BAH-00420367 IP5-00174050
Ms M.HARI MANASA
24-03-1994 32 Y 1 M 26 D (F)
Dr. SUDHARANI BAIRRAJU

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SURGERY DETAILS

Date : 20/05/26

Patient Name: Miss. M. Hari Manasa Date of Birth: 24/03/1994 Age: 32y

Gender: female Ward : 3VT-OT UHID No.: BAH-00420367

Date of Surgery: 20/5/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Patient oocyte Retrieval.

Time in : 09:10 Am Time Out : 09:30 Am

		NAME	AMOUNT
1.	Surgeon	Dr. Sudharani. B	
2.	Anaesthetist	Dr. Ameen	
3.	Assistant Surgeon	Dr. M. Pooja.	
4.	OT Technician	Bro. Venkat	
5.	Circulating Nurse	Sis. Rajini	
6.	Assistant Nurse	Sis. Swaroopa.	

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

Signature of the Surgeon

R265-025337
Signature of Circulating Nurse

Order No: 5-000961713 3/133 Order by: Swaroopa

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

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 : IP5-00174050 **Admit Date** : 20-May-2026 **Admit Time** : 08:10 AM **UHID** : BAH-00420367

Patient Details :

Patient Name	: Ms M.HARI MANASA	**Age**	: 32 Y 1 M 26 D
Guardian	: MR.M.V.RAMA RAJU	**DOB**	: 24-03-1994
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Married
Address (H)	: #501 kranthi ceon jayabheri Gachibowli Hyderabad Telangana INDIA 500032	**Phone No**	: 9550007037/ 9849909184
		E-mail	: nomailid@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : RC 406 **Ward Name** : 4F-GYN RECOVERY

Room No : RC 406 **Admission Type** : First Visit

Contact Details :

Name : MR.M.V.RAMA RAJU **Relationship** : Father

Contact Address : #501 kranthi ceon jayabheri Gachibowli Hyderabad Telangana INDIA 500032 **Phone No** : 9550007037

B. Sathu kumari

Signature

Doctor Details :

Doctor Name : Dr. SUDHARANI BAIRRAJU **Specialisation** : INFERTILITY

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash **Payor Name** : SELFPAY

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ACTIVITY RECORD FOR BILLING

BAH-00420367 IP5-00174050
Ms M.HARI MANASA
24-03-1994 32 Y 1 M 26 D (F)
Dr. SUDHARANI BAIRRAJU

Name _____

UHID _____ 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
20/5/21	8:58Am	MICU	IVF-OT	Swaroopa.
20/5/21	9:35Am	IVF-OT	MICU	Swaroopa
20/5/21	11:45Am			

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

Ms M.HARI MANASA
24-03-1994 32 Y 1 M 26 D (F)
Dr. SUDHARANI BAIRRAJU

OOcyte Retrival

CONSUMABLES OF OT

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Circulating staff : ..... Technician : Venkat Sai ... Date : 20/5/3949 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		4				Vaccum Suction Set		
05 cc		2	Gloves			Surgical Gloves		
02 cc		2				Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade			Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL			Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml		01	Koochies					
Mini spike		01	Ointments					
			Suction Catheter			Mother gown	01	01
Fentanyl		01	Cap, Mask			proto gown	02	02
Morphine			Gauze Pack	5/5	5/5	NS 100ml	02	02
Ketamine			Mop Pack			Minispike	01	01
Propofol		02	Steristrip			RL 500ml	01	01
Rocuronium			Underpad			Inj. Augmentin 1.2g	01	01
Glycopyrolate			Draw sheet	02	02	Allesorb	01	01
Myopyrolate			Abgel			10cc Syrage	02	02
Ondansetron			Foleys catheter			D- Water	02	02
Pencan 25g/ Spinal Needle 22			Urobag			Three way	01	01
Bupivacaine 0.25%			Chest Drainage Catheter			Intrafix	01	01
Bupivacaine 0.25%(Heavy)			Romodrain bag			cotton balls	01	01
Antibiotics			Bandage			Hip leggings	01	01
Gauze		01	Tegaderm			camera cover	01	01
Suppositories			Ioban			Encore 6½	02	02
Anamol : 80mg / 250mg / 170 mg			Double J Stent			foot cover	01	01
Supridol : 100mg			Vaccum Suction set			10cc Syrge	01	02
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet			20G Cannula	01	01
Tab. Misoprost : 200mg			Betadine Solution					
O2 mask (+)		01	Microshield					
Inj Midazolam		01	Cotton Balls					
			Latex Gloves					
			Ramdione Scrub					
			Saral					

Surgeon Dr. Sudharani B Anaesthesiologist Dr. Ameen Nurse Sis Swaroopa Br. Venkat OT Technician

Order No. : 96172/7/128 Ordered by : Sis. Swaroopa

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
20/5/26	Cardiac monitor	8:25 Am	11:30 Am	S-0009617/ 32	Swaroopa
20/5/26	ultrasound machine	9:18 Am	9:28 Am	R265-025337	Swaroopa
20/5/26.					

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
20/5/26	IV Cannulation	01	5-000961 7133	Sivaroop
20/5/26	PAC	OP Basis		

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

BAH-00420367 IP5-00174050
Ms M.HARI MANASA
24-03-1994 32 Y 1 M 26 D (F)
Dr. SUDHARANI BAIRRAJU

Patient S

BirthRight™ FERTILITY BY RAINBOW HOSPITALS

OUTPATIENT NURSING ASSESSMENT FORM

Date: 20/5/26 Time: 8:16Am

Chief Complaint: -

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

If yes , identify -

Vital Signs : Temperature: 98.6°F Pulse: 74b/min Respiratory Rate 18/min

BP 100/62mmHg SpO_2 100% Weight 56.7kg Height 1.59 BMI 22.41

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: Swaroopa Nurse Name: Swaroopa

Date & Time: 20/5/26 08:26Am

Patient Sticker

BAH-00420367 IP5-00174050
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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☐ 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
						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr Pooja

Date & Time : 20/5/26 @ 8:45 Am

Nurse Name & Signature: Sis-Swaroopa

Date & Time : 20/5/26 @ 8:50 Am

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/5/26 8:40 Am	Patient came for Oocyte Retrieval Pt c/c/c Temp (N) PR - 68bpm BP - 112/74 mmHg P/A: Soft	
		Patient can be shifted to OT for OR Dr Pooja
		9.30 am 20/5/26.
20/5/26 2pm	Patient comfortable Discharge summary explained	
		Patient can be discharged Dr Pooja

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

FORM-S

CONSENT FORM FOR ASSISTED REPRODUCTIVE TECHNOLOGY PROCEDURE

BirthRight™ FERTILITY BY RAINBOW HOSPITALS

Patient Name: HARI MANASA MUDUNURI Age 32 UHID No. BAH-00420367

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: HARI MANASA MUDUNURI

Signature: [signature]

Date & Time: 09-05-2026 3:20pm

~~Husband~~ Mothers Name: B. SESHU KUMARI

Signature: B. Seshu Kumari

Date & Time: 09/5/26 @ 3:20 pm

Endorsement by the ART Clinic:

I/we have personally explained to HARI MANASA MUDUNURI and ——— 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: HARI MANASA MUDUNURI

Signature: [signature]

Date & Time: 09-05-2026 3:20pm

~~Husband~~ Mothers Name: B. SESHU KUMARI

Signature: B. Seshu Kumari

Date & Time: 09/5/26 @ 3:20pm

Name, Address and Signature : [signature]

of the Witness from the clinic Swaroopa

Date & Time: 09/5/26 @ 3:30 pm

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 : 09/5/26 @ 3:40 pm

Name of the Doctor: Dr Sadhana Banerjee

Signature: [signature]

Date & Time: 09/5/26 @ 03:35 pm

FORM-12

CONSENT FORM FOR OOCYTE RETRIEVAL / EMBRYO TRANSFER

BirthRight™ FERTILITY BY RAINBOW HOSPITALS

Patient Name: HARI MANASA MUDUNURI Age: 32 UHID No: BAH-00420367

Address: 501, KRANTI CEON, JAYABHERI PINE VALLEY, GACHIBOWLI, HYD 500032

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

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

I / We consent to:

a) Being prepared for oocyte retrieval by the administration of hormones and other drugs.

b) The retrieval of oocyte(s) from my ovaries under ultrasound guidance / Laparoscopy and under Anaesthesia

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

I / We understand that:

I / We had a full discussion with Dr. Sudhavani. 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: HARI MANASA MUDUNURI

Signature:

Date & Time: 20/5/26 @ 8:20Am

mother
Husband Name: B. SESHU KUMARI

Signature: B. Seshu Kumari

Date & Time: 20/5/26 @ 8:20Am

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: HARI MANASA MUDUNURI
Signature:
Date & Time: 20/5/26 @ 8:20Am

Mother
Husband Name: B. SESHU KUMARI
Signature: B. Seshu kumari
Date & Time: 20/5/26 @ 8:20Am

Endorsement by the ART Clinic:

I/ we have personally explained to Hari Manasa. M and (Mother) Seshu Kumari 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: HARI MANASA MUDUNURI
Signature:
Date & Time: 20/5/26 @ 8:20Am

Name, Address and Signature:
of the Witness from the clinic Swaroop
Date & Time: 20/5/26 @ 8:30Am

Name of the Doctor: Dr Sridharani Bairaju
Signature:
Date & Time: 20/5/26 @ 8:25Am

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~~ Mother (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~~ Mother Name: B. SESHU KUMARI
Address: Hyd
Signature: B. Seshu kumari
Date & Time: 20/5/26 @ 8:20Am

Name, Address and Signature:
of the Witness from the clinic Swaroop
Date & Time: 20/5/26 @ 8:30Am

Name of the Doctor: Dr Sridharani Bairaju
Signature :
Date & Time : 20/5/26 @ 8:25Am

BirthRight Fertility by
Rainbow Hospitals, Banjara Hills
8-2-120/103/1, Survey No. 403, Road No. 2,
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CONSENT FOR ANAESTHESIA

Authorization By: ☑ Patient ☐ Patient Attendant

Operative Procedure: OOCYTE RETRIEVAL

Anaesthesiologist: Dr. Ayesha Surgeon: Dr. SUDHARANI BAIRRAJU

Please read this before you consent for Anaesthesia

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief can be achieved by infusing weak solutions of local anaesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

Specific High Risk(s): The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders
☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease
☑ Others Laryngospasm, Bronchospasm, Intraop Anaphylaxis

Declaration by Patient Attendant

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

Patient / Patient Attendant:

Signature: [signature]
Name: HARI MANASA MUDUNURI
Relationship with patient: SELF
Date & Time: 5-14-2026 12:20 pm

Witness:

Signature: [signature]
Name: B. SESHU KUMARI
Date & Time: 20/5/2026 8.40 AM

Doctor (who is taking consent):

Signature: [signature] Name: Dr. SK Ayesha Date 14/5/26 Time: 12:20pm

Patient Sticker

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అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స: .....

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

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

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

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

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

రోగి / రోగి అటెండెంట్:

సంతకం: .....

పేరు: .....

రోగితో సంబంధం: .....

తేదీ & సమయం: .....

సాక్షి:

సంతకం: .....

పేరు: .....

తేదీ & సమయం: .....

డాక్టర్ :

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

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: M. Hari MANASA Age: 32 Sex: Female UHID.No : BAH - 00420367

Date: 14/5/26 Time: 12:15pm Proposed Operation: Oocyte Retrieval

Diagnosis:

B.P / CRT: 100/67 mmHg H.R: Weight: 56.7kg BMI - 22 ASA Physical Status: ☐1 ☐2 ☐3 ☐4 ☐5

Laboratory Data:

Hgb: 12.3	Glucose:	Protein:	HIV:	X-Ray:	
PCV: 39	Urea:	Alb:	HBS Ag:	ECG:	
WBC: 7830	Creat:	Total Bill:	HCV:	2D Echo:	
Plate: 3.0 lakhs	Na:	Dir. Bill:	Blood group: O +ve	Stress/Anglo:	
PT:	K:	LDH:	T3	Other:	
PTT:	Ca++:	Alk phos:	T4		
INR:	Mg++:	Amylase:	TSH		
	Cl -:	SGOT/SGPT:			

Allergies: IBUPROFEN, unknown ? food allergy. (SHELL FISH, SOY)

Medical History: CVS : NIL SIGNIFICANT

RESP : Diabetes :

CNS :

Renal : unexplained pain over (R) VL c discolouration

Hepatic / GE : Physical Activity: Rx c Steroid

Others : Post covid vaccination, unexplained Myalgias & Difficulty in breathing episode.

Past Anaesthetic History:

Physical Exam:

Airway: MP 1 (2) 3 4 Mouth Opening: Adequate Mentohyoid Distance: 3FB Neck: (N) Teeth: (N) Alignment

Lungs : BAE (+), Clear

Heart: S_1S_2 (+)

CNS: NAD

Pregnant: ☐ Yes ☐ No ☐ NA Venous Access Site : Peripheral (+) Spine Exam for regional : Midline

Anaesthetic Plan: ☐ MAC ☐ REGIONAL ☐ GA-ETT ☐ LMA

Peri-Operative Plan Explained to the Patient: ☑ Yes ☐ No

CURRENT MEDICATIONS	DOSAGE
CETROLIX	s/c 0.25
PERGOVERIS	225 IU s/c

Pre-Operative Instructions:

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours; Others 6 Hours — ✓ Explained
3. Informed Consent: ☐ Standard ☐ High Risk
4. Post Operative Pain Management: ☐ Discussed with Patient
5. Other Instructions:

Signature: Name: Dr. St. Ayesha.

BAH-00420367 IP5-00174050
Ms M.HARI MANASA
24-03-1994 32 Y 1 M 26 D (F)
Dr. SUDHARANI BAIRRAJU

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition:	☐ Yes ☑ No	Fasting Status: Adequate > 6hrs.	
Physical Status:	☑ Patient Identified	☑ Consent Present	☑ Chart Reviewed

H.R:	B.P / CRT:	SpO_2: 100%	R.R: 20/mt.	Last Feed:

Pre-OP Diagnosis: ..... Operation: Oocyte Retrieval Date : .....

Surgeon: Dr. Sudharani Bairraju Anaesthesiologist: Dr. Anuseen Technician: Venkat

TIME 9:AM 9:15 9:30

N_2O /AIR/O_2 LPM 6L O_2

HALO /SO /SEVO

Drugs:

MIDAZOLAM 1mg

FENTANYL 100mcg

PROPOFOL 100mg

FIO_2 / SaO_2 100 100

$ETCO_2$ 18 18

ECG SR SR

Temperature

Urine Output

Fluids Blood RINGER LACTATE 10 →

Antibiotic –

Suppository –

Blood Loss –

NOTES –

B.P
V Systolic
Λ Diastolic
X Mean
• Heart Rate

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

240 220 200 180 160 140 120 100 80 60 40 20 10 0

LAB Values

ABG

GRBS

Others

☐ Equipment Checked and Functional
☑ BP (D)
☑ Cuff Site: .....
☐ Art Site: .....
☑ EKG Lead
☐ Temp Site
☐ FIO_2 Monitor
☐ Agent Monitor
☑ Pulse Oximeter
☑ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position: Lithotomy
☑ Pressure Points Checked

Eye Care:
☐ Oint
☑ Tape
☐ Padding
☐ Awake

Temp:
☐ HME ☐ Fluid Warmer
☐ Cling Film ☐ OH Warmer
☐ Hugger's ☐ Cotton Wool
☐ Other

Times:
Anaes Start: 9:10AM
OP Start: .....
OP End: 9:30AM
Leave OR: .....

Anaesthesia:
☐ GA
☑ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP: .....
☐ ART: .....
☑ IV: (R) hand.
☐ IV: .....
☐ IV: .....

Induction
☐ IV ☐ Inhal
☐ Pre O_2 ☐ RSI
☐ Others Face Mask @ 6L O_2

☐ Mask ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
ETT# ..... at ..... cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug: .....

☐ Awake ☐ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# ..... Attempts: .....
Difficulty Why? .....

☐ **Bilat = BS**
☐ Semi-Closed Circle
☐ Closed Circle
☐ Other

Regional:
Extremity Specify: .....
☐ Spinal ☐ Epidural ☐ Caudal
Others: .....
Position: .....
Site: .....
Needle Size: ..... Depth: .....
Parasthesia ☐ Yes ☐ No
Catheter at skin ..... cm
Drug Name & Conc: .....
Bolus: .....
Infusion: .....
Block Level: .....
Comments: .....

Transportation to
☐ PACU ☐ ICU ☑ Other
Relaxant Reversed ☐ Yes ☐ No ☑ NA

Name of the Doctor : Dr. Anuseen
Signature of the Doctor : .....

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Ms M.HARI MANASA
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Dr. SUDHARANI BAIRRAJU

Patient

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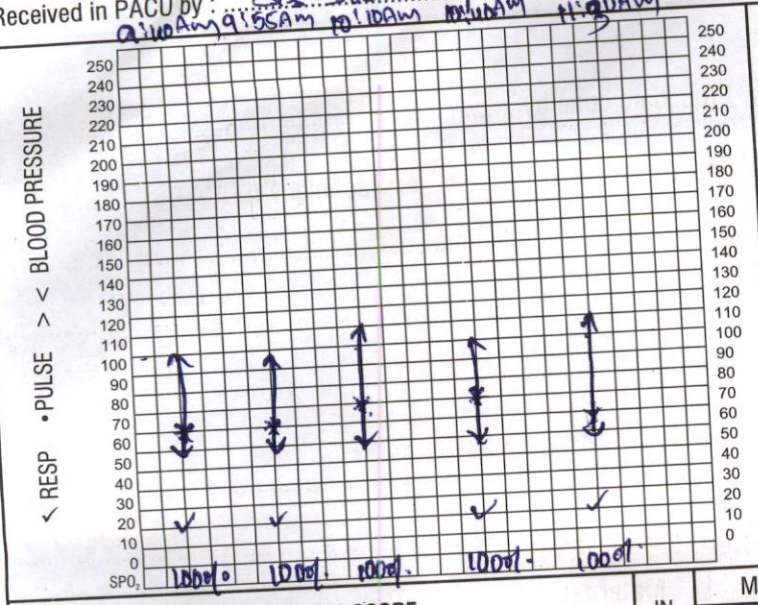
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Sis. Swaroopa Time Received : 9:35 Am Time Discharged : 12 pm

9:40Am 9:55Am 10:10Am 10:40Am 11:30Am



IV Cannula Site : Rt hand.

- [x] O_2 Mask
- [ ] Tracheostomy
- [ ] Oral Airway
- [ ] Nasal Prongs
- [ ] T-Piece
- [ ] Nasal Airway

Vomiting : [ ] Yes [x] No
NG Tube : [ ] Yes [x] No
Drain: [ ] Yes [x] No
Urinary Catheter: [ ] Yes [x] No
Chest Tube: [ ] Yes [x] No
Nil Oral [x] Yes [ ] No
Drug:
IV Fluids: 10 RL @ mlflow
Oral Feeds: Allow

POST ANAESTHESIA SCORE
(Modified Aldrete Score)

		IN	MINUTES 30	60	90	OUT
Able to move 4 extremities voluntary or on command Able to move 2 extremities voluntary or on command Able to move 0 extremities voluntary or on command	= 2 = 1 = 0 ACTIVITY	1	2	2	2	2
Able to deep breathe & cough freely Dyspnea or limited breathing Apneic	= 2 = 1 = 0 RESPIRATION	1	2	2	2	2
BP ± 20 of Pre Anaesthetic leve BP ± 20-50 of Pre Anaesthetic leve BP ± 50 of Pre Anaesthetic leve	= 2 = 1 = 0 CIRCULATION	2	2	2	2	2
Fully awake Arousable on calling Not responding	= 2 = 1 = 0 CONSCIOUSNESS	2	2	2	2	2
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0 COLOR	2	2	2	2	2
	TOTAL	8	10	10	10	10

SCORING INTERPRETATION

A Minimum Total Score of 8 is Required for Discharge

Exceptions to this, are to be explained in the space below by the Discharging Physician:

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
20/5/26	9:40Am	0	Nil	Swaroopa

Pain Tool Used: [ ] N PASS [ ] FLACC [ ] Wong Baker [x] NPS

Reassessment Frequency:
1. Every eight hours for all hospitalized patients.
2. For post surgical patient, patient with chronic pain, patient with severe pain
   a. *Every* 2 hours for first 24 hours
   b. After 24 hours every 4 hours
   c. *Prior* to pain reliving intervention
   d. With in 30-60 minutes after pain relief intervention

Anaesthesiologist Name : Dr. Anuleen
Anaesthesiologist Signature: Anu
Date & Time: 20/5/26 @ 11:45Am

PACU Nurse Name : Sis. Swaroopa
PACU Nurse Signature: 20/5/26
Date & Time: 20/5/26 @ 9:38Am

Transferred to Unit by (PACU): Billing
Date & Time: 20/5/26 @ 11:45Am

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: ..... Time: ..... Procedure done by .....

CSE /Spinal /Epidural Position : ..... Space :..... Technique (LOR/LOS) .....

Depth: ..... Catheter at Skin: ..... Attempts : .....

Parasthesia : Yes/No if yes details : .....

Solution Composition : .....

Any other issues :

a) .....

b) .....

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level Left Right	Maternal BP	Maternal Pulse	FHR	Comments

Delivery Details : Time : ..... APGAR: ..... SVD / Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected : .....

Patient Satisfaction : .....

Discharge /Shifting ordered by .....

Doctor Signature .....

Patient Sticker

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24-03-1994 32 Y 1 M 26 D (F)
Dr. SUDHARANI BAIRRAJU

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ht TALS livery

DRUG CHART

Date of Admission: 20/5/26 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:				

Signe

VERIFIED BY : Name

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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Ms M.HARI MANASA
24-03-1994 32 Y 1 M 26 D (F)
Dr. SUDHARANI BAIRRAJU

Weight. 56.7kg Ward. IVF-07

VARI

		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
20/8/26	08:39AM	Inj Augmentin	1.2g	IV		Swarooja Rajini

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

BAH-00420367 IP5-00174050
Ms M.HARI MANASA
24-03-1994 32 Y 1 M 26 D (F)
Dr. SUDHARANI BAIRRAJU

I.V. FLUIDS CHART

Weight. 56.7kg Ward. IUF 5

		...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
20/5/26	8:30 Am	1 ⊙ RINGER LACTATE	IV	200ml/hr	[signature]	[signature] Roji	20/5/26	[signature]	[signature] [signature]

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

BAH-00420367 IP5-00174050
Ms M HARI MANASA
24-03-1994 3z Y 1 M 26 D (F)
Dr. SUDHARANI BAIRRAJU

CHECKLIST

Surgeon : Dr. SudharaniB
Asst. Surgeon : Dr. M. pooja
Anaesthetist : Dr. Ameen
Scrub Nurse : Sis. Swaroopa

Patient Name : M. Hari Manasa Age : 3 y 1 m Gender : female
UHID No. : BAH-00420367 Surgery Name : Oocyte Retrieval
Date : 20/5/26 In-time : 08:58 Am Out-time : 09:36 Am

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 8:45 Am

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 : Amm
Name : Dr. Ameen

Before Skin Incision ➤➤

TIME OUT Time: 9:05 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 - Oocyte Retrieval	☑ Yes	☐ No	
Anticipated Critical Events			
Surgeon Reviews:			
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? – Bleeding; 15-20 min; <5 ml	☐ Yes	☐ No	☐ NA
Anaesthesia Team Reviews: Dissociation			
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 :
Name : Swaroopa

Before Patient Leaves Operating Room

SIGN OUT Time: 9:30 Am

Nurse Verbally Confirms with the Team:			
The Name of the Procedure Recorded	☑ Yes	☐ No	
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	☑ Yes	☐ No	☐ NA
The Specimen is Labelled (including patient name)	☑ Yes	☐ No	☐ NA
Whether there are any Equipment Problems to be addressed	☐ Yes	☐ No	☑ NA
To Surgeon, Anaesthetist and Nurse:			
What are the key concerns for recovery and management of this patient?	☐ Yes	☑ No	

Signature : B Sudharani
Name : Dr. Sudharani B

Patient Sticker

BAH-00420367 IP5-00174050
Ms M.HARI MANASA
24-03-1994 32 Y 1 M 26 D (F)
Dr. SUDHARANI BAIRRAJU

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date : 20/5/26

To Be Filled In By Assigned Nurse :

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

Name of Surgeon : Dr. Sudharani B Date of Admission : 20/5/26

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	Swaroopa
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	Swaroopa
3.	Patient's body temperature immediately post operation (Recovery Room) 36.5 °C ☐ Oral Or ☑ Axilla (Goal : 36-37 °C)	Swaroopa
4.	Name of doctor or staff administering the antibiotic : Dr. Swaroopa Date & Time of antibiotic administration : 20/5/26 @ 8:39 Am Date & Time procedure started : 20/5/26 @ 09:10 Am	Swaroopa.

- 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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BirthRight™ FERTILITY BY RAINBOW HOSPITALS

POST PROCEDURE CARE PLAN

Date & Time: 20/5/26 @ 9:25 Am

Patient Name: Miss Hari Manasa Age: 32y UHID No: BAH-00420367

Procedure Done: Oocyte Retrieval

Post Procedure Diagnosis: POR

Post-Operative Monitoring Parameters / Frequency: SPO2, PR, BP every 5 mins for 15 mins, 15 mins for 1 hour, 30 mins for 1 hour 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: Oocyte freezing. Review on Dr/Ds of cycle

Name of the Doctor: for Dr. Sudharani B.

Signature:

Date & Time: 20/5/26 @ 9:25 Am

Note: Plan of care will be readjusted if necessary