Patient Sti

BAH-00521107 IP5-00176211
Mrs ANITHA SURAKANTI
12-10-1997 28 Y 8 M 28 D (F)
Dr. SUDHARANI BAIRRAJU

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SURGERY DETAILS

Date : 10/4/26

Patient Name: Anitha Surakanti Date of Birth: 12/10/1997 Age:

Gender: F Ward : IVF OT UHID No.: BAH-00521107

Date of Surgery: 10/4/26 ☐ OT -1 ☐ ~~OT -2~~ ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : frozen embryo transfer

Time in : 01:30pm Time Out : 01:45pm

		NAME	AMOUNT
1.	Surgeon	Dr Sudharani B	
2.	Anaesthetist	-	
3.	Assistant Surgeon	Dr Akula	
4.	OT Technician	-	
5.	Circulating Nurse	RS Swarupa	
6.	Assistant Nurse	Sy Mallesh	

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

R265-034305

Signature of the Surgeon

Signature of Circulating Nurse

Order No: S-0009696 260/260 Order by: Swarupa

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

BAH-00521107 IP5-00176211
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PET

CONSUMABLES OF OT

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Circulating Staff : ..... Technician : ..... Date : 10/7/26. Time : 01:30pm

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			Major Pack			Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : A / P / N						Suction Catheter		
HME filter : A / P / N						Feeding Tube		
Syringes : 10 cc						Vaccum Suction Set		
05 cc			Gloves			Surgical Gloves		
02 cc						Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade			Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL			Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml			Koochies					
			Ointments					
			Suction Catheter			Mother gown	01	01
Fentanyl			Cap, Mask	3/3	3/3.	Proto gown	01	01
Morphine			Gauze Pack			NLS 500ml	01	01
Ketamine			Mop Pack			10cc Syringe	01	01
Propofol			Steristrip			foot cover	02	02
Rocuronium			Underpad	01	01	Leucofix	01	01
Glycopyrolate			Draw sheet	02	02	Euroglove 6½	01	01
Myopyrolate			Abgel					
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
			Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set					
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution					
			Microshield					
			Cotton Balls					
			Latex Gloves					
			Ramdione Scrub					
			Saral					

Surgeon Dr Sadhaeib Anaesthesiologist Nurse Swaroop OT Technician

Order No. : 5-00096962577258 Ordered by : Swaroop

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

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 : IP5-00176211 **Admit Date** : 10-Jul-2026 **Admit Time** : 11:46 AM **UHID** : BAH-00521107

Patient Details :

Patient Name	: Mrs ANITHA SURAKANTI	**Age**	: 28 Y 8 M 28 D
Guardian	: Mr RAVINDER REDDY	**DOB**	: 12-10-1997
Gender	: Female	**Religion**	: Hindu
Occupation	:	**Martial Status**	: Married
Address (H)	: PLOT NO 56, BESIDE JJ HOSPITAL, 1ST FLOOR, A.Gs Staff Quarters Hyderabad Telangana INDIA 500045	**Phone No**	: 9391594511/ 9666281010
		E-mail	: ravireddysurakanti@gmail.com

Admission Details :

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

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

Contact Details :

Name : Mr RAVINDER REDDY **Relationship** : Husband

Contact Address : PLOT NO 56, BESIDE JJ HOSPITAL, 1ST FLOOR, A.Gs Staff Quarters Hyderabad Telangana INDIA 500045 **Phone No** : / 9391594511

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

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.

BAH-00521107 IP5-00176211
Mrs ANITHA SURAKANTI
12-10-1997 28 Y 8 M 28 D (F)
Dr. SUDHARANI BAIRRAJU

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Mrs ANITHA SURAKANTI**	**Age :**	**28 Y 8 M 28 D**
IP No:	**IP5-00176211**	**Sex:**	**Female**
Consultant:	**Dr. SUDHARANI BAIRRAJU**	**Ward/Bed No:**	**4F-OT COMPLEX/POST OP 412**

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned also consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science and that no guarantee have been made to me as the results of my evaluation and I or treatment.

I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal items and valuables.

"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process as per evidence based guidelines".

Note:
1 We do not allow use of medication brought from outside by the patient.
2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.
Receivers Signature:.....)

3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.
4 Financial and billing counseling has been done to me.

Signature of Patient/Relative:

Name:

Relationship: Husband.

Date: 10/7/26 Time: 11.47.

Witness Name:

Wittness Signature:

Patient Address:

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Hyderabad Telangana INDIA 500045

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ACTIVITY RECORD FOR BILLING

Name :_____

UHID N BAH-00521107 IP5-00176211
Mrs ANITHA SURAKANTI
12-10-1997 28 Y 8 M 28 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
10/4/26	01:20 pm	Gynaecology	IVF OT	
10/4/26	01:20	IVF OT	Gynaecology	

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
10/1/26	Monitor	11:30 AM	12:10pm	5-0009696259	
10/1/26	Ultrasound	01:35pm	01:45pm	R65-034305	

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Patient Sticker

BAH-00521107 IP5-00176211
Mrs ANITHA SURAKANTI
12-10-1997 28 Y 8 M 28 D (F)
Dr. SUDHARANI BAIRRAJU

BirthRight™ FERTILITY BY RAINBOW HOSPITALS

OUTPATIENT NURSING ASSESSMENT FORM

Date: 10/7/26 Time: 11:55 AM

Chief Complaint: -

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

If yes , identify -

Vital Signs : Temperature: 98.2°F Pulse: 84b/m Respiratory Rate 19b/m

BP 113/72mmHg SpO_2 100% Weight 52.1 Height 1.55 BMI 21.7

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: Swarna

Date & Time: 10/7/26 @ 12:20 pm

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PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
10/7/21	12pm	0	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	–	[signature]
10/7/21	11:00 pm	0	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	–	[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		

Re-assessment Frequency:

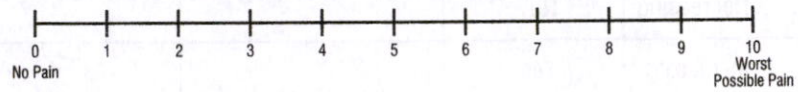
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
   a) At least every 2 hours for the first 24 hours
   b) Then every 4 hours.
   c) Prior to pain pain-relieving intervention.
   d) Within 30 – 60 minutes after pain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

Docu.No: RCHBH /FRM / CLINICAL / 152

(P.T.O)

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
10/7 12pm	☑ Medical ☐ Nursing ☐ Others:	☑ Initial ☐ Modified ☐ Per-Op ☐ Post Op	patient came for FET	FET done complication:	Frozen embryo transfer		☐ Nursing ☐ Others:
10/7/26 12:20pm	☐ Medical ☑ Nursing ☐ Others:	☐ Initial ☐ Modified ☑ Per-Op ☐ Post Op	patient came for frozen embryo transfer	given Cefuroxime positive	shifted to OT for FET		☑ Medical ☐ Others:
10/7/26 4:50pm	☑ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☑ Post Op	monitor vitals	Safe discharge	Discharge medication		☐ Medical ☑ Nursing ☐ Others:
10/7/26 05:55pm	☐ Medical ☑ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☑ Post Op	procedure done without any complications	given 2 hrs rest	explained about medicines and discharged acutely doctor advise		☑ 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	10/7/26 12pm			Fall Risk Grading		
		Score						
History of Falling (immediately or w/in 3 months)	Yes	25						
	No	0	0			**Risk Level**	**Morse Fall Score (MFS)**	**Action**
Secondary Diagnosis (more than one diagnosis)	Yes	15						
	No	0	0					
Ambulatory Aid	Furniture	30				Low Risk	0 - 24	Standard Fall Precaution
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0					
IV / Heparin Lock or Saline	Yes	20						
	No	0	0			Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
GAIT / Transferring	Impaired	20						
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0	0					
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0	0					
Total Morse Fall Scale Score:			0					
		Signature						

Tick (✓) whichever precaution taken.

Risk Level and Interventions

Low Risk (0 – 24) (Standard Falls Precautions)

- ☐ Ensure patients use their prescribed eye glasses if any, in the hospital
- ☐ Use chairs with arm rests
- ☐ Use safety straps on stretchers and wheelchairs while transporting patients

Moderate Risk (25-50) Apply all low risk intervention and

- ☐ Assist and/or supervise ambulation. Reinforce to always call for assistance
- ☐ Hourly safety check
- ☐ Assess patient after visitors, leave to ensure safety measures in place

High Risk (≥ 51) Apply all low and moderate risk interventions, and.

- ☐ Initiate constant observation by healthcare provider as appropriate to patient's needs

Patient

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/26 12pm	patient came for frozen embryo transfer. PR – 72b/m BP – 113/71mmHg SpO_2 – 100%. RR – 17/m	plan can be shifted to OT for ET
		Advised. Dr Sudharani 2. vappa
10/7/26 4pm	Pt stable discharge. medications explained.	plan can be discharged.
		Advised.

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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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	Inj HALD	100 mg	IM	OD		☐C ☐DC
2	T. METROL	400mg	PO	OD		☐C ☐DC
3	T. PROCYNORA	2mg	PO	TID		☐C ☐DC
4	T. ECOSPRIN.	150 mg	PO	OD		☐C ☐DC
5	T. FOLIC ACID	5mg	PO	OD		☐C ☐DC
6						☐C ☐DC
7						☐C ☐DC
8						☐C ☐DC
9						☐C ☐DC
10						☐C ☐DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : .....

Date & Time : 10/7/21 @ .....

Nurse Name & Signature: .....

Date & Time : 10/7/21 @ 12:10pm .....

FORM-6

CONSENT FORM FOR ASSISTED REPRODUCTIVE TECHNOLOGY PROCEDURE

BirthRight™ FERTILITY BY RAINBOW HOSPITALS

Patient Name: Anthe Sunakanti Age 28yr UHID No. BAH-105.21107

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.

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: Antha Sivakanth

Signature:

Date & Time: 10/4/26 P 12pm

Husband Name: Ravinder

Signature:

Date & Time: 10/4/26 P 12pm

Endorsement by the ART Clinic:

I/we have personally explained to Antha S and Ravinder 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: Antha Sivakanth

Signature:

Date & Time: 10/4/26 P 12pm

Husband Name: Ravinder

Signature:

Date & Time: 10/4/26 P 12pm

Name, Address and Signature :

of the Witness from the clinic Birthright fertility

Date & Time: 10/4/26 P 12.30 pm

Name of the ART Clinic: BirthRight Fertility by Rainbow Hospitals, Banjara Hills

Address: 8-2-120/103/1, Survey No. 403, Road No. 2, Banjara Hills, Hyderabad, Telangana-500 034.

Date & Time : 10/4/26 P 12:15pm

Name of the Doctor: Dr Sudharan B

Signature:

Date & Time: 10/4/26 P 12:10pm

CONSENT FORM FOR FROZEN EMBRYO TRANSFER

BirthRi
FERTIL
BY RAINBOW HO

Patient Name: Anthe Sivakali Age: 28yr UHID No: BAH-IVF-21107

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

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

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

We understand that

1. There is no certainty that a pregnancy will result from this procedure even in cases where good quality embryos are placed.
2. The pregnancy achieved may not always result in the delivery of a full term/normal living child.
3. There are inherent risks of unexpected complications with any medical procedure. I shall not hold the doctors, employees, management of the hospital liable should any such event arise during the procedure.

I have been given a suitable opportunity to take part in counselling about the implications of the proposed treatment. The type of anaesthetic proposed (general/regional/sedation) has been discussed in terms which I have understood.

Informed Consent:

The above information has been read out and explained to me in my own language (in the event that it is necessary) and it has been explained to me that this form has the authority of a legal document.

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

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

Patient Name: Anthe Sivakali
Signature:
Date & Time: 10/7/26 @ 12pm

Spouse Name: Surendra
Signature:
Date & Time: 10/7/26 @ 12pm

Endorsement by Assisted Reproductive Technology Clinic:

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

Name of the Doctor: Dr Sudhara B
Signature:
Date & Time: 10/7/26 @ 12:10pm

BAH-00521107 IP5-00176211
Mrs ANITHA SURAKANTI
12-10-1997 28 Y 8 M 28 D (F)
Dr. SUDHARANI BAIRRAJU

IST

Surgeon : Dr Sudharani B
Asst. Surgeon : Dr Akbal
Anaesthetist : –
Scrub Nurse : BS Swaroop

Patient Name : Anitha Shakil Age : 28y Gender : F
UHID No. : BAH-00521107 Surgery Name : Frozen embryo baf
Date : 10/7/26 In-time : 01:25pm Out-time : 01:50pm

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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 : AM

Name :.....

Before Skin Incision ➤➤

TIME OUT Time: 01:30pm

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? Difficult transfer. 10 mins –o– ☐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 : R

Name : Swaroop

Before Patient Leaves Operating Room

SIGN OUT Time: 01:45pm

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

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

Signature :.....

Name : Dr Sudharani B

Patient

BAH-00521107 IPS-00176211
Mrs ANITHA SURAKANTI
12-10-1997 28 Y 8 M 28 D (F)
Dr. SUDHARANI BAIRRAJU

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date : 10/7/25

To Be Filled In By Assigned Nurse :

Department : IVF OT Duration of Procedure : 10 mins

Name of Surgeon : Dr. Sudharani B Date of Admission : 10/7/25

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 :	
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	
3.	Patient's body temperature immediately post operation (Recovery Room) 36.5 °C ☐ Oral Or ☑ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : ..... Date & Time of antibiotic administration : ..... Date & Time procedure started : 10/7/25 at 11.30 am	

- 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

Patient Sticker

BAH-00521107 IP5-00176211
Mrs ANITHA SURAKANTI
12-10-1997 28 Y 8 M 28 D (F)
Dr. SUDHARANI BAIRRAJU

BirthRight™ FERTILITY BY RAINBOW HOSPITALS

POST PROCEDURE CARE PLAN

Date & Time: 10/7/26 @ 2pm

Patient Name: Anitha Suraketi Age: 28yr UHID No: BAH-00521107

Procedure Done: Frozen embryo transfer.

Post Procedure Diagnosis: Frozen embryo transfer (FET).

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: β-hCG after 12 days, Inteal support.

Name of the Doctor: Dr. Sudharani

Signature: for Dr. Sudharani

Date & Time: 10/7/26 @ 2pm

Note: Plan of care will be readjusted if necessary

Patient Sticker

BAH-00521107 IP5-00176211
Mrs ANITHA SURAKANTI
12-10-1997 28 Y 8 M 28 D (F)
Dr. SUDHARANI BAIRRAJU

BirthRight™ FERTILITY BY RAINBOW HOSPITALS

NOTES

☑ No Known Drug Allergies
☐ Drug Allergies ..... n2kDA .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
10/1/26	12pm	pre procedure patient mrs Anitha Surakanti came for frozen embryo transfer. file taken from patient side. demographic details verified with full name, UHID number, doctor name and procedure name. given admission for to attender. Afr admission given bed and stub given and given instructions about procedure and advised to keep bladder full for procedure. At pre doctor advise patient shifted to OT malla 60/01/26
10/1/26	01:12pm	Intra procedure patient taken into OT for frozen embryo transfer. patient name, UHID number, procedure husband name confirmed. given lithotomy position and under aseptic precautions processed embryo witnessed with patient others and advised comfortable rest. Afr comfortable rest patient shifted back to gynec ward. malla 60/01/26
10/1/26	01:55pm	post procedure Afr 2 hrs rest patient discharged accordingly doctor observed and explained about medications and advised to Avoid

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

BAH-00521107 IP5-00176211
Mrs ANITHA SURAKANTI
12-10-1997 28 Y 8 M 28 D (F)
Dr. SUDHARANI BAIRRAJU

BirthRight FERTILITY BY RAINBOW HOSPITALS

NURSES NOTES

☐ No Known Drug Allergies
☐ Drug Allergies ..... & KNDA .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		(Rpt afb 14 days) and given instructions for further
		Bp 109/68 mm/hg
		Spo2 100%
		pule 82 b/m
		RR 18/m
		P/v soft
		Noella 60/0/57

NOTE : DO NOT WRITE OUTSIDE THE MARGINS