	2	2	2
BP ± 20 of Pre Anaesthetic leve = 2 BP ± 20-50 of Pre Anaesthetic leve = 1 BP ± 50 of Pre Anaesthetic leve = 0	CIRCULATION	2	2	2	2	2
Fully awake = 2 Arousable on calling = 1 Not responding = 0	CONSCIOUSNESS	2	2	2	2	2
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0	COLOR	2	2	2	2	2
	TOTAL	9	10	10	10	10

SCORING INTERPRETATION

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:

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
10/7/26	9:30A	-0-	Nil	

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

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

Anaesthesiologist Name : Dr. TEJASVINI
Anaesthesiologist Signature:
Date & Time: 10/7/26 at 12pm

PACU Nurse Name : Swaroop
PACU Nurse Signature:
Date & Time: 10/7/26 at 9:35Am

Transferred to Unit by (PACU): Billy
Date & Time: 10/7/26 at 12pm

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : .....

Any other issues :

a) .....

b) .....

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

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

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

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

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Mrs HAFSA FATIMA
07-05-1997 29 Y 2 M 3 D (F)
Dr. SUDHARANI BAIRRAJU

Surgeon : Dr Sudharani B
Asst. Surgeon : Dr Akhila
Anaesthetist Dr Tejaswini
Scrub Nurse : Sri Swaroop

Patient Name : Hafsa fatima Age : 29 y Gender : F
UHID No. : BAH-00611929 Surgery Name : Oophorectomy
Date : 10/1/26 In-time : 08:55 Am Out-time : 09:35 Am

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 8:55 AM

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 : [signature]
Name : Dr. Tejaswini

Before Skin Incision ➤➤

TIME OUT Time: 09:00 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 ☑ Yes ☐ No

Anticipated Critical Events

Surgeon Reviews:
- What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? Pain, Bleeding. 20-30mins 0-5ml ☐ 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 : [signature]
Name : Swaroop

Before Patient Leaves Operating Room

SIGN OUT Time: 09:30 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 : [signature]
Name : Dr. Sudha

Patient S

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date : 10/7/26

To Be Filled In By Assigned Nurse :

Department : IVF OT Duration of Procedure : 20-30mins

Name of Surgeon : Dr Sudharani B Date of Admission : 10/7/26

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

		Staff Signature
1.	Antibiotic given prior to surgery ? ☑ Yes ☐ No ☑ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☑ Yes ☐ No Name of the Antibiotic : INJ. AUGMENTIN 1.2g	
2.	Hair Removal ☑ Yes ☐ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☐ Operating Room ☑ Other : None Skin preparation done (cleanse surgical area with antiseptic agent)? ☑ Yes ☐ No	
3.	Patient's body temperature immediately post operation (Recovery Room) 36.5 °C ☐ Oral Or ☑ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : Dr. Swaroop Date & Time of antibiotic administration : 10/7/26 at 08:36AM Date & Time procedure started : 10/7/26 at 09AM	

- 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

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POST PROCEDURE CARE PLAN

Date & Time: 10/7/26 @ 9:40 Am

Patient Name: Hafsa Fatima Age: 29 yr UHID No: BAH-00611929

Procedure Done: Oocyte retrieval

Post Procedure Diagnosis: Oocyte retrieval done

Post-Operative Monitoring Parameters / Frequency: Monitor PR, BP, RR, SPO2 every 5 min for 15 min, every 15 min for an hour, fully till discharge

Special Patient Positioning and Requirements:

Nutritional Instructions: Bland Diet

When to Start Mobilization: after gaining consciousness

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: Day 3 / Day 5 to discuss regarding Embryos, all fine.

Name of the Doctor: Dr. Sudharani

Signature:

Date & Time: 10/7/26 @ 9:45 Am

Note: Plan of care will be readjusted if necessary