Patient Sticker

Rainbow® Children's Hospital
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SURGERY DETAILS

BAH-00625784 IP5-00176024
Mrs PABBISETTY J N V S SWETHA
14-08-1995 30 Y 10 M 22 D (F)
Dr. SUDHARANI BAIRRAJU

Patient

Date : 06/7/26

..... Date of Birth: ..... Age: .....

Gender: ..... Ward : IVF OT UHID No.: .....

Date of Surgery: 06/7/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : frozen Embryo Transfer

Time in : 01:50pm Time Out : 02:15pm

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

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

R265-033553

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 5-0009690316/31 b. Order by: Swaroop

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

BAH-00625784 IP5-00176024
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FET

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CONSUMABLES OF OT

3447

Circulating staff :..... Technician : ..... Date : 06/2/26 Time : 2pm

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					
Fentanyl			Cap, Mask	3/3	3/3	Mothergown	01	01
Morphine			Gauze Pack			proto gown	02	02
Ketamine			Mop Pack			All round	01	01
Propofol			Steristrip			Leaufing	01	01
Rocuronium			Underpad	01	01	NC Singh	01	01
Glycopyrolate			Draw sheet	02	02	Glove Enor 6½	02	02
Myopyrolate			Abgel			foot cowl	02	02
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 Anaesthesiologist Nurse OT Technician

Order No. : E-0009690311/312 Ordered by : .....

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

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 : IP5-00176024 **Admit Date** : 06-Jul-2026 **Admit Time** : 12:23 PM **UHID** : BAH-00625784

Patient Details :

Patient Name	: Mrs PABBISETTY J N V S SWETHA	**Age**	: 30 Y 10 M 22 D
Guardian	: Mr SWARNA SEKHAR	**DOB**	: 14-08-1995
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Married
Address (H)	: H NO 6-3-354/13/B3 , SURYA TEJA APARTMENTS, NEAR HIMALAYA BOOK STORE Panjagutta Hyderabad Telangana INDIA 500082	**Phone No**	: 9154300260/
		E-mail	: SEKHR.4U@GMAIL.COM

Admission Details :

Bed Type : DAY CARE **Bed No** : POST OP 412 **Ward Name** : 4F-OT COMPLEX

Room No : POST OP 412 **Admission Type** : First Visit

Contact Details :

Name	: Mr SWARNA SEKHAR	**Relationship**	: Husband
Contact Address	: H NO 6-3-354/13/B3 , SURYA TEJA APARTMENTS, NEAR HIMALAYA BOOK STORE Panjagutta Hyderabad Telangana INDIA 500082	**Phone No**	:

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**	: MEDI ASSIST INSURANCE TPA PVT LTD

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ACTIVITY RECORD FOR BILLING

Name :_____

UHID No. : BAH-00625784 IP5-00176024
Mrs PABBISETTY J N V S SWETHA
14-08-1995 30 Y 10 M 22 D (F)
Dr. SUDHARANI BAIRRAJU

_____Consultant: _____ Dept : _____

Date of Admi: _____Date of Discharge : _____Time: _____

Room / Bed No : _____ _____Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
06/7/26	01:50pm	Gynae Recvy	IVF OT	Swaroop
06/7/26	2:20pm	IVF OT	Gynae Recvy	Swaroop
06/7/26	3pm	Gynae Recvy	Billing	Sunil

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
06/2/26	Cardiac Monitor	12:30pm	1pm	5-0009690 315	
06/2/26	Ultrasound machine	2pm	2:10p	R265-03553	

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

BAH-00625784 IP5-00176024
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14-08-1995 30 Y 10 M 22 D (F)
Dr. SUDHARANI BAIRRAJU

BirthRight™ FERTILITY BY RAINBOW HOSPITALS

OUTPATIENT NURSING ASSESSMENT FORM

Date: 06/7/26 Time: 12:32pm

Chief Complaint: .....

.....

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

If yes , identify .....

Vital Signs : Temperature: 98.6°F Pulse: 70b/min Respiratory Rate 17/min

BP 99/66mmHg SpO_2 100% Weight 61kg Height 1.62 BMI 23.2

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: Swaroopa

Date & Time: 06/7/26 at 12:45pm

BAH-00625784 IP5-00176024
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PAIN ASSESSMENT FORM

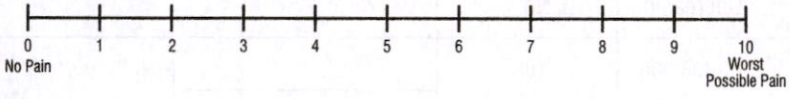
Date	Time	Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
06/7/26	12:30pm	0	–	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	–nil–	8
				☐ Continuous ☐ Intermittent	☐ Acute ☐ 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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MULTI-DISCIPLINARY PLAN OF CARE FORM

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Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
06/2/26	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☑ Modified ☐ Per-Op ☐ Post Op					☑ Nursing ☐ Others:
06/2/26 12:50pm	☐ 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's order		☐ Medical ☐ Others:
06/2/26	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☑ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☑ Nursing ☐ Others:
06/2/26	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Procedure has done under aseptic precautions under ultrasound guidline.	Advised rest to Patient for 30-45mins	Explained about discharge medication as Per doctor's 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		06/2/20 1pm		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				
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0		0				
Total Morse Fall Scale Score:				0				
		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

Pati

BAH-00625784 IP5-00176024
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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						☐ 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 : .....

Date & Time : .....

Nurse Name & Signature: Swaroopa S R

Date & Time : 06/12/16 at 12:40pm

FORM-6

CONSENT FORM FOR ASSISTED REPRODUCTIVE TECHNOLOGY PROCEDURE

BirthRight™ FERTILITY BY RAINBOW HOSPITALS

Patient Name: Pabbisetty J N V S Swetha Age 30 UHID No. BAH-00625784

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.J.N.V.S. Swetha

Signature: P.Swetha

Date & Time: 6th July 26 12:35

Husband Name: Sekhar

Signature:

Date & Time: 6-July 12.35

Endorsement by the ART Clinic:

I/we have personally explained to P.J.N.V.S.Swetha and Sekhar 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.J.N.V.S. Swetha

Signature: P.Swetha

Date & Time: 6th July 26 12:35

Husband Name: Sekhar

Signature:

Date & Time: 6 July 12.35

Name, Address and Signature :

of the Witness from the clinic

Date & Time: 06/7/26 at 1pm

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 : 06/7/26 at 12.10 p.m.

Name of the Doctor: Dr. Sudhaarani B

Signature:

Date & Time: 06/7/26 at

CONSENT FORM FOR FROZEN EMBRYO TRANSFER

BirthRight™ FERTILITY BY RAINBOW HOSPITALS

Patient Name: Pabbisetty J.N.V.S. Swetha Age: 30 UHID No: BAH-00625784

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

- ☑ Self Gametes
- ☐ Donor Sperm
- ☐ Donor Oocytes
- ☐ 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: P.J.N.V.S. Swetha Spouse Name: Sekhar Suvarna

Signature: P.Swetha Signature:

Date & Time: 6th July 12:35 Date & Time: 6th July 12.55

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. Sudhaeani B Signature:

Date & Time: 06/7/26 at

BAH-00625784 IP5-00176024
Mrs PABBISETTY J N V S SWETHA
14-08-1995 30 Y 10 M 22 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

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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LIST

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

Patient Name : P JNV S Swetha Age : Gender :
UHID No. : BAH-0062 I 784 Surgery Name : RET
Date : 06/7/16 In-time : 01:50pm Out-time : 02:45pm

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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: 01:55pm

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, 10-15 mg Anticipated Blood Loss? Nil- ☐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 : Swaroop

Before Patient Leaves Operating Room

SIGN OUT Time: 2:10pm

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 : Dr Sudharani B

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POST PROCEDURE CARE PLAN

Date & Time: 06/2/26.

Patient Name: P. J. N. V. S. Swetha Age: 30 y/f UHID No: BAH-00625784

Procedure Done: .....

Post Procedure Diagnosis: .....

Post-Operative Monitoring Parameters / Frequency: .....

.....

.....

Special Patient Positioning and Requirements: .....

.....

Nutritional Instructions: .....

.....

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: .....

.....

Name of the Doctor: .....

Signature: .....

Date & Time: .....

Note: Plan of care will be readjusted if necessary

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Mrs PABBISETTY J N V S SWETHA
14-08-1995 30 Y 10 M 22 D (F)
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NURSES NOTES

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
06/2/26	12:41pm	Pre-procedure Notes:- Mrs. P. Swetha patient has come for frozen Embryo Transfer. Patient file taken. Identification of patient has done by patient full name, UHID Number and procedure name. Given sterile gown, face mask, headcap to the patient. Vitals checked informed doctor. As pe doctor orders with full bladder shifted the patient to OT. S Swetha 06/2/26
06/2/26	1:55pm	Intra-operative Notes: Once again patient identification has done by patient full name UHID Number & procedure name. Placed patient into lithotomy position under ultrasound guidline, & aseptic precaution procedure has done Swetha 06/2/26
06/2/26	2:15pm	Post - procedure Notes Shifted the patient to observation room to take rest for 30 mins. As per doctor

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)
		Oldy explained about discharge medication. As per doctor order patient discharge. Swathi DISH
06/2/25	2:20pm	Post vi Early
		Temp- 98.6°F
		BP- 113/71mHg
		Puls-90b/m
		Resp- N/A
		SPO2- 100%
		P/A - Soft Swathi DISH

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

(P.T.O)