

ADMISSION SHEET

Registration Details :



Admission No : IP5-00173899 Admit Date : 16-May-2026 Admit Time : 08:10 AM UHID : BAH-00651123

Patient Details :

Patient Name : Mrs NAGA LAKSHMI PATNALA Age : 36 Y 11 M 7 D  
Guardian : MR RAJESH POTHARAJU DOB : 09-06-1989  
Gender : Female Religion :  
Occupation : Martial Status : Married  
Address (H) : FLAT 203, SRI HARSHA ARCADE, PRAKASH NAGAR Begumpet Hyderabad Telangana INDIA 500016  
Phone No : 9884907700/ 9884907700  
E-mail : NO@GAMIL.COM

Admission Details :

Bed Type : DAY CARE Bed No : PRE OP 402 Ward Name : 4F-OT COMPLEX  
Room No : PRE OP 402 Admission Type : First Visit

Contact Details :

Name : MR RAJESH POTHARAJU Relationship : Husband  
Contact Address : Phone No : / 9884907700

*Rajesh*

Signature

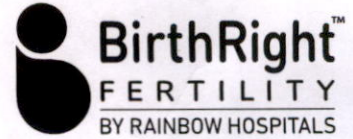
Doctor Details :

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

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00  
Payor Name : SELFPAY

BAH-00651123      IPS-00173899  
Mrs NAGA LAKSHMI PATNALA  
09-06-1989      36 Y 11 M 7 D (F)  
Dr. SUDHARANI BAIRRAJU



### OUTPATIENT NURSING ASSESSMENT FORM

Date: 16/5/26 Time: 8:15 AM

Chief Complaint: .....

Allergies:  Yes  No  Medications  Blood Transfusion  Food  Not Known

If yes, identify .....

Vital Signs: Temperature: 97.6°F Pulse: 88 bpm Respiratory Rate 19 bpm

BP 102/63 SpO<sub>2</sub> 99% Weight 79.1 Height 1.52 BMI 34.2

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

**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**

**IF YES FOR ANY CATEGORY = RISK FOR FALLING**  
**Fall Risk Intervention:**  
 Escort while ambulating  
 Assist Patient  
 Educate patient and family on fall precautions/prevention

**Psycho-Social-Economic-Spiritual Screening:**  No Significant Findings  
 Single  Married  Lives Alone  Lives with family  Lives with friends  Abnormal behaviour

Inform the physician about any unusual concerns about patients Psychological / Social Status: Nil

Inform the physician about any spiritual needs, if applicable

Nurse Signature: [Signature]

Nurse Name: Suneeta

Date & Time: 16/5/26 at 8:15 AM

BAH-0065123 IP5-00173899  
 Mrs NAGA LAKSHMI PATNALA  
 09-06-1989 36 Y 11 M 7 D (F)  
 Dr. SUDHARANI BAIRRAJU



*0047E  
 RRRRUCAC*



**CONSUMABLES OF OT**

It takes a lot to treat the little.

BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

Circulating Swab ..... Technician : *Kubel* Date : *16/5/2018* Time : *9 AM*

| Anaesthesia Disposables            | Qty    |           | Surgical Disposables    | Qty        |            | Disposables (Baby Side) | Qty       |           |
|------------------------------------|--------|-----------|-------------------------|------------|------------|-------------------------|-----------|-----------|
|                                    | Issued | Used      |                         | Issued     | Used       |                         | Issued    | Used      |
| ET tube                            |        |           | Major Pack              |            |            | Inj Vit.K               |           |           |
| LMA                                |        | <i>3</i>  | Sutures                 |            |            | Cord Clamp              |           |           |
| ECG leads : A/P/N                  |        | <i>03</i> |                         |            |            | Suction Catheter        |           |           |
| HME filter : A/P/N                 |        | <i>01</i> |                         |            |            | Feeding Tube            |           |           |
| Syringes : 10 cc                   |        | <i>4</i>  |                         |            |            | Vaccum Suction Set      |           |           |
| 05 cc                              |        | <i>2</i>  | Gloves                  |            |            | Surgical Gloves         |           |           |
| 02 cc                              |        | <i>2</i>  |                         |            |            | Gauze Pack              |           |           |
| 01 cc                              |        | <i>-</i>  |                         |            |            | Syringe 1ml / 2ml       |           |           |
| Cautery plate : A/P/N              |        | <i>-</i>  | Surgical blade          |            |            | Surgical Blade # 20     |           |           |
| IV set                             |        |           | NG tube                 |            |            | Koochies (S)            |           |           |
| RL                                 |        | <i>01</i> | Cautery pencil          |            |            |                         |           |           |
| NS : 10ml / 100ml / 500ml / 1000ml |        | <i>01</i> | Koochies                |            |            | Molteni gown            | <i>01</i> | <i>01</i> |
| <i>air spike</i>                   |        | <i>01</i> | Ointments               |            |            | proto gown              | <i>03</i> | <i>03</i> |
| <i>Vacuum set</i>                  |        | <i>01</i> | Suction Catheter        |            |            | RL 500ml                | <i>02</i> | <i>02</i> |
| Fentanyl                           |        | <i>01</i> | Cap, Mask               | <i>5/5</i> | <i>5/5</i> | NS 500ml                | <i>01</i> | <i>01</i> |
| Morphine                           |        |           | Gauze Pack              | <i>05</i>  | <i>05</i>  | mini spike              | <i>01</i> | <i>01</i> |
| Ketamine                           |        |           | Mop Pack                |            |            | Intera fix              | <i>01</i> | <i>01</i> |
| Propofol                           |        | <i>03</i> | Steristrip              |            |            | three way               | <i>01</i> | <i>01</i> |
| Rocuronium                         |        | <i>-</i>  | Underpad                |            |            | Inj. Augmentin 2g       | <i>01</i> | <i>01</i> |
| Glycopyrolate                      |        | <i>-</i>  | Draw sheet              | <i>02</i>  | <i>02</i>  | ice Syringe             | <i>01</i> | <i>01</i> |
| Myopyrolate                        |        | <i>-</i>  | Abgel                   |            |            | Allesorb                | <i>01</i> | <i>01</i> |
| Ondansetron                        |        | <i>01</i> | Foleys catheter         |            |            | foot cover              | <i>01</i> | <i>01</i> |
| Pencan 25g / Spinal Needle 22      |        | <i>01</i> | Urobag                  |            |            | cotton balls            | <i>01</i> | <i>01</i> |
| Bupivacaine 0.25%                  |        |           | Chest Drainage Catheter |            |            | Hip leggings            | <i>01</i> | <i>01</i> |
| Bupivacaine 0.25% (Heavy)          |        | <i>01</i> | Romodrain bag           |            |            | D-water                 | <i>02</i> | <i>02</i> |
| Antibiotics                        |        |           | Bandage                 |            |            | 10cc Syringe            | <i>02</i> | <i>02</i> |
| <i>Gaure</i>                       |        | <i>01</i> | Tegaderm                |            |            | Encore 6 1/2            | <i>01</i> | <i>01</i> |
| Suppositories                      |        |           | loban                   |            |            | glo Glo Cannula         | <i>01</i> | <i>01</i> |
| Anamol : 80mg / 250mg / 170 mg     |        |           | Double J Stent          |            |            | INS, DEM 1gm            | <i>01</i> | <i>01</i> |
| Supridol : 100mg                   |        |           | Vaccum Suction set      |            |            | Camera cover            | <i>01</i> | <i>01</i> |
| Justin : 12.5 mg / 25mg / 100mg    |        |           | Plastic Bed Sheet       |            |            | <i>24. top gel</i>      | <i>01</i> | <i>01</i> |
| Tab. Misoprost : 200mg             |        |           | Betadine Solution       |            |            |                         |           |           |
| <i>blue 1/2</i>                    |        | <i>02</i> | Microshield             |            |            |                         |           |           |
| <i>Sig midasdam</i>                |        | <i>01</i> | Cotton Balls            |            |            |                         |           |           |
| <i>02 max cas</i>                  |        | <i>01</i> | Latex Gloves            |            |            |                         |           |           |
|                                    |        |           | Ramdione Scrub          |            |            |                         |           |           |
|                                    |        |           | Saral                   |            |            |                         |           |           |

Surgeon *Dr. Sudhacani B* Anaesthesiologist *Dr. Akhila* Nurse *Sis. Swaroopa* OT Technician *Prashanth*

Order No. : *5-0009611053/052* Ordered by : *Sis. Swaroopa*

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

ACTIVITY RECORD FOR BILLING

BAH-00651123 IP5-00173899  
Mrs NAGA LAKSHMI PATNALA  
09-06-1989 36 Y 11 M 7 D (F)  
Name : Dr. SUDHARANI BAIRRAJU Patnala

BAH-00651123 IP5-00173899  
Mrs NAGA LAKSHMI PATNALA  
09-06-1989 36 Y 11 M 7 D (F)  
Dr. SUDHARANI BAIRRAJU



SURGERY DETAILS

Date : 16/5/26  
Patient Name: Mrs. Naga Lakshmi P Date of Birth: 09/6/1989 Age: 36 yrs  
Gender: Female Ward : IVF-OT UHID No.: BAH-00651123  
Date of Surgery: 16/5/26  OT-1  OT-2  OT-3  OT-4  OBG OT-1  OBG OT-2  
Name of the Surgery : Patient couple Retrieval

Time in : 09:00 AM Time Out : 10:00 AM

|                      | NAME                   | AMOUNT |
|----------------------|------------------------|--------|
| 1. Surgeon           | <u>Dr. Sudharani B</u> |        |
| 2. Anaesthetist      | <u>Dr. Akhila</u>      |        |
| 3. Assistant Surgeon | <u>Dr. Pooja</u>       |        |
| 4. OT Technician     | <u>Bro Prashanth</u>   |        |
| 5. Circulating Nurse | <u>Sis. Tyothi</u>     |        |
| 6. Assistant Nurse   | <u>Sis - Swaroopa</u>  |        |

Special Equipment:  Laparoscopy  Broncoscope  Harmonic  Morcelator  
 C-ARM  Cystoscopy  Versa Point  Liver Cusa  
 Others ultrasound guided

[Signature]  
Signature of the Surgeon

[Signature]  
Signature of Circulating Nurse

Order No: 5-0009611057/057 Order by: [Signature]





## PAIN ASSESSMENT FORM

| Date    | Time     | Pain Score (0/10) | Location              | Duration   | Acuity  | Character   | Modifying Factors   | Patient / Family Educated  | Intervention             | Sign               |
|---------|----------|-------------------|-----------------------|--|---|---|---|--|--------------------------|--------------------|
| 16/5/26 | 8:20 AM  | 0                 | —                     | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            | — Nil / —                | <i>[Signature]</i> |
| 16/5/26 | 10:15 AM | 5-6               | lower legs<br>Abdomen | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input checked="" type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input checked="" type="checkbox"/> Aching <input type="checkbox"/> Burning | <input checked="" type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input checked="" type="checkbox"/> Yes<br><input type="checkbox"/> No | 2ml 5. Perc. Iqin<br>Iv. | <i>[Signature]</i> |
| 16/5/26 | 10:35 AM | 0-2               | —                     | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input checked="" type="checkbox"/> Decreasing | <input checked="" type="checkbox"/> Yes<br><input type="checkbox"/> No | Advised rest             | <i>[Signature]</i> |
| 16/5/26 | 11:55 AM | 0                 | —                     | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            | — Nil / —                | <i>[Signature]</i> |
|         |          |                   |                       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            |                          |                    |
|         |          |                   |                       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            |                          |                    |
|         |          |                   |                       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            |                          |                    |
|         |          |                   |                       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            |                          |                    |
|         |          |                   |                       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            |                          |                    |
|         |          |                   |                       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            |                          |                    |

**Re-assessment Frequency:**

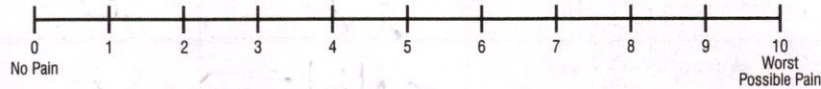
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
  - a) At least every 2 hours for the first 24 hours
  - b) Then every 4 hours.
  - c) Prior to pain pain-relieving intervention.
  - d) Within 30 – 60 minutes after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

# PAIN ASSESSMENT TOOLS

## FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

| CATEGORY      | SCORING                                      |   |  |
|---------------|--|---|--|
|               | 0  | 1   | 2  |
| Face          | No Particular expression or smile            | Occasional Grimace or Frown, withdraw, Disoriented                          | Frequent to constant frown, quivering chin, clenched jaw |
| Legs          | Normal Position or Relaxed                   | Uneasy, restless, tense   | Kicking, or legs brawn up                                |
| Activity      | Laying quietly normal position, moves easily | Squirming shifting back and forth, tense                                    | Arched, right, or Jerking                                |
| Cry           | No Cry (Awake or asleep)                     | Moans or whimpers occasional complaint                                      | Crying steadily, screams of sobs, frequent complaints    |
| Consolability | Content, relaxed                             | Reassured by occasional touching, hugging, or being talked to, distractible | Difficult to console or comfort                          |

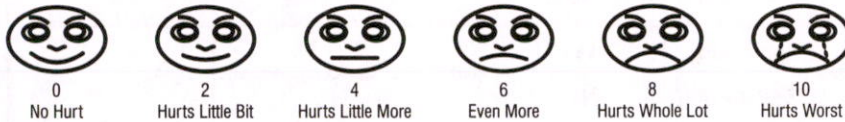
## Numerical Pain Scale (Obstetric and Gynecology)



## Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

| Assessment Criteria                            | Sedation  |   | Normal<br>0                                   | Pain / Agitation   |   |
|--|---|---|---|--|---|
|  | -2  | -1  |   | 1  | 2   |
| <b>Crying Irritability</b>                     | 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  |
| <b>Behavior State</b>                          | No arousal to any stimuli<br>No spontaneous movement    | Arouses minimally to stimuli<br>Little spontaneous movement | Appropriate for gestational age               | Restless, squirming<br>Awakens frequently  | Arching, kicking constantly awake or<br>Arouses minimally / no movement (not sedated)   |
| <b>Facial Expression</b>                       | Mouth is lax<br>No expression                           | Minimal expression with stimuli                             | Relaxed Appropriate                           | Any pain expression intermittent   | Any pain expression continual   |
| <b>Extremities Tone</b>                        | No grasp reflex<br>Flaccid tone                         | Weak grasp reflex<br>decreased muscle tone                  | Relaxed hands and feet<br>Normal Tone         | Intermittent clenched toes, fists or finger splay<br>Body is not tense                     | Continual clenched toes, fists, or finger splay<br>Body is tense  |
| <b>Vital Signs HR, RR, BP, SaO<sub>2</sub></b> | No variability with stimuli<br>Hypoventilation or apnea | Less than 10% variability from baseline with stimuli        | Within baseline or normal for gestational age | Increase 10-20% from baseline<br>SaO <sub>2</sub> 76-85% with stimulation - quick recovery | Increase greater than 20% from baseline, SaO <sub>2</sub> less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator |

## Wong - Baker (Pediatrics) Above 7 Years





# MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: B/L Tubal Block

| Date Time           | Discipline  | Type   | Patient Needs / Problem List   | Goal  | Plan / Intervention   | Signature | Team Verification   |
|---------------------|---|--|--|---|---|-----------|---|
| 16/5/26<br>8:15 AM  | <input checked="" type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others: | <input checked="" type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input type="checkbox"/> Per-Op<br><input type="checkbox"/> Post Op            | Oocyte Retrieval   | to retrieve oocytes without complications     | Oocyte Retrieval under USG guidance                             | Swape     | <input checked="" type="checkbox"/> Nursing<br><input type="checkbox"/> Others:                                     |
| 16/5/26<br>8:20 AM  | <input type="checkbox"/> Medical<br><input checked="" type="checkbox"/> Nursing<br><input type="checkbox"/> Others: | <input type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input checked="" type="checkbox"/> Per-Op<br><input checked="" type="checkbox"/> Post Op | Patient has come for oocyte retrieval                                  | vital check informed doctor Placed IV cannula | shifted patient to OT upon doctor's order                       | Pan       | <input type="checkbox"/> Medical<br><input type="checkbox"/> Others:  |
| 16/5/26<br>10 AM    | <input checked="" type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others: | <input checked="" type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input type="checkbox"/> Per-Op<br><input checked="" type="checkbox"/> Post Op | Vitals monitoring Rest for 2 hours                                     | to discharge patient without complaints       | follow post op orders   | Swape     | <input type="checkbox"/> Medical<br><input checked="" type="checkbox"/> Nursing<br><input type="checkbox"/> Others: |
| 16/5/26<br>10:10 AM | <input type="checkbox"/> Medical<br><input checked="" type="checkbox"/> Nursing<br><input type="checkbox"/> Others: | <input type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input type="checkbox"/> Per-Op<br><input checked="" type="checkbox"/> Post Op            | Procedure has done under ultrasound guidance under aseptic precautions | Advised rest for 2 hours. Vitals monitoring   | Explained about discharge medication accords to doctor's order. | Pan       | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others:            |
|                     | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others:            | <input type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input type="checkbox"/> Per-Op<br><input type="checkbox"/> Post Op                       |  |   |   |           | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others:            |

BAH-00651123 IP5-00173899  
 Mrs NAGA LAKSHMI PATNALA  
 08-08-1990 36 Y 11 M 7 D (F)  
 Dr. SUDHARANI BAIRRAJU



# Morse Fall Risk Assessment Form

| Choose Highest Applicable Score from each Category |                               | Date / Time | Fall Risk Grading |  |                               |                        |  |
|--|-------------------------------|-------------|-------------------|--|-------------------------------|------------------------|--|
|  |                               | Score       |                   |  |                               |                        |  |
| History of Falling (immediately or w/in 3 months)  | Yes                           | 25          |                   |  | Risk Level                    | Morse Fall Score (MFS) | Action   |
|  | No                            | 0           | 0                 |  |                               |                        |  |
| Secondary Diagnosis (more than one diagnosis)      | Yes                           | 15          | 15                |  | Low Risk                      | 0 - 24                 | Standard Fall Precaution                         |
|  | No                            | 0           |                   |  |                               |                        |  |
| Ambulatory Aid                                     | Furniture                     | 30          |                   |  | Moderate Risk                 | 25 - 50                | Implement Moderate Fall Prevention Intervention  |
|  | Crutches, Cane(S), Walker     | 15          |                   |  |                               |                        |  |
|  | None /Bed Rest /Nurse Assist  | 0           |                   |  |                               |                        |  |
| IV / Heparin Lock or Saline                        | Yes                           | 20          | 20                |  | High Risk                     | ≥ 51                   | Implement High Risk Fall Prevention Intervention |
|  | No                            | 0           |                   |  |                               |                        |  |
| GAIT / Transferring                                | Impaired                      | 20          |                   |  | Total Morse Fall Scale Score: | 35                     | Signature  |
|  | Weak (uses touch for balance) | 10          |                   |  |                               |                        |  |
|  | Normal /On Bed Rest /Immobile | 0           |                   |  |                               |                        |  |
| Mental Status                                      | Forgets limitations           | 15          |                   |  |                               |                        |  |
|  | Oriented to own ability       | 0           | 0                 |  |                               |                        |  |
|  |                               |             |                   |  |                               |                        |  |

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

## Morse Fall Risk Assessment Form

| Choose Highest Applicable Score from each Category   |                               | Date / Time |  |  |  |               | Fall Risk Grading         |   |  |
|--|-------------------------------|-------------|--|--|--|---------------|---------------------------|---|--|
|  |                               | Score       |  |  |  |               |                           |   |  |
| History of Falling<br>(immediately or w/in 3 months) | Yes                           | 25          |  |  |  | Risk Level    | Morse Fall Score<br>(MFS) | Action  |  |
|  | No                            | 0           |  |  |  |               |                           |   |  |
| Secondary Diagnosis<br>(more than one diagnosis)     | Yes                           | 15          |  |  |  | Low Risk      | 0 - 24                    | Standard Fall<br>Precaution                               |  |
|  | No                            | 0           |  |  |  |               |                           |   |  |
| Ambulatory Aid                                       | Furniture                     | 30          |  |  |  | Moderate Risk | 25 - 50                   | Implement<br>Moderate Fall<br>Prevention<br>Intervention  |  |
|  | Crutches, Cane(S), Walker     | 15          |  |  |  |               |                           |   |  |
|  | None /Bed Rest /Nurse Assist  | 0           |  |  |  |               |                           |   |  |
| IV / Heparin Lock or Saline                          | Yes                           | 20          |  |  |  | High Risk     | ≥ 51                      | Implement High<br>Risk Fall<br>Prevention<br>Intervention |  |
|  | No                            | 0           |  |  |  |               |                           |   |  |
| GAIT / Transferring                                  | Impaired                      | 20          |  |  |  | High Risk     | ≥ 51                      | Implement High<br>Risk Fall<br>Prevention<br>Intervention |  |
|  | Weak (uses touch for balance) | 10          |  |  |  |               |                           |   |  |
|  | Normal /On Bed Rest /Immobile | 0           |  |  |  |               |                           |   |  |
| Mental Status  | Forgets limitations           | 15          |  |  |  | High Risk     | ≥ 51                      | Implement High<br>Risk Fall<br>Prevention<br>Intervention |  |
|  | Oriented to own ability       | 0           |  |  |  |               |                           |   |  |
| Total Morse Fall Scale Score:                        |                               |             |  |  |  |               |                           |   |  |
|  |                               | 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

BAH-00651123 IP5-00173899  
 Mrs NAGA LAKSHMI PATNALA  
 09-06-1989 36 Y 11 M 7 D (F)  
 Dr. SUDHARANI BAIRRAJU

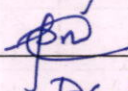
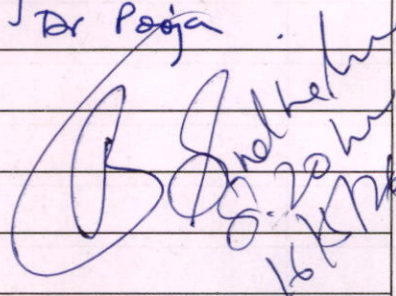
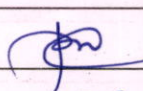
Patient



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

**BirthRight™**  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time        | Progress Notes   | Doctor's Order   |
|--------------------|--|--|
| 16/8/26<br>8:20 AM | Patient came for Oocyte Retrieval                                  |  |
|                    | Ptc/c/c<br>Temp (N)<br>PR - 88 bpm<br>BP - 120/80 mmHg<br>P/A: Sp4 |  |
|                    |  | Patient can be shifted to OT for OR<br><br>Dr Pooja |
| 16/8/26<br>8:20 AM | Patient comfortable  | <br>Dr Pooja  |
|                    | Discharge Summary explained  | Patient can be discharged<br><br>Dr Pooja            |



BAH-00651123 IP5-00173899  
 Mrs NAGA LAKSHMI PATNALA  
 09-06-1989 36 Y 11 M 7 D (F)  
 Dr. SUDHARANI BAIIRAJU

Patient St



## MEDICATION RECONCILIATION FORM

Drug Allergies: ..... NADA .....  Not known any Drug Allergies

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

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

| S.No | MEDICATION NAME<br>(GENERIC NAME CAPITAL LETTERS) | DOSE<br>(mg, mcg) | ROUTE<br>(PO, NG, SC, IV) | FREQUENCY | LAST DOSE<br>Date / Time | ON<br>ADMISSION<br>/ SHIFTING                                     |
|------|---|-------------------|---------------------------|-----------|--------------------------|---|
| 1    | TAB FOLIC ACID                                    | 5mg               | PO                        | OD        | 15/5/20                  | <input checked="" type="checkbox"/> C <input type="checkbox"/> DC |
| 2    | TAB THYRONORM                                     | 50mg              | PO                        | OD        | 16/5/20                  | <input checked="" type="checkbox"/> C <input type="checkbox"/> DC |
| 3    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC            |
| 4    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC            |
| 5    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC            |
| 6    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC            |
| 7    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC            |
| 8    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC            |
| 9    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC            |
| 10   |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC            |

\* C - Continue, DC - Discontinue

### MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: ..... Dr Poosja .....  
 Date & Time: ..... 16/5/20 @ 8:30 AM .....

Nurse Name & Signature: ..... Sudhara .....

Date & Time: ..... 16/5/20 at 8:35 AM .....

BAH-00651123 IP5-00173899  
 Mrs NAGA LAKSHMI PATNALA  
 09-06-1989 36 Y 11 M 7 D (F)  
 Dr. SUDHARANI BAIIRAJU

Patient



# DRUG CHART

Date of Admission: 16/5/20 Drug Allergies: NADA  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)

|                          |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--------------------------|-------|--------------|------------|--------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>DRUG :</b>            |       |              |            | Date<br>Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                     | Route | Frequency    | Start Date |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Doctor's Signature       |       | Valid Period | Pharm.     |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions: |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|                          |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--------------------------|-------|--------------|------------|--------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>DRUG :</b>            |       |              |            | Date<br>Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                     | Route | Frequency    | Start Date |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Doctor's Signature       |       | Valid Period | Pharm.     |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions: |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|                          |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--------------------------|-------|--------------|------------|--------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>DRUG :</b>            |       |              |            | Date<br>Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                     | Route | Frequency    | Start Date |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Doctor's Signature       |       | Valid Period | Pharm.     |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions: |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

VERIFIED BY : Name

|  |       |           |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--|-------|-----------|------------|--------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>DRUG :</b>                                      |       |           |            | Date<br>Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose   | Route | Frequency | Start Date |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor Starting the Drugs: |       |           |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                           |       |           |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>Daily Doctor's Endorsement by a Sign</b>        |       |           |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>DRUG :</b>                                      |       |           |            | Date<br>Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose   | Route | Frequency | Start Date |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor Starting the Drugs: |       |           |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                           |       |           |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>Daily Doctor's Endorsement by a Sign</b>        |       |           |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>DRUG :</b>                                      |       |           |            | Date<br>Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose   | Route | Frequency | Start Date |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor Starting the Drugs: |       |           |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                           |       |           |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>Daily Doctor's Endorsement by a Sign</b>        |       |           |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>DRUG :</b>                                      |       |           |            | Date<br>Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose   | Route | Frequency | Start Date |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor Starting the Drugs: |       |           |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                           |       |           |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>Daily Doctor's Endorsement by a Sign</b>        |       |           |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

BAH-00651123 IP3-00173539  
 Mrs NAGA LAKSHMI PATNALA  
 09-06-1989 36 Y 11 M 7 D (F)  
 Dr. SUDHARANI BAIRRAJU

Weight 79.1kg Ward SVPOF



|    |  |            |  |            |  |            |            |
|----|--|------------|--|------------|--|------------|------------|
| te |  |            |  |            |  |            |            |
| ie |  | Nurse Sig. |  | Nurse Sig. |  | Nurse Sig. | Nurse Sig. |

|                                |           |  |           |  |           |  |           |  |
|--------------------------------|-----------|--|-----------|--|-----------|--|-----------|--|
| <b>DRUG :</b>                  | Dose      |  | Dose      |  | Dose      |  | Dose      |  |
|                                | Dr. Sign. |  | Dr. Sign. |  | Dr. Sign. |  | Dr. Sign. |  |
| Route                          | Dose      |  | Dose      |  | Dose      |  | Dose      |  |
|                                | Dr. Sign. |  | Dr. Sign. |  | Dr. Sign. |  | Dr. Sign. |  |
| 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. |  |

|                      |      |            |      |            |      |            |      |            |
|----------------------|------|------------|------|------------|------|------------|------|------------|
| <b>VARIABLE DOSE</b> | Date |            | Date |            | Date |            | Date |            |
|                      | Time |            | Time |            | Time |            | Time |            |
|                      |      | Nurse Sig. |      | Nurse Sig. |      | Nurse Sig. |      | Nurse Sig. |

|                                |           |  |           |  |           |  |           |  |
|--------------------------------|-----------|--|-----------|--|-----------|--|-----------|--|
| <b>DRUG :</b>                  | Dose      |  | Dose      |  | Dose      |  | Dose      |  |
|                                | Dr. Sign. |  | Dr. Sign. |  | Dr. Sign. |  | Dr. Sign. |  |
| Route                          | Dose      |  | Dose      |  | Dose      |  | Dose      |  |
|                                | Dr. Sign. |  | Dr. Sign. |  | Dr. Sign. |  | Dr. Sign. |  |
| 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        |
|---------|---------|---------------------------------|-----------------------------|-------|-----------|---------------|
| 16/5/26 | 8:45AM  | Inj. AMOXICILLIN<br>CLAVULANATE | 1-2gm                       | IV    | @kmj      | Bwae<br>A     |
| 16/5/26 | 10:00AM | Inj. PARACETAMOL                | 1gm                         | IV    | @kmj      | Bwae<br>Dyoth |
|         |         |                                 |                             |       |           |               |
|         |         |                                 |                             |       |           |               |
|         |         |                                 |                             |       |           |               |
|         |         |                                 |                             |       |           |               |
|         |         |                                 |                             |       |           |               |
|         |         |                                 |                             |       |           |               |
|         |         |                                 |                             |       |           |               |
|         |         |                                 |                             |       |           |               |
|         |         |                                 |                             |       |           |               |

VERIFIED BY: Swaine Signature



M-6  
**CONSENT FORM FOR  
ASSISTED REPRODUCTIVE TECHNOLOGY PROCEDURE**

Patient Name: Nagalakshmi Age 36 UHID No. BAH-00651123

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.

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

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).

A pregnancy may result from treatment.

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: Naga lakshmi.....

Husband Name: Rajesh Potharaju.....

Signature: Lakshmi.....

Signature: Rajesh.....

Date & Time: 08-05-26 11:15 AM.....

Date & Time: 08-05-26 11:15 AM.....

**Endorsement by the ART Clinic:**

I/we have personally explained to Naga lakshmi and Rajesh P 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: Naga lakshmi.....

Husband Name: Rajesh Potharaju.....

Signature: Lakshmi.....

Signature: Rajesh.....

Date & Time: 08-05-26 11:15 AM.....

Date & Time: 08-05-26 11:15 AM.....

Name, Address and Signature : [Signature].....

of the Witness from the clinic Swaroop.....

Date & Time: 08/5/26 @ 11:30 AM.....

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 : 08/5/26 @ 11:25 AM.....

Name of the Doctor: Dr. Sudhanai Bawriya.....

Signature: [Signature].....

Date & Time: 8/5/26, 11:16 AM.....

FORM-12  
CONSENT FORM FOR  
OOCYTE RETRIEVAL / EMBRYO TRANSFER



Patient Name: Maga Lakshmi Age: 34 UHID No: BA1700651123

Address: Flat 203, Sree Harsha Arcade, Parkash Nagar, Hrd

Name & Address of the ART Clinic: Birthright Fertility By Rainbow Hospital

I / We have asked the clinic named above to provide us with treatment services to help us to bear a child.

**I / We consent to:**

- a) Being prepared for oocyte retrieval by the administration of hormones and other drugs.
- b) The retrieval of oocyte(s) from my ovaries under ultrasound guidance / Laparoscopy and under Anaesthesia

BirthRight Fertility by  
Rainbow Hospitals, Banjara Hills  
8-2-120/10371, Survey No. 2,  
Banjara Hills, Hyderabad, Telangana-500 034.

**I / We understand that:**

I / We had a full discussion with Dr. Sudharani B. about the above procedures and the risks and complications involved and I have been given oral and written information about them 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 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.

I / We consent that I/we shall be the legal parent(s) of the child and the child will have all the legal rights on me, in case of anonymous gamete / embryo donation.

I / We 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.

Wife / Woman Name: Maga Lakshmi Husband Name: Rakesh Pottharaju

Signature: Lakshmi Signature: Rakesh

Date & Time: 16/5/20 @ 8:40 AM Date & Time: 16-05-20 08:40 AM

**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. We have had the Opportunity to ask questions, all of which have been answer to our 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 means as deemed appropriate by the professional team of BirthRight Fertility by Rainbow hospital. We understand that we will become legal parents of any resulting child and the child will have all the normal legal rights to us. With our signatures, we certify that we understand the implication of these procedures.

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: Naga Lakshmi

Husband Name: Rajesh Potharaju

Signature: Lakshmi

Signature: Rajesh

Date & Time: 16/5/26 @ 8:40 AM

Date & Time: 16/5/26, 8:40 AM

**Endorsement by the ART Clinic:**

I/ we have personally explained to Naga Lakshmi and Rajesh P. 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: Naga Lakshmi

Name, Address and Signature: [Signature]

Signature: Lakshmi

of the Witness from the clinic [Signature]

Date & Time: 16/5/26 @ 8:40 AM

Date & Time: 16/5/26 @ 8:40 AM

Name of the Doctor: Dr Sudhanand Banerjee

Signature: [Signature]

Date & Time: 16/5/26, 8:40 AM

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: Rajesh Potharaju

Name, Address and Signature: [Signature]

Address: Flat 203, Sree Harsha Arcade

of the Witness from the clinic [Signature]

Signature: Rajesh

Date & Time: 16/5/26 @ 8:40 AM

Date & Time: 16/5/26, 8:40 AM

Name of the Doctor: Dr Sudhanand Banerjee

Signature: [Signature]

Date & Time: 16/5/26, 8:40 AM

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

BAH-00651123 IP5-00173899  
 Mrs NAGA LAKSHMI PATNALA  
 09-06-1989 36 Y 11 M 7 D (F)  
 Dr. SUDHARANI BAIRRAJU



# CONSENT FOR ANAESTHESIA

Authorization By:  Patient  Patient Attendant

Operative Procedure: Oocyte Retrieval  
 Anaesthesiologist: Dr. Subramanyam Surgeon: Dr. Sudharani Bairraju

**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: Hemodynamic instability, Laryngospasm, Desaturation.

**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: [Signature]  
 Name: P. Nagalakshmi  
 Relationship with patient: \_\_\_\_\_  
 Date & Time: 8/5/26 2pm

**Witness:**  
 Signature: [Signature]  
 Name: Rakesh Potharaju  
 Date & Time: 8/5/26 @ 2pm

**Doctor (who is taking consent):**  
 Signature: [Signature] Name: Dr. Amieen Date 8/5/26 Time: 2pm

## 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 శిరస్థాపన 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 నార్మోటిక్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై లిస్ట్:

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, అలెర్జిక్ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెన్స్ యాక్సెస్, ఆర్థిరియల్ 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 స్వచ్ఛమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

నాక్షి:

సంతకం: .....

సంతకం: .....

పేరు: .....

పేరు: .....

రోగితో సంబంధం: .....

తేదీ & సమయం: .....

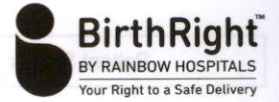
తేదీ & సమయం: .....

డాక్టర్ :

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

DIFFICULT AIRWAY NO NECK EXTENSION  
VENTILATION

**Department of Anaesthesiology**  
**PRE-ANAESTHETIC EVALUATION**



Name: Nayalaxmi Patrale Age: 36 Sex: F UHID.No: BHH-00651123  
 Date: 2/5/26 Time: 2 PM Proposed Operation: Oocyte Retrieval  
 Diagnosis: 1° Infertility  
 B.P / CRT: 130/70 H.R: 88 Weight: 78 kgs ASA Physical Status:  1  2  3  4  5

**Laboratory Data:**

Hgb: 10.8 Glucose: ..... Protein: ..... HIV: ..... X-Ray: .....  
 PCV: ..... Urea: ..... Alb: ..... HBS Ag: ..... ECG: .....  
 WBC: 7030 Creat: ..... Total Bill: ..... HCV: ..... 2D Echo: .....  
 Plate: 3.45 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: NKA

Medical History: CVS: KClO Hypothyroidism x 2 to 3yr

RESP: H/o mild cough @ Diabetes: ⊖

CNS: ⊖

Renal: ⊖ MTR > 4.

Hepatic / GE: fence Physical Activity: Active

Others: - H/o Rheumatoid Arthritis during childhood → osteoarthritis.

V/E Past Anaesthetic History: - H/o Lt - herniorrhaphy eye back, H/o Salpingectomy.  
- H/o laparoscopic surgery for fallopian tube removal

Physical Exam: apetite

Airway: MP 1 2 3 4 Mouth Opening: > 3F Mentohyoid Distance: < 3F Neck: ↓ 3yr been  
 Teeth: ↓ CA

Lungs: BAC → NO NECK extension → Bucktooth ⊕

Heart: 95 @ ↑ Broad neck ⊕ XX/XX

CNS: NAM, HMF ⊕ "stiff neck" XX/XX

Pregnant:  Yes  No  NA Venous Access Site: ⊕ Spine Exam for regional: Palpable

Anaesthetic Plan:  MAC  REGIONAL  GA-ETT  LMA

Peri-Operative Plan Explained to the Patient:  Yes  No

| CURRENT MEDICATIONS | DOSAGE        |
|---------------------|---------------|
| <u>T. THYRONA</u>   | <u>50 mcg</u> |
|                     |               |
|                     |               |
|                     |               |

- Pre-Operative Instructions:**
- DVT Prophylaxis :
  - NIL ORAL → Water / ORS 2 Hours → Others 6 Hours → solid / milk
  - Informed Consent:  Standard  High Risk
  - Post Operative Pain Management:  Discussed with Patient
  - Other Instructions: - chowidar nikithanani

Signature: [Signature] Name: Dr. Anveen

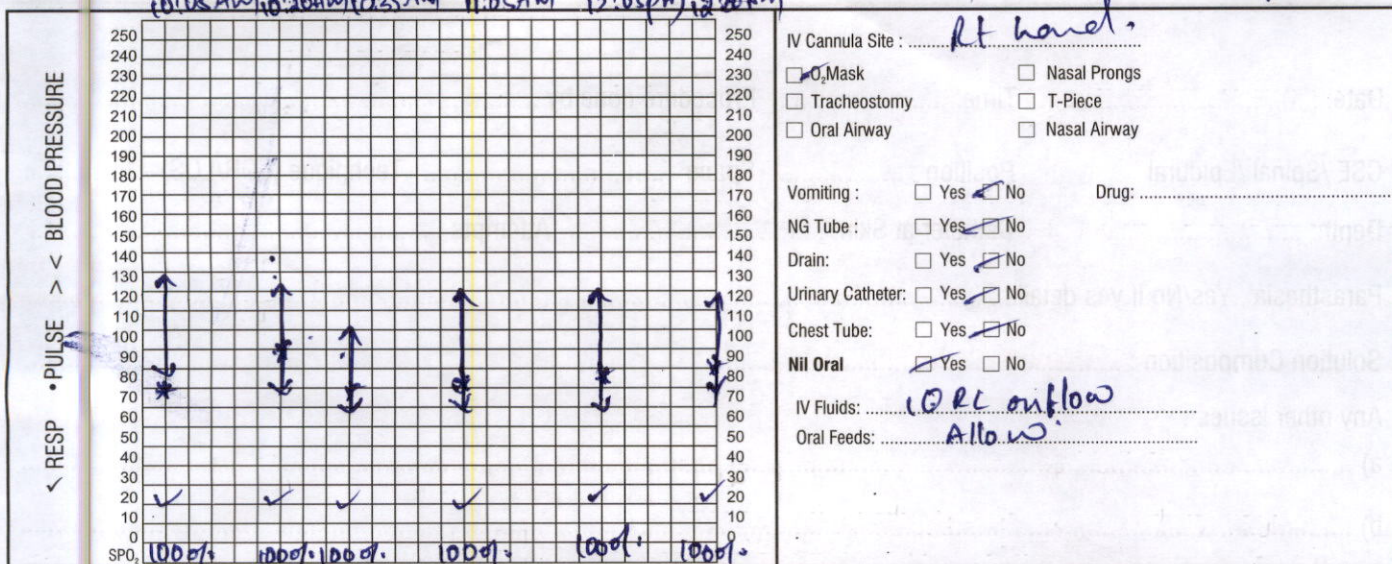


BAH-0651123 IP5-00173899  
 Mrs NAGA LAKSHMI PATNALA  
 09-06-1989 36 Y 11 M 7 D (F)  
 Dr. SUDHARANI BAIARRAJU



**POST-ANAESTHESIA CARE UNIT RECORD**

Received in PACU by : Sudhara Time Received : 10:05 AM Time Discharged : 1 pm



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

**PAIN ASSESSMENT AND MANAGEMENT FORM**

| Date    | Time     | Pain Score | Intervention            | Signature |
|---------|----------|------------|-------------------------|-----------|
| 16/5/26 | 10:10 AM | 05-6       | 200. PARACETAMOL 1gm IV | Sudhara   |
| 16/5/26 | 10:40 AM | 0-2        | — Advised rest —        | Sudhara   |
| 16/5/26 | 11:40 AM | 0          | — nil —                 | Sudhara   |

Pain Tool Used:  N PASS  FLACC  Wong Baker  NPS

**Reassessment Frequency:**

- Every eight hours for all hospitalized patients.
- For post surgical patient, patient with chronic pain, patient with severe pain
  - Every 2 hours for first 24 hours
  - After 24 hours every 4 hours
  - Prior to pain relieving intervention
  - With in 30-60 minutes after pain relief intervention

Anaesthesiologist Name : M. Lakshmi

Anaesthesiologist Signature : [Signature]

Date & Time : 16/5/26 at 12:40 pm

PACU Nurse Name : Sudhara

PACU Nurse Signature : [Signature]

Date & Time : 16/5/26 @ 10:10 AM

Transferred to Unit by (PACU): Billig

Date & Time : 16/5/26 @ 1 pm

Patient Sticker



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 |       | Maternal |       | FHR | Comments |
|------|-----------------------|------------|-------|-------|----------|-------|-----|----------|
|      |                       |            | Left  | Right | BP       | Pulse |     |          |
|      |                       |            |       |       |          |       |     |          |
|      |                       |            |       |       |          |       |     |          |
|      |                       |            |       |       |          |       |     |          |
|      |                       |            |       |       |          |       |     |          |
|      |                       |            |       |       |          |       |     |          |
|      |                       |            |       |       |          |       |     |          |
|      |                       |            |       |       |          |       |     |          |
|      |                       |            |       |       |          |       |     |          |
|      |                       |            |       |       |          |       |     |          |
|      |                       |            |       |       |          |       |     |          |
|      |                       |            |       |       |          |       |     |          |
|      |                       |            |       |       |          |       |     |          |
|      |                       |            |       |       |          |       |     |          |
|      |                       |            |       |       |          |       |     |          |
|      |                       |            |       |       |          |       |     |          |
|      |                       |            |       |       |          |       |     |          |
|      |                       |            |       |       |          |       |     |          |
|      |                       |            |       |       |          |       |     |          |

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 : .....



Surgeon : Dr. Sudhaani B  
 Asst. Surgeon : Dr. M. Poorna  
 Anaesthetist : Dr. Akhila  
 Scrub Nurse : Biswasee p

Patient Name : Naga Lakshmi Age 36y Gender : Female  
 UHID No. : BAH-006511 Surgery Name : Acute Retriev  
 Date : 16/5/26 In-time : 8:50 AM Out-time : 10:05 AM



Before Induction of Anaesthesia >>

Before Skin Incision >>

Before Patient Leaves Operating Room

| SIGN IN  |   | Time: <u>8:50 AM</u> |
|--|---|----------------------|
| <b>Patient Has Confirmed</b>   |   |                      |
| Identity   | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                      |
| Site   | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                      |
| Procedure  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                      |
| Consent  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                      |
| <b>Site Marked</b>   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA |                      |
| <b>Anaesthesia Safety Check Completed</b>                                | <input type="checkbox"/> Yes <input type="checkbox"/> No  |                      |
| <b>Pulse Oximeter on Patient &amp; Functioning</b>                       | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                      |
| <b>Does Patient have a:</b>  |   |                      |
| Known Allergy?   | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                             |                      |
| <b>Difficult Airway / Aspiration Risk?</b>                               |   |                      |
| Yes, & Equipment / Assistance Available                                  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                      |
| <b>Risk of &gt; 500ml Blood Loss (7ml/kg In Children)?</b>               |   |                      |
| Yes, and Adequate Intravenous Access and Fluids Planned                  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA |                      |
| Blood Units Reserved   | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA |                      |
| <b>Has Antibiotic Prophylaxis been given within the last 60 minutes?</b> | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                      |
| Signature : <u>(Signature)</u>   |   |                      |
| Name : <u>DR. AKHILAK</u>  |   |                      |

| TIME OUT  |   | Time: <u>9:05 AM</u>   |
|---|---|--|
| <b>Confirm all team members have introduced themselves by Name and Role</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| <b>Surgeon, Anaesthesia Professional and Nurse Verbally Confirm</b>   |   |  |
| Correct Patient (Check ID Band)   | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |  |
| Correct Site  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |  |
| Correct Procedure   | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |  |
| <b>Anticipated Critical Events</b>  |   |  |
| <b>Surgeon Reviews:</b>   |   |  |
| What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss?  | <u>Bleeding, 50-60 min, 5-10ml</u>  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |
| <b>Anaesthesia Team Reviews:</b>  |   |  |
| Are There Any Patient-specific Concerns?  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA |  |
| <b>Nursing Team Reviews:</b>  |   |  |
| Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns?   | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |  |
| <b>Is Essential Imaging Displayed?</b>  |   |  |
| Power Supply, Earthing, Power Backup and functioning of equipment checked.  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |  |
| Signature : <u>(Signature)</u>  |   |  |
| Name : <u>(Signature)</u>   |   |  |

| SIGN OUT  |   | Time: <u>10:00 AM</u> |
|---|---|-----------------------|
| <b>Nurse Verbally Confirms with the Team:</b>                             |   |                       |
| The Name of the Procedure Recorded  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                       |
| That Instrument, Sponge and Needle Counts are Correct (or Not Applicable) | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                       |
| The Specimen is Labelled (including patient name)                         | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                       |
| Whether there are any Equipment Problems to be addressed                  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA |                       |
| <b>To Surgeon, Anaesthetist and Nurse:</b>                                |   |                       |
| What are the key concerns for recovery and management of this patient?    | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                             |                       |
| Signature : <u>(Signature)</u>  |   |                       |
| Name : <u>Dr. Sudhaani B</u>  |   |                       |

BAH-00651123 IP5-00173899  
 Mrs NAGA LAKSHMI PATNALA  
 09-06-1989 36 Y 11 M 7 D (F)  
 Dr. SUDHARANI BAIRRAJU



## BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 16/5/26

Department : IVP-OT Duration of Procedure : 50-60 mins

Name of Surgeon : Dr. Sudharani Date of Admission : 16/5/26

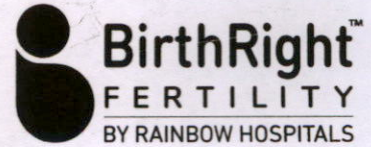
Bundle Care Criteria : (Tick (✓) if done)

|    |   | Staff Signature |
|----|---|-----------------|
| 1. | Antibiotic given prior to surgery ? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Single Dose Antibiotic or <input type="checkbox"/> Long Antibiotic Regime<br>Antibiotic administered within 60 minutes prior to incision ? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>Name of the Antibiotic : Inj. Augmentin 1gm/1c                |                 |
| 2. | Hair Removal <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No if Yes : Surgical Clipper<br>Department where Hair Removed : <input type="checkbox"/> Ward <input type="checkbox"/> Operating Room<br><input checked="" type="checkbox"/> Other : Home<br>Skin preparation done (cleanse surgical area with antiseptic agent)? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                 |
| 3. | Patient's body temperature immediately post operation (Recovery Room) 36.5 °C<br><input type="checkbox"/> Oral Or <input checked="" type="checkbox"/> Axilla (Goal : 36-37 °C)  |                 |
| 4. | Name of doctor or staff administering the antibiotic : Sis. Swaroop?<br>Date & Time of antibiotic administration : 16/5/26 @ 8:12 AM<br>Date & Time procedure started : 16/5/26 @ 9:08 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

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09-06-1989 36 Y 11 M 7 D (F)  
Dr. SUDHARANI BAIARRAJU

Patient



## POST PROCEDURE CARE PLAN

Date & Time: 16/5/26 @ 10:10Am

Patient Name: Mrs. Naga lakshmi Age: 36y UHID No: BAH 00651123

Procedure Done: Oocyte Retrieval

Post Procedure Diagnosis: B/c Tubal block

Post-Operative Monitoring Parameters / Frequency: SPO<sub>2</sub>, PR, BP every 5min for 15min, for min for 1hour, 30mins for 1hour, hourly till discharge

Special Patient Positioning and Requirements: Avoid prone position

Nutritional Instructions: Bland Diet

When to Start Mobilization: Recovery after anaesthesia

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: follow post op orders

Name of the Doctor: for Dr. Sudharani

Signature:

Date & Time: 16/5/26 @ 10:10Am

**Note:** Plan of care will be readjusted if necessary