

BAH-00651123 IP5-00176260
Mrs NAGA LAKSHMI PATNALA
09-06-1989 37 Y 1 M 2 D (F)
Dr. SUDHARANI BAIRRAJU



SURGERY DETAILS

Date : 11/7/26

Patient Name: Mrs Naga Lakshmi Date of Birth: Age: 37y

Gender: F Ward: IVF UHID No.:

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 : 3:10pm

Time Out : 3:35pm

	NAME	AMOUNT
1. Surgeon	Mr Sudharani	
2. Anaesthetist	-	
3. Assistant Surgeon	Mr Akshith	
4. OT Technician	-	
5. Circulating Nurse	Maalish	
6. Assistant Nurse	-	

Special Equipment: ☐ Laparoscopy

☐ Broncoscope

☐ Harmonic

☐ Morcelator

☐ C-ARM

☐ Cystoscopy

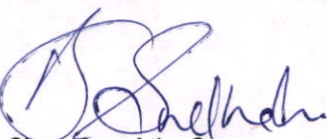
☐ Versa Point

☐ Liver Cusa

☐ Neuro Cusa

☒ Others under uterine sleeve guidewire

R265-034501


Signature of the Surgeon

50009698105


Signature of Circulating Nurse

Order No.:

Order by: Maalish

Patient Name: Alga Lathi P

Ref

CONSUMABLES OF OT

6756

Circulating staff : Mallik Technician : _____ Date : 11-7-12 Time : _____

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	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	Mother gown	01	01
Morphine			Gauze Pack			prob gown	01	01
Ketamine			Mop Pack			lucinglue 6/2	01	01
Propofol			Steristrip			1 cc syringe	01	01
Rocuronium			Underpad	01	01	fast cover	02	02
Glycopyrolate			Draw sheet	01	01	NS sheet	01	01
Myopyrolate			Abgel			transfix	01	01
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
			Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set					
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution					
			Microshield					
			Cotton Balls					
			Latex Gloves					
			Ramdione Scrub					
			Saral					

Sudhara

Anaesthesiologist

Nurse

Mallik

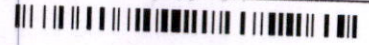
OT Technician

5-009698042

Ordered by : Mallik

ADMISSION SHEET

Registration Details :



Admission No : IP5-00176260

Admit Date : 11-Jul-2026

Admit Time : 12:11 PM

UHID : BAH-00651123

Patient Details :

Patient Name : Mrs NAGA LAKSHMI PATNALA

Age : 37 Y 1 M 2 D

Guardian : MR RAJESH POTHARAJU

DOB : 09-06-1989

Gender : Female

Religion :

Occupation :

Marital Status : Married

Address (H) : FLAT 203, SRI HARSHA ARCADE, PRAKASH
NAGAR Begumpet Hyderabad Telangana
INDIA 500016

Phone No : 9884907700/ 9884907700

E-mail : NO@GAMIL.COM

Admission Details :

Bed Type : DAY CARE

Bed No : POST OP 411

Ward Name : 4F-OT COMPLEX

Room No : POST OP 411

Admission Type : First Visit

Contact Details :

Name : MR RAJESH POTHARAJU

Relationship : Husband

Contact Address :

Phone No : / 9884907700

Rajesh

Signature

Doctor Details :

Doctor Name : Dr. SUDHARANI BAIRRAJU

Specialisation : INFERTILITY

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :

Payment Mode : Cash

Deposit Amount : 19999.89

Payor Name : SELFPAY

ACTIVITY RECORD FOR BILLING

Name : _____ BAH-00651123 IP5-00176260
Mrs NAGA LAKSHMI PATNALA
09-06-1989 37 Y 1 M 2 D (F)
UHID No. : _____ Dr. SUDHARANI BAIRRAJU
Date of Admission : _____ Consultant : _____ Dept : _____
Room / Bed No : _____ Ward : _____ Suggested Billable bed type : _____



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
11/7/26	3:10pm	Gyne delivery	Wf OT	
11/7/26	3:40pm	Wf OT	Gyne delivery	

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



OUTPATIENT NURSING ASSESSMENT FORM

Date: 11/7/26 Time: 12:18pm

Chief Complaint: new

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

If yes, identify new

Vital Signs: Temperature: 98.2° Pulse: 89b/m Respiratory Rate 19b/m

BP 122/84 SpO₂ 100 Weight 78.6 Height 1.52 BMI 34

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 unusual concerns about patients Psychological / Social Status:

Inform the physician about any spiritual needs, if applicable

Nurse Signature: [Signature]

Nurse Name: Maalika

Date & Time: 11/7/26 @ 12:18pm

BAH-00651123 IP5-00176260
Mrs NAGA LAKSHMI PATNALA
09-06-1989 37 Y 1 M 2 D (F)
Dr. SUDHARANI BAIRRAJU



PAIN ASSESSMENT FORM

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date	Time	Age (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
11/7/24	2pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	—	
11/7/24	3:30pm	0	NA	☐ 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:

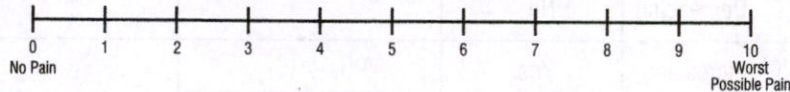
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

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 drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Numerical Pain Scale (Obstetric and Gynecology)



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, SaO₂	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

Wong - Baker (Pediatrics) Above 7 Years



MULTI-DISCIPLINARY PLAN OF CARE FORM

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
11/2 2pm	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	patient came for FET	Frozen Embryo about transfer complication	FET		☒ Nursing ☐ Others:
11/7 2:40pm	☐ Medical ☒ Nursing ☐ Others:	☐ Initial ☐ Modified ☒ Per-Op ☐ Post Op	patient came for frozen embryo transfer	provided optimal position	Shifted to OT for procedure		☒ Medical ☐ Others:
11/7 3:10pm	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	monitored vitals	safe discharge	Discharge medication		☐ Medical ☒ Nursing ☐ Others:
11/7 3:45pm	☐ Medical ☒ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	procedure was done without any complication	Given 2 hrs rest	Explain medicals and discharge adequately with orders		☒ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

BAH-00651123 IP5-00176260
 Mrs NAGA LAKSHMI PATNALA
 09-06-1989 37 Y 1 M 2 D (F)
 Dr. SUDHARANI BAIIRAJU

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

BirthRight[™]
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	Fall Risk Grading		
		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					

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



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 PROXYNOL	2mg	PO	TD		☒ C ☐ DC
2	TAB FOLIC ACID	5mg	PO	BD		☒ C ☐ DC
3	TAB METOPROLOL	1mg	PO	BD		☒ C ☐ DC
4	INJ HART	100mg	IM	BD		☐ 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. Sudharani*

Date & Time: 11/7/26 2 1pm

Nurse Name & Signature: *Shabana*

Date & Time: 11/7/26 2 1pm



FORM-6
CONSENT FORM FOR
ASSISTED REPRODUCTIVE TECHNOLOGY PROCEDURE

Patient Name: Mrs. naga lakshmi Age 37y UHID No. MAH-10651123

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.

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: Alga lakshi patwala

Signature: lakshi

Date & Time: 11/7/26 P 12:18pm

Husband Name: Rajesh potharaji

Signature: Rajesh

Date & Time: 11/7/26 P 12:18pm

Endorsement by the ART Clinic:

I/we have personally explained to Alga lakshi and Rajesh potharaji 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: Alga lakshi patwala

Signature: lakshi

Date & Time: 11/7/26 P 12:18pm

Husband Name: Rajesh potharaji

Signature: Rajesh

Date & Time: 11/7/26 P 12:18pm

Name, Address and Signature :

of the Witness from the clinic

Date & Time: 11/7/26 P 12:18pm

Name of the ART Clinic:

Address:

Date & Time : 11/7/26 P 12:18pm

Name of the Doctor: Dr. Sudharan B

Signature: Sudharan B

Date & Time: 11/7/26 P 12:18pm

CONSENT FORM FOR FROZEN EMBRYO TRANSFER

BAH-00651123 IP5-00176260
Mrs NAGA LAKSHMI PATNALA
09-06-1989 37 Y 1 M 2 D (F)
Dr. SUDHARANI BAIRAJU



Patient Name: Mrs Naga Lakshmi Age: 37 y UHID No: BAH-W 651123

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

- ☒ Self Gametes ☐ Donor Oocytes
☐ Donor Sperm ☐ Donor Gametes

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: Naga Lakshmi Patnala
Signature: Lakshmi
Date & Time: 11/7/20 @ 12:18pm

Spouse Name: Lakshmi Patnala
Signature: Lakshmi
Date & Time: 11/7/20 @ 12:18pm

Endorsement by Assisted Reproductive Technology Clinic:

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

Name of the Doctor: Dr Sudharani B
Date & Time: 11/7/20 @ 12:18pm

Signature: [Signature]

BAH-00651123 IP5-00176260
Mrs NAGA LAKSHMI PATNALA
09-06-1989 37 Y 1 M 2 D (F)
Dr. SUDHARANI BAIIRAJU



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>11/7/26</u>	patient came for FETV Embryo transfer PR - 89/uit BL - 122/84 SpO₂ - 100% RR - 18cpm CRS / NAD	plan Shift to OT for FET
<u>11/7/26</u>	patient stable Discharge medication explained.	plan can be discharged.



10



SURGICAL SAFETY CHECKLIST

Surgeon : Mr Sudh as 6
Asst. Surgeon : Mr. Mahesh
Anaesthetist : AB
Scrub Nurse : Mahesh

Patient Name : Alexa Lakshmi Age : 37y Gender : F
UHID No. BAL-651122 Surgery Name : FEU
Date : 11/7/26 In-time : 3:10 pm Out-time 3:45

BAH-00651123 IP5-00176260
Mrs NAGA LAKSHMI PATNALA
09-06-1989 37 Y 1 M 2 D (F)
Dr. SUDHARANI BAIRAJU

Right
HOSPITALS
Safe Delivery



Before Induction of Anaesthesia >>

Before Skin Incision >>

Before Patient Leaves Operating Room

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 : <u>MAHESH</u>		
Name :		

TIME OUT		Time: <u>3:15 pm</u>
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 : <u>MAHESH</u>		
Name : <u>Mahesh</u>		

SIGN OUT		Time: <u>3:35 pm</u>
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 : <u>Mr Sudharani</u>		
Name : <u>Mr Sudharani</u>		

BAH-00651123 IP5-00176260
Mrs NAGA LAKSHMI PATNALA
09-06-1989 37 Y 1 M 2 D (F)
Dr. SUDHARANI BAIRRAJU



POST PROCEDURE CARE PLAN

Date & Time: 11/7/26 @ 3:40pm

Patient Name: Mrs Naga Lakshmi P Age: 37yr UHID No: MAC - W 51123

Procedure Done: T 107en Embryo transfer (FET)

Post Procedure Diagnosis: FET done

Post-Operative Monitoring Parameters / Frequency: —

Special Patient Positioning and Requirements: —

Nutritional Instructions: Normal Diet

When to Start Mobilization: —

Special Referrals: —

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

Any Other Post-Operative Care Needed including Required Follow Up: B-AcG after 12 days, luteal support

Name of the Doctor: Dr. Sudharani

Signature: for Dr. Lakshmi

Date & Time: 11/7/26 @ 3:40pm

Note: Plan of care will be readjusted if necessary



NURSES NOTES

☒ No Known Drug Allergies

☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
11/7/20	3:00pm	<u>Pre procedure</u> patient Mrs Naga Lakshmi Patna Came for frozen embryo transfer. Checkup details verified with file name, OTID number, clinic name and procedure name. Sent to embryologist to fetch Curret from both cups. Admission was done. Given red and sterile gown, head cap and face mask. Told to patient to keep bladder full for procedure. As per clinic admission patient shifted to OT for embryo transfer Nallab 608017
11/7/20	3:15pm	<u>Intra procedure</u> patient later int. for procedure. Sugar not done by Circulating nurse. Litholy position provided. Catheter inserted. procedure performed embryo transfer into patient uterine and advised to rest in OT after transfer shifted to recovery room for 2 hr rest. Nallab 608017

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

