

MAH-00371748 IP5-00173762
Mrs VENKATA NAVEENA POCHA
01-04-1995 31 Y 1 M 12 D (F)
Dr. SUDHARANI BAIRRAJU



SURGERY DETAILS

Date : 13/5/26

Patient Name: Mrs Naveena Pocha Date of Birth: 01/04/1995 Age: 31y

Gender: Female Ward: IUF OT UHID No.: MAH-00371748

Date of Surgery: 13/5/26 OT-1 OT-2 OT-3 OT-4 OBG OT-1 OBG OT-2

Name of the Surgery : Patient Oocyte Retrieval

Time in : 09:00 AM

Time Out : 09:30 AM

	<u>NAME</u>	<u>AMOUNT</u>
1. Surgeon	<u>Dr. Sudharani B</u>
2. Anaesthetist	<u>Dr. Adithi</u>
3. Assistant Surgeon	<u>Dr. M. Pooja</u>
4. OT Technician	<u>Bro Venkat</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
 Neuro Cusa Others ultra Sound guideline

265-024063

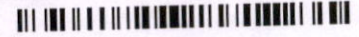
Signature of the Surgeon

Signature of Circulating Nurse

Order No: 5-0009605848/248

Order by: Swaroopa

ADMISSION SHEET



Registration Details :

Admission No : IP5-00173762 Admit Date : 13-May-2026 Admit Time : 08:32 AM UHID : MAH-00371748

Patient Details :

Patient Name : Mrs VENKATA NAVEENA POCHA Age : 31 Y 1 M 12 D
Guardian : Mr MALLU DASARATHARAMI REDDY DOB : 01-04-1995
Gender : Female Religion :
Occupation : Martial Status : Married
Address (H) : FLAT NO G3, MEGA SRI APTS, RD NO 7, ANAJANEYA NAGAR, MOOSAPET Bharat Nagar colony Hyderabad Telangana INDIA 500018
Phone No : 7730054476
E-mail : na@gmail.com

Admission Details :

Bed Type : DAY CARE Bed No : PRE OP 405 Ward Name : 4F-OT COMPLEX
Room No : PRE OP 405 Admission Type : First Visit

Contact Details :

Name : Mr MALLU DASARATHARAMI REDDY Relationship : Husband
Contact Address : FLAT NO G3, MEGA SRI APTS, RD NO 7, ANAJANEYA NAGAR, MOOSAPET Bharat Nagar colony Hyderabad Telangana INDIA 500018
Phone No : / 7730054476


Signature

Doctor Details :

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

Payment Details :

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

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ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP No : _____ Consultant: _____ Dept : _____

Date of Admission: _____ Time : _____ Date of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
13/5/26	08:55AM	Gyne Recons	IVF OT	Swacoopa.
13/5/26	09:30AM	IVF-OT	Gyne Recons	Swacoopa.
13/5/26	11:30AM	Gyne Recons	Billing	Swacoopa.

Cross Consultation Visit

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



OUTPATIENT NURSING ASSESSMENT FORM

Date: 13/5/26 Time: 8:35 am

Chief Complaint:

Allergies: Yes No Medications Blood Transfusion Food Not Known

If yes, identify

Vital Signs: Temperature: 98.6°F Pulse: 72bpm Respiratory Rate: 17/min
 BP: 97/60mmHg SpO₂: 99% Weight: 56.8kg Height: 1.61 BMI: 21.9

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 unusual concerns about patients Psychological / Social Status: nil

Inform the physician about any spiritual needs, if applicable

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date & Time: 13/5/26 @ 8:35am



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
13/5/26	9:40 AM	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	- 10/ -	A
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Re-assessment Frequency:

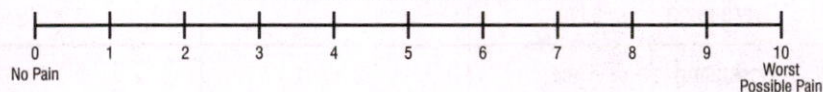
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years





MULTI-DISCIPLINARY PLAN OF CARE FORM

Unexplained Infertility

Diagnosis:

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
13/5/26 8:34 AM	<input checked="" type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Modified <input type="checkbox"/> Per-Op <input type="checkbox"/> Post Op	Oocyte Retrieval	to retrieve oocytes without complications	Oocyte Retrieval under USG guidance		<input checked="" type="checkbox"/> Nursing <input type="checkbox"/> Others:
13/5/26 8:40 AM	<input type="checkbox"/> Medical <input checked="" type="checkbox"/> Nursing <input type="checkbox"/> Others:	<input type="checkbox"/> Initial <input type="checkbox"/> Modified <input checked="" type="checkbox"/> Per-Op <input type="checkbox"/> Post Op	patient has come for oocyte retrieval	placed IV cannula and Id band, vital checked	shifted patient to OT upon doctor order		<input type="checkbox"/> Medical <input type="checkbox"/> Others:
13/5/26 09:23 AM	<input checked="" type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:	<input type="checkbox"/> Initial <input type="checkbox"/> Modified <input type="checkbox"/> Per-Op <input checked="" type="checkbox"/> Post Op	Rest for 2 hours	to discharge patient without complaints	All freeze		<input type="checkbox"/> Medical <input checked="" type="checkbox"/> Nursing <input type="checkbox"/> Others:
13/5/26 09:45 AM	<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:	<input type="checkbox"/> Initial <input type="checkbox"/> Modified <input type="checkbox"/> Per-Op <input type="checkbox"/> Post Op	procedure has done under ultra sound guideline under aseptic techniques	advised rest to patient for 2 hrs vitals monitoring	explained patient about discharge medication according to doctor order		<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:
	<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:	<input type="checkbox"/> Initial <input type="checkbox"/> Modified <input type="checkbox"/> Per-Op <input type="checkbox"/> Post Op					<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:

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*P. oocyte
 retained*

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CONSUMABLES OF OT

Clin: _____ Technician: *Venkatesh* Date: *13/5* **3948** Time: *PM*

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube			Major Pack			Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads: <i>A/P/N</i>		<i>03</i>				Suction Catheter		
HME filter: A/P/N						Feeding Tube		
Syringes : 10 cc		<i>2</i>				Vaccum Suction Set		
05 cc		<i>2</i>	Gloves			Surgical Gloves		
02 cc		<i>1</i>				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		<i>01</i>	Koochies			Mother gown	<i>01</i>	<i>01</i>
<i>nic spike</i>		<i>01</i>	Ointments			proto gowns	<i>02</i>	<i>02</i>
<i>Endo seal msc (A)</i>		<i>01</i>	Suction Catheter			Inj Augmentin 1.2gm	<i>01</i>	<i>01</i>
Fentanyl		<i>01</i>	Cap, Mask	<i>5/5</i>	<i>5/5</i>	RL 500 ml	<i>01</i>	<i>01</i>
Morphine			Gauze Pack			NS 100 ml	<i>02</i>	<i>02</i>
Ketamine			Mop Pack			foot cover	<i>02</i>	<i>02</i>
Propofol		<i>02</i>	Steristrip			Three way	<i>01</i>	<i>01</i>
Rocuronium			Underpad			20G cannula	<i>01</i>	<i>01</i>
Glycopyrolate		<i>01</i>	Draw sheet	<i>02</i>	<i>02</i>	Bitea fix	<i>01</i>	<i>01</i>
Myopyrolate			Abgel			Encore 6 1/2	<i>02</i>	<i>02</i>
Ondansetron			Foleys catheter			10cc Syngel	<i>02</i>	<i>02</i>
Pencan 25g/ Spinal Needle 22			Urobag			5cc syngel	<i>01</i>	<i>01</i>
Bupivacaine 0.25%			Chest Drainage Catheter			D-water	<i>02</i>	<i>02</i>
Bupivacaine 0.25%(Heavy)			Romodrain bag			Camera cover	<i>01</i>	<i>01</i>
Antibiotics			Bandage			Allesorb	<i>01</i>	<i>01</i>
<i>Sig midazolam</i>		<i>01</i>	Tegaderm			Transo fix (minis)	<i>01</i>	<i>01</i>
Suppositories			loban					
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					
<i>Gauze</i>		<i>01</i>	Microshield					
			Cotton Balls					
			Latex Gloves					
			Ramdione Scrub					
			Saral					

Surgeon *Dr. Sudharani B* Anaesthesiologist *Dr. Adithi* Nurse *Swaroopa* OT Technician *Bro. Venka*

Order No. : *5-0009605840/839* Ordered by : *Swaroopa*

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	Fall Risk Grading			
		Score				
History of Falling (immediately or w/in 3 months)	Yes	25				
	No	0	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15				
	No	0	0			
Ambulatory Aid	Furniture	30				
	Crutches, Cane(S), Walker	15				
	None /Bed Rest /Nurse Assist	0	0			
IV / Heparin Lock or Saline	Yes	20	20			
	No	0				
GAIT / Transferring	Impaired	20				
	Weak (uses touch for balance)	10				
	Normal /On Bed Rest /Immobile	0	0			
Mental Status	Forgets limitations	15				
	Oriented to own ability	0	0			
Total Morse Fall Scale Score:			20			
		Signature	<i>Sudh</i>			

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

Patient Sticker



Morse Fall Risk Assessment Form

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

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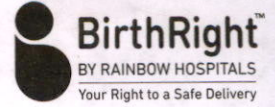
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MEDICATION RECONCILIATION FORM

Drug Allergies: NADA Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: Shifted to:

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
	<u>PAB CABERGOLINE</u>	<u>0.5mg</u>	<u>PO</u>	<u>on</u>	<u>12/5/20</u>	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
2						<input 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
						<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. Poorna

Date & Time: 13/5/20 @ 8:35 AM

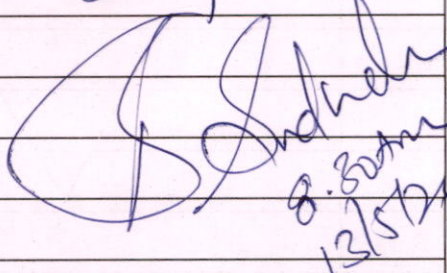
Nurse Name & Signature: Swaroop

Date & Time: 13/5/20 @ 8:40 AM

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Dr. SUDHARANI BAIRRAJU



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/5/26 8:30AM	Patient came for oocyte Retrieval Pfcldc Temp (N) PR - 88bpm Bp - 11/70mmHg P/A: sop	Patient can be shifted to OT for OR Dr. Poopa.  8:30am 13/5/26
13/5/26 12pm	Patient comfortable vitals stable Discharge summary explained	Patient can be discharged Dr. Poopa.

CONSENT FORM FOR ASSISTED REPRODUCTIVE TECHNOLOGY PROCEDURE



Patient Name: Venkata naveena pocha Age 34y UHID No. MAH-0037748

I/We have requested the clinic Birth Right 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).
- (vi) A pregnancy may result from treatment.
- (vii) Treatment may be abandoned at any time if there are problems in the laboratory or with the culture system.

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

Informed Consent:

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

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

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

Wife / Woman Name: P. Venkata Naveena
Signature: P.V. Naveena
Date & Time: 01/5/26 @ 2pm

Husband Name: M. Dasayatha Rami Reddy
Signature: M. Dasayatha Rami Reddy
Date & Time: 01/5/26 @ 2pm

Endorsement by the ART Clinic:

I/we have personally explained to venkata naveena ^{potha} and Dasayatha Rami Reddy 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: P. Venkata Naveena
Signature: P.V. Naveena
Date & Time: 01/5/26 @ 2pm

Husband Name: M. Dasayatha Rami Reddy
Signature: M. Dasayatha Rami Reddy
Date & Time: 01/5/26 @ 2pm

Name, Address and Signature: [Signature]
of the Witness from the clinic Rwacoopg
Date & Time: 01/5/26 @ 2:30pm

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: 01/5/26 @ 2:20pm

Name of the Doctor: Dr. Sudhakar B.
Signature: [Signature]
Date & Time: 01/5/26 @ 2:15pm

FORM-12

**CONSENT FORM FOR
OOCYTE RETRIEVAL / EMBRYO TRANSFER**



Patient Name: Venkata Naveena Poeha Age: 31y UHID No: MAT-00371748

Address: Hyd

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

I / We understand that:

I / We had a full discussion with Dr. Sudhakar 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: P. Venkata Navana

Husband Name: M. Dasaratha Rami Reddy

Signature: P.V. Navana

Signature: M. Dasaratha Rami Reddy

Date & Time: 13/5/26 @ 08:35AM

Date & Time: 13/5/26 @ 8:13AM

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 on 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: P. Venkata Naveena

Husband Name: M. Dasaratha Rami Reddy

Signature: P.V. Naveena

Signature: M. Dasaratha Rami Reddy

Date & Time: 13/5/26 @ 08:35am

Date & Time: 13/5/26 @ 08:35am

Endorsement by the ART Clinic:

I/ we have personally explained to ^{Pocho} Venkata Naveena and Dasaratha Rami Reddy 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: P. Venkata Naveena

Name, Address and Signature: [Signature]

Signature: P.V. Naveena

of the Witness from the clinic Swaroop

Date & Time: 13/5/26 @ 08:35am

Date & Time: 13/5/26 @ 8:40am

Name of the Doctor: Dr. Sudharani Banerjee

Signature: [Signature]

Date & Time: 13/5/26 @ 08:35am

BirthRight Fertility by
Rainbow Hospitals, Banjara Hills
8-2-120/103/1, Survey No. 403, Road No. 2,
Banjara Hills, Hyderabad, Telangana - 500034.

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: M. Dasaratha Rami Reddy

Name, Address and Signature: [Signature]

Address: Flat No: G3, Megastar Apts, Moosapet

of the Witness from the clinic Swaroop

Signature: M. Dasaratha Rami Reddy

Date & Time: 13/5/26 @ 08:40am

Date & Time: 13/5/26 @ 8:35am

Name of the Doctor: Dr. Sudharani B.

Signature: [Signature]

Date & Time: 13/5/26 @ 08:35am

BirthRight Fertility by
Rainbow Hospitals, Banjara Hills
8-2-120/103/1, Survey No. 403, Road No. 2,
Banjara Hills, Hyderabad, Telangana - 500034.

MAH-00371748 IP5-00173762
Mrs VENKATA NAVEENA POCHA
01-04-1995 31 Y 1 M 12 D (F)
Dr. SUDHARANI BAIKRAJU

ONSENT FOR ANAESTHESIA

Authorization By: Patient Patient Attendant

Operative Procedure: ovocyte Retrieval

Anaesthesiologist: Dr. Tejavini 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, Bradycardia

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: Naveena
Name: P. Venkata Naveena
Relationship with patient: Self
Date & Time: 5/5/2026 12:25pm

Witness:
Signature: M. Dasaratharani Reddy
Name: M. Dasaratharani Reddy
Date & Time: 5/5/2026 12:25pm

Doctor (who is taking consent):
Signature: [Signature] Name: Dr. Tejavini Date: 5/5/2026 Time: 12:25pm

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.

లిజనల్ 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 రిస్క్:

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.
 లిజనల్ 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 సింట్రిల్ వెనెస్ యాక్సెస్, ఆర్థిరియల్ లైన్, సపోజిటిలీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, లిజనల్ 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:

సాక్షి:

సంతకం:

సంతకం:

పేరు:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



Name: Venkata Naveena Pocha Age: 32y Sex: Female UHID No: MAH-00371748
 Date: 5/05/2026 Time: 12:20pm Proposed Operation: oocyte Retrieval
 Diagnosis: Infertility ; under IVF treatment
 B.P / CRT: 103/68 H.R: 70/w Weight: 56.8kgs ASA Physical Status: 1 2 3 4 5

Laboratory Data:

Hgb: <u>14.1</u>	Glucose: <u>/</u>	Protein: <u>/</u>	HIV: <u>/</u>	X-Ray: <u>/</u>
PCV: <u>42.1</u>	Urea: <u>/</u>	Alb: <u>/</u>	HBS Ag: <u>/</u>	ECG: <u>/</u>
WBC: <u>5400</u>	Creat: <u>/</u>	Total Bill: <u>/</u>	HCV: <u>/</u>	2D Echo: <u>/</u>
Plate: <u>2.1</u>	Na: <u>/</u>	Dir. Bill: <u>/</u>	Blood group: <u>/</u>	Stress/Anglo: <u>/</u>
PT: <u>/</u>	K: <u>/</u>	LDH: <u>/</u>	T3: <u>/</u>	Other: <u>/</u>
PTT: <u>/</u>	Ca++: <u>/</u>	Alk phos: <u>/</u>	T4: <u>/</u>	
INR: <u>/</u>	Mg++: <u>/</u>	Amylase: <u>/</u>	TSH: <u>/</u>	
	Cl-: <u>/</u>	SGOT/SGPT: <u>/</u>		

Allergies: NKDA

Medical History: CVS: 9
 RESP: Diabetes: -
 CNS: not significant
 Renal: not significant
 Hepatic / GE: Physical Activity: METS > 4
 Others: not significant

Past Anaesthetic History: n/o laparoscopic surgery 4 years ago & GA unsuccessful.

Physical Exam: (N)
 Airway: MP 1 2(3)4 Mouth Opening: Adequate Mentohyoid Distance: RFB Neck: (N) Teeth: intact
 Lungs: BAE (+) clear
 Heart: S1S2 (+) TVS: Wenckebach I mild
 CNS: MMET (+)
 Pregnant: Yes No NA Venous Access Site: accessible Spine Exam for regional: adenomyosis

Anaesthetic Plan: MAC REGIONAL GA-ETT LMA
 Peri-Operative Plan Explained to the Patient: Yes No

CURRENT MEDICATIONS	DOSAGE
<u>Tab. GLYCOMET SR</u>	<u>500mg</u>

- Pre-Operative Instructions:**
- DVT Prophylaxis: Yes explained
 - NIL ORAL: Water / ORS 2 Hours
Others 6 Hours
 - Informed Consent: Standard High Risk
 - Post Operative Pain Management: Discussed with Patient
 - Other Instructions: N

Signature: [Signature] Name: DR. Tejaswini

MAH-00371155
 Mrs VENKATA NAVEENA POCHA
 01-04-1995 31 Y 1 M 12 D (F)
 Dr. SUDHARANI BAIRRAJU



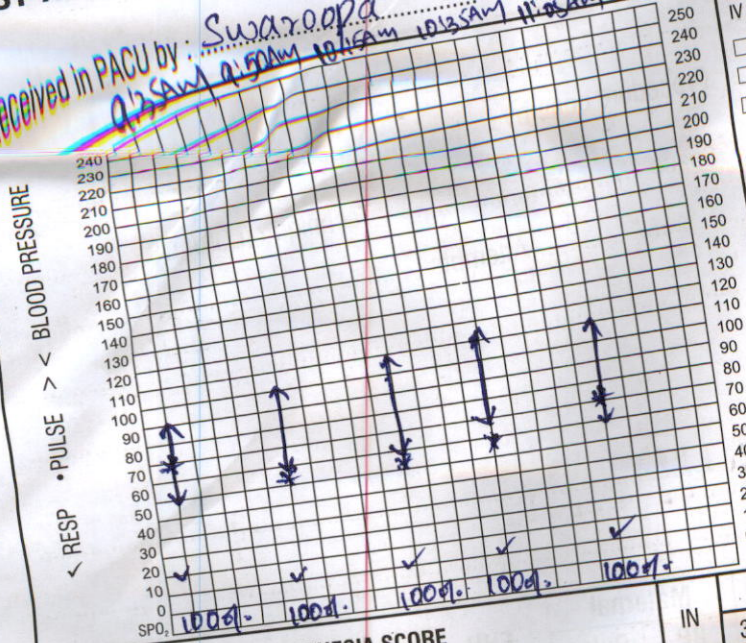
UNIT RECORD

POST-ANAESTHESIA

Received in PACU by: Swaroop
02:55AM 09:30AM 10:15AM 10:35AM 11:05AM

Time Received: 9:30AM

Time Discharged: 12pm



IV Cannula Site: Rt hand

O₂ Mask
 Tracheostomy
 Oral Airway

Nasal Prongs
 T-Piece
 Nasal Airway

Vomiting: Yes No
 NG Tube: Yes No
 Drain: Yes No
 Urinary Catheter: Yes No
 Chest Tube: Yes No
 Nil Oral
 IV Fluids: 100cc on flow
 Oral Feeds: Allow

Drug:

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

Date	Time	Pain Score	Intervention
13/5/26	9:35AM	0	nil

Signature

[Signature]

Pain Tool Used: N PASS FLACC Wong Baker NPS

Anaesthesiologist Name: Dr. Anand

Anaesthesiologist Signature: [Signature]

Date & Time: 13/5/26 at 11:30AM

PACU Nurse Name: Sis. Swaroopa

PACU Nurse Signature: [Signature]

Date & Time: 13/5/26 @ 01:40AM

- Reassessment
- Every 15 minutes
 - For post-operative patients.
 - For patients with chronic pain, patient with severe pain
 - For patients with severe pain
 - For patients with severe pain
 - For patients with severe pain

Transferred to ward for pain relief intervention

Date & Time:

MAH-00371748 IP5-00173762
 Mrs VENKATA NAVEENA POCHA
 01-04-1995 31 Y 1 M 12 D (F)
 Dr. SUDHARANI BAIRRAJU



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																			



SAFETY CHECKLIST

Surgeon : Dr. Sudhaeani B
 Asst. Surgeon : Dr. M. Pooja
 Anaesthetist : Dr. Adithi
 Scrub Nurse : Swarna P.

Patient Name : Mrs. Naveena P.V Age : 31y Gender : Female
 UHID No. : mat-00371 Surgery Name : Ovary to Retrieval
 Date : 13/5/26 In-time : 8:50 AM Out-time : 9:30 AM



Before Induction of Anaesthesia >>

Before Skin Incision >>

Before Patient Leaves Operating Room

SIGN IN		Time: <u>8:42</u>
Patient Has Confirmed		
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	
Site Marked	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA	
Anaesthesia Safety Check Completed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Pulse Oximeter on Patient & Functioning	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Does Patient have a:		
Known Allergy?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Difficult Airway / Aspiration Risk?		
Yes, & Equipment / Assistance Available	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Risk of > 500ml Blood Loss (7ml/kg in Children)?		
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 type="checkbox"/> No <input checked="" type="checkbox"/> NA	
Has Antibiotic Prophylaxis been given within the last 60 minutes?		
	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Signature : <u>Adithi</u>		
Name : <u>Dr. Adithi N</u>		

TIME OUT		Time: <u>08:58 AM</u>
Confirm all team members have introduced themselves by Name and Role <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm		
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	
Anticipated Critical Events		
Surgeon Reviews:		
What are the Critical or Unexpected Steps, Operative Duration, <u>10-15m Bleeding</u> Anticipated Blood Loss? <u>0-2ml</u> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA		
Anaesthesia Team Reviews:		
Are There Any Patient-specific Concerns? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA		
Nursing Team Reviews:		
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		
Is Essential Imaging Displayed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA		
Power Supply, Earthing, Power Backup and functioning of equipment checked. <input type="checkbox"/> Yes <input type="checkbox"/> No		
Signature : <u>Rubi</u>		
Name : <u>(Sara) Tyothi</u>		

SIGN OUT		Time: <u>9:28 AM</u>
Nurse Verbally Confirms with the Team:		
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 type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" 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	
To Surgeon, Anaesthetist and Nurse:		
What are the key concerns for recovery and management of this patient? <u>Pain Bleeding</u> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Signature : <u>Dr. Sudhaeani B</u>		
Name : <u>Dr. Sudhaeani B</u>		

Patient Sticker

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 Children's
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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 13/5/26

Department : IUP-OT Duration of Procedure : 20-30 min

Name of Surgeon : Dr. Sudharani B. Date of Admission : 13/5/26

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

		Staff Signature
1.	Antibiotic given prior to surgery ? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Name of the Antibiotic : INTI-AUGMENTIN 2gm IV	
2.	Hair Removal <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No if Yes : Surgical Clipper Department where Hair Removed : <input type="checkbox"/> Ward <input type="checkbox"/> Operating Room <input checked="" type="checkbox"/> Other : Home 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 <input type="checkbox"/> Oral Or <input checked="" type="checkbox"/> Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : Dr. Swaroop Date & Time of antibiotic administration : 13/5/26 @ 08:45 AM Date & Time procedure started : 13/5/26 @ 09 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

Docu. No. : RCHBH/ FRM / CLINICAL / 038

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POST PROCEDURE CARE PLAN

Date & Time: 13/5/26 @ 9:30 AM

Patient Name: Mrs. Venkata Naveena Age: 31y UHID No: MAH-00371748

Procedure Done: Oocyte Retrieval

Post Procedure Diagnosis: Unexplained Infertility

Post-Operative Monitoring Parameters / Frequency: (SPO, IPR, BP) every 5mins for 15mins
15mins for 1hour, 30min for 1hr. Hourly till discharge

Special Patient Positioning and Requirements: Avoid prone position

Nutritional Instructions: Bland Diet

When to Start Mobilization: Recovery after Anesthesia

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: All freeze

Name of the Doctor: Dr. Sudharani

Signature: [Signature]

Date & Time: 13/5/26 @ 9:30 AM

Note: Plan of care will be readjusted if necessary