Patient Sticker

MAH-00390589 IP5-00176096
Mrs FAUZIYA SHAIKH
03-08-1997 28 Y 11 M 5 D (F)
Dr. SUDHARANI BAIRRAJU

Rainbow® Children's Hospital
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SURGERY DETAILS

Date : 08/7/26

Patient Name: Mrs. fauziya shaik Date of Birth: 03/08/1997 Age: 28y

Gender: female Ward : IVF OT UHID No.: MAH - 00390589

Date of Surgery: 08/7/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Oocyte detrieval

Time in : 09:15 Am Time Out : 09:30 Am

	NAME	AMOUNT
1. Surgeon	Dr. Sudharani B	
2. Anaesthetist	Dr. Tejaswini	
3. Assistant Surgeon	Dr Akhila.	
4. OT Technician	Dr. Prashanth	
5. Circulating Nurse		
6. Assistant Nurse	Sis. Swaroop.	

Special Equipment:
☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☑ Others ultrasound guidlie
R265-033817

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 5-0009692902/902 Order by: Swaroop.

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

MAH-00390589 IPS-00176096
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Oocyte Retrieval (D)

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CONSUMABLES OF OT

Circ ..... Technician : Prashanth Date : 08/7/23449 Time : 9:15 Am

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			Major Pack			Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads (A) / P / N		3				Suction Catheter		
HME filter : A / P / N						Feeding Tube		
Syringes : 10 cc		3.				Vaccum Suction Set		
05 cc		1.	Gloves			Surgical Gloves		
02 cc		2				Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade			Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL		1.	Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml		1	Koochies					
Inj Emeset		1.	Ointments			Mother gown	01	01
midazolam		1	Suction Catheter			proto gloves	02	02
Fentanyl		1	Cap, Mask	5/5	5/5	Inj. Augmentil 2g	01	01
Morphine			Gauze Pack	02	02	Camera covers	01	01
Ketamine			Mop Pack			Intra fix	01	01.
Propofol		2	Steristrip			Three way	01	01.
Rocuronium			Underpad			D-wate	02	02
Glycopyrolate			Draw sheet	0		20G Cannula	01	01
Myopyrolate			Abgel			Hip leggings	01	01
Ondansetron			Foleys catheter			100 mcg Asthal	01	01
Pencan 25g/ Spinal Needle 22			Urobag			foot cover	02	02
Bupivacaine 0.25%			Chest Drainage Catheter			Upside Suit	01	01
Bupivacaine 0.25%(Heavy)			Romodrain bag			Transofix	01	01
Antibiotics			Bandage			Encore glove 6½	01	01
Nayal prans Eltor (A)		1	Tegaderm			Encore glove 7	01	01
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					
Ephedrine		1	Microshield					
			Cotton Balls					
			Latex Gloves					
			Ramdione Scrub					
			Saral					

Surgeon Dr. Sudharani B Anaesthesiologist Dr. Tejaswini Nurse Swaroopa Prashanth OT Technician

Order No. : 5-0009b2e99/898 Ordered by : Swaroopa.

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 : IP5-00176096 **Admit Date** : 08-Jul-2026 **Admit Time** : 08:13 AM **UHID** : MAH-00390589

Patient Details :

Patient Name	: Mrs FAUZIYA SHAIKH	**Age**	: 28 Y 11 M 5 D
Guardian	: SELF	**DOB**	: 03-08-1997
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: Erragadda Hyderabad Telangana INDIA 500018	**Phone No**	: 7208020320
		E-mail	: no@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : PRE OP 404 **Ward Name** : 4F-OT COMPLEX

Room No : PRE OP 404 **Admission Type** : First Visit

Contact Details :

Name : SELF **Relationship** : C/O

Contact Address : Erragadda Hyderabad Telangana INDIA 500018 **Phone No** : / 7208020320

Vishakha
Signature

Doctor Details :

Doctor Name : Dr. SUDHARANI BAIRRAJU **Specialisation** : INFERTILITY

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

Payment Mode : Cash **Deposit Amount** : 0.00

Payor Name : SELFPAY

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ACTIVITY RECORD FOR BILLING

Name :_____

UHID N MAH-00390589 IP5-00176096
Mrs FAUZIYA SHAIKH
03-08-1997 28 Y 11 M 5 D (F)
Dr. SUDHARANI BAIRRAJU
_____Consultant: _____ Dept : _____

Date of :_____Date of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
08/7/26.	9:00	Gynec Rem	IVF OT	Swaroop.
08/7/26	9:35Am	IVF OT	Gyn Re	Swaroop.
08/7/26.	01pm	Gynec Rem	Billing	Swaroop.

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
08/7/16	Cardiac Monitor	8:15Am	12pm	5-0009692-901	
08/7/16	Ultrasound Machine	9:15Am	09:30Am	R205-0338/7	

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
08/06	Rt Cannulation	01	5-0009692902	
01/07/26	PAC (on Basis)		5-0009692902	

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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OUTPATIENT NURSING ASSESSMENT FORM

Date: 08/8/26 Time: 08:15 Am

Chief Complaint: —

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

If yes, identify —

Vital Signs: Temperature: 98.6°F Pulse: 67 b/min Respiratory Rate 17 b/m

BP 111/69 mmHg SpO_2 100% Weight 47kg Height 158 cm BMI 18

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: Saroop

Date & Time: 08/8/26 at 8:30 Am

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PAIN ASSESSMENT FORM

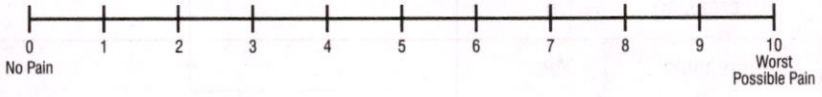
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
08/7/26	9AM	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	—Nil—	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ 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
8/7/26 9AM	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	patient came for oocyte retrival	oocyte retrival without complication	oocyte retrival Anaesthesia		☑ Nursing ☐ Others:
08/7/26 9:05AM	☐ Medical ☑ Nursing ☐ Others:	☐ Initial ☐ Modified ☑ Per-Op ☐ Post Op	Patient has come for oocyte Retrieval	Placed ID Band. vitals checked. IV cannula placed	shifted patient to OT upon doctors orders		☐ Medical ☐ Others:
8/7/26 9:35AM	☑ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Monitor vitals, W/b bleeding P/V	Safe Discharge	Early Ambulation Discharge medications		☐ Medical ☑ Nursing ☐ Others:
08/7/26 9:40Am	☐ Medical ☑ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☑ Post Op	Procedure has done under ultrasound guidline, under aseptic precautions.	Advised rest for abs. Vitals monitoring. for abs.	Explained about medication as per doctor's orders.		☐ 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	08/7/26 8:30Am		
		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	20		
	No	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:			20		
		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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7/26 9 Am	patient came for ocupe retrieval PR – 67 bpm BP – 111/69 mmHg SpO2 – 100% RR – 18 cpm CVS / NAD RS	plan Shift to OT for oocyte retrieval – NBM – PAC – IV antibiotics [signature] [signature] 9.50 am 8/7/26
8/7/26 2 pm	pt stable discharge medications explained.	plan can be discharged [signature]

Docu. No. : RCHBH /FRM / CLINICAL / 088

(P.T.O)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Docu. No. : RCHBH /FRM / CLINICAL / 088

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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 : Dr. Sudharani. B

Date & Time : 8/7/26 @ 8.30 Am

Nurse Name & Signature: Sis. Swaroopa R B

Date & Time : 08/7/26 at 08:30 Am

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CHART

Date of Admission: 08/7/26 Drug Allergies: NKDA ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name ..... ature .....

Patient Sticker

REGULAR PRESCRIPTIONS

Weight. .... Ward. ....

DRUG :

Dose	Route	Frequency	Start Date

Date ▸ Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Date ▸ Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Date ▸ Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Date ▸ Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Patient Stic

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Weight. 62kg Ward. ICU

VARIABLE DO

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

VARIABLE DOSE

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
8/7	08:36AM	MOXICILLIN CLAVULANATE	1.2g	IV		
8/7/26	09:20AM	Inj PARACETOMOL	1gm	IV		

MAH-00390589 IP5-00176096
Mrs FAUZIYA SHAIKH
03-08-1997 28 Y 11 M 5 D (F)
Dr. SUDHARANI BAIRRAJU

I.V. FLUIDS CHART

Weight. 40kg Ward. ICU-07

Da	of I.V. Fluid (= Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
08/7/26	8:20am / ORL	IV	ff	A		08/7/26		

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

FORM-6

CONSENT FORM FOR ASSISTED REPRODUCTIVE TECHNOLOGY PROCEDURE

BirthRight™ FERTILITY BY RAINBOW HOSPITALS

Patient Name: Mrs. Fauziya Shaik Age 29y UHID No. PAH.0039058g

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.

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

3. I/ We fully consent to these procedures and to the administration of such drugs and anesthetics as may be necessary. We also consent to any other operative measures, which may be found to be necessary in the course of the treatment.
4. I/ We have been told of the risks of ultrasound directed follicle aspiration.
5. I/ We are aware that we are free to withdraw or vary the terms of this consent until the gametes and/ or embryos have been used in accordance with my/ our wishes. I am aware that this will have to be a written request.
6. There is no certainty that a pregnancy will result from these procedures even in cases where good quality embryos are transferred.
7. If a clinical pregnancy does result from assisted conception treatment, I/ we understand there is an accepted risk of multiple pregnancy, an ectopic pregnancy or of a miscarriage. I/ We understand that as in natural conception, there is a small risk of fetal abnormality.
8. Medical and scientific staff can give no assurance that any pregnancy will result in the delivery of a normal living child.
9. The uncertainty of the outcome of the procedure has been fully explained to me/ us.

   I/ We fully understand the risks of treatment including;
   (i) It is not possible to guarantee that a follicle will develop in a given cycle and that occasionally cycles have to be abandoned before egg retrieval.
   (ii) There is a risk that spontaneous ovulation can happen prior to/or during the egg retrieval.
   (iii) An egg is not always recovered from a follicle at the time of egg retrieval.
   (iv) Any eggs may be collected and fertilization of any collected eggs will occur.
   (v) Is a risk that the cycle will be abandoned before Embryo Transfer if there is failure of fertilization, abnormal fertilization or failure of the embryo to cleave (divide).
   (vi) A pregnancy may result from treatment.
   (vii) Treatment may be abandoned at any time if there are problems in the laboratory or with the culture system.

10. I/ We have been fully informed of all that is involved with the In Vitro Fertilization / Intracytoplasmic Sperm Injection technique and have been advised regarding the chances of success, the possibility of multiple pregnancy occurring and other possible complications of treatment by the doctor. I/ We have also received information relating to treatment by these techniques in order to assist us to become more fully aware of what is involved.

Informed Consent:

The above information has been read out and explained to me in own language (in the event that it is necessary), and it has been explained to me that this form has the authority of a legal document. We have had the opportunity to ask questions, all of which have been answered to my satisfaction.

Unreservedly and in my full sense I hereby give my fully informed and non-coerced consent to undergo any or all of the aspects of treatment as noted above by any means as deemed appropriate by the professional team of BirthRight Fertility by Rainbow Hospitals. We understand that we will become the legal parents of any resulting child and the child will have all the normal legal rights on us. With our signatures, we certify that we understand the implication of these procedures.

The degree of procedure proposed has been explained to me and my spouse in detail including the complications and the associated mortality and morbidity. The benefits and risks of this procedure have been explained to me. I have also been told about the alternatives available for this procedure including the advantages and disadvantages of the alternative.

Wife / Woman Name: Fauziya Shaikh

Signature:

Date & Time: 08/7/26 at 8:15Am

Husband Name: Aakash Gajare

Signature: vishakha

Date & Time: 08/7/26 at 8:15Am

Endorsement by the ART Clinic:

I/we have personally explained to Fauziya and vishakha 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: Fauziya. Shaikh.

Signature:

Date & Time: 08/7/26 at 8:15Am

Husband Name: vishakha Gajare (friend)

Signature: vishakha

Date & Time: 08/7/26 at 08:15Am

Name, Address and Signature :

of the Witness from the clinic Swaroopa.

Date & Time: 08/07/26 at 8:30Am

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

Name of the ART Clinic:

Address:

Date & Time : 08/7/26 at 8:35Am

Name of the Doctor: Dr. Sudhaparna

Signature:

Date & Time: 08/7/26 at 08:35Am

FORM - 13

CONSENT FORM FOR THE DONOR OF OOCYTES

BirthRight FERTILITY BY RAINBOW HOSPITALS

I, Ms / Mrs Fauziya Abdul Rehaman Shaikh

Address: C/403 4th floor Haider Baug Bulding near Mumbra police Station Narayan Nagar, Thane, Maharastra - 400612

Mobile number 7208020320 Aadhar card number 234291791239

Willingly consent to donate my oocyte to couple/individual who are unable to have a child by other means. At this stage and to the best of my knowledge I am free of any infectious diseases or genetic disorders.

I have had a full discussion with Dr Preethi Reddy. G on 27/06/2026

I have been counselled by Dr. Meghna on 27/06/2026

(I understand that there will be no direct or indirect contact between me and the recipient, and my personal identity will not be disclosed to the recipient or to the child born through the use of my gamete.. If applicable)

I understand that I shall have no rights whatsoever on the resulting offspring and vice versa.

I understand that the method of treatment may include:

1. Stimulating my ovaries for multifollicular development.
2. The recovery of one or more of my eggs under ultrasound-guidance or by laparoscopy under sedation or general anesthesia.
3. The fertilization of my oocytes with recipient's husband's or donor sperm and transferring the resulting embryo into the recipient.

I understand and accept that the drugs that are used to stimulate the ovaries to raise oocytes have temporary side effects like nausea, headaches and abdominal bloating. Only in a small proportion of cases, a condition called ovarian hyper stimulation occurs where there is an exaggerated ovarian response. Such cases can be identified ahead of time but only to a limited extent. Further, at times the ovarian response is poor or absent in spite of using a high dose of drugs. Under these circumstances, the treatment cycle will be cancelled.

I hereby consent to the process of donation and related procedures mentioned earlier. I have also been informed of complications (including damage, injury, infertility or mortality/death), risks and all related matters that may arise from the said procedure and having understood the same, I hereby provide my informed consent for the procedure(s) outlined herein.

I hereby agree that all the information being provided, hereunder is being provided with consent for the purposes of the procedure of In Virto Fertilization and related/ancillary procedures. Such information includes my identity proofs and my personal details and I hereby authorise the usage, storage, processing of the same for the purposes mentioned herein.

In the event of any complication or any other circumstance in which I am rendered unable to provide instructions, then you may reach out to the person below mentioned and keep them informed. In any event, the said authorised person shall also be duly informed of the process (during the process).

Wife/Women Name: Fauziya Abdul Rehaman

Address: Baug Bulding, near Mumbra policeStation Narayan Nagar, Maharastra - 400006

Signature: [signature]

Date & Time: 27/06/2026 at 2pm

Doc. No.: BRFRH /FRM /CLINICAL / 077

(P.T.O)

Endorsement by the ART Clinic:

I/we have personally explained to Tanzila Abdul Rehman ... the details and implications of her signing this consent / approval form, and made sure to the extent humanly possible that she understands these details and implications.

Name of the Witness from the clinic: .....

Address: BirthRight Fertility by Rainbow Hospitals, Kondapur Survey No. 09 Part, Whitefields, Kondapur, Serilingampally Mandal, Rangareddy Dist, Hyderabad, India - 500084.

Signature: .....

Date & Time: 22/6/26 at 2:30pm

Name of the Docter: Dr. Preethi Reddy. G for

Signature: .....

Date & Time: 22/6/26 at 2:30pm

Name of the ART Clinic: BirthRight Fertility by Rainbow Hospitals, Kondapur Survey No. 09 Part, Whitefields, Kondapur, Serilingampally Mandal, Rangareddy Dist, Hyderabad, India - 500084.

Date & Time: 22/6/26 at 2:30pm

Name of the ART Bank: Cryo Bree Sai ART Bank

Address: 12-105, Road No. 1, PELT Colony, Medipally, Canara Bank near, Bachupally, Hyderabad, Telangana - 500098

Note: (This form will be filled by the ART clinic but a copy of the same has to be maintained by the ART bank in case the donor was recruited and screened by the bank).

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MAH-00390589 IP5-00176096
Mrs FAUZIYA SHAIKH (F)
03-08-1997 28 Y 11 M 5 D
Dr. SUDHARANI BAIRRAJU

CONS[ENT FOR AN]AESTHESIA

Patient Name : Fauziya Age : 28yrs Gender : Male ☐ Female ☐

UHID NO: Surgeon Name : Dr. Preeti

Anaesthesiologist : Dr. Swathi Operative procedure planned : oocyte retrieval

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief without numbness can be achieved by infusing weak solutions of local anesthetics arid narcotic drugs to particular parts of the body after surgery or injury, using catheters.

Specific High Risk (s) : The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

- ☐ Heart disease
- ☐ Hepatic disorders
- ☐ Incapacitating Cronic Obstructive Pulmonary Disease
- ☐ Hypertension
- ☐ Shock
- ☐ Diabetes mellitus
- ☐ Multiple organ failure
- ☐ Others : hypotension, bradycardia, tachycardia, post op oxygenation
- ☐ Renal failure
- ☐ Polytrauma / Renal Tubular Acidosis

(Cross-out if not applicable)

- Doctor to document in medical record also if necessary

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient the above mentioned operation / Diagnostic / Therapeutic procedures.

I authorize and give consent for anaesthesia (☐ Regional / ☐ General Anesthesia / ☐ Monitored Anesthesia Care as considered appropriate by the anaesthesia team.

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, risk, benefits and alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anesthesia.

I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, asthmatic reactions, headaches.

I authorize the anaesthesia team to perform any additional procedures (for example, Cental Venous Pressure line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter in need arises.

I understand that the above mentioned consultant anesthesiologist or occasionally a colleague puted by him / her will administer the Anaesthesia.

I have been explained all my queries in the language understood by me.

Patient / Patient Attendant :

Signature : [signature]

Name : Fauziya

Relationship with Patient: Self.

Date & Time : 8/7/26 8:35Am

Witness :

Signature : Vishakha

Name : Vishakha

Date & Time : 8/7/26 Am

Doctor (who is taking the consent) :

Signature : [signature]

Name : Dr. Neepuy

1/7/2026

Docu. No. : RCH / FRM / CLINICAL / 021

MAH-00390589 IP5-0017[illegible]
Mrs FAUZIYA SHAIKH
03-08-1997 28 Y 11 M 5 D (F)
Dr. SUDHARANI BAIRRAJU

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Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Fauziya Age: 28yrs Sex: female UHID.No : —

Date: 1/7/2026 Time: 12:45pm. Proposed Operation: oocyte retrieval

Diagnosis: DONOR.

B.P / CRT: 118/75 H.R: 68 Weight: 47.5kg. ASA Physical Status: ☑1 ☐2 ☐3 ☐4 ☐5

Laboratory Data:

Hgb: 10.9.	Glucose:	Protein:	HIV:	X-Ray:
PCV:	Urea: 0.7	Alb:	HBS Ag: -ve.	ECG:
WBC: 4440	Creat:	Total Bill:	HCV:	2D Echo:
Plate: 2.9.	Na:	Dir. Bill:	Blood group: B+	Stress/Anglo:
PT:	K:	LDH:	T3	Other:
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH 4.7	
	Cl -:	SGOT/SGPT:		

Allergies: NKDA.

Medical History: CVS : NAD

RESP : Diabetes : NAD

CNS :

Renal : 2016

Hepatic / GE : → 2 LSCS Physical Activity:

Others : 2022

Past Anaesthetic History:

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: 3 fingers Mentohyoid Distance: N Neck: N Teeth: N.

Lungs : AEBE clear

Heart: NSS20

CNS:

Pregnant: ☐ Yes ☐ No ☐ NA | Venous Access Site : | Spine Exam for regional : 15/15 N

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

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

Signature: Name: Dr. Noopur

Docu. No. : RCH/ERM / CLINICAL / 044

-00176096
M 5 D (F)
JJ

ANAESTHESIA CHART

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...ment:

...on: ☐ Yes ☑ No | Fasting Status: confirmed

☑ Patient Identified | ☑ Consent Present | ☑ Chart Reviewed

B.P / CRT: 126/92mmHg | SpO_2: 100% | R.R: 18/min | Last Feed: >6hrs

DONOR | Operation: Oocyte Retrieval | Date: 8/7/26

dharani Bairaju | Anaesthesiologist: Dr. Tejasini | Technician: Prashanth

9:30AM

1mg

50mcg + 50mcg

50mg + 20 + 20 + 10mg.

PA... OL 1g.

FIO_2 100 100

$ETCO_2$

ECG

Temperature

Urine Output

Fluids / Blood: RINGER LACTATE 500ml.

Antibiotic

Suppository

Blood Loss

NOTES

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

Tourniquet on Time
Tourniquet off Time
Throat Pack In
Throat Pack Out

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

LAB Values: ABG / GRBS / Others

☑ Equipment Checked and Functional
☑ BP
☑ Cuff Site: (L) UL
☐ Art Site: ....
☐ EKG Lead
☐ Temp Site
☐ FIO_2 Monitor
☐ Agent Monitor
☑ Pulse Oximeter
☑ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position: lithotomy
☑ Pressure Points Checked

Eye Care:
☐ Oint
☐ Tape
☐ Padding
☐ Awake

Temp:
☐ HME ☐ Fluid Warmer
☐ Cling Film ☐ OH Warmer
☐ Hugger's ☐ Cotton Wool
☐ Other

Times:
Anaes Start: 9:15AM
OP Start: ↓
OP End: ↓
Leave OR: 9:30AM.

Anaesthesia:
☐ GA
☑ Monitored Anaesthesia Care
☐ Regional

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

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

NASAL PRONGS c ETCO2.

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

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

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

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

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

Name of the Doctor: Dr. Tejasini

Signature of the Doctor: [signature]

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Mrs FAUZIYA SHAIKH
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Dr. SUDHARANI BAIRRAJU

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POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Sis Swaroopa. Time Received : 9:40 AM Time Discharged : 12:30 pm

Time	9:35AM	9:50AM	10:05AM	10:35AM	11:05AM
BP (approx.)	120/65	125/65	120/55	115/65	110/65
Resp	✓	✓	✓	✓	✓
SPO_2	99%	99%	100%	99%	99%

✓ RESP • PULSE > < BLOOD PRESSURE

IV Cannula Site : Rt hand.

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

Vomiting : ☐ Yes ☑ No Drug: ....

NG Tube : ☐ Yes ☑ No

Drain: ☐ Yes ☑ No

Urinary Catheter: ☐ Yes ☑ No

Chest Tube: ☐ Yes ☑ No

Nil Oral ☑ Yes ☐ No

IV Fluids: O RL on flow

Oral Feeds: Allow

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

SCORING INTERPRETATION

A Minimum Total Score of 8 is Required for Discharge

Exceptions to this, are to be explained in the space below by the Discharging Physician:

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
08/7/26.	9:30AM	- 0 -	— Nil —	[signature]

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

Anaesthesiologist Name : Dr. Tejaswini

Anaesthesiologist Signature: [signature]

Date & Time: 08/7/26 at 12pm

PACU Nurse Name : Swaroopa

PACU Nurse Signature: [signature]

Date & Time: 08/7/26 at 9:35AM

Reassessment Frequency
1. Every eight hours for all hospitalized patients
2. For post surgical patient, Patient with chronic ...
a. Every 2 hours for first 24 hours
b. After 24 hours every ... hours
... pain relieving ...

Transfer ... 60 min ...

Date & ...

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : ....

Any other issues :

a) ....

b) ....

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

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

Time : ....

Tip Inspected : ....

MAH-00390589 IP5-00176096
Mrs FAUZIYA SHAIKH
03-08-1997 28 Y 11 M 5 D (F)
Dr. SUDHARANI BAIRRAJU

Surgeon : Dr. Sudharani
Asst. Surgeon : Dr. Akhila.
Anaesthetist : Dr. Tejas.
Scrub Nurse : Swaroopa. G.

Patient Name : fauziya Shaik Age : 28y Gender : F
UHID No. : MAH-003900589 Surgery Name : Oocyte Retrieval
Date : 08/7/26 In-time : 09:10 Am Out-time : 09:35 Am

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 8:35 Am

Patient Has Confirmed
- Identity ☑ Yes ☐ No
- Site ☐ Yes ☑ No
- Procedure ☑ Yes ☐ No
- Consent ☑ Yes ☐ No

Site Marked ☐ Yes ☐ No ☐ NA

Anaesthesia Safety Check Completed ☑ Yes ☐ No

Pulse Oximeter on Patient & Functioning ☑ Yes ☐ No

Does Patient have a:
- Known Allergy? ☐ Yes ☑ No

Difficult Airway / Aspiration Risk?
- Yes, & Equipment / Assistance Available ☐ Yes ☑ No

Risk of > 500ml Blood Loss (7ml/kg In Children)?
- Yes, and Adequate Intravenous Access and Fluids Planned ☐ Yes ☑ No ☐ NA
- Blood Units Reserved ☐ Yes ☑ No ☐ NA

Has Antibiotic Prophylaxis been given within the last 60 minutes? ☑ Yes ☐ No ☐ NA

Signature : [signature]
Name : Dr. Tejasvini

Before Skin Incision ➤➤

TIME OUT Time: 9:15 Am

Confirm all team members have introduced themselves by Name and Role ☑ Yes ☐ No

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm
- Correct Patient (Check ID Band) ☑ Yes ☐ No
- Correct Site ☑ Yes ☐ No
- Correct Procedure ☑ Yes ☐ No

Anticipated Critical Events

Surgeon Reviews:
- What are the Critical or Unexpected Steps, Operative Duration, 10-15 mins - Bleeding.
- Anticipated Blood Loss? 0-5ml ☐ Yes ☐ No ☐ NA

Anaesthesia Team Reviews:
- Are There Any Patient-specific Concerns? ☐ Yes ☑ No ☐ NA

Nursing Team Reviews:
- Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☑ Yes ☐ No ☐ NA
- **Is Essential Imaging Displayed?** ☐ Yes ☐ No ☑ NA
- Power Supply, Earthing, Power Backup and functioning of equipment checked. ☑ Yes ☐ No

Signature : [signature]
Name : Swaroop.

Before Patient Leaves Operating Room

SIGN OUT Time: 09:30 Am

Nurse Verbally Confirms with the Team:
- The Name of the Procedure Recorded ☑ Yes ☐ No
- That Instrument, Sponge and Needle Counts are Correct (or Not Applicable) ☑ Yes ☐ No ☐ NA
- The Specimen is Labelled (including patient name) ☑ Yes ☐ No ☐ NA
- Whether there are any Equipment Problems to be addressed ☐ Yes ☐ No ☑ NA

To Surgeon, Anaesthetist and Nurse:
- What are the key concerns for recovery and management of this patient? ☐ Yes ☑ No

Signature : [signature]
Name : Dr. Sudharani B

Patient Sticker

MAH-00390589 IPS-00176096
Mrs FAUZIYA SHAIKH
03-08-1997 28 Y 11 M 5 D (F)
Dr. SUDHARANI BAIRRAJU

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date : 08/7/26

To Be Filled In By Assigned Nurse :

Department : IVF OT Duration of Procedure : 10-15 mins

Name of Surgeon : Dr. Sudharani-B Date of Admission : 08/7/26

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

		Staff Signature
1.	Antibiotic given prior to surgery ? ☑ Yes ☐ No ☑ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☑ Yes ☐ No Name of the Antibiotic : INJ AUGMENTIN 1.2gm IV	Surya.
2.	Hair Removal ☑ Yes ☐ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☐ Operating Room ☑ Other : Home Skin preparation done (cleanse surgical area with antiseptic agent)? ☑ Yes ☐ No	Surya
3.	Patient's body temperature immediately post operation (Recovery Room) 36.5 °C ☐ Oral Or ☑ Axilla (Goal : 36-37 °C)	Surya
4.	Name of doctor or staff administering the antibiotic : Sis. Swaroop. Date & Time of antibiotic administration : 08/7/26 at 08:36 AM Date & Time procedure started : 08/7/26 at 09:15 AM	Dr

- Ensure form is filled in completely by assigned staff whenever patient had surgery
- If any bundle care criteria has not been observed or unmet, assigned staff must inform infection control nurse for management
- All forms (Bundle care and when required SSI form) are completed properly
- Forms must always be kept in Infection Control folder in respective department

MAH-00390589 IP5-00176096
Mrs FAUZIYA SHAIKH
03-08-1997 28 Y 11 M 5 D (F)
Dr. SUDHARANI BAIRRAJU

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POST PROCEDURE CARE PLAN

Date & Time: 8/1/2026 @

Patient Name: Mrs. Fauziya Shaikh Age: 28y UHID No: MAH-00390589.

Procedure Done: Oocyte retrieval.

Post Procedure Diagnosis: Oocyte retrieval done

Post-Operative Monitoring Parameters / Frequency: Monitor PR, BP, RR, SpO2 every 5min for 15min, every 15min for 120mins, then till discharge

Special Patient Positioning and Requirements: —

Nutritional Instructions: Bland Diet.

When to Start Mobilization: after Consciousness.

Special Referrals: —

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

Any Other Post-Operative Care Needed including Required Follow Up: —

Name of the Doctor: Dr Sudharani

Signature: Dr Sunil.

Date & Time: 8/1/2026 @

Note: Plan of care will be readjusted if necessary

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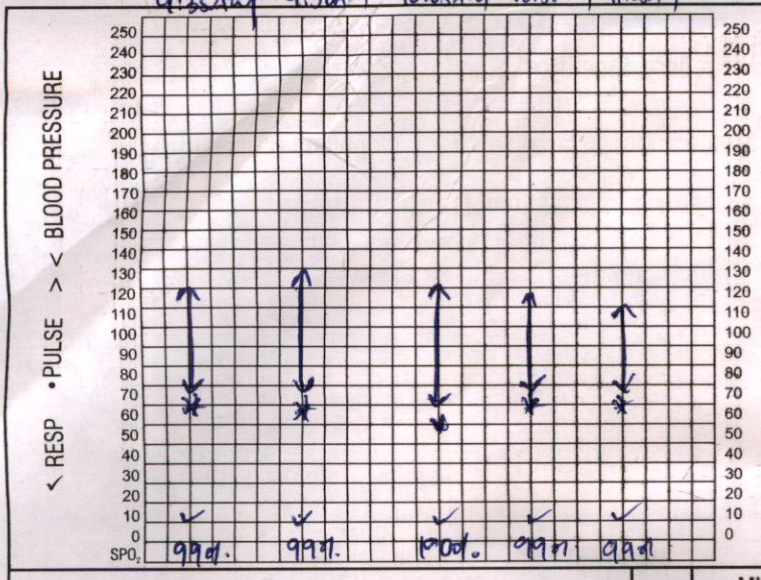
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Sis. Swaroopa. Time Received : 9:40AM Time Discharged : 12:30pm

9:35AM 9:50AM 10:05AM 10:35AM 11:05AM



IV Cannula Site : Rt hand.

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

Vomiting : ☐ Yes ☑ No Drug: .....
NG Tube : ☐ Yes ☑ No
Drain: ☐ Yes ☑ No
Urinary Catheter: ☐ Yes ☑ No
Chest Tube: ☐ Yes ☑ No
Nil Oral ☑ Yes ☐ No
IV Fluids: ORL onflow
Oral Feeds: Allow

POST ANAESTHESIA SCORE (Modified Aldrete Score)		IN	MINUTES 30	60	90	OUT	SCORING INTERPRETATION
Able to move 4 extremities voluntary or on command Able to move 2 extremities voluntary or on command Able to move 0 extremities voluntary or on command	= 2 = 1 = 0 ACTIVITY	1	2	2	2	2	A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to deep breathe & cough freely Dyspnea or limited breathing Apneic	= 2 = 1 = 0 RESPIRATION	2	2	2	2	2	
BP ± 20 of Pre Anaesthetic leve BP ± 20-50 of Pre Anaesthetic leve BP ± 50 of Pre Anaesthetic leve	= 2 = 1 = 0 CIRCULATION	2	2	2	2	2	
Fully awake Arousable on calling Not responding	= 2 = 1 = 0 CONSCIOUSNESS	2	2	2	2	2	
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0 COLOR	2	2	2	2	2	
	TOTAL	9	10	10	10	10	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
08/7/26	9:30AM	- 0 -	— Nil —	Swaroop

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

Anaesthesiologist Name : Dr. Tejaswini
Anaesthesiologist Signature: .....
Date & Time: 08/7/26 at 12pm

PACU Nurse Name : Swaroop
PACU Nurse Signature: .....
Date & Time: 08/7/26 at 9:35AM

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

Transferred to Unit by (PACU): Billing
Date & Time: 08/7/26 at 12:20pm

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : .....

Any other issues :

a) .....

b) .....

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

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

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

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....