BAH-00580619 IP5-00176751
Mrs KOTHAKONDA AKHILA
02-08-1997 28 Y 11 M 20 D (F)
Dr. SUDHARANI BAIRRAJU

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SURGERY DETAILS

Date : 22/7/26

Patient Name: Mrs. K. Akhila. Date of Birth: 02/8/1997 Age: 28y

Gender: female Ward : IVF OT UHID No.: BAH-00580619

Date of Surgery: 22/7/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Patient Oocyte Retrieval

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

		NAME	AMOUNT
1.	Surgeon	Dr. Sudharani. B	
2.	Anaesthetist	Dr. Sriramya.	
3.	Assistant Surgeon	Dr. Akhila	
4.	OT Technician	Sis. Shirisha	
5.	Circulating Nurse	-	
6.	Assistant Nurse	Sis Swaroopa	

Special Equipment: ☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☑ Others ultrasound Machine/Guidline

265-036517

Signature of the Surgeon

Signature of Circulating Nurse

Order No: S-0009715988/988 Order by: Swaroopa.

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Occyte Retrieval

CONSUMABLES OF OT

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Circulating staff :..... Technician KUNNUSHIRISHA Date : 22/7/26 Time : @9! Am

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			Major Pack			Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : A / P / N		03				Suction Catheter		
HME filter : A / P / N						Feeding Tube		
Syringes : 10 cc		02				Vaccum Suction Set		
05 cc		02	Gloves			Surgical Gloves		
02 cc		02				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		01	Koochies					
Tupen		01	Ointments					
Mini spike		01	Suction Catheter			Mother gown	01	01
Fentanyl		01	Cap, Mask	5/5	5/5	proto gowns	02	02
Morphine			Gauze Pack			NS 100ml	02	02
Ketamine			Mop Pack			RL 500 ml	01	01
Propofol		03	Steristrip			Inj. Augmentin 1.2g	01	01
Rocuronium			Underpad			Three way	01	01
Glycopyrolate			Draw sheet			Intrafix	01	01
Myopyrolate			Abgel			20G Cannula	01	01
Ondansetron			Foleys catheter			Camera cover	01	01
Pencan 25g/ Spinal Needle 22			Urobag			Allesorb	01	01
Bupivacaine 0.25%			Chest Drainage Catheter			foot cover	02	02
Bupivacaine 0.25%(Heavy)			Romodrain bag			povidine	01	01
Antibiotics			Bandage			Nelton 10G	01	01
Midaz		01	Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set					
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution					
Nasal prongs (A)		01	Microshield					
Vaccum set		01	Cotton Balls					
Nasal airway (28)			Latex Gloves					
		01	Ramdione Scrub					
Lox 2% jelly		01	Saral					

Surgeon Dr. Sudharani Anaesthesiologist Dr Sri Ranga Nurse Swaroop Shirisha OT Technician

Order No. : 5-000971598 3/984 Ordered by : Swaroop

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

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ACTIVITY RECORD FOR BILLING

Name :_____

UHID N_____ Consultant: _____ Dept : _____

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Date o_____ : _____ Date of Discharge : _____ Time: _____

Room _____ : _____ Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
22/7/21	8:55Am	Gyne Rec	IVF-OT	Swaroopa
22/7/21	9:30Am	IVF OT	Gyne Recov	Swaroopa
22/7/21	12pm	Gyne Rec	Billing	Swaroopa

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
22/7/26	Cardiac Monitor	8:30 Am	12pm	5-0009715987	[signature]
22/7/26	Ultrasound Machine	09Am	09:30Am	R265-036517	[signature]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
22/7/26	IV Cannulation	01	5-0009725988	
22/7/26	PAC	OP Basis	=	

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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PAIN ASSESSMENT FORM

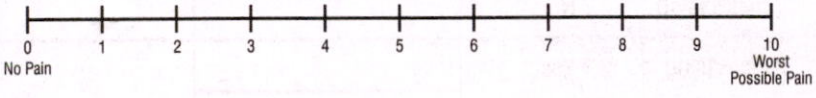
Date	Time	Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
22/7/26	8:30Am	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	—Nil—	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO_2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO_2 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO_2 less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

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MULTI-DISCIPLINARY PLAN OF CARE FORM

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Primary Subfertility with fibroid Uterus, Pre-Diabetic

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
22/7 8:45am	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	patient Came for oocyte retrieval	oocyte retrieval Event complication	oocyte retrieval under anesthesia.		☐ Nursing ☐ Others:
22/7/26 8:50Am	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Patient has come for oocyte Retrieval.	Vitals checked Placed IV Cannula	Shifted patient to OT as per doctor order.		☐ Medical ☐ Others:
22/7 9:30Am	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Monitor vitals, W/b bleeding P/V	Safe discharge	Discharge medications.		☐ Medical ☐ Nursing ☐ Others:
22/7/26 9:35A	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Procedure was done under ultrasound guidline & under aseptic precaution.	Vitals monitorg for 4hrs	Explaned about discharge medication as per doctor orders.		☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	22/7/26 8:30Am			Fall Risk Grading		
		Score						
History of Falling (immediately or w/in 3 months)	Yes	25				Risk Level	Morse Fall Score (MFS)	Action
	No	0	0					
Secondary Diagnosis (more than one diagnosis)	Yes	15	15					
	No	0				Low Risk	0 - 24	Standard Fall Precaution
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	0			Moderate Risk ✓	25 - 50	Implement Moderate Fall Prevention Intervention
GAIT / Transferring	Impaired	20						
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0	0					
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0	0					
Total Morse Fall Scale Score:			35					
		Signature	Dry					

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 Stic

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MEDICATION RECONCILIATION FORM

Drug Allergies: NKDA ☐ Not known any Drug Allergies

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

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

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr Akhila

Date & Time : 24/7/26 @ 8:24 AM

Nurse Name & Signature: Sis Swaroop 48

Date & Time : 22/7/26 at 8:50 AM

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Patient St

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7/2026 8:45 am	patient came for oocyte retrieval PR - 72 BP - 103/73 RR - 18 cpm SpO_2 - 100% P/A - soft	plan - PAC - NBM - shift to OT. [signature]
22/7/26 1 pm	patient stable discharge medications explained.	plan can be discharged [signature]

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

FORM-6

CONSENT FORM FOR ASSISTED REPRODUCTIVE TECHNOLOGY PROCEDURE

BirthRight™ FERTILITY BY RAINBOW HOSPITALS

Patient Name: K. Akeela Age 29 yrs UHID No. BATH-00580619

I/We have requested the clinic Birthright fertility by rainbow hospitals (name and address of clinic) to provide us with treatment services to help us bear a child.

We understand and accept (as applicable) that:

1. The drugs that are used to stimulate the ovaries for ovulation induction have temporary side- effects like nausea, headaches and abdominal bloating. Only in a small proportion of cases, a condition called ovarian hyperstimulation *occurs* where there is an exaggerated ovarian response. Such cases can be identified ahead of time but only to a limited extent. Further, at times the ovarian response is poor or absent in spite of using a high dose of drugs. Under these circumstances, the treatment cycle will be cancelled.
2. There is no guarantee that:
   (i) The oocytes will be retrieved in all cases.
   (ii) The oocytes will be fertilized.
   (iii) Even if there were fertilization, the resulting embryos would be of suitable quality to be transferred.

   All these unforeseen situations will result in the cancellation of any treatment.

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: Akhila K

Signature: K. Akhila

Date & Time: 13/7/26 @ 10:30 am

Husband Name: Vinay Kumar

Signature: V Kumar

Date & Time: 13/7/26 @ 10:30 am

Endorsement by the ART Clinic:

I/we have personally explained to Akhila K and Vinay Kumar 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: Akhila K

Signature: K. Akhila

Date & Time: 13/7/26 @ 10:30 am

Husband Name: Vinay Kumar

Signature: V Kumar

Date & Time: 13/7/26 @ 10:30 am

Name, Address and Signature : Malle

of the Witness from the clinic Birthright fertility

Date & Time: 13/7/26 @ 10:30 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 : 13/7/26 @ 10:30 am

Name of the Doctor: Dr Sudharan B

Signature: B Sudharan

Date & Time: 13/7/26 @ 10:30 am

FORM-12

CONSENT FORM FOR OOCYTE RETRIEVAL / EMBRYO TRANSFER

BirthRight™ FERTILITY BY RAINBOW HOSPITALS

Patient Name: Akila K Age: 29yrs UHID No: BAH-0058619

Address: Hyd.

Name & Address of the ART Clinic: Birthright fertility by rainbow hospitals

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 8-2-120/103/1, Survey No. 450, Road 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: Akila K

Signature: K Akila

Date & Time: 22/7/26 08:30Am

Husband Name: Vinay / Cmay

Signature: Kumar

Date & Time: 22/7/26 at 08:30Am

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: Akila K

Signature: K. Akila

Date & Time: 22/7/26 at 08:30Am

Husband Name: Vinay Kumar

Signature:

Date & Time: 22/7/26 at 08:30Am

Endorsement by the ART Clinic:

I/ we have personally explained to Akhila K. and Vinay Kumar 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: Akila K

Signature: K. Akila

Date & Time: 22/7/26 at 08:30Am

Name, Address and Signature:

of the Witness from the clinic

Date & Time: 22/7/26 at 08:35Am

Name of the Doctor: Dr Sudharan B

Signature:

Date & Time: 22/7/26 at 08:36Am

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: Vinay Kumar

Address: Hyd.

Signature:

Date & Time: 22/7/26 at 08:30Am

Name, Address and Signature:

of the Witness from the clinic Swaroopa

Date & Time: 22/7/26 at 08:35Am

Name of the Doctor: Dr Sudharan B

Signature :

Date & Time : 22/7/26 at 08:36Am

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-00580619 IP5-00176751
Mrs KOTHAKONDA AKHILA
02-08-1997 28 Y 11 M 20 D (F)
Dr. SUDHARANI BAIRRAJU

Patient S

Rainbow® Children's Hospital
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DRUG CHART

Date of Admission: 22/7/26 Drug Allergies: NKDA ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

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

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

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

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

Patient Sticker

REGULAR PRESCRIPTIONS

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

DRUG :

Date ▸ / Time ▾

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor
Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Date ▸ / Time ▾

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor
Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Date ▸ / Time ▾

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor
Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Date ▸ / Time ▾

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor
Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

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Weight. 67.3kg Ward. 2VPOT

VAR

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
2/2/	08:30Am	INJ AMOXICILLIN + CLAVULENATE	1.2g	IV		
2/2/	9:10Am	INJ PARACETAMOL	1g	IV		

VERIFIED BY ..... Signature .....

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I.V. FLUIDS CHART

Weight. 63.3kg Ward. IVF OT

		...nposition of I.V. Fluid (...mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
21/10	8:30Am	(1) RL	IV	75 ml/hr			22/10/[illegible]		

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

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Surgeon : Dr. Sudha rani B
Asst. Surgeon : Dr. Akhila
Anaesthetist : Dr. Sri Ramya
Scrub Nurse : Swaroop

Patient Name : Mst. K. Akhi Age : 28y Gender : F
UHID No. : BAH-00580619 Surgery Name : ODUT Retrieval
Date : 22/7/26 In-time : 08:55Am Out-time : 09:35Am

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 8:40Am

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

Site Marked ☐Yes ☑No ☐NA

Anaesthesia Safety Check Completed ☑Yes ☐No

Pulse Oximeter on Patient & Functioning ☑Yes ☐No

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

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

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

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

Signature : SR

Name : DR. K. SRI RAMYA

Before Skin Incision ➤➤

TIME OUT Time: 09 Am

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

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

Anticipated Critical Events

Surgeon Reviews:
- What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? Pain, Bleeding 15-20mins (0.5ml) ☐Yes ☐No ☐NA

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

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

Signature : S

Name : Swaroop

Before Patient Leaves Operating Room

SIGN OUT Time: 09:30Am

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

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

Signature : D Sudharani

Name : Dr. Sudharani B

Patient Sticker

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date : 22/7/26

To Be Filled In By Assigned Nurse :

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

Name of Surgeon : Dr. Sudharani B Date of Admission : 22/7/26

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

		Staff Signature
1.	Antibiotic given prior to surgery ? ☑ Yes ☐ No ☑ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☑ Yes ☐ No Name of the Antibiotic : Inj. Augmentin 1.2gm IV	Swaroop
2.	Hair Removal ☑ Yes ☐ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☐ Operating Room ☑ Other : Home Skin preparation done (cleanse surgical area with antiseptic agent)? ☑ Yes ☐ No	Swaroop
3.	Patient's body temperature immediately post operation (Recovery Room) 36.5 °C ☐ Oral Or ☑ Axilla (Goal : 36-37 °C)	Sw
4.	Name of doctor or staff administering the antibiotic : Sri. Swaroop Date & Time of antibiotic administration : 22/7/26 at 8:30AM Date & Time procedure started : 22/7/26 09AM	S

- 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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POST PROCEDURE CARE PLAN

Date & Time: 22/7/2026 @ 9:30Am

Patient Name: Mrs. Akila K. Age: 28y UHID No: BAH-00580619

Procedure Done: Oocyte retrieval

Post Procedure Diagnosis: Oocyte retrieval done

Post-Operative Monitoring Parameters / Frequency: monitor PR, BP, SpO2, RR every 5mins for 15mins, every 15mins for 1hr, hrly till discharge

Special Patient Positioning and Requirements: Avoid prone position

Nutritional Instructions: Bland Diet

When to Start Mobilization: after consciousness

Special Referrals: —

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

Any Other Post-Operative Care Needed including Required Follow Up: All pre medications

Name of the Doctor: Dr Sudharani

Signature: for Akhila.

Date & Time: 22/7/2026 @ 9:30 Am

Note: Plan of care will be readjusted if necessary

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NURSES NOTES

☑ No Known Allergies

☐ Drug Allergies ..... NKDA .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
22/7/26	08:30AM	Pre-Procedure Notes:- Mrs. K. Akhila patient has come for oocyte retrieval. Took patient file identification of patient has done by patient full Name, UHID Number and procedure Name. Given mother gown, face mask, head cap to wear. placed ID band, vitals checked informed doctor. Placed an I.V cannula. Given an antibiotic as per doctor's order. patient Emptied bladder shifted patient to OT as per doctor's order. Informed Health Care team. Swaroop 018
22/7/26	9AM	Intra-procedure Note:- Once again patient identification done by patient full Name UHID Number & procedure Name. placed patient into Litho tomy position. Under ultrasound guidline & under aseptic precautions procedure has done Swaroop 018

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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NURSES NOTES

☒ Drug Allergies ..... NKDA .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
22/7/20	9:35am	Post procedure Notes
		- Shifted patient to observation room to take rest for obs. vitals monitored vitals are stable. patient had food. No complaints Explained about post-procedure medication as per doctor orders. patient discharged without any complaints
		Dr 0184B
		vitals
		Temp- 98.6°F
		Bp- 103/57mmHg
		Pulse- 76b/m
		Resp- 18/m
		SpO2- 100%
		P/A - soft
		Dr 0184B

NOTE : DO NOT WRITE OUTSIDE THE MARGINS