BAH-00656158 IP5-00175011
Mrs MONISHA PRASAD
30-01-1995 31 Y 4 M 12 D (F)
Dr. SUDHARANI BAIRRAJU

SURGERY DETAILS

Date : 11/6/2026

Patient Name: MONISHA Date of Birth: 30/1/1995 Age: 31 yrs

Gender: femal Ward : IVF OT UHID No.: BAH-00656158

Date of Surgery: 11/6/26 ☑ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Oocytes retrieval.

Time in : 9:am Time Out : 9:30 am

		NAME	AMOUNT
1.	Surgeon	: Dr Sudharani Bairraju	–
2.	Anaesthetist	: Dr Aditi	–
3.	Assistant Surgeon	: Dr pooja	–
4.	OT Technician	: Bro Ravi	–
5.	Circulating Nurse	: Sis Mable	–
6.	Assistant Nurse	: Sis Swaroopa	–

Special Equipment: ☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☑ Others under ultrasound guidline
R265-029205

Signature of the Surgeon Signature of Circulating Nurse

Order No: 5-000965 2653/654 Order by: Mable

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

BAH-00656158 IP5-00175011
Mrs MONISHA PRASAD
30-01-1995 31 Y 4 M 12 D (F)
Dr. SUDHARANI BAIRRAJU

Oocyte Retrieval

CONSUMABLES OF OT

3433

Technician : Bro.N.Ravi Date : 11/6/26 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	3	3				Suction Catheter		
HME filter : A / P / N						Feeding Tube		
Syringes : 10 cc	2	2				Vaccum Suction Set		
05 cc			Gloves			Surgical Gloves		
02 cc	2	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	1	1	Koochies					
Minispike	1	1	Ointments			Mother gown	01	01
			Suction Catheter			proto gowns	02	02
Fentanyl	1	1	Cap, Mask	5/5	5/5	Inj. Augmentin 1.2	01	01
Morphine			Gauze Pack			Inj. Paracetamol	01	01
Ketamine			Mop Pack			Hip leggings	01	01
Propofol	2	2	Steristrip			10cc syringe	01	01
Rocuronium			Underpad	01	01	5cc syringe	01	01
Glycopyrolate			Draw sheet	02	02	1cc syringe	01	01
Myopyrolate			Abgel			foot covers	02	02
Ondansetron			Foleys catheter			Camera cover	01	01
Pencan 25g/ Spinal Needle 22			Urobag			NS 100ml	03	03
Bupivacaine 0.25%			Chest Drainage Catheter			Mini spike	01	01
Bupivacaine 0.25%(Heavy)			Romodrain bag			20G cannula	02	02
Antibiotics			Bandage			Three way	01	01
			Tegaderm			RL 500ml	01	01
Suppositories			Ioban			D-water	02	02
Anamol : 80mg / 250mg / 170 mg			Double J Stent			Allesorb	01	01
Supridol : 100mg			Vaccum Suction set			Inj. Tramadol 50mg	01	01
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet			Inj. Perinorm 10mg	01	01
Tab. Misoprost : 200mg			Betadine Solution			5cc syringe	01	01
[illegible]	1	1	Microshield			Interfix	02	02
O2 nasal prongs	1	1	Cotton Balls					
			Latex Gloves					
			Ramdione Scrub					
			Saral					

Surgeon Dr. Sudharani. B Anaesthesiologist Dr. Adithi Nurse Swaroopa OT Technician

Order No. : 5-00096526 u9/5-00096526 50 Ordered by : Swaroopa

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

ACTIVITY RECORD FOR BILLING

BAH-00656158 IP5-00175011
Mrs MONISHA PRASAD
30-01-1995 31 Y 4 M 12 D (F)
Dr. SUDHARANI BAIRRAJU

Name : ______

UHID No. : ______ IP No : ______ 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
11/6/26	8:40am	Gyn recovery	IVF OT.	[signature]
11/6/26	9:30am	IVF OT	Gyn recovery	[signature]
11/6/26	02pm	Gyn Rec	Billing	[signature]

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
11/6/26	Monitor	8:30am	12pm	5-0009652654	[illegible]
10/6/26	ultrasound guide	9Am	9:30Am	R265-029203	[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
11/6/26	IV placement	1	5-0009652 654	[signature]
11/6/26	PAC (op Basis)	OP Basis	–	[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 : IP5-00175011 **Admit Date** : 11-Jun-2026 **Admit Time** : 08:24 AM **UHID** : BAH-00656158

Patient Details :

Patient Name	: Mrs MONISHA PRASAD	**Age**	: 31 Y 4 M 12 D
Guardian	: Mr SHIVA KRISHNEEL	**DOB**	: 30-01-1995
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Married
Address (H)	: 8-2-686/M/2, Banjara Hills Hyderabad Telangana INDIA 500034	**Phone No**	: 8143129201
		E-mail	: NO@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 SHIVA KRISHNEEL	**Relationship**	: Husband
Contact Address	: 8-2-686/M/2, Banjara Hills Hyderabad Telangana INDIA 500034	**Phone No**	: 8143129201

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

OUTPATIENT NURSING ASSESSMENT FORM

Date: 16/6/26 Time: 8:30 Am

Chief Complaint: —

—

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

If yes , identify —

Vital Signs: Temperature: 98.6°F Pulse: 90 b/min Respiratory Rate 18/min

BP 109/83 mmHg SpO_2 99%. Weight 78 Height 1.59 BMI 30.9

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

RISK FOR FALL:		
History of Falling: within past 3 months	☐ Yes	☑ No
Ambulatory Aids:		
Wheelchair	☐ Yes	☑ No
Crutches / Cane / Walker	☐ Yes	☑ No
Uses furniture for support	☐ Yes	☑ No
Gait/Transferring:		
Bedrest / immobile	☐ Yes	☑ No
Weak	☐ Yes	☑ No
Impaired	☐ Yes	☑ No
Mental Status:		
Forgets limitations	☐ Yes	☑ No
Vulnerable Patient	☐ Yes	☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening:

☑ Normal Activity of Daily Living

If there is abnormal ADL check one of the following

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

Inform consultant for positive criteria

Nutritional Screening: ☐ No Abnormalities Detected

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

Inform consultant for positive criteria

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

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

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

Inform the physician about any spiritual needs, if applicable

Nurse Signature: [signature] Nurse Name: Swaroopa

Date & Time: 16/6/26 at 8:40 Am

BAH-00656158 IP5-00175011
Mrs MONISHA PRASAD
30-01-1995 31 Y 4 M 12 D (F)
Dr. SUDHARANI BAIRRAJU

PAIN ASSESSMENT FORM

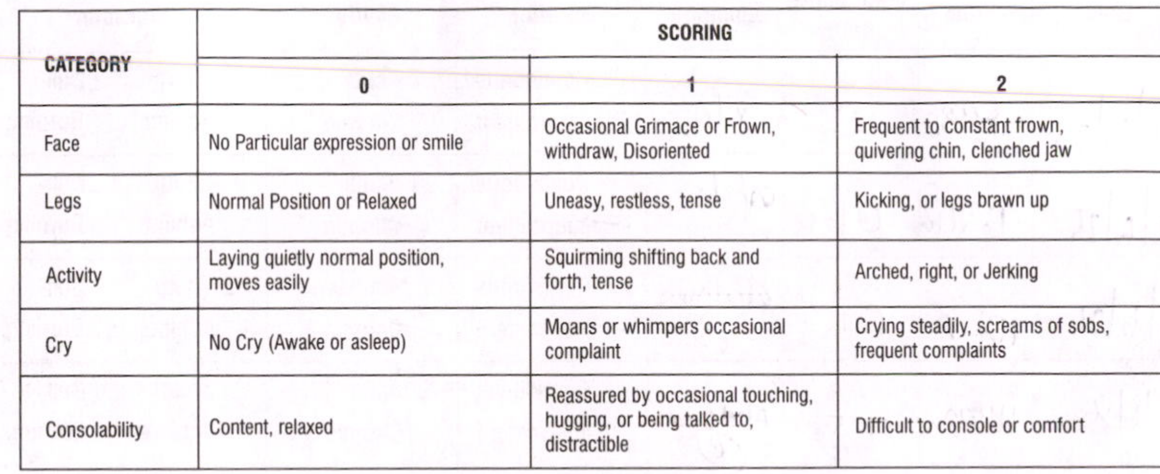
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
11/6/26	8:30	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	—	[signature]
11/6/26	9:20am	01-6	Abdmen	☐ Continuous ☑ Intermittent	☐ Acute ☑ Chronic	☐ Sharp ☑ Dull ☐ Aching ☐ Burning	☑ Increasing ☐ Decreasing	☑ Yes ☐ No	IV. pcm given	[signature]
11/6/26	10am	01-5	Abdmen (R)	☐ Continuous ☑ Intermittent	☐ Acute ☑ Chronic	☑ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	Position provided	[signature]
11/6/26	11:50Am	0[illegible]-5	Abddom (R)	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Inj. Ileanadol in 100ml NS	[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		

Re-assessment Frequency:

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

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

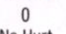


CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs brawn up
Activity	Laying quietly normal position, moves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

Numerical Pain Scale (Obstetric and Gynecology)

0 No Pain — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 Worst Possible Pain

Wong - Baker (Pediatrics) Above 7 Years



0 No Hurt | 2 Hurts Little Bit | 4 Hurts Little More | 6 Even More | 8 Hurts Whole Lot | 10 Hurts Worst

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

BAH-00656158 IP5-00175011
Mrs MONISHA PRASAD
30-01-1995 31 Y 4 M 12 D (F)
Dr. SUDHARANI BAIRRAJU

MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: Primary Subfertility c̄ Male factor

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
11/6/26 8:35am	☑ Medical ☐ Nursing ☐ Others:	☑ Initial ☐ Modified ☐ Per-Op ☐ Post Op	patient came for oocyte retrieval	oocyte retrieval cont complications	oocyte retrieval	[signature]	☑ Nursing ☐ Others:
11/6/26 8:40am	☐ Medical ☑ Nursing ☐ Others:	☐ Initial ☐ Modified ☑ Per-Op ☐ Post Op	patient came for oocyte retrieval	IV cannula placed	shifted to OT for retrieval	[signature]	☑ Medical ☐ Others:
11/6/26 9:20am	☑ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☑ Post Op	monitor vitals, w/f bleeding P/V	safe Discharge	Discharge medications	[signature]	☐ Medical ☑ Nursing ☐ Others:
11/6/25 9:30am	☐ Medical ☑ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☑ Post Op	without any complication procedure was done.	explained about medical/diet	Discharged accordingly doctor order	[signature]	☑ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

BAH-00656158 IP5-00175011
Mrs MONISHA PRASAD
30-01-1995 31 Y 4 M 12 D (F)
Dr. SUDHARANI BAIRRAJU

Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	11/6/26 8:40a	11/6/26 12:30PM	
		Score			
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0	0	0	
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0	0	0	
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0	0	0	
IV / Heparin Lock or Saline	Yes	20	20	20	
	No	0			
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0	0	0	
Mental Status	Forgets limitations	15			
	Oriented to own ability	0	0	0	
Total Morse Fall Scale Score:			20	20	
		Signature	[illegible]	[illegible]	

Fall Risk Grading		
Risk Level	Morse Fall Score (MFS)	Action
✓ Low Risk	0 - 24	Standard Fall Precaution
Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
High Risk	≥ 51	Implement High Risk Fall Prevention Intervention

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

Patient Sticker

Morse Fall Risk Assessment Form

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

Fall Risk Grading

Risk Level	Morse Fall Score (MFS)	Action
Low Risk	0 - 24	Standard Fall Precaution
Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
High Risk	≥ 51	Implement High Risk Fall Prevention Intervention

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

BAH-00656158 IP5-00175011
Mrs MONISHA PRASAD
30-01-1995 31 Y 4 M 12 D (F)
Dr. SUDHARANI BAIRRAJU

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: Gynec delivery Shifted to: OT

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						☐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 [signature]

Date & Time : 11/6/26 @ 8:45 am

Nurse Name & Signature: Neel mable

Date & Time : 11/6/26 @ 8:50 am

Docu. No. : RCHBH /FRM / GENERAL / 090

BAH-00656158 IP5-00175011
Mrs MONISHA PRASAD
30-01-1995 31 Y 4 M 12 D (F)
Dr. SUDHARANI BAIRRAJU

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/6/26 8:35AM	patient came for oocyte retrival.	plan
		- PAC
	PR - 90	- consent
	BP - 109/83	- shift to OT for oocyte retrival.
	SpO_2 - 99%	
	CVS / NAD	
	RS	
		[signature]
		[signature] 9:20am 11/6/26
11/6/26 3pm	pt stable	
		plan
	Discharge medications explained.	- can be discharged
		[signature]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

BAH-00656158 IP5-00175011
Mrs MONISHA PRASAD
30-01-1995 31 Y 4 M 12 D (F)
Dr. SUDHARANI BAIRRAJU

DRUG CHART

Date of Admission: 11/6/26 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 / 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 ....

Mrs MONISHA PRASAD
30-01-1995 31 Y 4 M 12 D (F)
Dr. SUDHARANI BAIRRAJU

REGULAR PRESCRIPTIONS

Weight. 78 Kg Ward. IVF 05

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

BAH-00656158 IPS-00175011
Mrs MONISHA PRASAD
30-01-1995 31 Y 4 M 12 D (F)
Dr. SUDHARANI BAIRRAJU

Weight. 78 kg Ward. IIA OT

	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.	

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
11/6	8:30	INJ AMOXICILLIN +CLAVULUNATE	1.2g	IV	[signature]	[signature]
11/6	930	INJ PARACETAMOL	1gm	IV	[signature]	[signature]
11/6/26	11.20	INJ PERINORM	10mg	IV	[signature]	[signature]
11/6/26	11.22	INJ TRAMADOL	50mg in 100ml NS	IV slow	[signature]	[signature]

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

BAH-00656158 IP5-00175011
Mrs MONISHA PRASAD
30-01-1995 31 Y 4 M 12 D (F)
Dr. SUDHARANI BAIRRAJU

I.V. FLUIDS CHART

Weight. 78kg Ward. I.V.605

		...sition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
11/6/26	8:30	1 ORL	IV	ff	A	[signature] / [signature]	11/6/26	A	[signature] / [signature]

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

FORM-6
CONSENT FORM FOR ASSISTED REPRODUCTIVE TECHNOLOGY PROCEDURE

Patient Name: Monisha Prasad Age 31 UHID No. BAH -00656158

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.

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

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: Monisha PRASAD

Signature: [signature]

Date & Time: 30/05/26 2pm

Husband Name: SHIVA K CHAND

Signature: [signature]

Date & Time: 30/05/26 2pm

Endorsement by the ART Clinic:

I/we have personally explained to Monisha and SHIVA krishna 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: MONISHA PRASAD.

Signature: [signature]

Date & Time: 30/08/26 2pm

Husband Name: SHIVA K CHAND

Signature: [signature]

Date & Time: 30/05/26 2pm

Name, Address and Signature : [signature]

of the Witness from the clinic Swaroopa

Date & Time: 30/5/26 at 2:20pm

Name of the ART Clinic: BirthRight Fertility by Rainbow Hospitals, Banjara Hills

Address: 8-2-120/113/1, Survey No. 403, Road No. 2, Banjara Hills, Hyderabad, Telangana 500 034.

Date & Time : 30/5/26 at 2:10pm.

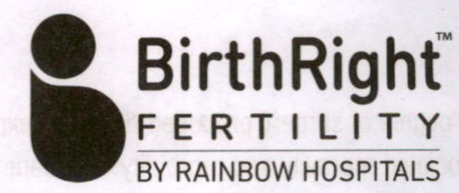
Name of the Doctor: Dr. Sudharani B

Signature: [signature]

Date & Time: 30/5/26 at 2:05pm

FORM-12

CONSENT FORM FOR OOCYTE RETRIEVAL / EMBRYO TRANSFER



Patient Name: Monisha Prasat. Age: 31 UHID No: BAH-00.65615.8

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

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: Monisha Prasad

Signature: [signature]

Date & Time: 11/6/2026 @ 8:40am

Husband Name: Shiva krishnaa

Signature: [signature]

Date & Time: 11/6/2026 @ 8:40 am

Informed consent:

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

Unreservedly and in my full sense I hereby give my fully informed and non-coerced consent to undergo any or all of the aspects of treatment as noted above by means as deemed appropriate by the professional team of BirthRight Fertility by Rainbow hospital. We understand that we will become legal parents of any resulting child and the child will have all the normal legal rights 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: monisha Prasad

Signature: [signature]

Date & Time: 11/6/26 @ 8:40am

Husband Name: Shiva Krishneel

Signature: [signature]

Date & Time: 11/6/26 @ 8:40 am

Endorsement by the ART Clinic:

I/ we have personally explained to monisha Prasad and Shiva Krishneel 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: monisha Prasad.

Signature: [signature]

Date & Time: 11/6/26 @ 8:40am

Name, Address and Signature: [signature]

of the Witness from the clinic Maelle / Birthright hosp

Date & Time: 11/6/26 @ 8:40am

Name of the Doctor: Dr Sudharani B

Signature: [signature]

Date & Time: 11/6/26 @ 8:40am

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: Shiva Krishneel

Address: [signature]

Signature:

Date & Time: 11/6/26 @ 8:40am

Name, Address and Signature: [signature]

of the Witness from the clinic Birthright by rainbow hospitals

Date & Time: 11/6/2026 @ 8:40am

Name of the Doctor Dr Sudharani B

Signature : [signature]

Date & Time : 11/6/26 @ 8:40 am

CONSENT FOR ANAESTHESIA

Authorization By: ☑ Patient ☐ Patient Attendant

Operative Procedure: Oocyte Retrieval.

Anaesthesiologist: Dr. Tejaswini 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 Desaturation.

Declaration by Patient Attendant

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team

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

Patient / Patient Attendant:

Signature: [signature]

Name: Monisha Prasad.

Relationship with patient: Self

Date & Time: 3/6/26 2:40pm

Witness:

Signature: [signature]

Name: Shiva K Chand

Date & Time: 3/6/26 2:40pm.

Doctor (who is taking consent):

Signature: [signature] Name: Dr. Tejaswini Date 3/6/26 Time: 2:40pm.

Patient Sticker

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

Name: Monisha. Age: 31Y Sex: Female. UHID.No: BAH-00656158.

Date: 3/06/2026 Time: 2:35pm Proposed Operation: Oocyte Retrieval.

Diagnosis: under IVF therapy.

B.P / CRT: 107/63 H.R: .... Weight: 78.3kgs ASA Physical Status: ☑1 ☐2 ☐3 ☐4 ☐5

Laboratory Data:

Hgb: 8.7	Glucose: /	Protein: /	HIV: NR	X-Ray: /
PCV:	Urea: /	Alb: /	HBS Ag: NR	ECG: /
WBC:	Creat: /	Total Bill: /	HCV: NR	2D Echo: /
Plate: 2.2	Na: /	Dir. Bill: /	Blood group: O +ve	Stress/Anglo: /
PT:	K: /	LDH: /	T3	Other: /
PTT: /	Ca++: /	Alk phos: /	T4	
INR: /	Mg++: /	Amylase: /	TSH 2.84	
	Cl-: /	SGOT/SGPT: /		

Allergies: Allergic to contrast dye
→ rashes
→ edema
→ breathing difficulty.

Medical History: CVS:
RESP:
CNS:
Renal:
Hepatic / GE:
Others:
} Not significant

Diabetes: —

Physical Activity: Active

Past Anaesthetic History: Diagnostic Laparoscopy & Hysteroscopy April 2025. uneventful

Physical Exam: (N)

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

Lungs: BAE (+)

Heart: S_1S_2 (+)

CNS: HMF (+).

Pregnant: ☐ Yes ☑ No ☐ NA | Venous Access Site: accessible Spine Exam for regional: (N).

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

1. DVT Prophylaxis:
2. NIL ORAL → Water / ORS 2 Hours → Others 6 Hours ✓
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☑ Discussed with Patient
5. Other Instructions:
CBP, TSH, HbA1c.

Signature: [signature] Name: Dr. Tejaswini

BAH-00656158 IP5-00175011
Mrs MONISHA PRASAD
30-01-1995 31 Y 4 M 12 D (F)
Dr. SUDHARANI BAIRRAJU

ANAESTHESIA CHART

Pre Induction Assessment:

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

H.R: 84	B.P / CRT: 135/81	SpO₂: 100 %	R.R: 16/min	Last Feed: 7 hr

Pre-OP Diagnosis: 1° Infertility
Operation: Pessary / Polyp [illegible]
Date: 1/8/2[illegible]
Surgeon: Dr Sudharani
Anaesthesiologist: Dr Adithi
Technician: Ravi

TIME	9, 9:30
N_2O /AIR/O_2 LPM	6 Litre
HALO /ISO /SEVO	
Drugs:	
INJ MIDAZOLAM	1.5 MG
INJ FENTANYL	75 MCG, 2 Times
INJ PROPOFOL	60+60+ 20+20 MG
FiO_2 / SaO_2	100, 100
$ETCO_2$	34, 32
ECG	SR, SR
Temperature	
Urine Output	
Fluids Blood	IVF RL①

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
☑ Cuff Site: LUL
☐ Art Site: ....
☑ EKG Lead 3 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
OP Start: 9:10
OP End: 9:24
Leave OR: 9:30

Anaesthesia:
☐ GA
☑ Monitored Anaesthesia Care
☐ Regional cDRUGs

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

Induction
☑ IV ☐ Inhal
☐ Pre O_2 ☐ RSI
☐ Others c face mask

☐ 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 Adithi
Signature of the Doctor: [signature]

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Sis Swaroopa. Time Received : 9:35Am Time Discharged : 1pm

Times: 9:30Am, 9:50Am, 10:05Am, 10:35Am, 11:05Am, 12:15pm, 1pm

✓ RESP • PULSE > < BLOOD PRESSURE (chart 0–250)

SPO₂: 100% · 100% · 100% · 100% · 100% · 100% · 100%

IV Cannula Site : Rt hand

☐ O₂ Mask ☐ Tracheostomy ☐ Oral Airway ☐ Nasal Prongs ☐ T-Piece ☐ Nasal Airway

Vomiting :	☐ Yes	☑ No
NG Tube :	☐ Yes	☑ No
Drain:	☐ Yes	☑ No
Urinary Catheter:	☐ Yes	☑ No
Chest Tube:	☐ Yes	☑ No
Nil Oral	☑ Yes	☐ No

Drug: ....

IV Fluids: IORL on flow

Oral Feeds: Allow

POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	30	60	90	OUT
Able to move 4 extremities voluntary or on command = 2 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 0		ACTIVITY	2	2	2	2	2
Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0		RESPIRATION	2	2	2	2	2
BP ± 20 of Pre Anaesthetic leve = 2 BP ± 20-50 of Pre Anaesthetic leve = 1 BP ± 50 of Pre Anaesthetic leve = 0		CIRCULATION	2	2	2	2	2
Fully awake = 2 Arousable on calling = 1 Not responding = 0		CONSCIOUSNESS	2	2	2	2	2
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0		COLOR	2	2	2	2	2
		TOTAL	10	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	Signatu
11/06/26	9:35Am	7-8	INJ PARACETAMOL 1gm IV given	Swaroo
11/6/26.	10:35Am	5-6	Rest & change in position	Sw
11/6/26.	11:35Am	4-5	Rest	Sw

Pain Tool Used: ☐ N PASS ☐ FLACC ☐ Wong Baker ☑ NPS

Anaesthesiologist Name : Dr Ratita

Anaesthesiologist Signature: [signature]

Date & Time: 11/06/26 @ 12:48pm

PACU Nurse Name : Swaroopa

PACU Nurse Signature: [signature]

Date & Time: 11/6/26 at 9:35Am

Reassessment Frequency:

1. Every eight hours for all hospitalized patients.
2. For post surgical patient, patient with chronic pa
   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 pai

Transferred to Unit by (PACU): ....

Date & Time: 11/6/26

Patient Sticker

Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : ....

Any other issues :

a) ....

b) ....

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level Left	Level 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: ....

Doctor Name: ....

Date and Time : ....

SURGICAL SAFETY CHECKLIST

Surgeon : Dr Sudharai
Asst. Surgeon : Dr Prasia
Anaesthetist : Dr Aditi
Scrub Nurse : Swarnapr

Patient Name : Monisha Age : 31y Gender : F
UHID No. BAH-00656158 Surgery Name : Oocyte retrieval
Date : 11/6/26 In-time : 9:05am Out-time : 9:30am

Before Induction of Anaesthesia ➤➤

SIGN IN Time: 8:45

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 (contrast)

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 : Aditi

Name : Dr Aditi R

Before Skin Incision ➤➤

TIME OUT Time: 9:05am

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 Bleeding

Surgeon Reviews:

What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? (10 to 15 min; 0–2 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 : Mallh

Name : Malathi

Before Patient Leaves Operating Room

SIGN OUT Time: 9:30am

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 : B Sudharai

Name : Dr Sudharai B

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

BAH-00656158 IP5-00175011
Mrs MONISHA PRASAD
30-01-1995 31 Y 4 M 12 D (F)
Dr. SUDHARANI BAIRRAJU

BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date : 11/6/2026

To Be Filled In By Assigned Nurse :

Department : IVF OT Duration of Procedure : 30mins

Name of Surgeon : Dr Sudharani Bairraju Date of Admission : 11/6/26

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 : Inj. Augmentin 1.2g	[signature]
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	[signature]
	Patient's body temperature immediately post operation (Recovery Room) 37 °C ☐ Oral Or ☑ Axilla (Goal : 36-37 °C)	[signature]
4.	Name of doctor or staff administering the antibiotic : Dr Rojie Date & Time of antibiotic administration : 11/6/2026 0830 am Date & Time procedure started : 11/6/26 @ 9:10 am	[signature]

- Ensure form is filled in completely by assigned staff whenever patient had surgery
- If any bundle care criteria has not been observed or unmet, assigned staff must inform infection control nurse for management
- All forms (Bundle care and when required SSI form) are completed properly
- Forms must always be kept in Infection Control folder in respective department

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

BAH-00656158 IP5-00175011
Mrs MONISHA PRASAD
30-01-1995 31 Y 4 M 12 D (F)
Dr. SUDHARANI BAIRRAJU

POST PROCEDURE CARE PLAN

Date & Time: 11/6/2026 @ 9:30Am

Patient Name: Monisha prasad Age: 31 yrs UHID No: BAH-00656158

Procedure Done: Oocyte retrieval.

Post Procedure Diagnosis: Oocyte retrieval done

Post-Operative Monitoring Parameters / Frequency: monitor PR, BP, SPO_2, RR every 5mins for 15mins, every 15min for 1 hr, 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: ~~[illegible]~~ Day 2/3 of cycle

Name of the Doctor: for Dr. Sudharani

Signature: [signature]

Date & Time: 11/6/26 @ 9:30Am

Note: Plan of care will be readjusted if necessary