BAH-00633689 IP5-00176259
Mrs TAHURA
12-11-1997 28 Y 7 M 29 D (F)
Dr. SUDHARANI BAIRRAJU

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SURGERY DETAILS

Date : 11/7/26

Patient Name: Tahura Date of Birth: 12/11/1997 Age: 28y

Gender: f Ward : IVF OT UHID No.: BAH-00633689

Date of Surgery: 11/7/26 ☐ OT -1 ☐ ~~OT -2~~ ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Frozen embryo transfer

Time in : 2:15 pm Time Out : 2:35 pm

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

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

R265-034537

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 5-0009698062 Order by: Malathi

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

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 : IP5-00176259 **Admit Date** : 11-Jul-2026 **Admit Time** : 12:08 PM **UHID** : BAH-00633689

Patient Details :

Patient Name	: Mrs TAHURA		
Guardian	: Mr MOHAMMED RAFI	**Age**	: 28 Y 7 M 29 D
Gender	: Female	**DOB**	: 12-11-1997
Occupation	:	**Religion**	:
Address (H)	: SRT COLONY Yakutpura Hyderabad Telangana INDIA 500023	**Martial Status**	: Married
		Phone No	: 8790569443/ 9248636887
		E-mail	: mailtorafiuddin@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : POST OP 410 **Ward Name** : 4F-OT COMPLEX

Room No : POST OP 410 **Admission Type** : First Visit

Contact Details :

Name	: Mr MOHAMMED RAFI	**Relationship**	: Husband
Contact Address	: SRT COLONY Yakutpura Hyderabad Telangana INDIA 500023	**Phone No**	: 8790569443 / 9248636887

Signature

Doctor Details :

Doctor Name	: Dr. SUDHARANI BAIRRAJU	**Specialisation**	: INFERTILITY
Referral Doctor	: Self	**Phone No**	:
Co-Consultant	:		

Payment Details :

Payment Mode	: Cash	**Deposit Amount**	: 39999.56
		Payor Name	: SELFPAY

Patient Sticker

Tahira

6755

FET

CONSUMABLES OF OT

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Circulating staff : Mahell Technician : Date : 11/7/24 Time :

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			Mother gown	01	01
			Ointments			prob gown	01	01
			Suction Catheter			10 Syringe	01	01
Fentanyl			Cap, Mask	3/3	3/3	Transofix	01	01
Morphine			Gauze Pack			Cannula	01	01
Ketamine			Mop Pack			100 ml NS	01	01
Propofol			Steristrip			foot Covers		
Rocuronium			Underpad	01	01			
Glycopyrolate			Draw sheet	01	01			
Myopyrolate			Abgel					
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 Sadhana Anaesthesiologist Nurse OT Technician

Order No. : S-0050698062/8061 Ordered by : Mahell

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

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ACTIVITY RECORD FOR BILLING

BAH-00633689 IP5-00176259
Mrs TAHURA 28 Y 7 M 29 D (F)
12-11-1997
Dr. SUDHARANI BAIRRAJU

Name :___ _____

UHID No. : _ _____Consultant: _____ Dept : _____

Date of Admission: _____ Time : _____Date of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
11/4/26	2:15 pm	Gyn recovery	IVF OT	
11/4/26	2:35 pm	Gyn recovery	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
11/7/22	Mindray	1:10pm	2:40pm	5-0009698082	
11/7/22	Ultra Sound	2:15pm	2:35pm	R265-034537	

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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Mrs TAHURA
12-11-1997 28 Y 7 M 29 D (F)
Dr. SUDHARANI BAIRRAJU

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OUTPATIENT NURSING ASSESSMENT FORM

Date: 11/7/26 Time: 12:15pm

Chief Complaint: NIL

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

If yes , identify –

Vital Signs : Temperature: 97.6°F Pulse: 82b/m Respiratory Rate 18b/m

BP 110/70 SpO_2 100 Weight 50.7 Height 1.57 BMI 20.6

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: .....

Inform the physician about any spiritual needs, if applicable

Nurse Signature: ..... Nurse Name: Mahila

Date & Time: 11/7/2026 @ 12:29pm

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PAIN ASSESSMENT FORM

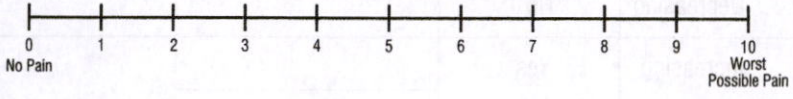
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
11/7/26	1:30pm	0	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	- -	[illegible]
11/7/26	2:30pm	0	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	- -	[illegible]
				☐ 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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Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
11/7/26 1:30pm	☑ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☑ Per-Op ☐ Post Op	Patient came for frozen embryo transfer	frozen embryo transfer without complication	frozen embryo transfer		☑ Nursing ☐ Others:
11/7/26 1:35pm	☐ Medical ☑ Nursing ☐ Others:	☐ Initial ☐ Modified ☑ Per-Op ☐ Post Op	patient came for frozen embryo transfer	Given Confortable position	shifted to OT for embryo transfer		☑ Medical ☐ Others:
11/7/26 2:30pm	☑ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☑ Post Op	monitor vitals	Safe discharge	Discharge medication.		☑ Medical ☐ Nursing ☐ Others:
11/7/26 2:40pm	☐ Medical ☑ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☑ Post Op	procedure done without any complications	Given 2 hours rest.	explained medications and discharged accordingly doctor advs		☐ 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	11/4/26		
		Score			
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0	0		
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0	0		
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0	0		
IV / Heparin Lock or Saline	Yes	20			
	No	0	0		
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0	0		
Mental Status	Forgets limitations	15			
	Oriented to own ability	0	0		
Total Morse Fall Scale Score:			0		
		Signature			

Fall Risk Grading		
Risk Level	**Morse Fall Score (MFS)**	**Action**
Low Risk	0 - 24	Standard Fall Precaution
Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
High Risk	≥ 51	Implement High Risk Fall Prevention Intervention

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

BAH-00633689 IP5-00176259
Mrs TAHURA
12-11-1997 28 Y 7 M 29 D (F)
Dr. SUDHARANI BAIRRAJU

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☐ 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	TAB PANTOPRAZOLE	40mg	PO	OD		☐C ☐DC
2	TAB FOLIC ACID	5mg	PO	OD		☐C ☐DC
3	TAB ECOSPRIN	150 mg	PO	OD		☐C ☐DC
4	INJ PAN	40mg	IV	OD		☐C ☐DC
5	TAB MEDROL	16mg	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. Allwin Allwin

Date & Time : 11/7/26 @ 1:30pm

Nurse Name & Signature: Mahi

Date & Time : 11/7/26 @ 1:30pm

BirthRight™ FERTILITY BY RAINBOW HOSPITALS

FORM-6

CONSENT FORM FOR ASSISTED REPRODUCTIVE TECHNOLOGY PROCEDURE

Patient Name: Mrs. Tahura Age 28 yr UHID No. BAH-10633689

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.
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: Tahmina

Signature: Tahmina

Date & Time: 11/7/26 @ 12:12pm

Husband Name: Mohd Rafi

Signature: Rafi

Date & Time: 11/7/26 @ 12:12pm

Endorsement by the ART Clinic:

I/we have personally explained to Tahmina and Mohd Rafi 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: Tahmina

Signature: Tahmina

Date & Time: 11/7/26 @ 12:12pm

Husband Name: Mohd Rafi

Signature: Rafi

Date & Time: 11/7/26 @ 12:12pm

Name, Address and Signature : .....

of the Witness from the clinic Birthright fertility

Date & Time: 11/7/26 @ 12:12pm

BirthRight Fertility by
Rainbow Hospitals, Banjara Hills
8-2-120/103/1, Survey No. 463, Road No. 2,
Banjara Hills, Hyderabad, Telangana-500 034.

Name of the ART Clinic:

Address:

Date & Time : 11/7/26 @ 12:12pm

Name of the Doctor: Dr. Sudharani B

Signature:

Date & Time: 11/7/26 12:12pm

CONSENT FORM FOR FROZEN EMBRYO TRANSFER

BAH-00633689 IP5-00176259
Mrs TAHURA
12-11-1997 28 Y 7 M 29 D (F)
Dr. SUDHARANI BAIRRAJU

BirthRight™ FERTILITY BY RAINBOW HOSPITALS

Patient Name: Tahura Age: 28yr. UHID No: BAH-00633689

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

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

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

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: Tahura Spouse Name: Mohd rafi

Signature: Tahura Signature: Rafi

Date & Time: 11/7/26 @ 12:12pm Date & Time: 11/7/26 @ 12:12pm

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 Signature: Sudharani

Date & Time: 11/7/26 @ 12:12pm

BAH-00633689 IPS-00176259
Mrs TAHURA
12-11-1997 28 Y 7 M 29 D (F)
Dr. SUDHARANI BAIRRAJU

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/7/26	patient came for frozen embryo transfer	plan
	BR – 88/mt	– Shift to OT for FET
	BP – 110/70	
	SpO2 – 100%.	
	RR – 18cpm	
	CVS/RS/P/A	Advised
		Dr Sudharani 2.10pm
12/7/2026	pt stable	
	Discharge medications explained.	plan
		– can be discharged

BAH-00633689 IP5-00176259
Mrs TAHURA
12-11-1997 28 Y 7 M 29 D (F)
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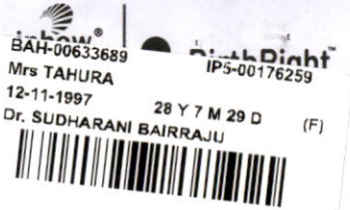
PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

SURGICAL SAFETY CHECKLIST

Surgeon : M Sudharani B
Asst. Surgeon : M Akhila
Anaesthetist : –
Scrub Nurse : Mallikarjuna

Patient Name : Tahura Age : 28Y Gender : F
UHID No. : BAH-00633689 Surgery Name : FEP
Date : 11/7/22 In-time : 2:10pm Out-time : 2:40pm



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 : NA

Name :.....

Before Skin Incision ➤ ➤

TIME OUT Time: 2:15pm

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? ☐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 : Mallikarjuna

Before Patient Leaves Operating Room

SIGN OUT Time: 2:40p

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 :.....

Name : M Sudharani B

BAH-00633689 IP5-00176259
Mrs TAHURA
12-11-1997 28 Y 7 M 29 D (F)
Dr. SUDHARANI BAIRRAJU

BirthRight™ FERTILITY BY RAINBOW HOSPITALS

POST PROCEDURE CARE PLAN

Date & Time: 11/7/26 @ 2135 pm

Patient Name: Tahura Age: 28 yrs UHID No: BAH-00633689

Procedure Done: frozen embryo transfer (FET)

Post Procedure Diagnosis: FET done

Post-Operative Monitoring Parameters / Frequency: monitor vitals

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: BhCG after 9 days
Luteal support

Name of the Doctor: Dr Sudharani B

Signature: Dr Sudhi.

Date & Time: 11/7/26 @ 2:40pm

Note: Plan of care will be readjusted if necessary