

BAH-00607458 IP5-00176698
Mrs AKHILA THALLAPALLY
20-07-1996 30 Y 0 M 1 D (F)
Dr. SUDHARANI BAIRAJU

Patient



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Children's
Hospital
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BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

SURGERY DETAILS

Date : 21/7/26

Patient Name: Mrs. Akhila Thallapally Date of Birth: 20/7/1996 Age: 30y

Gender: female Ward: IVF-OT UHID No.: BAH-00607458

Date of Surgery: 21/7/26 ☐ OT-1 ☐ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery: F Zogen Embryo Transfer

Time in : 12pm

Time Out : 12:20pm

	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: ☐ Laparoscopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☒ Others ultrasound guideline.

Signature of the Surgeon

R265-036365

Signature of Circulating Nurse

Order No: 5-0009714239/239

Order by: Swaroopa

BAH-00607458 IP5-00176698
Mrs AKHILA THALLAPALLY
20-07-1998 30 Y O M 1 D (F)
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PET

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CONSUMABLES OF OT

Technician : Date : 21/7/26 Time : 12pm

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			Mother gown	01	01
Fentanyl			Cap, Mask	3/3	3/3	NS 100ml	01	01
Morphine			Gauze Pack			foot covers	02	02
Ketamine			Mop Pack			Enrole 6's	01	01
Propofol			Steristrip			proto gown	01	01
Rocuronium			Underpad					
Glycopyrolate			Draw sheet					
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. Sudhara ni B Anaesthesiologist

Nurse Swaroopa

OT Technician

Order No. : 5-0009714230/231.. Ordered by :

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

ADMISSION SHEET



Registration Details :

Admission No : IP5-00176698 Admit Date : 21-Jul-2026 Admit Time : 10:37 AM UHID : BAH-00607458

Patient Details :

Patient Name : Mrs AKHILA THALLAPALLY Age : 30 Y 0 M 1 D
Guardian : Mr SRIKAR BOINPALLY DOB : 20-07-1996
Gender : Female Religion :
Occupation : Martial Status : Married
Address (H) : 1-2-593/59 LOTUS GAGAN VIHAR FLAT NO Phone No : 8125814672/ 9052651252
601 Himayathnagar Hyderabad Telangana E-mail : srikarboinpally@gmail.com
INDIA 500029

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 SRIKAR BOINPALLY Relationship : Husband
Contact Address : 1-2-593/59 LOTUS GAGAN VIHAR FLAT NO Phone No : 8125814672 / 9052651252
601 Himayathnagar Hyderabad Telangana INDIA
500029

Signature

Doctor Details :

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

Payment Details :

Deposit Amount : 79606.39
Payment Mode : Cash Payor Name : SELFPAY

ACTIVITY RECORD FOR BILLING

Name : T. Akhila

UHID : BAH-00607458 IP5-00176698
Mrs AKHILA THALLAPALLY
20-07-1996 30 Y 0 M 1 D (F)
Date : Dr. SUDHARANI BAIRRAJU

Consultant : _____ Dept : _____

e : _____ Date of Discharge : _____ Time : _____

Room : _____ ward : _____ Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
21/7/26	11:55 AM	Gyne Key	IVF OT	Sudharani
21/7/26	12:15 PM	IVF OT	Gyne Key	Sudharani
21/7/26	2 PM	Gyne Key	IVF OT	Sudharani

Cross Consultation Visit

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

[illegible][illegible][illegible][illegible][illegible]

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

.....

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.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

BAH-00607458 IP5-00176698
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20-07-1996 30 Y 0 M 1 D (F)
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PAIN ASSESSMENT FORM

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BirthRight
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Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
21/7/26	11AM	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	— Nil —	
				☐ 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		
				☐ 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:

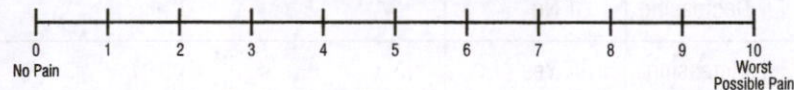
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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 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

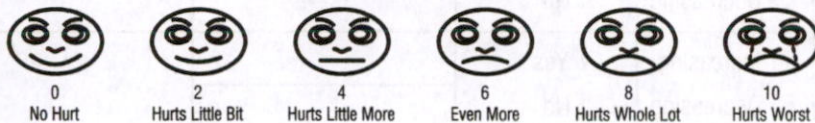
Numerical Pain Scale (Obstetric and Gynecology)



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, SaQ	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

Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
21/7/26 11 AM	☒ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☒ Per-Op ☐ Post Op	Patient came for frozen embryo transfer.	Frozen embryo to transfer without complication	Frozen embryo transfer		☒ Nursing ☐ Others:
21/7/26 11:30 AM	☐ Medical ☒ Nursing ☐ Others:	☐ Initial ☐ Modified ☒ Per-Op ☐ Post Op	Patient has come for frozen embryo transfer.	vitals checked Infused doctor	Shifted patient to OT accordg to doctors order		☐ Medical ☐ Others:
21/7/26 12:30 PM	☒ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	monitors vitals	Safe Discharge	Discharge medications		☐ Medical ☒ Nursing ☐ Others:
21/7/26 12:35 PM	☐ Medical ☒ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	Procedure has done under ultrasound guidance, under aseptic precautions	Advised sent to Patient for 30 mins	Explained about discharge medication as per doctors order.		☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:



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: NADA ☒ 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	T. FOLIC ACID	5mg	PO	OD		☒ C ☐ DC
2	T. ASPIRIN	150mg	PO	OD		☒ C ☐ DC
3	T. ASPIRIN	150mg				☐ C ☐ DC
4	T. ESTROGET	2mg	PO	TID		☒ C ☐ DC
5	INTHALD	100mg	in	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. Akhila

Date & Time: 21/7/26 at 11:20 AM

Nurse Name & Signature: Swaroopa

Date & Time: 21/7/26 at 11:20 AM

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20-07-1996 30 Y 0 M 1 D (F)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>21/7/26</u> 11 AM	patient came for frozen embryo transfer vitab PR - 79 bpm BP - 103/67 mmHg SpO2 - 100% RR - 19 cpm	plan. — Can be shifted to OT <u>debut</u>
<u>21/7/2026</u> 2:30 PM	patient stable Discharge medications explained.	plan — can be discharged <u>debut</u>

Dr. SUDHARANI BAIKIAS

[illegible]

CONSENT FORM FOR ASSISTED REPRODUCTIVE TECHNOLOGY PROCEDURE



Patient Name: T. Achila Age 30y UHID No. BAH-00604758

I/We have requested the clinic Birth Right 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.

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: AKHILA THALLAPALLY

Husband Name: SHRIKAR BOINPALLY

Signature: [Signature]

Signature: [Signature]

Date & Time: 21-07-2026 @ 10:38 AM

Date & Time: 21-07-2026 @ 10:38 AM

Endorsement by the ART Clinic:

I/we have personally explained to Akhila and Shrikar 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: AKHILA THALLAPALLY

Husband Name: SHRIKAR BOINPALLY

Signature: [Signature]

Signature: [Signature]

Date & Time: 21-07-2026 @ 10:38 AM

Date & Time: 21-07-2026 @ 10:38 AM

Name, Address and Signature: [Signature]

of the Witness from the clinic Swaroopa

Date & Time: 21/7/26 at 11 AM

Name of the ART Clinic: _____

Name of the Doctor: Dr. Sudharani B

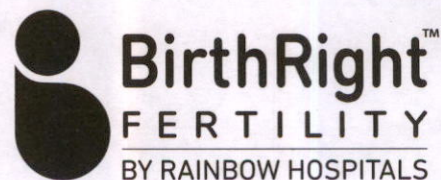
Address: _____

Signature: [Signature]

Date & Time: 21/7/26 at 11:10 AM

Date & Time: 21/7/26 @ 10:45 AM

CONSENT FORM FOR FROZEN EMBRYO TRANSFER



Patient Name: T. Archila Age: 30y UHID No: BAH-00607458

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: AKHILA THALLAPALLY

Spouse Name: SRIKAR BOINPALLY

Signature: [Signature]

Signature: [Signature]

Date & Time: 21-07-2026 10:38Am

Date & Time: 21-07-2026 10:38Am

Endorsement by Assisted Reproductive Technology Clinic:

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

Name of the Doctor: Dr. Sudharani B

Signature: [Signature]

Date & Time: 21/7/26 @ 10:45Am



KLIST

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

Patient Name : *Akhila T* Age : *30y* Gender : *F*
UHID No. : *BAH-006074* Surgery Name : *LET*
Date : *21/7/16* In-time : *11:55Am* Out-time : *12:15pm*

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: <i>12pm</i>
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, <i>10-15m</i> Anticipated Blood Loss? <i>0</i> ☐ 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 : <i>[Signature]</i>		
Name : <i>Swasop</i>		

Before Patient Leaves Operating Room

SIGN OUT		Time: <i>12:20pm</i>
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 : <i>[Signature]</i>		
Name : <i>Dr. Sudharani B</i>		



POST PROCEDURE CARE PLAN

Date & Time: 21/7/26 at 12:30p

Patient Name: Akhila T Age: 30y UHID No:

Procedure Done: FET done 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-HCG after

12 days, Anted support

Name of the Doctor: Dr. Sudharani

Signature: [Signature]

Date & Time: 21/7/26 @ 12:30pm

Note: Plan of care will be readjusted if necessary