Patient Sticker

BAH-00579214 IP5-00174601
Mrs BIRALA VENKATA SAI APURVA
09-06-1993 32 Y 11 M 23 D (F)
Dr. SUDHARANI BAIRRAJU

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SURGERY DETAILS

BAH-00579214 IP5-00174601
Mrs BIRALA VENKATA SAI APURVA
09-06-1993 32 Y 11 M 23 D (F)
Dr. SUDHARANI BAIRRAJU

Date : 01/6/26.

Patient Name: ..... Date of Birth: 09/6/1993 Age: 32y

Gender: ..... Ward : IVF OT UHID No.: .....

Date of Surgery: 01/6/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Frozen Embryo Transfer.

Time in : 01:25pm Time Out : 01:35pm

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

Special Equipment: ☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☑ Others ultrasound guidlie
R265-02 7607

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 5-0009637758/758 Order by: Swaroopa

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

BAH-0059214 IP5-00174601
Mrs BIRALA VENKATA SAI APURVA
09-06-1993 32 Y 11 M 23 D (F)
Dr. SUDHARANI BAIRRAJU

RET

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CONSUMABLES OF OT

Circulating staff : - Technician : - Date : 01/06/23430 Time : 2:20pm

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			Major Pack			Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : A / P / N						Suction Catheter		
HME filter : A / P / N						Feeding Tube		
Syringes : 10 cc						Vaccum Suction Set		
05 cc			Gloves			Surgical Gloves		
02 cc						Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade			Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL			Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml			Koochies					
			Ointments					
			Suction Catheter			Mother gown	01	01
Fentanyl			Cap, Mask	3/3	3/3	NS 100ml	02	02
Morphine			Gauze Pack			1cc Syringe	01	01
Ketamine			Mop Pack			Encore 6	02	02
Propofol			Steristrip			Minispike	01	01
Rocuronium			Underpad	01	01	foot cover	02	02
Glycopyrolate			Draw sheet	02	02	proto gown	02	02
Myopyrolate			Abgel					
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
			Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set					
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution					
			Microshield					
			Cotton Balls					
			Latex Gloves					
			Ramdione Scrub					
			Saral					

Surgeon Dr. Sudhaeani B Anaesthesiologist - Nurse Swaroop OT Technician

Order No. : S-0009837759/755 Ordered by : Swaroop.

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

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ACTIVITY RECORD FOR BILLING

BAH-00579214 IP5-00174601
Name Mrs BIRALA VENKATA SAI APURVA
09-06-1993 32 Y 11 M 23 D (F)
Dr. SUDHARANI BAIRRAJU
UHID

Consultant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
01/6/26	2pm	Gyn Ken	EVF OT	Swaroopa.
01/6/26	2:40pm	EVF OT	Gyn Ken	Swaroopa
01/6/26.	11:10pm	Gyn Le	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
01/6/20	Cardiac Monitor	2pm	2:20pm	5-000963 7757	[signature]
01/6/20	ultrasound machine	2:25pm	2:35pm	R265 02 7607	[signature]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Banjara Hills

8-2-120/103/1,2,3,4 and 5,Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad ,Telangana, India ,500034.
TEL NO :+91-40-4466 5555
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP5-00174601 **Admit Date** : 01-Jun-2026 **Admit Time** : 01:22 PM **UHID** : BAH-00579214

Patient Details :

Patient Name	: Mrs BIRALA VENKATA SAI APURVA	**Age**	: 32 Y 11 M 23 D
Guardian	: Mr NIKETH CHENNA MADHAV	**DOB**	: 09-06-1993
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Married
Address (H)	: H NO 13-1-215/1/A, B S P COLONY MOTHINAGAR, Sanathnagar Hyderabad Telangana INDIA 500018	**Phone No**	: 9908330002/ 9642991989
		E-mail	: NIKETH29@GMAIL.COM

Admission Details :

Bed Type : DAY CARE **Bed No** : POST OP 409 **Ward Name** : 4F-OT COMPLEX

Room No : POST OP 409 **Admission Type** : First Visit

Contact Details :

Name	: Mr NIKETH CHENNA MADHAV	**Relationship**	: Husband
Contact Address	: H NO 13-1-215/1/A, B S P COLONY MOTHINAGAR, Sanathnagar Hyderabad Telangana INDIA 500018	**Phone No**	: 9908330002 / 9642991989

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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8-2-120/103/1,2,3,4 and 5,Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad ,Telangana, India ,500034.
TEL NO :+91-40-4466 5555
WEB : https://rainbowhospitals.in

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Mrs BIRALA VENKATA SAI APURVA**	**Age :**	**32 Y 11 M 23 D**
IP No:	**IP5-00174601**	**Sex:**	**Female**
Consultant:	**Dr. SUDHARANI BAIRRAJU**	**Ward/Bed No:**	**4F-OT COMPLEX/POST OP 409**

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

Patient, be deemed advisable or necessary.

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

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

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

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

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

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

Signature of Patient/Relative:

Name: Nikesh Chowa Mother.
Relationship: Mother
Date: 01/06/2026 Time: 1:24pm
Witness Name:
Witness Signature:

Patient Address:
H NO 13-1-215/1/A, B S P COLONY
MOTHINAGAR, Sanathnagar
Hyderabad Telangana INDIA 500018

BAH-00579214 IP5-00174601
Mrs BIRALA VENKATA SAI APURVA
09-06-1993 32 Y 11 M 23 D (F)
Dr. SUDHARANI BAIRRAJU

FORM-6

CONSENT FORM FOR ASSISTED REPRODUCTIVE TECHNOLOGY PROCEDURE

BirthRight™ FERTILITY BY RAINBOW HOSPITALS

Patient Name: W/ BIRALA VENKATA SAI APURVA Age 32 UHID No. BAH-005792-W

I/We have requested the clinic Birthright fertility By Rainbow Hospital. (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.

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

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: BIRALA VENKATA SAI APURVA

Signature: B.V. Sai Apurva

Date & Time: JUN 1, 2026 2pm

Husband Name: NIKETH CHENNA MADHAV

Signature:

Date & Time: JUN 1, 2026 2pm

Endorsement by the ART Clinic:

I/we have personally explained to B.V. Sai Apurva and Niketh Chenna M 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: BIRALA VENKATA SAI APURVA

Signature: B.V. Sai Apurva

Date & Time: JUN 1, 2026 2pm

Husband Name: NIKETH CHENNA MADHAV

Signature:

Date & Time: JUN 1, 2026 2pm

Name, Address and Signature :

of the Witness from the clinic Swaroop

Date & Time: Jun 1 2026 @ 2:20pm

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

Name of the ART Clinic:

Address:

Date & Time : Jun 01/26 @ 2:30 pm

Name of the Doctor: Dr. Sudhaarani

Signature:

Date & Time: 1 June 26 2:15 pm

CONSENT FORM FOR FROZEN EMBRYO TRANSFER

BirthRight™ FERTILITY BY RAINBOW HOSPITALS

Patient Name: BIRALA VENKATA SAI APURVA Age: 32 UHID No: BAH-0057921M.

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

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

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

We understand that

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

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

Informed Consent:

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

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

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

Patient Name: BIRALA VENKATA SAI APURVA Spouse Name: NIKETH CHENNA MADHAV

Signature: B.V.Sai Apurva Signature:

Date & Time: JUN 1, 2026 2pm Date & Time: JUN 1, 2026 2pm

Endorsement by Assisted Reproductive Technology Clinic:

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

Name of the Doctor: Dr. Sudhaeani.B Signature:

Date & Time: June 1. 2026 at 2:15pm

Patient Stick

BAH-00579214 IP5-00174601
Mrs BIRALA VENKATA SAI APURVA
09-06-1993 32 Y 11 M 23 D (F)
Dr. SUDHARANI BAIRRAJU

BirthRight™ FERTILITY BY RAINBOW HOSPITALS

OUTPATIENT NURSING ASSESSMENT FORM

Date: 01/6/26 Time: 01:35 pm

Chief Complaint: .....

.....

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

If yes , identify .....

Vital Signs : Temperature: 98.6°f Pulse: 70b/m Respiratory Rate 18/m

BP 117/75mHg SpO_2 100% Weight 54.7kg Height 1.62 BMI 20.8

Pain Screening: ☐ Yes ☐ No If Yes, Pain Score: ..... Pain Tool Used: ☐ Wong Baker ☐ NPS

RISK FOR FALL:

History of Falling: within past 3 months ☐ Yes ☑ No

Ambulatory Aids:

- Wheelchair ☐ Yes ☑ No
- Crutches / Cane / Walker ☐ Yes ☑ No
- Uses furniture for support ☐ Yes ☑ No

Gait/Transferring:

- Bedrest / immobile ☐ Yes ☑ No
- Weak ☐ Yes ☑ No
- Impaired ☐ Yes ☑ No

Mental Status:

- Forgets limitations ☐ Yes ☑ No
- Vulnerable Patient ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

- ☐ Escort while ambulating
- ☐ Assist Patient
- ☐ Educate patient and family on fall precautions/prevention

Functional Screening:

☑ Normal Activity of Daily Living

If there is abnormal ADL check one of the following

- ☐ Mobility Problems
- ☐ Dressing Problems
- ☑ Others .....

Inform consultant for positive criteria

Nutritional Screening: ☑ No Abnormalities Detected

- ☐ Abnormal BMI
- ☐ Appetite Problem
- ☐ Loss of Weight Observed in the past 3 Months
- ☐ Others .....

Inform consultant for positive criteria

Psycho-Social-Economic-Spiritual Screening: ☑ No Significant Findings

☐ Single ☑ Married ☐ Lives Alone ☐ Lives with family ☐ Lives with friends ☐ Abnormal behaviour

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

Inform the physician about any spiritual needs, if applicable

Nurse Signature: ..... Nurse Name: Swaroopa

Date & Time: 01/06/26 @ 2pm

Mrs BIRALA VENKATA SAI APURVA
09-06-1993 32 Y 11 M 23 D (F)
Dr. SUDHARANI BAIRRAJU

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PAIN ASSESSMENT FORM

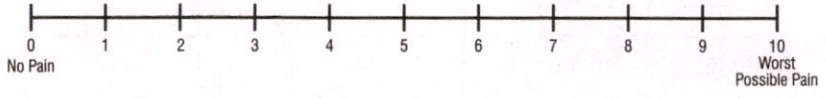
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
01/6/26	2pm	0	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	[signature]
				☐ Continuous ☐ Intermittent	☐ 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_2less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

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09-06-1993 32 Y 11 M 23 D (F)
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MULTI-DISCIPLINARY PLAN OF CARE FORM

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Diagnosis: Primary Subfertility with Endometriosis & POR

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
1/6/26 2pm	☑ Medical ☐ Nursing ☐ Others:	☑ Initial ☐ Modified ☐ Per-Op ☐ Post Op	patient came for frozen embryo transfer	frozen embryo transfer pregnancy count complication	frozen embryo transfer		☑ Nursing ☐ Others:
01/6/26 2:10pm	☐ Medical ☑ Nursing ☐ Others:	☐ Initial ☐ Modified ☑ Per-Op ☐ Post Op	Patient was come for frozen Embryo Transfer	Vitals checked Recorded	shifted patient to OT upon doctor orders		☑ Medical ☐ Others:
1/6/26 2:30pm	☑ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☑ Post Op	Monitor Vitals	Safe Discharge	Early Ambulation discharge medications		☐ Medical ☑ Nursing ☐ Others:
01/6/26	☐ Medical ☑ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☑ Post Op	Advised rest to Patient for 30 mins shifted to observation	Advised rest to patient for rest	Explained about discharge medications and to follow doctor orders		☑ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

BAH-00579214 IP5-00174601
Mrs BIRALA VENKATA SAI APURVA
09-06-1993 32 Y 11 M 23 D (F)
Dr. SUDHARANI BAIRRAJU

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time		01/6/26 4pm		Fall Risk Grading		
		Score						
History of Falling (immediately or w/in 3 months)	Yes	25						
	No	0		0		Risk Level	Morse Fall Score (MFS)	Action
Secondary Diagnosis (more than one diagnosis)	Yes	15						
	No	0		0				
Ambulatory Aid	Furniture	30				Low Risk	0 - 24	Standard Fall Precaution
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0		0				
IV / Heparin Lock or Saline	Yes	20						
	No	0		0		Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
GAIT / Transferring	Impaired	20						
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0		0				
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0		0				
Total Morse Fall Scale Score:				0				
		Signature						

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

Patient Sticker

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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				**Risk Level**	**Morse Fall Score (MFS)**	**Action**
	No	0						
Secondary Diagnosis (more than one diagnosis)	Yes	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						
IV / Heparin Lock or Saline	Yes	20				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20						
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0						
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)

- ☐ 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

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- ☐ Assess patient after visitors, leave to ensure safety measures in place

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

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SIA-10

Patient Sticker

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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. ESTRABET	2mg	PO	TID	11/6 9am	☑C ☐DC
2	T. CEFTRIN	1gm IV	PO	BD	11/6 1pm	☑C ☐DC
3	T. METROL	16 IV	PO	BD	11/6 1pm	☑C ☐DC
4	T. FOLIC ACID	5mg	PO	OD	11/6 1pm	☑C ☐DC
5	INJ HAD	100 mg	IM	OD	31/5 3pm	☑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 Ruhila

Date & Time : 1/6/2026 @ 2pm

Nurse Name & Signature: Sis Swaroopa.

Date & Time : 01/6/26 @ 2:10pm

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/6/26 12pm	patient came for PET PR – 80 bpm BP – 110/70 mm SpO2 – 100%	plan – Shift to OT
11/6/26 4pm	Pt Stable Discharge Medications explained.	plan – can be discharged

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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Dr. SUDHARANI BAIRRAJU

LIST

Surgeon : Dr. Sudharani B
Asst. Surgeon : Dr. Akhila
Anaesthetist : -
Scrub Nurse : Swaroopa

Patient Name : B.V. Sai Apurva Age : 32 yrs Gender : F
UHID No. : BAH-00579214 Surgery Name : FET
Date : 1/6/26 In-time : 2:15 pm Out-time : 2:30 pm

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Before Induction of Anaesthesia ➢ ➢

SIGN IN Time: ....

Patient Has Confirmed

- Identity ☐ Yes ☐ No
- Site ☐ Yes ☐ No
- Procedure ☐ Yes ☐ No
- Consent ☐ Yes ☐ No

Site Marked ☐ Yes ☐ No ☐ NA

Anaesthesia Safety Check Completed ☐ Yes ☐ No

Pulse Oximeter on Patient & Functioning ☐ Yes ☐ No

Does Patient have a:

- Known Allergy? ☐ Yes ☐ No

Difficult Airway / Aspiration Risk?

- Yes, & Equipment / Assistance Available ☐ Yes ☐ No

Risk of > 500ml Blood Loss (7ml/kg In Children)?

- Yes, and Adequate Intravenous Access and Fluids Planned ☐ Yes ☐ No ☐ NA
- Blood Units Reserved ☐ Yes ☐ No ☐ NA

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

Signature : ....

Name : ....

Before Skin Incision ➢ ➢

TIME OUT Time: 02:20 pm

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? Difficulty catheter tizet 5 mins 0 ml. ☐ Yes ☑ No ☐ NA

Anaesthesia Team Reviews:

Are There Any Patient-specific Concerns? ☐ Yes ☑ No ☐ NA

Nursing Team Reviews:

Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☑ Yes ☐ No ☐ NA

Is Essential Imaging Displayed? ☐ Yes ☑ No ☐ NA

Power Supply, Earthing, Power Backup and functioning of equipment checked. ☑ Yes ☐ No

Signature : [signature]

Name : Swaroopa

Before Patient Leaves Operating Room

SIGN OUT Time: 2:30 pm

Nurse Verbally Confirms with the Team:

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

To Surgeon, Anaesthetist and Nurse:

What are the key concerns for recovery and management of this patient? ☐ Yes ☑ No

Signature : [signature]

Name : Dr. Sudharani B

Doc. No. : RCHBH/ FRM / CLINICAL / 111

Patient Sticke

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date : 01/6/26

To Be Filled In By Assigned Nurse :

Department : RVF:OT Duration of Procedure : 10-15mins

Name of Surgeon : Dr. Sudharani B Date of Admission : 01/6/26

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 :	
2.	Hair Removal ☑ Yes ☐ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☐ Operating Room ☑ Other : Room Skin preparation done (cleanse surgical area with antiseptic agent)? ☑ Yes ☐ No	
3.	Patient's body temperature immediately post operation (Recovery Room) 36.5 °C ☐ Oral Or ☑ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : ..... Date & Time of antibiotic administration : ..... Date & Time procedure started : 01/6/26 @ 2:25pm	

- 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: 1/6/2026 @ 2:45 pm

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

Procedure Done: Frozen embryo transfer (FET)

Post Procedure Diagnosis: FET done

Post-Operative Monitoring Parameters / Frequency: —

Special Patient Positioning and Requirements: —

Nutritional Instructions: Normal Diet

When to Start Mobilization: —

Special Referrals: —

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

Any Other Post-Operative Care Needed including Required Follow Up: β-hCG after 12 days
Luteal Support

Name of the Doctor: Dr. SudhaRani

Signature:

Date & Time: 1/6/2026 @ 2:45 pm

Note: Plan of care will be readjusted if necessary