Patient Sticker

Rainbow® Children's Hospital
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SURGERY DETAILS

BAH-00531990 IP5-00176691
Mrs SOUMYA Y
26-09-1989 36 Y 9 M 25 D (F)
Dr. SUDHARANI BAIRRAJU

Date : 21/7/26

Patient Name ..... Date of Birth: 26/9/1989 Age: 36y

Gender: female Ward : IVF OT UHID No.: BAH-00531990

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

Name of the Surgery : Patient Oocyte Retrieval

Time in : 9Am Time Out : 09:20Am

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

Special Equipment: ☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☑ Others ultra round guidli
R265-036302

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 5-000971394O/94O Order by: Swaroopa.

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

BAH-00531990 IP5-00176691
Mrs SOUMYA Y
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Dr. SUDHARANI BAIRRAJU

Oocyte Retrieval.

CONSUMABLES OF OT

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Circulating Staff ..... Technician : K. Shivaleela Date : 21/7/26 Time : 9 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		4				Vaccum Suction Set		
05 cc			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			Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml		1	Koochies			Mother gown	01	01
Mimispike		1	Ointments			NS 500ml	01	01
mida2		1	Suction Catheter			Proto gown	02	02
Fentanyl		1	Cap, Mask	5/5	5/5	RL 500ml	01	01
Morphine			Gauze Pack			Inj. Augmentil 1.2g	01	01
Ketamine			Mop Pack			20 G cannula	01	01
Propofol		2	Steristrip			Three way	01	01
Rocuronium			Underpad			Inda fix	01	01
Glycopyrolate			Draw sheet			Shoe Cover	02	02
Myopyrolate			Abgel			Hip leggings	01	01
Ondansetron			Foleys catheter			camera cover	01	01
Pencan 25g/ Spinal Needle 22			Urobag			Inj Tranexa 1gm	01	01
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					
IV P.CM		1	Microshield					
Nasal prong Etco6(A)		1	Cotton Balls					
			Latex Gloves					
			Ramdione Scrub					
			Saral					

Surgeon Dr. Sudharani B Anaesthesiologist Dr. Sri Ranga Nurse Suryacoop OT Technician

Order No. : 5-000971393 4/933 Ordered by : .....

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

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ACTIVITY RECORD FOR BILLING

Name :_____

UHID No. : _____ IP5-00176691 _____Consultant: _____ Dept : _____

BAH-00531990
Mrs SOUMYA Y
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Dr. SUDHARANI BAIRRAJU

Date of Admiss _____Date of Discharge : _____ Time: _____

Room / Bed No _____ Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
21/7/26	8:55Am	Gynae Ren	IVF-OT	Swaroopa.
21/7/26	9:25Am	IVF-OT	Gynae Ren	Swaroopa.
21/7/26	12pm	Gynae Ren	Billing	Swaroopa.

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
21/7/22	Cardiac Monitor	8:10Am	11:30Am	5-000971 3939	
21/7/22.	ultrasound guidlu.	9Am	9:15Am	R2 65-03630	

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
21/4/26	IV Cannulation PAC.	01 OP Basis	5-00097139405	

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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 : IP5-00176691 **Admit Date** : 21-Jul-2026 **Admit Time** : 08:07 AM **UHID** : BAH-00531990

Patient Details :

Patient Name	: Mrs SOUMYA Y	**Age**	: 36 Y 9 M 25 D
Guardian	: Mr KARTHIK	**DOB**	: 26-09-1989
Gender	: Female	**Religion**	: Hindu
Occupation	:	**Martial Status**	: Married
Address (H)	: #a block 207 RAINBOW VISTAS PHASE-I MOOSAPET Bharat Nagar Hyderabad Telangana INDIA 500018	**Phone No**	: 9000988279/
		E-mail	: nomailid@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : RC 407 **Ward Name** : 4F-GYN RECOVERY

Room No : RC 407 **Admission Type** : First Visit

Contact Details :

Name : Mr KARTHIK **Relationship** : Husband

Contact Address : #a block 207 RAINBOW VISTAS PHASE-I MOOSAPET Bharat Nagar Hyderabad Telangana INDIA 500018 **Phone No** : 9000988279

R.S.P.K

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

Patient Sticker

BAH-00531990 IP5-00176691
Mrs SOUMYA Y
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Dr. SUDHARANI BAIRRAJU

BirthRight™ FERTILITY BY RAINBOW HOSPITALS

OUTPATIENT NURSING ASSESSMENT FORM

Date: 21/7/26 Time: 8:10 Am

Chief Complaint: -

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

If yes , identify -

Vital Signs : Temperature: 98.5°F Pulse: 76/min Respiratory Rate 17/min

BP 103/65 mmHg SpO_2 100% Weight 70.2 kg Height 1.47 BMI 31.6

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: .....

Inform the physician about any spiritual needs, if applicable

Nurse Signature: ..... Nurse Name: Swaroop

Date & Time: 21/7/26 at 8:25 Am

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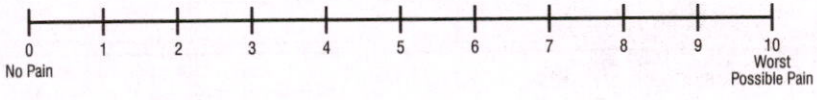
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
21/7/26	8:30AM	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	—Nil—	[signature]
2				☐ 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: Primary Subfertility c Advanced age, POR, male factor

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
21/7 8:15Am	☑ Medical ☐ Nursing ☐ Others:	☑ Initial ☐ Modified ☐ Per-Op ☐ Post Op	patient came for oocyte retrieval	oocyte retrieval Free of complication	oocyte retrieval under anesthesia		☑ Nursing ☐ Others:
21/7/26 8:30Am	☐ Medical ☑ Nursing ☐ Others:	☐ Initial ☐ Modified ☑ Per-Op ☐ Post Op	Patient has come for oocyte retrieval	vitals checked Placed IV Cannula.	Shifted patient to OT as per doctor orders.		☐ Medical ☐ Others:
21/7 9:25Am	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Monitor vitals, P/A Bleeding P/V	Safe Discharge	Discharge medications		☐ Medical ☑ Nursing ☐ Others:
21/7/26 9:30Am	☐ Medical ☑ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☑ Post Op	Procedure has done under ultrasound guidance	Observation/Monitor of vital sign for 2hrs.	Explaid about discharge, medications as per doctor 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	21/3/26 @8:30Am			Fall Risk Grading		
		Score						
History of Falling (immediately or w/in 3 months)	Yes	25				Risk Level	Morse Fall Score (MFS)	Action
	No	0	0					
Secondary Diagnosis (more than one diagnosis)	Yes	15						
	No	0	0					
Ambulatory Aid	Furniture	30				✓ Low Risk	0 - 24	Standard Fall Precaution
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0					
IV / Heparin Lock or Saline	Yes	20	20			Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20						
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0	0			High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
Mental Status	Forgets limitations	15						
	Oriented to own ability	0	0					
Total Morse Fall Scale Score:			20					
		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

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MEDICATION RECONCILIATION FORM

Drug Allergies: NKDA ☐ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.
(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ..... Shifted to: .....

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : .....

Date & Time : 21/2/26 @ 8:50 AM

Nurse Name & Signature: Swaroopa & RR

Date & Time : 21/2/26 at 8:55 Am

FORM-6

CONSENT FORM FOR ASSISTED REPRODUCTIVE TECHNOLOGY PROCEDURE

BirthRight™ FERTILITY BY RAINBOW HOSPITALS

Patient Name: Soumya. Y Age 36y UHID No. BAH-00531990

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.

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

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.

The degree of surgery 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 alternatives.

Wife / Woman Name: Soumya. Y

Signature: Soumya

Date & Time: 21/7/26 at 8:30Am

Husband Name: Karthik. K

Signature: K.S.K.N

Date & Time: 21/7/26 at 8:30Am

Endorsement by the ART Clinic:

I/ we have personally explained to Soumya. Y and Karthik 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.

Wife / Woman Name: Soumya. Y

Signature: Soumya

Date & Time: 21/7/26 at 8:30Am

Name, Address and Signature:

of the Witness from the clinic Saif

Date & Time: 21/7/26 at 8:45Am

Name of the Doctor: Dr Sudharani B

Signature:

Date & Time: 21/7/26 at 8:35Am

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

Consent of the Husband (As and If applicable)

As the Husband / Partner I consent to the course of the treatment outlined above. I understand that I will become the legal parent of the any resulting child, and that the child will have all the normal legal rights on me.

Husband Name: Karthik

Address: Hyd

Signature: K.S.K.N

Date & Time: 21/7/26 8:30Am

Name, Address and Signature:

of the Witness from the clinic Swaroop

Date & Time: 21/7/26 at 8:45A

Name of the Doctor: Dr. Sudharani B

Signature :

Date & Time : 21/7/26 at 8: 35Am

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

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CONSENT FOR ANAESTHESIA

Authorization By: ☑ Patient ☐ Patient Attendant

Operative Procedure: Ⓑ Doyle retrieval

Anaesthesiologist: Dr. Subrahmanyam Surgeon: Dr. Sudharani

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 can be achieved by infusing weak solutions of local anaesthetics and 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 ☐ Hypertension ☐ Diabetes ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders
☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease
☐ Others Desaturation, laryngospasm

Declaration by Patient Attendant

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team
  ☐ Regional Anaesthesia ☐ General Anaesthesia ☑ Monitored Anaesthesia Care
- 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, allergic reactions, headaches, variations in blood pressure, nausea and vomiting.
- I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Access, arterial line, use of suppositories and or nerve blocks for pain relief, changing from regional to general anaesthesia etc) which are considered necessary by them during the course of surgery.
- I also 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 if need arises.
- I acknowledge that the anaesthesiologist have informed me about the anaesthetic procedure, risk, benefits and alternative treatments.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:
Signature: Soumya
Name: Soumya. Y
Relationship with patient: Self
Date & Time: 13/7/26 at 12pm

Witness:
Signature: K.S.R. Kth
Name: K.S.R. KARTHIK
Date & Time: 21/7/26 at 8:35 Am

Doctor (who is taking consent):
Signature: Name: Dr Brunda Date 13/7/26 Time: 9:30 am

Patient Sticker

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అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స: .....

అనస్థీషియా వైద్యుడు: ..... శస్త్రచికిత్స నిపుణుడు: .....

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

సాధారణ అనస్థీషియా అనేది శస్త్రచికిత్స ముందు రోగిని పూర్తిగా అపస్మారక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్రావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు.

లీజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్కోటిక్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై రిస్క్స్:

క్రింద పేర్కొన్న వైద్య సమస్యల కారణంగా ఉండే అధిక ప్రమాదాల గురించి వైద్యులు నాకు వివరంగా చెప్పారు. నాకు ఉన్న సందేహాలను నేను అడిగాను మరియు అవి నివృత్తి చేయబడ్డాయి.

☐ హృదయ వ్యాధి ☐ రక్తపోటు ☐ మధుమేహం ☐ మూత్రపిండాల వైఫల్యం ☐ బహుళ అవయవ వైఫల్యం

☐ కాలేయ సమస్యలు ☐ షాక్ ☐ ఊబకాయం ☐ దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)

☐ ఇతరవి: .....

రోగి / రోగి అటెండెంట్

- అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
  ☐ లీజనల్ అనస్థీషియా ☐ జనరల్ అనస్థీషియా ☐ మానిటర్డ్ అనస్థీషియా కేర్
- అనస్థీషియా ఉపయోగంలో అప్పుడప్పుడూ జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. వీటిలో ఇంజెక్షన్ ఇచ్చిన చోట నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అలెర్జీ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెనస్ యాక్సెస్, ఆర్టీరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, లీజనల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందానికి నేను అనుమతి ఇస్తున్నాను.
- శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న వైద్యుల బృందానికి కూడా నేను అనుమతి ఇస్తున్నాను.
- అనస్థీషియా విధానం, ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయ చికిత్సల గురించి అనస్థీషియా వైద్యులు నాకు వివరించినట్లు నేను అంగీకరిస్తున్నాను.
- పై సమాచారం అంతా నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో వాటికి సమాధానాలు ఇచ్చారు. ఈ అనుమతి నేను పూర్తిగా స్పష్టమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం: .....

పేరు: .....

రోగితో సంబంధం: .....

తేదీ & సమయం: .....

సాక్షి:

సంతకం: .....

పేరు: .....

తేదీ & సమయం: .....

డాక్టర్ :

సంతకం: ..... పేరు: ..... తేదీ & సమయం: .....

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

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Name: Mrs. Soumya Y. Age: 36y Sex: f UHID.No : BAH-00531990

Date: 13/7/26 Time: 9:30 am Proposed Operation: Oocyte Retrieval.

Diagnosis: Infertility.

B.P / CRT: 123/84 mmHg H.R: 79bpm. Weight: 70.2kgs. ASA Physical Status: ☑1 ☐2 ☐3 ☐4 ☐5

Laboratory Data:

Hgb: 12.5	Glucose:	Protein:	HIV:	X-Ray:
PCV:	Urea:	Alb:	HBS Ag:	ECG:
WBC:	Creat:	Total Bill:	HCV:	2D Echo:
Plate: 2.89	Na:	Dir. Bill:	Blood group:	Stress/Anglo:
PT:	K:	LDH:	T3	Other:
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH	
	Cl -:	SGOT/SGPT:		

Allergies: NKDA.

Medical History: CVS : No Cardiac Complaints.

RESP : Occasional Dry Cough since 1week. Diabetes : –

CNS :

Renal :

Hepatic / GE : Physical Activity: ≥ 4 METS.

Others :

Past Anaesthetic History: Lap. Myomectomy LGA in 2025, Uneventful.

Physical Exam:

Airway: MP 1 (2) 3 4 Mouth Opening: (N) Mentohyoid Distance: (N) Neck: Short (N) Movements Teeth: Intact.

Lungs : B/L AE (+) clear

Heart: S1S2 (+)

CNS: NAD

Pregnant: ☐ Yes ☑ No ☐ NA | Venous Access Site : peripheral Spine Exam for regional : –

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:
   - CBP Report to be Shown at the time of admission (pt already has in her phone)
   - To check for VRTI before admission.

Signature: Name: Dr. Brunda

BAH-00531990
Mrs SOUMYA Y
26-09-1989
Dr. SUDHARANI BAIRRAJU
IP5-00176691
36 Y 9 M 25 D (F)

ANAESTHESIA CHART

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Pre Induction Assessment

Change in Patient Condition: ☐ Yes ☑ No | Fasting Status: Continued.

Physical Status: ☑ Patient Identified | ☑ Consent Present | ☑ Chart Reviewed

H.R: 76. | B.P / CRT: 117/80 mmHg | SpO_2: 99 % | R.R: | Last Feed:

Pre-OP Diagnosis: ..... | Operation: Cough Relival | Date: 21/2/2026

Surgeon: ..... | Anaesthesiologist: ..... | Technician: .....

TIME 9 X 20

N_2O /AIR O_2 LPM: 2L

HALO /SO /SEVO:

Drugs:

INJ. MIDAZOLAM - 2mg
INJ. FENTANYL - 100 µg
INJ. PROPOFOL - 100 mg + 50 mg Hourly IV.
INJ. TRANEXAMIC ACID - 1g IV
INJ. PARACETMOL 1g IV

FIO_2 / SaO_2: 100 99
$ETCO_2$: 35 34
ECG: SR SR
Temperature:
Urine Output:

Fluids / Blood: RL

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 0

Antibiotic

Suppository

Blood Loss

NOTES

LAB Values: ABG | GRBS | Others

☑ Equipment Checked and Functional
☑ BP
☑ Cuff Site: (L) Arm.
☐ Art Site: .....
☑ EKG Lead Bleed.
☐ 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: 9:00 AM
OP Start: .....
OP End: .....
Leave OR: 9:20 AM

Anaesthesia:
☐ GA
☑ Monitored Anaesthesia Care
☐ Regional

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

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

☐ Mask ☐ SGA Nasal prong
☐ 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. K. MADHU RAMYA
Signature of the Doctor: .....

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26-09-1989 36 Y 9 M 25 D (F)
Dr. SUDHARANI BAIRRAJU

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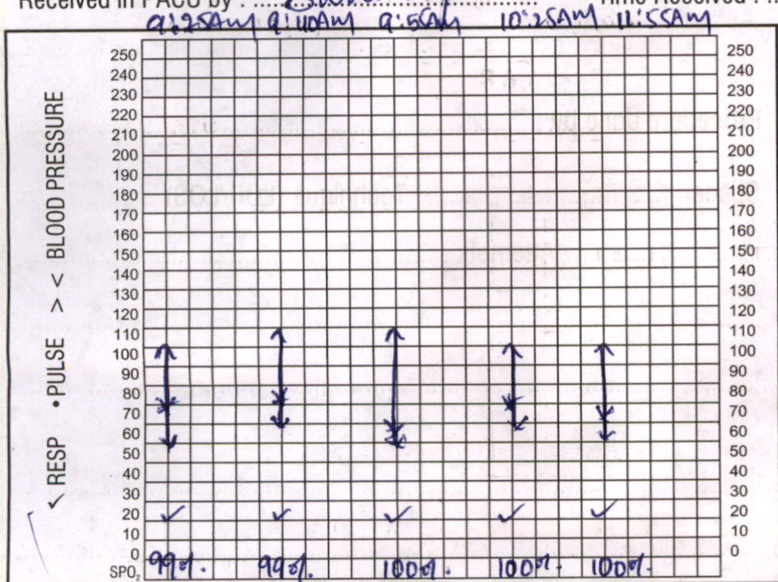
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Swaroopa Time Received : 9:25 AM Time Discharged : 12 pm



IV Cannula Site : Rt hand.

☐ O_2Mask ☐ 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: IO 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 = 2 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 0		ACTIVITY	1	2	2	2	2
Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0		RESPIRATION	2	2	2	2	2
BP ± 20 of Pre Anaesthetic leve = 2 BP ± 20-50 of Pre Anaesthetic leve = 1 BP ± 50 of Pre Anaesthetic leve = 0		CIRCULATION	2	2	2	2	2
Fully awake = 2 Arousable on calling = 1 Not responding = 0		CONSCIOUSNESS	2	2	2	2	2
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 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
21/7/26	9:25AM	0	—— Nill ——	[signature]

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

Anaesthesiologist Name : Dr. Deepthi Lavanya
Anaesthesiologist Signature: [signature]
Date & Time: 21/7/26 at 11:20AM

PACU Nurse Name : Swaroop
PACU Nurse Signature: [signature]
Date & Time: 21/7/26 at 9:25AM

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): Billig
Date & Time: 21/7/26 at 12:30pm.

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 : .....

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8:30am 21/1/2026	patient came for oocyte retrival.	plan
	PR - 77	Shift to OT for oocyte retrieval
	BP - 103/65	
	RR - 16 cpm	PAC
	SpO2 - 100%	NBM
21/1/2026 1pm	patient stable	plan
	Discharge medications explained.	Can be discharged

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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IART

Date of Admission: 21/7/26 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 ..... Signature .....

Patient Sticker

REGULAR PRESCRIPTIONS

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

DRUG :

Date ▸ Time ▾

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Date ▸ Time ▾

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Date ▸ Time ▾

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Date ▸ Time ▾

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Patient Sticker

BAH-00531990 IP5-00176691
Mrs SOUMYA Y
26-09-1989 36 Y 9 M 25 D (F)
Dr. SUDHARANI BAIRRAJU

Weight. 70.2kg Ward. IVF OT

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.	

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
21/8	8:36AM	INJ AMOXICILLIN + CLAVULUNATE	1.2g	IV	[signature]	Sujatha [signature]
21/8	9:10AM	INJ PARACETMOL	1g	IV	[signature]	[signature]
21/8	9:20AM	INJ TRANAXAMIC ACID	1g	IV	[signature]	[signature]

Signature .... VERIFIED BY : N

BAH-00531990
Mrs SOUMYA Y
26-09-1989 36 Y 9 M 25 D (F)
Dr. SUDHARANI BAIRRAJU
IP5-00176691

I.V. FLUIDS CHART

Weight. 70.2kg. Ward. 7 V R 01

Date	Time	Fluid (Infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
21/7/26	8:30AM	RINGER LACTATE	IV	RL			21/7/26		

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

BAH-00531990 IP5-00176691
Mrs SOUMYA Y
26-09-1989 36 Y 9 M 25 D (F)
Dr. SUDHARANI BAIRRAJU

LIST

Surgeon : Dr. Sudha[redacted]rani B
Asst. Surgeon : Dr. Akhila
Anaesthetist : Dr. Sri Ramya.
Scrub Nurse : Swaroopa.

Patient Name : Mrs. Soumya. Y Age : 36y Gender : F
UHID No. : BAH-00531990 Surgery Name : Oocyte Retrieval
Date : 21/7/26 In-time : 8:55Am Out-time : 09:35Am

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: 8:38AM

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. K SRI RAMYA.

Before Skin Incision ➤➤

TIME OUT Time: 9AM

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 mins Anticipated Blood Loss? 0-10ml — Pain, Bleeding ☐ 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 : Swaroopa.

Before Patient Leaves Operating Room

SIGN OUT Time: 9:20 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. Sudhaeani. B.

Patient Sticker

BAH-00531990 IP5-00176691
Mrs SOUMYA Y
26-09-1989 36 Y 9 M 25 D (F)
Dr. SUDHARANI BAIRRAJU

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 21/7/26

Department : IVF-OT Duration of Procedure : 15-20 min

Name of Surgeon : Dr. Sudharani.B Date of Admission : 21/7/26

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	
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 : Dr. Swaroopa. Date & Time of antibiotic administration : 21/7/26 at 8:36 Am Date & Time procedure started : 21/7/26 at 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

BAH-00531990 IP5-00176691
Mrs SOUMYA Y
26-09-1989 36 Y 9 M 25 D (F)
Dr. SUDHARANI BAIRRAJU

Patient Stic

BirthRight™ FERTILITY BY RAINBOW HOSPITALS

POST PROCEDURE CARE PLAN

Date & Time: 21/7/2026 @ 9:30 Am

Patient Name: ..... Age: ..... UHID No: .....

Procedure Done: Oocyte retrieval (OR)

Post Procedure Diagnosis: Oocyte retrieval

Post-Operative Monitoring Parameters / Frequency: Monitor PR, BP, SpO2, RR every 5min for 1hr, every 15min for 1 hr, 30 min till discharge

Special Patient Positioning and Requirements: avoid prone position

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: A.Sudha.

Date & Time: 21/7/2026 @ 9:30 Am

Note: Plan of care will be readjusted if necessary