Subject Access Request Team
Health Records Department
Gartnavel General Hospital
1053 Great Western Road
Glasgow
G12 0YN

NHS
Greater Glasgow and Clyde

MMA LEGAL
STOK, 43 - 59 PRINCES STREET,
STOCKPORT,
SK1 1RY

Date: **11th MAY 2026**
Your Ref: **100183**
Our Ref: SAR/TEAM/TH
Enquiries to: Tracy Hunter
Direct Line: 0141 211 0667
Email: tracy.hunter3@nhs.scot

Dear Sir/Madam

Re: Subject Access Request under the General Data Protection Regulation

Patient: GEORGINA LOGAN Date: 19.08.1954

Thank you for your request received **22ND APRIL 2026** in which you seek a copy of your client's personal information.

Your request has been dealt with in line with our requirements under Article 15 of the General Data Protection Regulation and I now attach the following:

GARTNAVEL GENERAL HOSPITAL – QUEEN ELIZABETH UNIVERSITY HOSPITAL – WEST AMBULATORY CARE HOSPITAL – NEW VICTORIA INFIRMARY - HOSPITAL RECORDS

Please be aware that these health records have been reviewed by a clinician and any information identifying or provided by a third party has been removed.

We process personal information to enable us to provide healthcare services for patients; support and manage our employees; to carry out research and clinical trials; maintain our accounts and records and to carry out data matching under the national fraud initiative. We also use CCTV systems for crime prevention.

This personal information can be both clinical and non-clinical in nature and can include

- Patient health records, photographs or radiology images
- Video/telephone recordings, including CCTV images

- Witness statements
- Incident reports
- Complaints files
- Emails

The source of our data includes Patients, General Practitioners, Healthcare, Social and Welfare organisations, Legal representatives and Police forces.

We sometimes need to share the personal information we process with the individual themselves and also with other organisations as listed above. Where this is necessary we are required to comply with all aspects of the General Data Protection Regulation

Where these organisations are based outside Europe we take all appropriate safeguards to protect your information.

Health records are kept for a limited time and this is noted below for your information

- Adult general hospital records – six years after the date of last entry
- Maternity records – 25 years after the birth of the last child
- Children's and young people's records – until the child or young person's 25th birthday.
- Mental health records – 20 years after the date of the last contact

If you have any queries, please do not hesitate to contact us.

If you are unhappy with how your request has been dealt with please contact the NHSGGC Data Protection Officer. Their contact details are noted below:

Data Protection Officer
Information Governance Department
NHS GG&C – 2nd Floor
1 Smithhills Street
Paisley
PA1 1EB
Email: data.protection@ggc.scot.nhs.uk

Yours sincerely

SAR Team

Outlook

GEORGINA LOGAN CHI 1908546042

From Jillian Andrew (NHS Greater Glasgow and Clyde) <Jillian.Andrew@nhs.scot>
Date Mon 11/05/2026 15:44
To Tracy Hunter (NHS Greater Glasgow and Clyde) <tracy.hunter3@nhs.scot>
Cc Donna McCarter (NHS Greater Glasgow and Clyde) <Donna.McCarter@nhs.scot>

10 attachments (744 KB)
GL1908546042.pdf; GL1908546042-01.pdf; GL1908546042-02.pdf; GL1908546042-03.pdf; GL1908546042-04.pdf; GL1908546042-05.pdf; GL1908546042-06.pdf; GL1908546042-07.pdf; GL1908546042-08.pdf; GL1908546042-09.pdf;

Hi Tracy

Please see attached open eyes notes.

Thanks

Jillian

Jillian Andrew
QEUH Eye Secretary
0141 451 (8)6067
Admin Block, Level 1, Zone 1
Secretary to: Dr Sonul Gajree, Dr Graeme Williams, Dr S A Bhatti, Dr Michael Hollifield

Examination

Patient Name	Mrs Georgina Logan	CHI	1908546042
Date of Birth	19 Aug 1954 (71)	CHI	1908546042
Consultant		Service	Medical Retina
Event Date	3 Feb 2025	Printed	11 May 2026
Patient's address	17 Sollas Place Glasgow GGC G13 4NA		

Visual Acuity
Snellen Metre

6/24 Glasses	6/7.5 Glasses

Drug Administration

Custom Lee Park (Custom)

Drug	Dose	Route	Administered by	Date	Time	
Tropicamide 1% single use eye drops (No Preservative)	1 drop	®	Lee Park	3 Feb 2025	14:45	✓
Tropicamide 1% single use eye drops (No Preservative)	1 drop	Ⓛ	Lee Park	3 Feb 2025	14:45	✓

Examination created by Lee Park on 3 Feb 2025 at 14:53

Examination last modified by Lee Park on 3 Feb 2025 at 14:53

Examination

Patient Name	Mrs Georgina Logan	CHI	1908546042
Date of Birth	19 Aug 1954 (71)	CHI	1908546042
Consultant		Service	Medical Retina
Event Date	3 Feb 2025	Printed	11 May 2026
Patient's address	17 Sollas Place Glasgow GGC G13 4NA		

Visual Acuity **Snellen Metre**	6/24 Glasses	6/7.5 Glasses

Drug Administration

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Tropicamide 1% single use eye drops (No Preservative)	1 drop	®	Lee Park	3 Feb 2025	14:45	✓
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Examination created by Lee Park on 3 Feb 2025 at 14:53

Examination last modified by Lee Park on 3 Feb 2025 at 14:53

Examination

Patient Name	Mrs Georgina Logan	CHI	1908546042
Date of Birth	19 Aug 1954 (71)	CHI	1908546042
Consultant		Service	Medical Retina
Event Date	4 Feb 2025	Printed	11 May 2026
Patient's address	17 Sollas Place Glasgow GGC G13 4NA		

Eye Diagnoses 4 Feb 2025 Right Epiretinal membrane

Follow-up Discharge to community optometrist

Investigation

Right ERM

Clinical Management Right ERM- VA and OCT appearance the same when discharged and patient not wanting surgery in 2022. Letter back to Optom/patient/GP

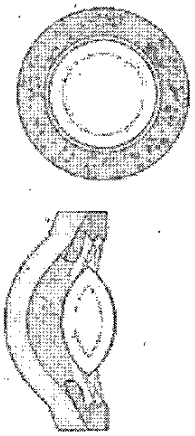
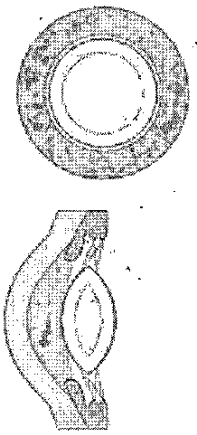
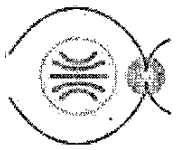
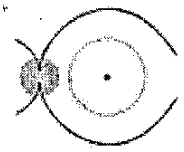
Examination created by David Gilmour on 4 Feb 2025 at 09:10

Examination last modified by David Gilmour on 4 Feb 2025 at 09:10

Examination

Patient Name	Mrs Georgina Logan	CHI	1908546042
Date of Birth	19 Aug 1954 (71)	CHI	1908546042
Consultant		Service	Medical Retina
Event Date	10 Apr 2025	Printed	11 May 2026
Patient's address	17 Sollas Place Glasgow GGC G13 4NA		

History Bilateral cataract
Right blurred vision

Visual Acuity ETDRS Letters	63 Glasses	76 Glasses
Anterior Segment	 Large pupil (diameter: 8mm)	 Large pupil (diameter: 8mm)
Intraocular Pressure	11mm Hg 09:05 I-care	12mm Hg 09:05 I-care
Macula	Epiretinal membrane 	No abnormality 
Eye Diagnoses	4 Feb 2025 Right Epiretinal membrane	

Drug Administration

Custom Pauline Nichol (Custom)

Drug	Dose	Route	Administered by	Date	Time	
Phenylephrine 2.5% single use eye drops (No Preservative)	1 drop	®	Pauline Nichol	10 Apr 2025	09:08	✓
Phenylephrine 2.5% single use eye drops (No Preservative)	1 drop	Ⓛ	Pauline Nichol	10 Apr 2025	09:08	✓
Tropicamide 1% single use eye drops (No Preservative)	1 drop	®	Pauline Nichol	10 Apr 2025	09:08	✓
Tropicamide 1% single use eye drops (No Preservative)	1 drop	Ⓛ	Pauline Nichol	10 Apr 2025	09:08	✓

Investigation OCT 10 Apr 2025 at 09:08:00 OCT - Macula

Clinical Management Right Phaco+ IOL+ Vtrectomy/ERM Peel GA DC (anxiety and phobia).

Examination created by Fiona Fadian on 10 Apr 2025 at 09:06

Examination last modified by Shohista Saidkasimova on 10 Apr 2025 at 09:41

NHS SCOTLAND

Gartnavel General Hospital
1053 Great Western Road
Glasgow
GGC
G12 0YN
Tel: 01412113000

Dr Richard Murphy
Barclay Clydeside
1265 - 1275 Dumbarton Road
Glasgow
G14 9UU

10 Apr 2025

Dear Dr Murphy,

Re: Georgina Logan, 17 Sollas Place, Glasgow, G13 4NA
DOB: 19 Aug 1954, CHI: 1908546042, CHI: 1908546042

Diagnosis:

4 Feb 2025	RIGHT Epiretinal membrane
	Bilateral mild cataract

Visual Acuity:

Visual Acuity	Right Eye	Left Eye
Glasses	**63**	**76**

Intraocular Pressure:

11 mmHg on the right, and 12 mmHg on the left (recorded on 10 Apr 2025)

Clinical Management:

Right Phaco+ IOL+ Vtrectomy/ERM Peel GA DC (anxiety and phobia)

Follow-up:

Discharge to community optometrist

Yours sincerely,

Shohista Saidkasimova

Signed on 10 Apr 2025, 13:56

Dr Shohista Saidkasimova

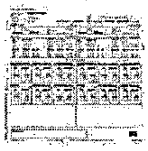
To: GP : Dr Richard Murphy, Barclay Clydeside, 1265 - 1275 Dumbarton Road, Glasgow, G14 9UU

Biometry

Patient Name	Mrs Georgina Logan	CHI	1908546042
Date of Birth	19 Aug 1954 (71)	CHI	1908546042
Consultant		Service	General Ophthalmology
Event Date	3 Jul 2025	Printed	11 May 2026
Patient's address	17 Sollas Place Glasgow GGC G13 4NA		

Attachment


B - Biometry Report


B - Biometry Report


B - Biometry Report

Biometry

	(R)				(L)		
AL:	24.96 mm				24.90 mm		
SNR:	N/A				N/A		
K1:	43.85 D	@	14.0°		44.27 D	@	2.0°
ΔK:	-3.83 D	@	14.0°		-2.55 D	@	2.0°
K2:	47.69 D	@	104.0°		46.82 D	@	92.0°
ACD:	3.61 mm				3.71 mm		
LVC:							
LVC Mode:							
Status	Phakic				Phakic		

General Comments

Device Comments:

General Comments

Target Refraction 0.00

General Comments

Target Refraction 0.00

Lens	Rayner RayOne Aspheric	®
Formula Used:		®
A constant:	118.7	®
IOL Power:	14.50	®
Predicted Refraction:	-0.38	®

No selection has been made - click the "Choose Lens" button to select a lens.

Biometry created by Keith Boyle on 3 Jul 2025 at 16:10

Biometry last modified by Alasdair Simpson on 11 Sep 2025 at 14:43

Visual Acuity 06 Nov 2025	32 Glasses (ETDRS Letters), 0 Pinhole (ETDRS Letters)	80 Glasses (ETDRS Letters)
Near Visual Acuity	Not recorded	Not recorded
Refraction 6 Nov 2025	-4.25/+3.25 X 95° -2.63 patient already dilated at subjective VAR with subjective 6/18 (ph NI), can see better if turning head to the right, if not turning head to the right VAR is only 6/24 Near add +2.50 N24 / Near add +4.00 N14	-3.00/+3.00 X 80° -1.50

Examination

Patient Name	Mrs Georgina Logan	CHI	1908546042
Date of Birth	19 Aug 1954 (71)	CHI	1908546042
Consultant		Service	Medical Retina
Event Date	3 Jul 2025	Printed	11 May 2026
Patient's address	17 Sollas Place Glasgow GGC G13 4NA		

History preop assesment today

Visual Acuity ETDRS Letters	58 Glasses, 50 Pinhole			76 Glasses	
Intraocular Pressure	12mm Hg	14:10	I-care	11mm Hg	14:10	I-care

Eye Diagnoses
4 Feb 2025 Right Epiretinal membrane
3 Jul 2025 Bilateral Cataract
3 Jul 2025 Bilateral Cataract

Drug Administration Preset - PSD Tropicamide 1% and Phenylephrine 2.5%

Drug	Dose	Route	Administered by	Date	Time	
Tropicamide 1% single use eye drops (No Preservative)	1 drop	R	Pauline Nichol	3 Jul 2025	14:16	✓
Tropicamide 1% single use eye drops (No Preservative)	1 drop	L	Pauline Nichol	3 Jul 2025	14:16	✓
Phenylephrine 2.5% single use eye drops (No Preservative)	1 drop	R	Pauline Nichol	3 Jul 2025	14:16	✓
Phenylephrine 2.5% single use eye drops (No Preservative)	1 drop	L	Pauline Nichol	3 Jul 2025	14:16	✓

Investigation OCT 3 Jul 2025 at 14:14:00

Clinical Management Proceed as planned Phaco/VPA LA DC

Examination created by Lynsey Watson on 3 Jul 2025 at 14:10

E:683747/G5JL8UHRG/

LOGAN, Georgina (Mrs)
CHI: 1908546042, CHI: 1908546042
DOB: 19-08-1954

Examination last modified by Shohista Saidkasimova on 3 Jul 2025 at 16:16

Operation booking

Patient Name	Mrs Georgina Logan	CHI	1908546042
Date of Birth	19 Aug 1954 (71)	CHI	1908546042
Consultant		Service	General Ophthalmology
Event Date	7 Jul 2025	Printed	11 May 2026
Patient's address	17 Sollas Place Glasgow GGC G13 4NA		

Diagnosis Right Epiretinal membrane

Operation

Procedures & OPCS codes

Right Phacoemulsification and Intraocular lens	
Right Vitrectomy	
Right Epiretinal membrane peel	C79.5

Information

Complexity	Medium	Decision Date	7 Jul 2025
Consultant required?	No Consultant	Site	Gartnavel General Hospital
Anaesthetic	GA		
Anaesthetic choice is	Patient preference	Operation priority	Routine
Patient needs to stop medication	No	Admission category:	Day case
		Total theatre time (mins):	110
		Special equipment required	No

Comments Doctor organising admission Gigon Anthony

Schedule operation	**Schedule options**	As soon as possible
	Patient Unavailable Periods	No known availability restrictions.
Contact Details	Patient: 01419523728	

Operation booking created by Anthony Gigon on 7 Jul 2025 at 15:01

Operation booking last modified by Anthony Gigon on 7 Jul 2025 at 15:01

Patient Name	Mrs Georgina Logan	CHI	1908546042
Date of Birth	19 Aug 1954 (71)	CHI	1908546042
Consultant		Service	Medical Retina
Event Date	12 Sep 2025	Printed	11 May 2026
Patient's address	17 Sollas Place Glasgow GGC G13 4NA		

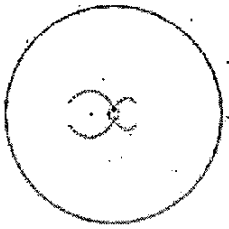
Operation(s) Performed:

- Right Phacoemulsification and Intraocular lens
- Right Vitrectomy
- Right Epiretinal membrane peel

First Surgeon	Assistant Surgeon	Supervising surgeon
Dr Alasdair Simpson	None	Dr Shohista Saidkasimova

Operation Details

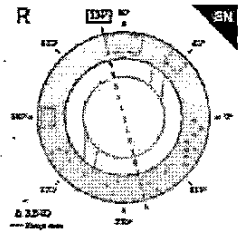
Vitrectomy

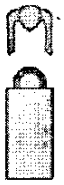


Gauge	25g
PVD Induced	Yes
Comments	Vitrectomy Blue dye Adherent ERM and ILM came as well, limite peel Search - no breaks FAX Ports - massage Eye firm Ic cef S/c dex

Membrane peel Membrane blue

Cataract





Incision site :	Corneal
Length :	2.80
Meridian :	90
Incision type :	Pocket
Details :	Posterior chamber IOL (In-the-bag fixation), large pupil (diameter: 8mm), corneal pocket incision at 12 o'clock, sideport at 9, and 1 o'clock
IOL type :	Rayner RayOne Aspheric
IOL power :	14.50
Predicted refraction :	-0.38
IOL position :	In the bag
Phaco CDE :	Not recorded
PCR Risk :	1.04%

Agent(s)	None	**Cataract complications**	None Suture placed but removed at the end
Anaesthetic	**Type**		**Comments**
	GA		None

Per-operative drugs Cefuroxime injection.....mg in 0.1ml (intracamerally)

Post-op instructions

2/52 Dr SS
Home
No Posture

Chloramphenicol QID 1/52
PRed Fort QID 4/52
Acular TID 4/52

Comments None

Operation note created by Alasdair Simpson on 12 Sep 2025 at 10:22

Operation note last modified by Alasdair Simpson on 12 Sep 2025 at 10:22

Examination

Patient Name	Mrs Georgina Logan	CHI	1908546042
Date of Birth	19 Aug 1954 (71)	CHI	1908546042
Consultant		Service	Medical Retina
Event Date	25 Sep 2025	Printed	11 May 2026
Patient's address	17 Sollas Place Glasgow GGC G13 4NA		

Visual Acuity ETDRS Letters	23 Glasses, 32 Pinhole	75 Glasses

Intraocular Pressure	9mm Hg	09:31	I-care	14mm Hg	09:31	I-care

Drug Administration Preset - PSD Tropicamide 1% and Phenylephrine 2.5%

Drug	Dose	Route	Administered by	Date	Time	
Tropicamide 1% single use eye drops (No Preservative)	1 drop	R	Gayle Williamson	25 Sep 2025	09:32	✓
Tropicamide 1% single use eye drops (No Preservative)	1 drop	L	Gayle Williamson	25 Sep 2025	09:32	✓
Phenylephrine 2.5% single use eye drops (No Preservative)	1 drop	R	Gayle Williamson	25 Sep 2025	09:32	✓
Phenylephrine 2.5% single use eye drops (No Preservative)	1 drop	L	Gayle Williamson	25 Sep 2025	09:32	✓

Investigation OCT 25 Sep 2025 at 09:32:00 OCT - Macula

Examination created by Marcus Blackett on 25 Sep 2025 at 09:31

Examination last modified by Gayle Williamson on 25 Sep 2025 at 09:32

Examination

Patient Name	**Mrs Georgina Logan**	CHI	**1908546042**
Date of Birth	**19 Aug 1954 (71)**	CHI	**1908546042**
Consultant		Service	**Medical Retina**
Event Date	**6 Nov 2025**	Printed	**11 May 2026**
Patient's address	**17 Sollas Place Glasgow GGC G13 4NA**		

History

Worried right eye not seeing
But very anxious - sisters died recently "might just be my nerves"

Visual Acuity
ETDRS Letters

32 Glasses, 0 Pinhole	**80 Glasses**

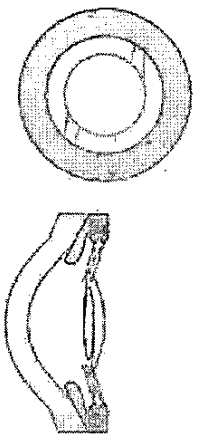
Refraction

Sphere	Cylinder	Axis	Type
-4.25	+3.25	95	Focimetry
-3.00	+4.00	85	Retinoscopy
-3.00	+3.00	80	Subjective

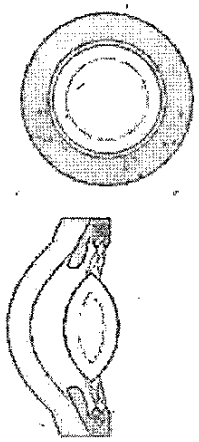
Sphere	Cylinder	Axis	Type
-3.00	+3.00	80	Focimetry

patient already dilated at subjective
VAR with subjective 6/18 (ph NI), can see better if turning head to the right, if not turning head to the right VAR is only 6/24
Near add +2.50 N24 / Near add +4.00 N14

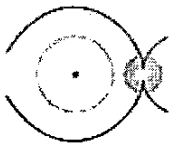
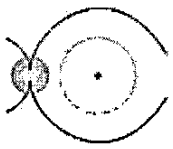
Anterior Segment



Posterior chamber IOL (In-the-bag fixation)
Large pupil (diameter: 8mm)



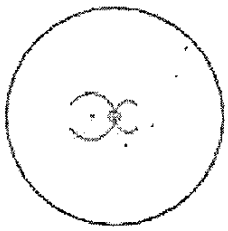
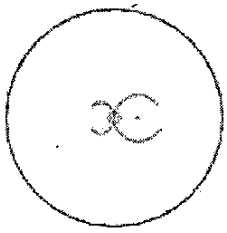
Large pupil (diameter: 8mm)

Intraocular Pressure	9mm Hg	09:00	I-care	15mm Hg	09:00	I-care	
Macula	Comments: looks good 			No abnormality 			
Eye Diagnoses	**4 Feb 2025 Right Epiretinal membrane** 3 Jul 2025 Bilateral Cataract			3 Jul 2025 Bilateral Cataract			

Drug Administration

Preset - PSD Tropicamide 1% and Phenylephrine 2.5%

Drug	Dose	Route	Administered by	Date	Time	
Tropicamide 1% single use eye drops (No Preservative)	**1 drop**	®	**Helena Thompson**	**6 Nov 2025**	**09:03**	✓
Tropicamide 1% single use eye drops (No Preservative)	**1 drop**	Ⓛ	**Helena Thompson**	**6 Nov 2025**	**09:03**	✓
Phenylephrine 2.5% single use eye drops (No Preservative)	**1 drop**	®	**Helena Thompson**	**6 Nov 2025**	**09:03**	✓
Phenylephrine 2.5% single use eye drops (No Preservative)	**1 drop**	Ⓛ	**Helena Thompson**	**6 Nov 2025**	**09:03**	✓

Fundus	No abnormality 			No abnormality 			
Investigation	**OCT**	**6 Nov 2025 at 09:01:00** ⓘ					
Clinical Management	Surprised vision isn't better - no epxlanation for poor vision Optom will kindly refract to see if VA can be improved Review 2/12 with refraction - please check pupils						

Examination created by Elaine Lyons on 6 Nov 2025 at 09:00

Examination last modified by Maria Del Rosario Gil on 6 Nov 2025 at 10:57

Examination

Patient Name	Mrs Georgina Logan	CHI	1908546042
Date of Birth	19 Aug 1954 (71)	CHI	1908546042
Consultant		Service	Medical Retina
Event Date	4 Feb 2025	Printed	11 May 2026
Patient's address	17 Sollas Place Glasgow GGC G13 4NA		

Eye Diagnoses **4 Feb 2025 Right Epiretinal membrane**

Follow-up **Discharge to community optometrist**

Investigation

Right ERM

Clinical Management Right ERM- VA and OCT appearance the same when discharged and patient not wanting surgery in 2022. Letter back to Optom/patient/GP

Examination created by David Gilmour on 4 Feb 2025 at 09:10

Examination last modified by David Gilmour on 4 Feb 2025 at 09:10

Subject Access Request Team
Health Records Department
Gartnavel General Hospital
1053 Great Western Road
Glasgow
G12 0YN

NHS
Greater Glasgow and Clyde

MMA LEGAL
STOK, 43 - 59 PRINCES STREET,
STOCKPORT,
SK1 1RY

Date: **11th MAY 2026**
Your Ref: **100183**
Our Ref: SAR/TEAM/TH
Enquiries to: Tracy Hunter
Direct Line: 0141 211 0667
Email: tracy.hunter3@nhs.scot

Dear Sir/Madam

Re: Subject Access Request under the General Data Protection Regulation

Patient: GEORGINA LOGAN Date: 19.08.1954

Thank you for your request received **22ND APRIL 2026** in which you seek a copy of your client's personal information.

Your request has been dealt with in line with our requirements under Article 15 of the General Data Protection Regulation and I now attach the following:

GARTNAVEL GENERAL HOSPITAL – QUEEN ELIZABETH UNIVERSITY HOSPITAL – WEST AMBULATORY CARE HOSPITAL – NEW VICTORIA INFIRMARY - HOSPITAL RECORDS

Please be aware that these health records have been reviewed by a clinician and any information identifying or provided by a third party has been removed.

We process personal information to enable us to provide healthcare services for patients; support and manage our employees; to carry out research and clinical trials; maintain our accounts and records and to carry out data matching under the national fraud initiative. We also use CCTV systems for crime prevention.

This personal information can be both clinical and non-clinical in nature and can include

- Patient health records, photographs or radiology images
- Video/telephone recordings, including CCTV images

- Witness statements
- Incident reports
- Complaints files
- Emails

The source of our data includes Patients, General Practitioners, Healthcare, Social and Welfare organisations, Legal representatives and Police forces.

We sometimes need to share the personal information we process with the individual themselves and also with other organisations as listed above. Where this is necessary we are required to comply with all aspects of the General Data Protection Regulation

Where these organisations are based outside Europe we take all appropriate safeguards to protect your information.

Health records are kept for a limited time and this is noted below for your information

- Adult general hospital records – six years after the date of last entry
- Maternity records – 25 years after the birth of the last child
- Children's and young people's records – until the child or young person's 25th birthday.
- Mental health records – 20 years after the date of the last contact

If you have any queries, please do not hesitate to contact us.

If you are unhappy with how your request has been dealt with please contact the NHSGGC Data Protection Officer. Their contact details are noted below:

Data Protection Officer
Information Governance Department
NHS GG&C – 2nd Floor
1 Smithhills Street
Paisley
PA1 1EB
Email: data.protection@ggc.scot.nhs.uk

Yours sincerely

SAR Team

MANUAL PATIENT RECORDS

ALL HOSPITAL RECORDS HELD NHSGGC	☐		
ACS	☐		
BEATSON HOSPITAL	☐		
CANNIESBURN HOSPITAL	☐		
DENTAL HOSPITAL	☐		
GARTNAVEL GENERAL HOSPITAL	☐		
GLASGOW ROYAL INFIRMARY	☐		
INVERCLYDE ROYAL HOSPITAL	☐	MATERNITY	☐
NEW VICTORIA ACH	☐		
PRINCESS ROYAL MATERNITY	☐		
QUEEN ELIZABETH UNIVERSITY HOSPITAL	☐	MATERNITY	☐
ROYAL ALEXANDRA HOSPITAL	☐	MATERNITY	☐
ROYAL HOSPITAL FOR CHILDREN	☐		
STOBHILL HOSPITAL	☐		
VALE OF LEVEN	☐	MATERNITY	☐
WEST AMBULATORY CARE HOSPITAL	☐		
WESTERN INFIRMARY RECORDS	☐		

Including:

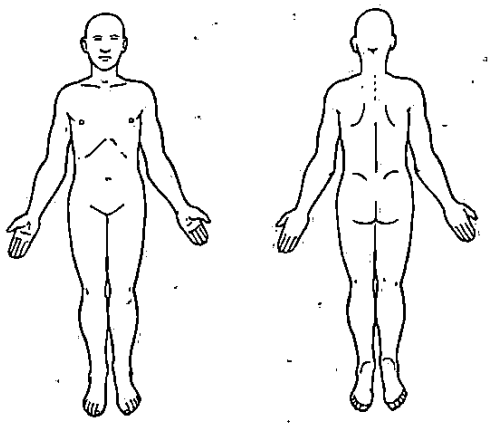
BADGERNET	☐		
CAREVUE	☐		
MEDICAL ILLUSTRATION	☐		
METAVISION	☐		
PHYSIOTHERAPY	☐		
RADIOLOGY	☐		
WEST MARC	☐		
LABS	☐		

Name : J. Roberts Ward : L8M Hospital Number : .....

PRESSURE SORE RISK ASSESSMENT

TORRANCE GRADE OF PRESSURE SORE

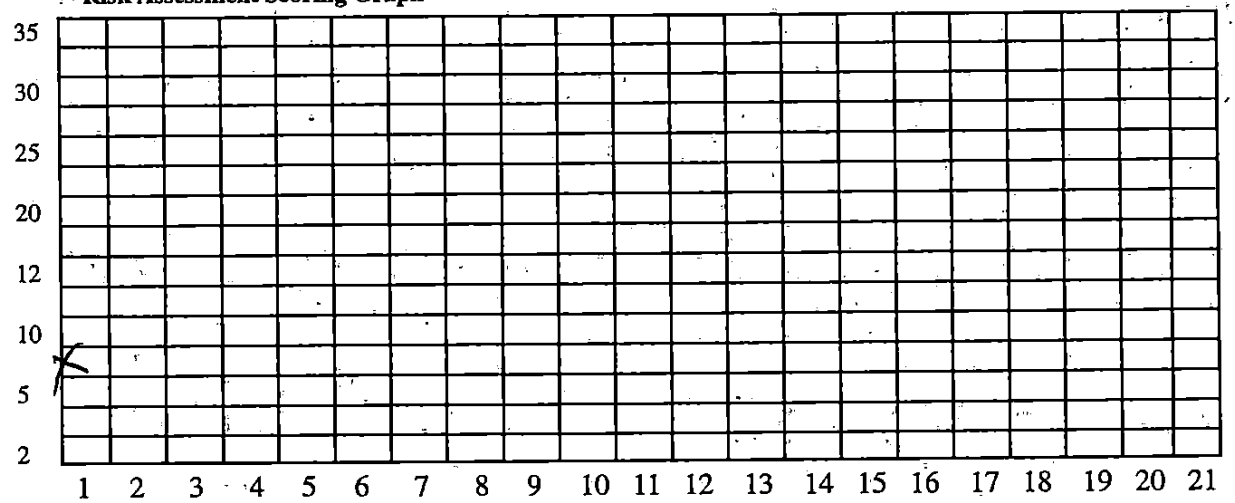
0 = no damage
1 = blanching hyperaemia (red area)
2 = non-blanching hyperaemia and/or superficial break
3 = ulceration progress through to meet subcutaneous tissue
4 = ulcer extends through fat to meet underlying muscle
5 = damage through muscle and/or necrotic tissue



DOCUMENT SEVERITY AND SITE OF PRESSURE DAMAGE ON ABOVE DIAGRAM

NB : ALL NURSING INTERVENTION MUST BE DOCUMENTED IN THE CARE PLAN

▲ Risk Assessment Scoring Graph



Waterlow Assessment

No.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Score	14																				
Date	15/4																				
Initials	AL																				

Build/ Weight for Height		**Skin Type (Visual Risk)**		**Mobility**		**Sex**		**Special Risks**	
Average	0	Healthy	0	Fully	0	Male	1	Tissue Malnutrition e.g.	
Above Average	1	Tissue Paper	1	Restless	1	Female	2	Terminal Cachexia	8
Obese	2	Dry	1	Apathetic	2	14 - 49	1	Cardiac Failure	5
Below Average	3	Oedematous	1	Restrictive	3	50 - 64	2	Peripheral Vascular Disease	5
		Clammy (Temp ↑)	1	Inert/Traction	4	65 - 74	3	Anaemia	2
Appetite		Discoloured	2	Chairbound	5	75 - 80	4	Smoking	1
Average	0	Broken Spot	3			81+	5		
Poor	1			**Major Surgery/Trauma**				**Medication**	
NG Tube/ Fluids Only	2	**Continence**		Orthopaedic	5			Cytotoxics	4
Nil by mouth	3	Complete/catheterised	0	Below waist/spinal	5			High dose steroids	4
Anorexic	3	Occasional incontinence	1	On operating table > 2hours	5			Anti-inflammatory drugs	4
		Cath/faecal incontinence	2						
		Doubly Incontinent	3						

Score :10 + AT RISK
15 + HIGH RISK
20 + VERY HIGH RISK

Neurological Deficit e.g.
Diabetes, Multiple Sclerosis,CVA,Motor-Sensory Paraplegia 4-6

0568695MI

UNIT WEST 1 — PATIENT NURSING HISTORY

DATE OF ADMISSION 17-11-87.
TIME 10.45 pm. WARD S.S.W.
PATIENTS NAME Georgina Roberts.
HOSPITAL W.I.G.
ADDRESS 13, Sollas Place. Knightswood.
CONSULTANT McColl.
HOSPITAL NO.
G.P. McCluskey - Dunkeeny Rd.
TELEPHONE NO. —
TELEPHONE NO.
DATE OF BIRTH 19-9-54. AGE 32yrs.
OCCUPATION Housewife.
RELIGION R/C.
SACRAMENTS OF THE SICK
NEXT OF KIN (1) Husband - John Roberts.
NEXT OF KIN (2)
ADDRESS As above.
ADDRESS
TELEPHONE NO. —
TELEPHONE NO.
RELATIVES NOTIFIED OF ADMISSION Present.
CLOTHING LISTED Yes - locker 3.
PATIENT SPOKEN TO BY CONSULTANT
PATIENTS OWN DRUGS In cupboard.
RELATIVES SPOKEN TO BY CONSULTANT

SOCIAL CIRCUMSTANCES Lives at home with husband & 3 children.

REASON FOR ADMISSION Took O/D because daughter is in Yorkhill with brain tumour - has had 4 ops. Husband lost his job & is now drinking heavily. (History from husband)

PATIENTS PERCEPTION OF ILLNESS Patient drowsy.

DIAGNOSIS/OPERATION O/D Co-codamol, Temazepam, Methylcellulose, & Trazolam.

OTHER HEALTH PROBLEMS Previous O/D in 1984 when family pressure was high.

ALLERGIES ?

Unable to get further information- Patient too drowsy

MAINTAINING A SAFE ENVIRONMENT

NUTRITION

ELIMINATION

HYGIENE

SLEEP

MOBILITY

SENSES

BREATHING

OTHER RELEVANT INFORMATION

DISCHARGE PLANNING: HOME HELP ☐ COMMUNITY NURSE ☐ AMBULANCE ☐

DRESSINGS ☐ CASHIER ☐ MEDICATION ☐ APPOINTMENT ☐

TICK (√) WHEN ARRANGED

OBSERVATIONS ON ADMISSION

TEMPERATURE 36' PULSE 80 RESPIRATIONS

BLOOD PRESSURE 100/70 HEIGHT WEIGHT

URINALYSIS

SIGNATURE OF ADMITTING NURSE

UNIT WEST 1 NAME: Georgina Roberts. DATE OF ADMISSION: 17/11/87

HOSPITAL: W.I.G. HOSPITAL NO:

DATE	PATIENT PROGRESS REPORT	SIGNATURE
17/11/87.	Admitted via [redacted] M/S corridor following ingestion of several types of drugs:- i.e. Temazepam, Trizolam, Co-codamol + methylcellulose. On admission drowsy but rousable. Recordings stable. Paracetamol levels not detected.	
18/11/87.	Slept soundly. Alert this morning tho' very tired. Recordings satisfactory. Has passed urine.	
	Seen by Dr McColl. Patient may be discharged home after seeing Psychiatrist. Husband wishes also to speak to Psychiatrist.	L Bugeli
	Seen by Dr Logie and may be discharged home. Given out patient appointment as a couple.	L Bugeli

PATIENT CARE PLAN: **UNIT WEST I** NAME: Georgina Roberts. WARD: SSW DATE OF ADMISSION: 17/11/87.

HOSPITAL: W.I.G. HOSPITAL NO.

DATE COMM.	BASIC CARE & PERSONAL HYGIENE	DATE DISC.	DATE COMM.	TECHNICAL CARE	D D
17/11/87.	Basin with help.				
				OBSERVATIONS	
			17/11/87	Hrly Temp, Pulse & BP.	
	MOBILISATION				
17/11/87.	Bed rest till fully conscious.				
				WOUND CARE	
	DIET				
17/11/87.	Ordinary / full fluids.				
	BLADDER & BOWEL CARE			SPECIMENS / INVESTIGATIONS	
17/11/87	Bed pans / up to toilet as able				
	SPECIAL NEEDS				

GREATER GLASGOW HEALTH BOARD

CLINICAL CHART

NAME Georgina Roberts HOSPITAL W.I.G.

WARD S.S.W. HOSPITAL NUMBER .....

DATE	17/11/87				18/11/87																			
TIMES					6	10	2	6	10															

TEMP °C: 40.0° 39.5° 39.0° 38.5° 38.0° 37.5° 37.0° 36.5° 36.0°

PULSE/min: 150 140 130 120 110 100 90 80 70 60 50 40

RESP/min: 30 20

O–O ●–● X–X

10 10 10 10 9 9

BOWELS																								
WEIGHT																								

UNIT WEST 1 — PATIENT NURSING HISTORY

DATE OF ADMISSION 9.7.85. TIME 8.45pm WARD S.S.W.

PATIENTS NAME GEORGINA ROBERTS. HOSPITAL W.I.G

ADDRESS 13 SOLLAS PLACE. CONSULTANT BALL.

GLASGOW. HOSPITAL NO.

G.P. M'CLUSKEY.

TELEPHONE NO. 944 7817 (SISTER) TELEPHONE NO. 121 DUNKENNY RD.

DATE OF BIRTH 19.8.55. AGE 30. OCCUPATION

RELIGION C/S. SACRAMENTS OF THE SICK

NEXT OF KIN (1) JOHN ROBERTS (HUSBAND) NEXT OF KIN (2)

ADDRESS As above. ADDRESS

TELEPHONE NO. 944 7817. TELEPHONE NO.

RELATIVES NOTIFIED OF ADMISSION Yes. CLOTHING LISTED

PATIENT SPOKEN TO BY CONSULTANT PATIENTS OWN DRUGS

RELATIVES SPOKEN TO BY CONSULTANT

SOCIAL CIRCUMSTANCES Lives c/c husband & 2 children.
Daughter ill c/c brain tumour.
Marriage problems.
Non smoker & drinker.

REASON FOR ADMISSION O/D of Ativan x 24 Tabs
Tegretol ?

PATIENTS PERCEPTION OF ILLNESS Understands.

DIAGNOSIS/OPERATION

OTHER HEALTH PROBLEMS Renal calculi 1984.
? U.T.I.

ALLERGIES ✱MORPHINE✱.

DATE OF ADMISSION:

HOSPITAL NO.:

WARD:

NAME:

NIT WEST 1.

OSPITAL:

PATIENT PROGRESS REPORT – PLEASE SIGN + DATE EACH ENTRY	EVALUATION DATE	AIM	PROBLEM	TE

MAINTAINING A SAFE ENVIRONMENT

NUTRITION Normal.

ELIMINATION Dysuria.

HYGIENE Self caring.

SLEEP problems sleeping.

MOBILITY No problems.

SENSES Normal.

BREATHING Normal.

OTHER RELEVANT INFORMATION

DISCHARGE PLANNING: HOME HELP ☐ COMMUNITY NURSE ☐ AMBULANCE ☐

DRESSINGS ☐ CASHIER ☐ MEDICATION ☐ APPOINTMENT ☐

TICK (√) WHEN ARRANGED

OBSERVATIONS ON ADMISSION

TEMPERATURE 36.5°C. PULSE 100. RESPIRATIONS 20.

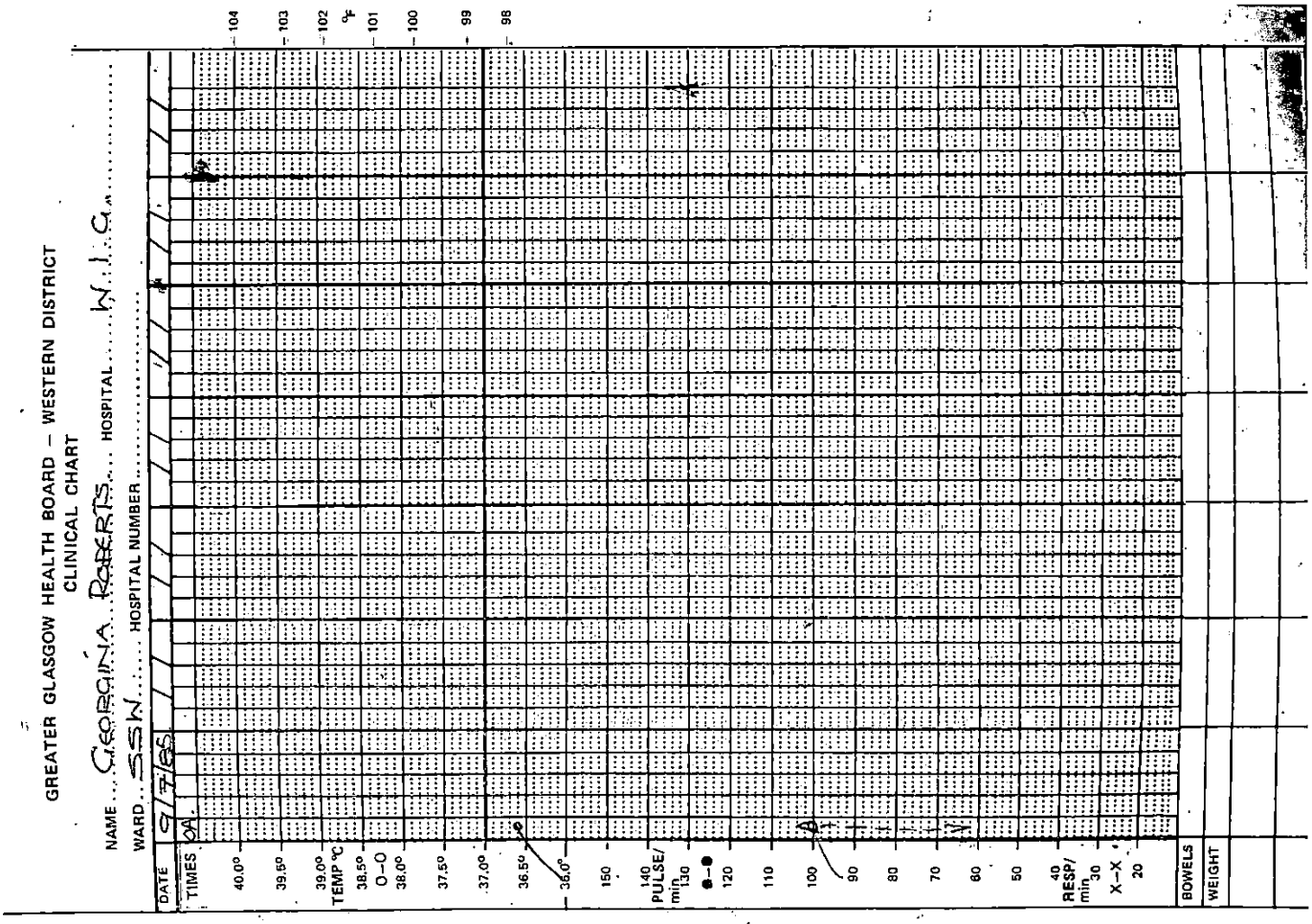
BLOOD PRESSURE 102/64 HEIGHT WEIGHT

URINALYSIS

SIGNATURE OF ADMITTING NURSE St/N. C. McGrath

GREATER GLASGOW HEALTH BOARD – WESTERN DISTRICT
CLINICAL CHART

NAME ... GEORGINA ROBERTS ... HOSPITAL ... W.I.G.
WARD ... SSW ... HOSPITAL NUMBER ...



PATIENT CARE PLAN: UNIT WEST I NAME: GEORGINA ROBERTS WARD: SSW DATE OF ADMISSION: 9.7.85

HOSPITAL: W.I.G. HOSPITAL NO.

DATE COMM.	BASIC CARE & PERSONAL HYGIENE	DATE DISC.
9.7.85	self caring.	
	MOBILISATION	
9.7.85	as able.	
	DIET	
9.7.85	Normal.	
	BLADDER & BOWEL CARE	
	B	
	SPECIAL NEEDS	

DATE COMM.	TECHNICAL CARE
	OBSERVATIONS
9.7.85	T.P.R. 4°
	B.P. 4°
	WOUND CARE
	SPECIMENS: Routine urine.
	INVESTIGATIONS

Lap. Steri.

Urine pH6
NAD

NURSING NOTES

E		DATE	TIME	A.M. T	P	R	B/O	P.M. T	P	R	B/O	IN TAKE	OUT PUT
180	Arranged admission to G9-10. TPR urine permission slip Gaviscon Mist Pulv Kpk 1/11 supps x bath urine for prognosticon Theatre breakfast nil am fast discontinued.	8/9/80	2										
			6					36	80				
			10	36	76		70						
	2 glycerine supps given @ 3pm ½ good effect												
180	Slept well. Theatre breakfast this am. Ready for theatre												
	Omnopon 10mg + Atropine 0.6mg given I.M at 9.30am	9/9/80	2										
	Returned from theatre @ 11.00 AM Laparoscopic	M Blake	6	36	82								
	Discharged under general anaesthetic		10	36	80								
	½ hr B.P. & Pulse:- Satisfactory	TH.											
	Wound check:- MIN												
	Ergotrate 10mg TID @ 11.30 AM N.P.O.												
	Recordings satisfactory H.A.U.												
	tolerating fluids and diet.												
	c/o slight headache no specific												
180	Slept all night. No complaints.	10/9/80	2										
	Bath - clips off - home.	1	6	36	70								
			10										

NURSING NOTES

DATE	TIME	A.M. T	A.M. P	A.M. R	A.M. B/O	P M T	P M P	P M R	P M B/O	IN TAKE	OUT PUT

No. | PINK | BLUE | GEORGINA ROBERTS. | STRIPE | AGE 26 | BLACK | BED No | Religion C/E | GREEN | UNIT No. | CONSULTANT Dr Sharp

PRESCRIPTION SHEET

REGULAR PRESCRIPTIONS

	Date Commenced	DRUG (BLOCK LETTERS)	DOSE	METHOD OF ADMIN	TIMES OF ADMINISTRATION A.M. 2	A.M. 4	A.M. 6	A.M. 8	A.M. 10	M.D. 12	P.M. 2	P.M. 4	P.M. 6	P.M. 8	P.M. 10	P.M. 12	Other Times	SIGNATURE	DISCONTINUED DATE	DISCONTINUED INITIALS
A	9-9-80	CYCLIMORPH	10 mg	im				4hr			PRN									
B																				
C																				
D																				
E																				
F																				
G																				
H																				
I																				
J																				
K																				
L																				
M																				
N																				

URINE

DIAGNOSIS

OPERATIONS

ONCE ONLY PRESCRIPTIONS

INTRAVENOUS FLUIDS

DATE GIVEN	DRUG (BLOCK LETTERS	DOSE	METHOD OF ADMIN	TIME OF ADMIN.	SIGNATURE	GIVEN BY INITIALS
9-9-80	OMNOPON	10mg	im	0930		N.B.
9-9-80	ATROPINE	0.6mg	im	0930		

WARD	NAME OF PATIENT	UNIT NUMBER	CONSULTANT	DRUG SENSITIVITY
	[redacted]			

[redacted]

NURSING NOTES

	DATE	TIME	A.M. T	P	R	B/O	P.M. T	P	R	B/O	IN TAKE	OUT PUT
Admitted as emergency to Ward C6 at 9pm T ? R ? Patient ambulant. Using spec. up to the bathroom. Orders BP - Pulse chart B ? 12/7 ? as above	24.5.72						98	84		½		
	O.D.											
Complained of pain abdomen pain at 3am but settled after oral pain relief	25.5.72			98	88	½	98	84		½		
BP 125/65 To be seen by Dr. Watt + Psyc. Social worker	O O											
Slept very well. IV had urine collection commenced at 9am. - cancelled. To go home	26.5.72			99	64	½						
	O D											

NURSING NOTES

ATE	DATE	TIME	A.M. T	P	R	B/O	P.M. T	P	R	B/O	IN TAKE	OUT PUT

PRESCRIPT N [redacted] SHEET

Western Infirmary, Glasgow.

REGULAR PRESCRIPTIONS

	Date Commenced	DRUG (BLOCK LETTERS)	DOSE	METHOD OF ADMIN.	TIMES OF ADMINISTRATION: A.M. 6	A.M 8	A.M 10	MD. 12	P.M. 2	P.M. 6	P.M. 10	MN. 12	OTHER TIMES	SIGNATURE	DISCONTINUED: DATE	DISCONTINUED: INITIALS
A.																
B.																
C.																
D.																
E.																
F.																
G.																
H.																
K.																
M.																
N.																

URINE

DIAGNOSIS

Overdose of Resparn.

OPERATIONS

Ordinary diet.

ONCE ONLY PRESCRIPTIONS

DATE GIVEN	DRUG (BLOCK LETTERS)	DOSE	METHOD OF ADMIN.	TIME OF ADMIN.	SIGNATURE	GIVEN BY INITIALS
25/6/72	DESFERRIOXAMINE	1000mg	IM	3 10pm	D Robertson	HH.

INTRAVENOUS FLUIDS

WARD	NAME OF PATIENT	AGE	UNIT NUMBER	CONSULTANT

DRUG SENSITIVITY

Patient Information

Miss Georgina Logan
19/08/1954
Phone No : *07500390352*

17 Sollas Pl
GLASGOW
G13 4NA

Seen By GP *Dr AH Morgan*
Registered GP *Dr AH Morgan*

12/05/2011 **Encounter** **ST1 REGISTRAR** severy epigastric pain, associated with sweating and claminass. Severe nausea worse after taking food. The pain has been there for the last 2 days on and off. Had stoped all her medications including Nicorandil and Omeprazole for week prior to this, but restarted now. BP 130/72, hr 82. abdomen soft with epigastric tenderness. Please note had perfussionn deffects on Thalium scan. ?IMP: epigastric pain ?Cardiac ? Gastric. Directed to A&E

07/05/2011 **Data Entry**

Read Code 6C0.. Primary prevention of ischaemic heart disease

06/05/2011 **Data Entry** **Dr M Duffy**

Acute Rx Transvasin Heat RUB x Apply 4 times daily x 80

Acute Rx Methocarbamol TABS 750MG x 2 tabs 4 times daily x 112 disp weekly

Acute Rx Co-Dydramol 10mg/500mg TABS x 1 or 2 Tabs 3 times daily x 30

Acute Rx Alimemazine Tartrate TABS 10MG x 1 Tab At night x 28

05/05/2011 **Data Entry**

03/05/2011 **Encounter** **ST3 REGISTRAR** Complaining of leg pain cramps mainly at night, note recommenced on quinine sulphate
Asked for ppi again

Repeat Rx Omeprazole CAPS 20MG x 1 Cap In the morning x 28

Patient Information

Miss Georgina Logan
19/08/1954
Phone No : *07500390352*

17 Sollas Pl
GLASGOW
G13 4NA

Seen By GP *Dr AH Morgan*
Registered GP *Dr AH Morgan*

High Priority Read Codes

Start Date	Date Recorded	Code	Priority	Description	Modifier
None	24/05/1972	SL...	High	Overdose of drug Freetext : 30 feospan	
None	24/02/1987	SL...	High	Overdose of drug Freetext : daughter mental handicap, subarachnoid cyst	1st
None	21/12/2009	N143.	High	Sciatica Freetext : Left L2/L3 Decompression + Discectomy	
None	17/01/1972	24D..	High	Soft systolic murmur	
01/2007	13/02/2007	78105	High	Laparoscopic cholecystectomy	
None	09/12/2009	7J30.	High	Primary decompression operations on lumbar spine	
None	09/07/1985	SL...	High	Overdose of drug	
None	08/09/2009	J51..	High	Diverticular disease	
None	07/02/1989	E204.	High	Neurotic depression reactive type	
30/09/2010	06/12/2010	J521.	High	Irritable bowel syndrome	
None	03/04/2006	9344.	High	Notes summary on computer	
None	01/03/2006	H33..	High	Asthma	
None	01/01/1966	A40..	High	Acute poliomyelitis	

Repeat Medication

Drug Name	Dose and Frquency	Quantity	Last Rx
Clenil Modulite 100 200 Dose Cfc Free INHAL 0MCG/DOSE	2 Puffs morning and night	1	05/05/2011
Salbutamol 200 Dose Cfc Free INHAL 00MCG/DOSE	2 Puffs Take as required	1	05/05/2011
Omeprazole CAPS 20MG	1 Cap In the morning	28	03/05/2011
Methocarbamol TABS 750MG	2 tabs 4 times daily	112 disp weekly	19/04/2011
Nicorandil TABS 10MG	1 Tab Twice daily	56	18/04/2011
Quinine Sulphate TABS 300MG	1 Tab At night	28 dispense weekly	18/04/2011
Simvastatin TABS 40MG	1 Tab In the morning	28 dispense weekly	18/04/2011
Aspirin Ec TABS 75MG	1 Tab In the morning	28 dispense weekly	18/04/2011
Clonidine Hydrochloride TABS 25MICROGRAMS	1 Tab morning and night	56 dispense weekly	18/04/2011

Drug Name	Dose and Frquency	Quantity	Last Rx
GABAPENTIN 300MG CAPS	2 Caps 3 times daily	168	18/04/2011
Tramadol Hydrochloride Mr CAPS 150MG	1 Cap morning and night	56	18/04/2011
Peptac Sf Aniseed LIQ	30 mls Take as required	500	21/03/2011

Acute Services Division
Emergency Care and
Medical Services Directorate

NHS
Greater Glasgow and Clyde

DEPARTMENT OF CARDIOLOGY

Western Infirmary
Dumbarton Road
Glasgow
G11 6NT
Direct Line: 0141 211 2803
Fax: 0141 211 1906

Dr Piotr Sonecki's Clinic of 29/03/2011

Our Ref: PS/LH//50551545H
Date: 06/04/2011

Dr Ann Morgan
Drumchapel Health Centre
80/90 Kinfauns Drive
G15 7TS

Dear Dr Morgan

Georgina Logan - 19/08/1954 - CHI: 1908546042
17 Sollas Place, Glasgow, Lanarkshire, G13 4NA

Please find a copy of this lady's myocardial perfusion scan. It shows some reperfusion defects and I will review her in the cardiac clinic to discuss the results and her symptoms.

Yours sincerely

Dr Piotr Sonecki
Consultant Cardiologist

NHS

North Glasgow Hospitals

Western Infirmary
LOGAN, Georgina
17 Sollas Place, Glasgow, , , G13 4NA
Referrer: Dr Martin Lindsay - WIG CARDIOLOGY OP

Diagnostic Imaging Report
DoB: **19/08/1954**
Chi No: **1908546042**
CRIS No: **5643817**
Hosp No: **50551545H**

VERIFIED Verified By: Dr Marion Barlow 09/03/11 1138 and: Dr Graham McCurrach.
NM Administration: Isotope: TECHNETIUM 99M TC Chemical: Tetrofosmin (myoview)
Activity: 397.0 Administered By: 1347146 Time: 1030
Clinical History : Chest pain and back problems.

NM MPS Tf stress :.
Stressed with cycle exercise limited by back pain.
ECG - non specific ST changes.

Apical septal reperfusion.
Mid septal fixed defect.
Basal septal fixed defect, infero-lateral reperfusion defect.

Ref. Src: Western Infirmary, Dumbarton Road, Glasgow, G11 6NT
Exams: NM MPS Tf stress
Exam Date: 01/03/11 Event: E-25563112

08966

DRUGS PRESCRIBED

Date given	Drug (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given by

PARENTERAL FLUID PRESCRIPTION SHEET

Date	FLUID	Volume	Time to run	Rate mls/hr	ADDED DRUGS	Quantity	Doctors Signature	Added by	Start time 24hr Clock	Put up by	Checked by	Serial/ Batch no

N.B. IF USING A SYRINGE DRIVER/INFUSION PUMP PLEASE USE THE "PRESCRIPTION AND ADMINISTRATION SHEET FOR MEDICINES GIVEN BY SYRINGE DRIVER/INFUSION PUMP"

REFUSAL TO REMAIN UNDER HOSPITAL CARE

I wish to take my discharge. I appreciate that this is against the advice and wishes of the Consultant or his or her deputy looking after me. I acknowledge that I have been informed of the risks of doing so and I accept full responsibility for my actions and any consequences arising from them.

Name *(print)* _____ Signature _____

I confirm that I have explained to the patient the risks that might arise out of his / her decision to take his / her own discharge.

Date _____ Signature _____ *(Medical Practitioner)*

DISCHARGE DETAILS (NURSING)

Treatment _____

_____

_____ Signed _____

(Please put initials in box)

Crutches ☐ Return appointment ☐ Advice Card ☐ Medication ☐

Escort to ward ☐ Relatives informed ☐ IRIS ☐ Transport ☐ Time booked ____

Discharged with _____ Admitted / transferred to _____

437 Rec/02/04

Patient's name GEORGINA 'OGAN Age 56 Date of Birth 190854

NURSING DOCUMENTATION - EMERGENCY DEPARTMENT

Date _____ Time _____ Triage Nurse _____ PC _____

_____

_____

_____ Triage category 1 2 3 4 5

Relatives present: Relatives informed:

INITIAL VITAL SIGNS

at:(Time) _____

HR: _____

BP: _____

RR: _____

SaO_2: _____

Temp: _____

G.C.S: _____

Signed _____

INITIAL MANAGEMENT

Nurse _____

Oxygen started _____ %: Signed _____ ECG: Signed _____

Signed _____

Other _____

Treatment _____

NEUROLOGICAL OBSERVATIONS

RESPONSIVENESS	TIME		hrs																						
	EYES OPEN	spontaneously 4																							
		to speech 3																							
		to pain 2																							
		none 1																							
	BEST VERBAL RESPONSE	orientated 5																							
		confused 4																							
		inappropriate words 3																							
		incomprehensible sounds 2																							
		none 1																							
	BEST MOTOR RESPONSE	obey commands 6																							
		localises pain 5																							
		normal flexion to pain 4																							
		abnormal flexion to pain 3																							
		extention to pain 2																							
		none 1																							
	COMA SCORE 15																								
	PUPILS	RIGHT	size (mm) Reaction																						
		LEFT	size (mm) Reaction																						
LIMB MOVEMENT	ARMS	Normal power																							
		Mild weakness																							
		Severe weakness																							
		Extention																							
		No response																							
	LEGS	Normal power																							
		Mild weakness																							
		Severe weakness																							
		Extention																							
		No response																							
	PUPIL SCALE (mm) 1 2 3 4 5 6 7	BLOOD PRESSURE mm Hg	230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30																						
		PULSE RATE																							
		RESPIRATORY RATE																							

1 eye closed by swelling = C

Endotracheal tube or Tracheostomy = E Dysphasia = D

Record the best arm response

Paralysed = P

2 += Reacts -=No Reaction C= Eye closed SL= sluggish pupil

3 Record right (R) and left (L) separately if there is a difference between the two sides

Fractured limb = #

4 40 39 38 37 Temp C° 36 35 34 33 32 31 30

5

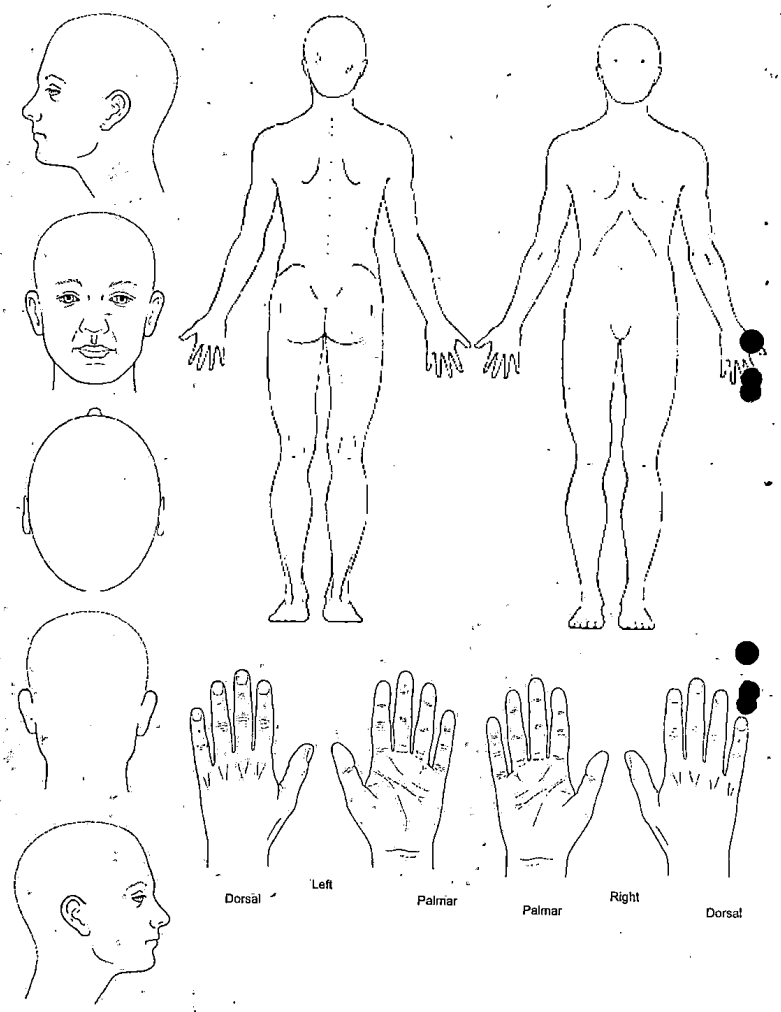
BLOOD GLUCOSE	Time																								
BM STIX	BM																								
PEAK FLOW	Time																								
	PF																								
VISUAL ACUITY	R. eye aided/unaided																								
	L. eye aided/unaided																								
	pH L. eye R. eye																								

Signed: _____

URINALYSIS

Urobilinogen µmol/L	Normal	3	16		33	66		131																	
Protein gm/L	Neg		Trace		0.30 +		1 ++		3 +++		>20 ++++														
pH	5.0	6.0	6.5	7.0	7.5	8.0	8.5																		
Blood	Neg	Non Haem	Haem Trace	Small +	Mod ++	Large +++																			
Specific Gravity	1.000	1.005	1.010	1.015	1.020	1.025	1.030																		
Ketones mmol/L	Neg	Trace	0.5	Small 1.5		Mod 4		Large 8		Large 16															
Bilirubin	Neg	Small +		Mod ++		Large +++																			
Glucose mmol/L	Neg	5.5 Trace		14 +		28 ++		55 +++		111 ++++															
Nitrites	Neg			Positive																					
Leucocytes	Neg	Trace		Small +		Mod ++		Large +++																	
BHCG	+ ve																								

Please annotate area of: Tenderness / Bruising / Swelling / Abrasions / Lacerations / Incised wounds



CLINICAL NOTES - EMERGENCY MEDICINE

Consultant GRANT Seen by BKIGHTS Staff Grade

Grade: FY1, FY2, ST1, ST2, ST3, ST4-6, FTSTA, LOCUM, ENP, CONSULTANT, OTHER *(Please circle)* At (time) 1220

Date 12/05/11

36 ♀ GP referred to ARE Chest pain.

Retrosternal chest pain. On + off for 3/7 ↓

- Sharp nature.
- Onset on exertion + calm
- Lasting 10-20 mins at time - settles c rest.
- Assoc c dizziness, dyspnoea + nausea

Exc. (-) submammary pain.

3 episodes pain this morning - last in GP's waiting room approx 11 00.

Now pain-free.

Under some stress recently. Injured all toes on 5/7 ago. Now restarted.

PMH Asthma as child → inhaler.
Left ankle.
L5 decompression lumbar spine Leg pain since
Diverticular disease
Depression + ODs.
Blind in
Thallium scan demonstrated perfusion defects.

DH Glyceryl trinitrate
Salbutamol
Omeprazole
Methocarbamol
Nicorandil
Diazepam Sat/Sun
Simvastatin
Ibuprofen
Clonidine
Enalapril
Ramipril
Lofexidine
NKDA

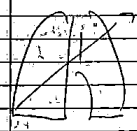
SH Never smoked
No alcohol
Retired - ill health

CLINICAL NOTES - EMERGENCY MEDICINE

Date

GE Appears well
Good colour
No oedema
T° 36.2°C

CVS HR 87
BP 103/62
HS 1+1+0 ✓ added

RS  RR 16
SpO2 99% RA
Chest clear
BS(N)

Abdo  Mild epigastric tenderness
No guarding
BS ✓
Remarks ✓ ✓

ECG - NSR, Nil acute

Imp ? Acute coronary Syndrome
? gastritis. (✓)

P IV access
Bloods - ME 09 + mitral troponin + amylase
ECG
CXR

Pcpm 300mg PO.
Refer → Medicine. Thanks!

[signature]
Brigita
SHO

CLINICAL NOTES - EMERGENCY M NE

Date

Date

UNITARY MEDICAL RECORD and [illegible]INATION

Consultant Dr Seaton Seen by Mcguire

Grade: FY1, FY2, ST1, ST2, ST3 (ST4-6, FTSTA, LOCUM, ENP, CONSULTANT, OTHER *(Please circle)* At (time) _____

Date

HISTORY

Presenting Complaint:

Chest pain / epigastric pain

History of Presenting Complaint:

(58) Non smoker,
Polio as child
Had surgery
Attends A Smith c/o – pressure sensation – apical septal base
– hypokinesis
Chronic pain
Diarrhoea.

2 different chest pains this morning

① Epigastric 'heartburn' after eating, feels gullet is spasming
Associated vomiting. Clears vomited x 4 yesterday.
Denies pain heaviness.
No wt loss No dysphagia

② Now has upper epigastric chest pain radiates to arm. Started
this a.m. Pain attends cardiology clinic.
Can come c minimal exertion No autonomic symptoms
Lasts for 10 mins per episode.

PH: Hypertension
Stroke mid 50's

Date

Past Medical History:

- Diabetes
- Obesity
- Hypertension
- MI
- CABG
- Rheumatic Fever
- TB

Allergies

Drug History:

Nil

Family and Social History:

EXAMINATION

Vital Signs: BP 103/62 P 90 RR 16 T Afb

O_2 Sat 97%

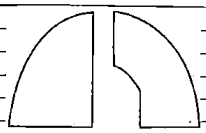
General Appearance: Lethargic

Cardiovascular

Hs SMM+
JVP ↑
No ede

Respiratory

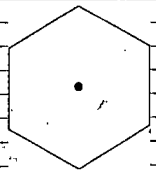
clear



Date

Abdominal

Soft.
Tender epigastrium
No guard.



Central / Peripheral Nervous System GCS.

EO MR VR

Other

INVESTIGATIONS DONE Time

U & E's		GLUC		LFT's		Para/Sal		Troponin		D - Dimer	
FBC		COAG		Blood Cultures		MSU		ABG			

ECG – Sn. T wave flatten/inversion laterally - old

CXR –

Other

DIFFERENTIAL DIAGNOSIS

1 Gastritis
2 Atypical CP.

Date

PLAN

1. ↑ omeprazole to 40 + gaviscon
2. Regular meds
3. Repeat trop 10 → Cardiac sense now. Despite persistent chest pain lady CP is very atypical
4. (2D) Echo

Name Mahoney Sign [signature] Grade ST6

Date 12/5/11 Time 1700

SENIOR REVIEW

Name	Sign	Grade	Date	Time

Date

CONSULTANT REVIEW

SPA.W

Evidence of IHD for cardiac perfusion

Slow

Settle CP symptoms not typical + cardiac risk factors + both good for 3/7

(c) cardiac pain / stable / worse

Strong FH of IHD. Non-smoker

ECG → Ant. T wave ↓s

→ ↑ ACS + ↑ omeprazole. Repeat trop. normal

Name [signature] Sign [signature] Date 12/5/11 Time

→ CARDIOLOGY

Results

Biochemistry			Haematology	Other
Na 138		Paracetamol	Hb 130	CXR
K 4.3		Salicylate	MCV 93.7	
CL 106			WCC 4.73	
Ur 7.6		D - Dimer	NEUT 2.95	
Cr 96			Platelets 285	
Gluc 4.5				
Ca^{2+}		ABG	INR	
Troponin < 0.04			APTT	
Amylase 45		O_2	PT	
Bil 11		CO_2		
AST 18		H^+		
ALT 22		BI		
ALP 60		BE		
γGT 19				
ALB 37		COHb		

AMO

LB

CP (1) <0.04 -TOT

(2) <0.04

Known to Dr SI
MPS MAR @
2041

Acute Services Division

CARDIOLOGY CONSULTATION

NHS Greater Glasgow and Clyde

Emergency Care and Medical Services Directorate

Ward	Room	Troponin

Hospital Label SOS.SIS 454
GEORGINA
LOGAN
19085240642

Date of Referral: 13-5-11
Time of Referral:
Referring Consultant: Dr SLATTON

INITIAL CARDIOLOGY ASSESSMENT DATE. TIME

Unstable angina ? precordial ECG TΔ
recent Nuclear stress test with evidence
of ischaemia (Dr Sowerski)

Aim to control angina ? Medical therapy

RECOMMENDED INVESTIGATIONS (IP OR OP) OPT for ergo D

RECOMMENDED TREATMENT T/F F3 D

CONSULTANT	NAME	SIGNATURE
	Dany	BELLY

RECOMMENDED FURTHER MANAGEMENT AFTER INVESTIGATIONS

RESPONSIBILITY FOR	Receiving Team	Cardiology
On-going in-patient care		✓
Discharge summary (notes to)		✓
Post Discharge Follow Up (AMAU)		✓

Follow Up	Medical	Cardiology	GP	None

Delivering better health

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NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES

LOGAN

19/8/54.

Date & Time		Signature, Print Name & Designation
13/5/11	CONWAY WR SHO	
	56y ♂ c FHx IHD / Repetitive chromosomality	
	Further 3Min of chest pain overnight	
	Ⓓ Rpt ECG + TROP this morn.	
	Await CARDIO R/V	
	Blue	
14/5	CP / n/v overnight	tve Phillips CP.
	ECG - n/c septum Inf, minor TWI	
	Headache c. T NVc - relieved	
	- Telemetry ICU / CCG	
	- ↓ ongoing pain BB → bradycardia	
	↓ dil amlodipine	
	Accepted	

193443

Date & Time		Signature, Print Name & Designation
15/5	VL	
	NO further palpitations. Slept well yesterday	
	TFT, Ca^{2+}, K^+ (N).	
	Top-up from recent CP.	
	Asks CP again.	
	Telemetry - SR, 62 bpm.	
	ECG: 62 bpm, LAD, no specific T wave inversion, NSR progressive -	
	Plan ① cont telemetry	
	② if no further symptoms ! ⑭ Monday with CP appt	
		Ward SR SPR
16/5	Pain well	
	- bpm	
	- CP appt is as planned	

NHS
Greater Glasgow and Clyde

Name	50551545H LOGAN F GEORGINA 19/08/1954 17 SOLLAS PLACE GLASGOW LANARKSHIRE G13 4NA CHI-1908546042	No.
PHYS/ SURG		

OUT-PATIENT HISTORY

DATE

10/08/10

6 years of CP

2/12

- pain in legs

→ 'makes to feet' (L) arm

Arm 100'

Arm c 40'

Hand 75'

Arm 40'

Arm (L) 40'

Wrist

else.

Stairs

Pain

Arm

Fine

(R) arm 40)

Nerve problem

BP

Renal

DM

FH x

(R) arm 40)

Stairs

Pain

Arm

Fine

(R) arm 40)

Limited to 50 yards due to pain in legs

Some exercise symptoms.

BP 109/66 HR 73

Exam (N)

(P) 1. MRI CAB / GPN

2. Brain MRI

3. Echo

4. 6/12.

Nurse Practitioner

OPEN BEFORE WRITING

DATE	CLINICAL NOTES

Plan Gastric lavage
Paracetamol level, U&E, Glucose
Admit to SSW.

18/11/87 32 year f

OD Dosulepin
Temazepam
Trazodone
Methylcellulose

} 6.30 pm 600 mg

— quantity unknown.
— patient too drowsy to give much of a Hx.

Reason :- daughter is dying of brain tumour at Yorkhill after 4 ops
+ husband recently lost his job + drinking heavily

Vomited once ? some return of tablets.
No other medical problems.
Previous OD 1982.

O/E Drowsy, but arousable + orientated.
No tachycardia + hypotension.
Pupils not pinpoint.
No focal neurological deficit.

Imp Mod - life threatening OD in 32 year f

Plan — Gastric Lavage → some return of tablets.
— Paracetamol level 10.30 pm.
— U&E's.
— Glucose.
— IV naloxone if pupils ↓ + consciousness level ↓

Rm 1.

TREATMENT CARD

ACCIDENT & EMERGENCY DE
WESTERN INFIRMARY
GLASGOW
G11 6NT
TEL: 041-339 8822

GREATER GLASGOW HEALTH BOARD

AE No. C/615092

ACCIDENT/EMERGENCY FORM

HOSPITAL CODE: 601

SURNAME: FOGERTY
FORENAMES: SHEILA GEORGINA
BIRTH SURNAME: WATTARSON
PATIENT'S OWN OCCUPATION: H/W
ADDRESS: 13 SOLLAS PLACE, KILWINNING
POSTCODE: KA13
TELEPHONE No.:
DATE OF BIRTH: 19/9/54 (32)
SEX: 2
MARITAL STATUS: M
RELIGION: R C
NEXT OF KIN: NAME: JOHN ROBERTS
RELATIONSHIP: HUSBAND
FAMILY DOCTOR: SURNAME: MCLUSKEY
INITIALS:
ADDRESS: SIA
ADDRESS: DUNCRUEY RD.
POSTCODE:
TELEPHONE No.: SIA
POSTCODE: KA15
TELEPHONE No.:
ACCIDENT/EMERGENCY | DATE OF ATTENDANCE: 17/11/87
PREVIOUS ATTENDANCE AT THIS HOSPITAL YES/NO: YES
IN/OUT PATIENT: IN
YEAR: 1987
TIME OF ATTENDANCE: 21.40
REASON FOR ATTENDANCE: O/D
DATE OF INJURY OR ILLNESS:
TIME OF INJURY:
TYPE (CODE):
SOURCE OF REFERRAL: GP ___ SELF 1 POLICE ___ OTHER (CODE) ___
ROAD TRAFFIC ACCIDENT PLACE:
DETAILS:
HOME ACCIDENT PROBABLE CAUSE:

TO BE COMPLETED BY MEDICAL OFFICER AFTER SEEING PATIENT

Dear Doctor,

The above-named patient attended Accident & Emergency Department today.

Diagnosis: OD

X-Ray film/ECG shows:

Treatment given: GASTRIC LAVAGE

Drugs ___ days supply of ___ has been given.

Tetanus Prophylaxis has/has not been administered. TT Course ___ TT Booster ___ HATI ___ (Please Tick)

Would you please arrange:

DISCHARGE CODES: Please Circle
(1.) Admission 3. Refer to G.P. 5. Died 7. Irregular Discharge
2. Discharge 4. Transfer to other hospital (see below) 6. Refer to O.P. Clinic (see below) 8. D.O.A.

Ward No. (if admitted)	Transfer to Hospital	Consultant (if admitted)
SSW		DR M'CEE.

Follow Up	Not arranged	Arranged	To be arranged

Clinic Referred to	AE	Hand	Fracture	Ortho	Medical	Surgical	Skin	ENT	Gyn.	Others Specify

Medical Officers Name (In Block Letters): DILLEMANE
Signature of Medical Officer:

Cons SR Reg SHO/HO Clin Assist (please circle)

X-Ray & Other Reports to be filed on this side (if the patient is not being admitted)

TO BE RE ED ON ARRIVAL

T 36 P 80 R BP 100/70

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYLAXIS)

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION	SIGNATURE	GIVEN BY

CONSULTANT REG/SHO JHO

SEEN BY AT (TIME)

CLINICAL NOTES

KEY TO CLINICAL NOTES
1 - HISTORY OF
2 - ON EXAMINATION
3 - X-RAY FINDINGS
4 - TREATMENT GIVEN
5 - DISPOSAL
6 - NAME OF MEDICAL OFFICER

DATE

P.C. O/D

HPC. Took Co-codamol, Temazepam, methylcellulose & Trazodone at 6.30pm. About 18 tablets in total. Reason for taking tablets is that daughter is in Yorkhill with brain tumour - has had 4 ops & husband has now lost his job & is drinking quite heavily. Most of history from husband as patient is drowsy. Has vomited once since taking tablets

DH - Temazepam, Trazodone, Co-codamol, methylcellulose

PMH - O/D 1984 when family pressure was high

O/E - Drowsy, but orientated & rousable
°Cyanosis / Anaemia / Lymphadenopathy
CVS Pulse 100/min regular
BP 100/70
HS I & II no added
Resp - Chest Clear
Abd - Soft non tender °LKKS BS ✓

NAME Georgina ROBERTS

HOSPITAL No

AGE 33

PHYS. SURG. McColl

DEPT. WARD

IN-PAT FORM 3

IN PATIENT CONTINUATION HISTORY

DATE	
18/11/87	Needs psychiatric help
18.11.87	Psychiatric opinion. 33 year old woman. Impulsive OD which she now regrets. But longstanding marital difficulties, plus worries re 12 year old daughter who has a sub arachnoid cyst. "Thumping on top of her" No evidence of depressive illness. Non-drinker. O/E: Affect neutral. Spontaneous in conversation. Does major problem as marital difficulties, which results in her having little emotional support in coping with her daughter. Imp impulsive OD, background of daughter's illness + marital problems. Plan OP follow up as couple – appt given for 30.11.87.

NT 24

STERN

FIRMARY

ASGOW

1.

ORTHOPAEDIC O.P. Appt

THIS CARD MUST BE RETURNED TO RECORDS OFFICE WITHIN 24 HOURS UNLESS FILED IN CASE RECORD

ACCIDENT AND EMERGENCY SERVICE

SURNAME: HARKSON | OTHER NAMES: GEORGINA | HOSPITAL No.:

ADDRESS: 46 ARGYLE ST. 11.5 | AGE: 16 | SEX: F | DATE OF BIRTH: 1/8/54

TEL. No. | AREA CODE | NEXT OF KIN: NAME | ADDRESS

DATE OF INJURY: / / | TIME OF INJURY: A.M. / P.M. | CIVIL STATUS: M S W | OCCUPATION: PARKER | INDUSTRY | TEL. No.

DATE OF ATTENDANCE: 26/4/71 | TIME IN: A.M. / P.M. 9.10 | RECEIVING CLERK: K.H. | TIME SEEN: A.M. / P.M.

REASON FOR ATTENDANCE (IF R.T.A. STATE): BACK CONTUSION

DATE:
PLACE:
TIME:
DETAILS:

SOURCE
- NOT ACCIDENT ☐
- ACCIDENT—ROAD ☐
- ACCIDENT—HOME ☐
- ACCIDENT—WORKS ☐
- ACCIDENT—OTHER ☐

TYPE OF ROAD ACCIDENT
- (PEDESTRIAN ☐
- (BICYCLE ☐
- (MOTOR CYCLE ☐
- (CAR ☐
- (OTHER VEHICLES ☐

METHOD
- OWN ACCOUNT ☐
- DR.'s LETTER ☑
- POLICE ☐

FAMILY DOCTOR: DR. KENNEDY | TEL.No. | ADDRESS: DUNKELD RD W.5

EXAMINED BY: D. Mills | REFERRED TO: (AS APPLICABLE) Orthopaed O.P. | INFECTION: YES ☐ NO ☑

DIAGNOSIS: No diagnosis

X-RAYED: YES / NO ✓ | RESULT:

DRUGS | DOSE | TIME A.M. / P.M. | TOURNIQUET APPLIED TIME A.M. / P.M.

TETANUS PROPHYLAXIS

TYPE OF TOXOID

	DATE	INITIAL
1st DOSE		
2nd DOSE		
BOOSTER DOSE		

ANTIBIOTIC (Give preparation and dose)

PREPARATION	DOSE	DATE	INITIAL

TO BE COMPLETED UNDER MAJOR ACCIDENT PROCEDURE

DISPOSAL:

BLOOD TAKEN	RELATIVES NOTIFIED	RELIGION	CLOTHI
	YES/NO		RECORD
No. OF UNITS REQUIRED		CLERGY NOTIFIED	YES/

HISTORY

DATE

8-4-71 See Dr's letter.

Pain is worst when getting up in morning. Not there at present.

OE. No tenderness. No bony abnorm.

Forward flexion very good

Lat flexion " "

No symptoms in legs.

X-Ray to Orthopaed O.P. Thur

Department of Orthopaedic Surgery

MR A T REECE

Gartnavel General Hospital
1053 Great Western Road
GLASGOW
G12 0YN

Tel: 0141 211 3184/3185
Fax: 0141 211 3189

ASSESSMENT CLINIC Date: 17/11/2008

Mrs Georgina Logan 17 Sollas Place Glasgow G13 4NA
Hospital Number: 50551545H CHI: 1908546042

I saw this lady is the assessment clinic today. She has approximately a one year history of relapsing/remitting radicular pain in her left leg. She has had about five episodes of very severe left buttock and anterior thigh pain which lasts 3-4 weeks and then settles.

She had been seen previously by Judith Reid and also had an MRI scan which had shown left sided L2/3 disc causing impingement on the L2 root.

On seeing her today her last episode of severe pain settled about two weeks ago. She still has occasional sensation of pins and needles in the left leg and anterior thigh and that is in keeping on examination with slightly decreased sensation in the L2 dermatome in the mid section of her anterior thigh.

There is little else to find on neurological examination. Having reviewed her scan there certainly is a disc prolapse at L2/3 and I have therefore consented her for Microdiscectomy Left L2/3 level.

I will discuss the case with Mr Reece who unfortunately was not available at the assessment clinic today. She has been given a date for the 24th of this month.

TN/CG

Department of Orthopaedic Surgery

MR A T REECE

Gartnavel General Hospital
1053 Great Western Road
GLASGOW
G12 0YN

Tel: 0141 211 3184/3185
Fax: 0141 211 3189

ASSESSMENT CLINIC Date: 14/09/2009

Mrs Georgina Logan 17 Sollas Place Glasgow Lanarkshire G13 4NA
Hospital Number: 50551545H **CHI: 1908546042**

This lady still has pain in the appropriate distribution for the potential pathology identified on the MR scan at left L2 foramen. I am going to perform a diagnostic nerve root block here next week before proceeding probably within a couple of weeks after that if it's successful.

ATR/CG

Mr Reece
Consultant Orthopaedic Surgeon

22/09/2009

Left L2 Nerve Root Block

Name: Mrs Georgina Logan		**Ward:**	GGH - 2a
17 Sollas Place Glasgow Lanarkshire G13 4NA		**Surgeon:**	Mr Anthony Reece
Hospital No:	50551545H **D.O.B.:** 19/08/1954	**Assistant:**	
Indication:	Sciatica, lumbar region	**Anaesthetist:**	

2ml 0.5% Marcaine instilled at the foramen on the left of L2 using the image intensifier.

Post-op Instructions:
Review on the ward prior to discharge
Arrange appropriate subsequent action

Addenda:

Procedure	Code Type	Code
Local anaesthetic nerve block	OPCS 4.4	Y82.1
Left sided operation	OPCS 4.4	Z94.3

cc:

Drumchapel Health Centre
80/90 Kinfauns Drive
Glasgow
G15 7TS

Department of Orthopaedic Surgery

MR A T REECE

Gartnavel General Hospital
1053 Great Western Road
GLASGOW
G12 0YN

Tel: 0141 211 3184/3185
Fax: 0141 211 3189

ASSESSMENT CLINIC Date: 23/11/2009

Mrs Georgina Logan 17 Sollas Place Glasgow Lanarkshire G13 4NA
Hospital Number: 50551545H **CHI: 1908546042**

This lady attended the assessment clinic today. She is keen to proceed with L2/3 left sided decompression. She had good benefit to the recent L2 nerve block and has recently been seen by Mr Reece prior to listing for the above procedure.

The risks and benefits have been explained again today and consent has been obtained. Her date for surgery is Wednesday 2nd December and she will be admitted on the morning of her operation.

SS/CG

DEPARTMENT OF ORTHOPAEDIC SURGERY

ORTHOPAEDIC MEDICAL CLERK-IN

PATIENT LABEL

505J1545H
LOGAN F
GEORGINA 19/08/1954
17 SOLLAS PLACE
GLASGOW
LANARKSHIRE G13 4NA
CHI-1908546042

DATE 23/11/09

ARRANGED ADMISSON FOR: Spinal Decompression

BRIEF HISTORY:
Lower back and (L) leg pain

PAST MEDICAL HISTORY:
Asthma
IBS
Ops - cholecystectomy lap. - 2007

MI X	ANGINA X	BP X
CHOLESTEROL X	CVA X	DM X
RhF X	TB X	ASTHMA ✓
COPD X	EPILEPSY X	DU ✓
JAUNDICE X	DVT X	PTE X

DRUG HISTORY:
As per Kardex

ALLERGIES: NKDA

FAMILY HISTORY: X

S/H: LIVES WITH: Son

EMPLOYMENT: X

ALCOHOL: X

SMOKER: X

SYSTEMIC ENQUIRY:

Resp:

SOB ✓ 1 flight of stairs | Cough ✗ | Spit ✗

Haemoptysis ✗ | Fever ✗ | Sore Throat ✗

Wheeze ✗

CVS:

Othop ✗ | PND ✗ | Chest Pain ✗

Palpitations ✓ occasionally - ?anxiety | Ankle Oedema ✗

GI:

Dyspepsia ✓ often | Abdo Pain ✗ | Bowels Regular ✗ IBS

Blood or Mucous PR ✗ | N & V ✗

Appetite OK | Weight ✓

GU:

Dysuria ✗ | Haematuria ✗ | Recurrent UTIs

Frequency ✗ | Hesitancy ✗

Neuro:

FFF ✗ | Headaches ✗ | Numbness & Weakness ✗

Dysarthria ✗ | Diplopia ✗ | **M/S NECK MOVEMENTS**

ON EXAMINATION:

Blood Pressure 96/61 | Heart Rate 80bpm reg | Jaundice ✗

Anaemia ✗ | Cyanosis ✗ | Clubbing ✗

Lymph. ✗ | OED ✗

RESP:

Trachea Central

Percussion Resonant

Air Entry Clear - L=R

Breath Sounds Vesicular

No added sounds

CVS:

JVP ✓

HS 1+11 ✓

CALVES S+NT

APEX ✓

PP ✓ ✗✗

GI:

ASNT ✓

LKKS No organomegaly

REBOUND/GUARDING ✗

BS ✓

ROUTINE BLOODS

FBC/COAG/ESR ✓

U&E'S/ PROFILE/GLUCOSE

NEURO: Grossly Intact ✓

X-MATCH - UNITS ✗

G&S

ECG ✓ NSR

X-RAY ✓

Hopper (FY1)

Mr Reece
Consultant Orthopaedic Surgeon

09/12/2009

Left L2/3 Lumbar Decompression

Name: Mrs Georgina Logan **Ward:** GGH - 2a

17 Sollas Place Glasgow Lanarkshire G13 4NA **Surgeon:** Mr Anthony Reece

Hospital No: 50551545H **D.O.B.:** 19/08/1954 **Assistant:** Mr Simon Spencer

Indication: Sciatica, lumbar region **Anaesthetist:** Dr Brian McCreath

The patient was positioned on the spinal table following anaesthesia and pre-operative antibiotics. Check x-ray taken to verify level.

Moderate sized mid line incision at the appropriate level with subperiosteal dissection of the muscle mass and identification of very minimal amounts of inter laminar space left.

Using a mixture of kerosene rongeurs and a high speed burr, interlaminar space was re-created. The sagittal diameter of the main canal was narrow anyway. The main canal was decompressed including across to the right hand side across the midline. The bone was thickened vascularly and packed with wax. Bi-polar diathermy also used as was Floseal. There was good haemostasis control thereafter. The left lateral gutter was also de-roofed so that the nerve root was completely free. Straightforward discectomy performed.

Multiple lavages with saline throughout. At the end of the procedure there were no free fragments, no significant bleeding, no Kenolog used. Closed in layers with PDS, vicryl and subcuticular PDS to skin.

Post-op Instructions:
Neuro obs as per chart
Mobilise ASAP
Analgesia as prescribed

Addenda:

Procedure	Code Type	Code
Sciatica, lumbar region	ICD 10	M54.36
Unspecified primary decompression operations on lumbar spine	OPCS	V25.9
Unspecified primary excision of lumbar intervertebral disc	OPCS	V33.9
Level of spine one	OPCS	V55.1
Lumbar vertebra	OPCS	Z66.5
Left sided operation	OPCS	Z94.3

cc:

Drumchapel Health Centre
80/90 Kinfauns Drive
Glasgow
G15 7TS

CHI: 1908546042

13

Western Infirmary 1673268

Total Att: **11**

12 Mth Att: **2**

Title: **MRS**

LOGAN **Georgina**

DOB: **19/08/1954** Age: **60y** Sex: **Female**

17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow
Lanarkshire
G13 4NA
07774400790

Next of kin: **LOGAN, GEORGE**
Relationship: **Husband**
07774400790

GP: **PJ Weir**
08444 773318

Attendance Date: **26/10/2014** Arrival Time: **14:07**

Registration Time: **14:07** Date of Incident: **26/10/2014**

Major Incident Desc:

Reason for Attendance: **unwell adult**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **Not Recorded** Pain Score:

Triage Category: **3** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **26/10/2014 14:10** Nurse name: **Nurse Lauren Gunn**

Temp	**36.5**	C
HR	**89**	bpm
BP	**114/67**	mmHg
MAP	**82.67**	mmHg
RR	**16**	bpm
SpO2	**97**	%
Oxygen		%

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils-Right		Pupils-Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: **2/7 hx of abdo pain and D&v. known crohns disease. recently returned from Turkey**

WESTERN INFIRMARY
RESUS

Patient Sample Report

Patient

ID:	1908546042
Last Name:	**LOGAN**
First Name:	**GEORGINA**
Gender/Age:	Female, 60 years
Birth Date:	19.08.1954
Status:	**ACCEPTED**
Analyzed:	26.10.2014 15:30:20
Sample Type:	~~Arterial~~ venous
Account Number:	
Clinician:	
Operator ID:	NATALIE GRAHAM

Analyzer

Model:	GEM® *Premier 4000*
Area:	WIGRESUS
Name:	AERESUS
S/N:	06110216

Measured (37.0°C)		
cH	41.9	nmol/L
pCO_2	↑ 6.2	kPa
pO_2	~~↓ 2.4~~	~~kPa~~
Na^+	140	mmol/L
K^+	3.8	mmol/L
Cl^-	105	mmol/L
Ca^{++}	↓ 1.14	mmol/L
Hct	39	%
Glu	4.6	mmol/L
Lac	↓ 0.8	mmol/L
CO-Oximetry		
tHb	129	g/L
O_2Hb	↓ 36.3	%
COHb	0.9	%
MetHb	1.4	%
HHb	↑ 61.4	%
sO_2	↓ 37.2	%
Derived		
BE(B)	1.5	mmol/L
HCO_3^-(c)	27.2	mmol/L
Hct(c)	39	%
Operator Entered		
Temp	37.0	°C
O2 and Vent Settings		
FIO_2		%

↑↓ Outside Reference Range
↑↑ ↓↓ Outside Critical Range

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYAXIS)

Date given	Drug (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given by
26·10·14	BUSCOPAN	20mg	IV	1600	MG	RO
26·10·14	CYCLIZINE	50mg	IV	1600	MG	RO
26·10·14	COCODAMOL 30/500	TT	ORAL	NOT GIVEN	MG	RO
26·10·14	COCODAMOL 8/500	TT Stat	ORAL	1610	MG	RO

PARENTERAL FLUID PRESCRIPTION SHEET

Date	FLUID	Volume	Time to run	Rate mls/hr	ADDED DRUGS	Quantity	Doctors Signature	Added by	Start time 24hr Clock	Put up by	Checked by	Serial/ Batch no
26·10·14	NaCl 0·9%	500ml	1°	—	—	—	MG			RO		
26·10·14	NaCl 0·9%	500ml	2°	—	—	—	MG			RO		

N.B. IF USING A SYRINGE DRIVER/INFUSION PUMP PLEASE USE THE 'PRESRIPTION AND ADMINISTRATION SHEET FOR MEDICINES GIVEN BY SYRINGE DRIVER/INFUSION PUMP'

REFUSAL TO REMAIN UNDER HOSPITAL CARE

I wish to take my discharge. I appreciate that this is against the advice and wishes of the Consultant or his or her deputy looking after me. I acknowledge that I have been informed of the risks of doing so and I accept full responsibility for my actions and any consequences arising from them.

Name *(print)* _____ Signature _____

I confirm that I have explained to the patient the risks that might arise out of his / her decision to take his / her own discharge.

Date _____ Signature _____ *(Medical Practitioner)*

DISCHARGE DETAILS (NURSING)

Treatment _____

Signed *(Please put initials in box)*

Crutches ☐ Return appointment ☐ Advice Card ☐ Medication ☐

Escort to ward ☐ Relatives informed ☐ IRIS ☐ Transport ☐ Time booked ____

Discharged with _____ Admitted / transfered to _____

32646

Patient's name _____ Age _____ Date of Birth _____

NURSING DOCUMENTATION - ACCIDENT & EMERGENCY DEPARTMENT

1908546042
LOGAN
Georgina
17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire
G13 4NA

F
19/08/1954

Triage Nurse _____ PC _____

Triage category 1 2 3 4 5

Relatives informed:

INITIAL MANAGEMENT

Nurse _____

Oxygen started _____ %: Signed _____ ECG: Signed _____

Signed _____

Other _____

Treatment _____

INITIAL VITAL SIGNS

at:(Time) _____
HR: _____
BP: _____
RR: _____
SaO_2: _____
Temp: _____
G.C.S: _____

Signed _____

NEUROLOGICAL OBSERVATIONS

RESPONSIVENESS

TIME hrs

EYES OPEN: spontaneously 4; to speech 3; to pain 2; none 1 — eye closed by swelling =C

BEST VERBAL RESPONSE: orientated 5; confused 4; inappropriate words 3; incomprehensible sounds 2; none 1 — Endotracheal tube or Tracheostomy = E; Dysphasia=D

BEST MOTOR RESPONSE: obey commands 6; localises pain 5; normal flexion to pain 4; abnormal flexion to pain 3; extention to pain 2; none 1 — Record the best arm response; Paralysed =P

COMA SCORE 15

PUPILS

RIGHT: size (mm) / Reaction

LEFT: size (mm) / Reaction

+= Reacts; -=No Reaction; C= Eye closed; SL= sluggish pupil

LIMB MOVEMENT

ARMS: Normal power; Mild weakness; Severe weakness; Extention; No response

LEGS: Normal power; Mild weakness; Severe weakness; Extention; No response

Record right (R) and left (L) seperatly if there is a difference between the two sides

Fractured limb e.g.

BLOOD PRESSURE mm Hg: 230, 220, 210, 200, 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40, 30

PULSE RATE: 40, 39, 38, 37 Temp C°, 36, 35, 34, 33, 32, 31, 30

PUPIL SCALE (mm): 1, 2, 3, 4, 5, 6, 7

RESPIRATORY RATE

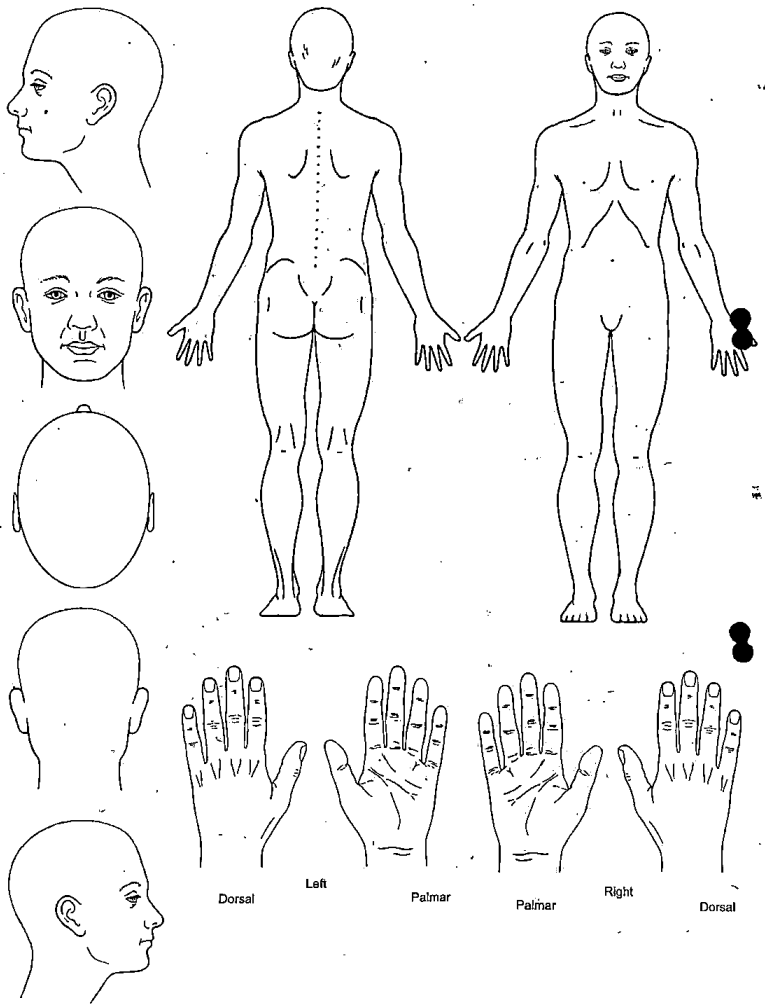
BLOOD GLUCOSE	Time						
BM STIX	BM						
PEAK FLOW	Time						
	PF						
VISUAL ACUITY	R. eye aided/unsided						
	L. eye aided/unaided						
	pH L. eye			R. eye			

Signed: _____

URINALYSIS

Urobilinogen µmol/L	Normal 3	16	33	66	131		
Protein gm/L	Neg	Trace	0.30 +	1 ++	3 +++	>20 ++++	
pH	5.0	6.0	6.5	7.0	7.5	8.0	8.5
Blood	Neg	Non Haem	Haem Trace	Small +	Mod ++	Large +++	
Specific Gravity	1.000	1.005	1.010	1.015	1.020	1.025	1.030
Ketones mmol/L	Neg	Trace 0.5	Small 1.5	Mod 4	Large 8	Large 16	
Bilirubin	Neg	Small +	Mod ++	Large +++			
Glucose mmol/L	Neg	5.5 Trace	14 +	28 ++	55 +++	111 ++++	
Nitrites	Neg	Positive					
Leucocytes	Neg	Trace	Small +	Mod ++	Large +++		
BHCG	+ ve	- ve					

Please annotate area of: Tenderness / Bruising / Swelling / Abrasions / Lacerations / Incised wounds



CLINICAL NOTES - EMERGENCY DEPARTMENT

Consultant HEPBURN Seen by N.GRAHAM

Grade: FY1, FY2, ST1, ST2, ST3, ST4-6, FTSTA, Locum, ENP, Consultant, Other (Please circle) CT At (time) 1510

Date

26-10-14

60 F

PC – abdo pain, D+V

HPC – often gets loose stools due to IBS. Doesn't usually have assoc. abdo pain / vomiting.
Last few days diarrhoea ++, crampy lower abdo pain feels like bowels being twisted. Taking buscopan tramadol, paracetamol but not helping. Also vomiting.
Off food. Not feverish.
° blood in stool. A little mucus.
Abdo pain is main issue as now feeling too nauseas to take oral meds & fluids.
Just back from Turkey 2/7 ago but didn't eat anything unusual

PMH – asthma
IBS
diverticular disease.
anxiety

DHx – ECG printed

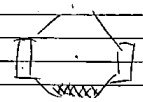
SHx – NS
° alcohol

Obs – (N)

O/E – looks dry
holding abdo in pain

HS 1+1+0

clear.



tender low abdo voluntary guarding
BS ✓
° mass.
° peritonism.

Imp – ? diverticulitis ?? gastroenteritis

(P) 1. IVA + bloods
2. IVF
3. urinalysis
4. analgesia
5. antiemetic
6. buscopan IV
7. ECG
8. referred surg.

CLINICAL NOTES - EMERGENCY DEPARTMENT

4666

Date

60 ♀

26/10. Pt/ Profuse diarrhoea + vomiting with crampy abdominal pain. Pain started in Turkey on holiday. Felt hot / clammy and cramps started first followed by loose stool ~ 20x a day. Vomiting fluid + dry retching.

Normally suffers from diverticulosis and says nobody knows the exact cause of her recent diarrhoea. ? investigated for crohns disease

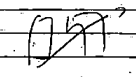
Some L sided flank pain and says this feels like a UTI — which she frequently suffers from.

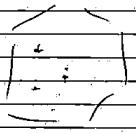
PMHx IBS
Diverticulosis — ST May 14 + Colonoscopy July '14
Asthma
Anxiety. chronic pain

MHx See Kardex
NKDA

SHx • Smoke
• Married

OE/ HS I + II ND. pulse regular





CLINICAL NOTES - EMERGENCY DEPART T

Date

Bloods FBC (N) LFT (N)
U+E (A) Amylase 28
CRP 41

Imp: Gastro enteritis? viral

P: Discuss with Consultant

• Will admit to Surg, if not thought suitable for a Medical Bed.

• IVF- ☑
• Stool culture ☐

DOOSHAN
FY2.

CLINICAL NOTES - EMERGENCY DEPARTMENT

Date

UNITARY MEDICAL RECORD

Consultant: _____ Seen By: _____

Grade: FY1 FY2 CMT1/2 ST3+ NP Other Time _____

Presenting Complaint

History Presenting Complaint

Past Medical History

Social History

- Home circumstances
- Exercise tolerance
- Driving
- Smoking history
- Alcohol History
- Activites of Daily Living

Systemic Enquiry:

- CVS
- Resp
- GI
- Neuro
- GUS
- Other

MEDICINES RECONCILIATION

PATIENT LABEL

Source of Medical History (2 Sources)

Patient	☐	Relative/Carer	☐
GP Phone call	☐	ECS	☐
Patient own Drugs	☐	Com. Pharmacist	☐
GP Letter/Summary	☐	Repeat Script	☐

Other (please specify) .....

Admission Medicines			Plan for Medicines (Dr Complete)				Comments
Name	Dose	Freq	Continue	Amend	Withold	Stop	Reason for Alteration

Allergies	List any over the counter alternative medicines
None known ☐	
	Do medicines need further clarification Yes ☐ No ☐
	Plan initiated by:
List collected by: Date:	Designation: Date:
Compliance aid: Yes ☐ No ☐	Community pharmacist: Phone:

Reviewed by: Designation: Date:

NHS GG&C Adult Risk Assessment for Venous Thromboembolism (VTE)

[excluding orthopaedics, obstetrics, gynaecology & ENT who have specialty-specific policies]

- **Risk Assessment must be completed for all patients within 24 hours of admission to hospital**
- **Patients must be reassessed every 48-72 hours or sooner if condition changes**
- **Reassessment must be documented in Kardex**
- **Please complete risk assessment and then sign and date Risk Assessment Result box at bottom of page.**

Pt Addressograph

Surgical patients start here

Non-operative [mainly medical] patients start here

Is the patient bed-bound or expected to have reduced mobility relative to normal state for ≥ 2 days?

Yes ☐ No ☐

Does the patient have any risk factors for thrombosis? (tick ✓ all that apply)

Age >60	☐	Use of oestrogen-containing contraceptive therapy	☐
Active cancer or cancer treatment	☐	Use of hormone replacement therapy	☐
Dehydration	☐	Pregnancy or < 6 weeks post partum [seek specialist advice]	☐
Known thrombophilias	☐	Critical care admission eg HDU/ITU	☐
Obesity (BMI>30)	☐	Total anaesthetic + surgical time >90 minutes	☐
Current significant medical condition e.g. Serious infection, Heart failure, Respiratory disease or Inflammatory disease	☐	Surgery involving pelvis or lower limb with a total anaesthetic + surgical time >60 minutes	☐
Personal history or first degree relative with a history of VTE	☐	Acute surgical admission with inflammatory or intra-abdominal condition	☐
Varicose veins with phlebitis	☐	Hip fracture	☐

- No thromboprophylaxis required.
- Continue to reassess every 48-72 hours or sooner if condition changes.
- Document all reassessments in drug kardex.
- Risk assessment now complete
- Complete Risk Assessment Result Box

Yes, 1 or more risk factors identified ☐

No risk factors identified ☐

Does the patient have any contraindications to pharmacological prophylaxis? (tick ✓ all that apply)

Active bleeding	☐	Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrands)	☐
Acquired bleeding disorders (e.g. acute liver failure)	☐	Neurosurgery, spinal or posterior eye surgery	☐
Concurrent use of anticoagulants (such as warfarin with INR>2)	☐	Lumbar puncture, epidural/spinal anaesthesia expected within the next 12 hours	☐
Acute stroke	☐	Other procedure with high bleeding risk – discuss with senior if unsure	☐
Uncontrolled hypertension (230/120 mmHg or higher)	☐	Lumbar puncture, epidural/spinal analgesia within the previous 4 hours	☐
Thrombocytopenia (<75 x 10⁹/l)	☐	Thyroid surgery	☐

- Discuss with senior clinical staff before prescribing pharmacological prophylaxis
- Consider mechanical prophylaxis e.g. AES unless contra-indicated.
- Reassess patient every 48-72 hours or sooner if condition changes

No contraindications to pharmacological prophylaxis identified ☐.

Contraindications to pharmacological prophylaxis identified ☐

Surgical patients – Enoxaparin 40mg + AES ☐*
*prior to application of AES, please check contraindications to AES
Medical patients – Enoxaparin 40mg ☐
Prescribe Enoxaparin at 6pm
[on day of surgery, at the later of either 4h post-op or 6pm]
Reduce Enoxaparin to 20mg if <50Kg or eGFR <30ml/minute/1.73m² ☐
Discontinue at discharge or when returned to pre-morbid mobility

Contraindications to anti-embolism stockings (AES) Y ☐ N ☐

Peripheral neuropathy	☐
Peripheral vascular disease	☐
Cellulitis or Gross oedema	☐
Leg deformity or Fragile skin	☐
Leg / foot ulcers	☐
Allergy	☐
Unusual leg size/shape	☐

Risk assessment result – please tick ✓ all that apply

VTE risk factors: YES ☐ NO ☐ Contraindications to pharmacological prophylaxis: YES ☐ NO ☐ Prescribed: LMWH ☐ AES ☐ NONE ☐
Patient informed of VTE risks and benefits of thromboprophylaxis YES ☐ NO ☐ N/A ☐ Information leaflet provided YES ☐ NO ☐
Print Assessor's Name: _____ Signature: _____ Date: _____

MIS 250744-2

EXAMINATION

Vital Signs: HR BP RR T O2 sats FIO2

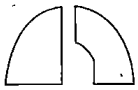
MEWS:

AMT: Age What year Date of birth Location AMT /4

General Appearance: Jaundice, anaemia, cyanosis, clubbing, oedema, Lymphadenopathy

Cardiovascular:

Respiratory



Abdominal

Neurological

PR

Other (if appropriate): e.g. musculoskeletal, skin

INVESTIGATIONS

ECG

CXR

Other

ABG

Time					
F1O2					
H+					
PO2					
PCO2					
HCO3					
BE					
LAC					

DIFFERENTIAL DIAGNOSIS

APPROPRIATE PROTOCOLS AND/OR CLINICAL SCORES (E.G. GRACE / MOD GENEVA)

Affix protocol sticker as required
i.e. Sepsis Six or ACS

MANAGEMENT AND FURTHER INVESTIGATIONS

SENIOR REVIEW / CONTINUATION

CONSULTANT REVIEW

Date/ time									
Na				HB			Paracetamol		
K				MCV			Salicylate		
Cl				WCC					
Ur				Neut					
Cr				Plts					
Gluc									
Ca									
Mg				INR					
Bil				APTT					
Ast				PT					
Alt									
GGT									
ALP				TROP					
Alb				D-Dimers					
CRP				Amylase					

Destination/ Speciality

EDD

Name: Sign: Date: Time:

E-Pacer PATIENT REPORT

Time	12:59	Date	26/10/2014

PATIENT AND INCIDENT DETAILS

Incident number	CR001672640.001
Name	GEORGINA LOGAN
Age	60Y
Date of birth	19/08/1954
Gender	Female
Incident location	17 SOLLAS PLACE YOKER GLASGOW
Incident post code	G13 4NA
Incident type	EMG
Call received	26/10/2014, 12:22
Call passed	26/10/2014, 12:23
Crew mobile	26/10/2014, 12:24
Crew at scene	26/10/2014, 12:31
Crew left scene	26/10/2014, 12:48
Receiving hospital and department	WEST Western Infirmary Glasgow

PRIMARY SURVEY

RESPONSE	
AVPU	Alert
AIRWAY	
Airway assessment	Clear
BREATHING	
Breathing rate	Normal
Respiratory rate	
CIRCULATION	
Pulse rate	Normal
Most peripheral pulse found	Radial
Cap refill rate	
Skin colour	Normal
C-SPINE INJURY	
Suspicion of CSI	No evidence of C-spine injury
PATIENT CONSENT	
Patient consent	Treatment benefits explained, Risks of condition explained, Risk of refusal explained, Capacity to understand risks and treatment, Advice given to patient
AMPDS	
Final code	01A01 Abdominal Pain
GCS	
Final GCS eye opening	Spontaneous
Final GCS verbal response	Orientated
Final GCS motor response	Obeys commands

VITAL SIGNS

Time hr : min	Pulse bpm	Pulse rhythm	Resp. rpm	BP mm Hg	Cap refill (secs)	Peak flow %	Blood sugar mmol / l	Pain score	Temp °C	SpO2 %	GCS Total	NEWS	RTS	ECG	Sepsis
13:35	102	Reg	16	102 / 70	<2 secs	-	7.6	0/10	36.0	100	15	3	7.8	-	1
	-	-	-	- / -	-	-	-	-	-	-	-	-	-	-	0

SEPSIS

Sepsis: Pneumonia	
Sepsis: UTI	
Sepsis: Other infection	
Sepsis: Abdo pain	
Sepsis: Diarrhoea	
Sepsis: Abdo distension	
Sepsis: Meningitis	
Sepsis: Cellulitis	
Sepsis: Septic arthritis	
Sepsis: Wound infection	

	Left	Right
Pupil size	Normal	Normal
Pupil reaction	Normal	Normal

AMPLE

Allergies	None
Other allergies	
Medication	WITH PTN.
Past history	ASTHSMA BACK PAIN IBS DIVIRTICULITIS
Last eaten	>5 hrs
Events prior	3 DAYS OF SICKNESS AND DIARRHEA AND CRAMPS.

EMERGENCY SERVICES ON SCENE

Paramedic	

FINAL OBSERVATION AND COMMENTS

ABDO PAIN / DIARRHEA APPROX EVERY 20 MINS -ABDO DISTENDED	
Report ID	3a8f79d9-a8c8-41e9-8223-2d6ffe5c144c

1908546042
LOGAN F
Georgina 19/08/1954
17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire
G13 4NA

Clinical Data

Last Emergency Care Summary received 14 October 2014

Allergy

Description	Date Recorded	Comments

Acute Medication (including those greater than 30 days)

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date

Repeat Medication

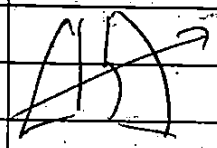
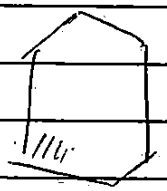
Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Dispensed Date	Cancel Date
In Practice	Hyoscine Butylbromide	10 mg Tablets	N/A	2 TABS 3 TIMES DAILY DISPENSE WEEKLY	09-Jul-2012	14-Oct-2014		
In Practice	Pregabalin	300 mg Capsules	N/A	1 CAP TWICE DAILY	09-Jul-2012	03-Oct-2014		
In Practice	Quinine Sulfate	300 mg Tablets	N/A	ONE TO BE TAKEN AT NIGHT DISPENSE WEEKLY	09-Jul-2012	03-Oct-2014		
In Practice	Methocarbamol	750 mg Tablets	N/A	2 TABS 4 TIMES DAILY	09-Jul-2012	03-Oct-2014		
In Practice	Omeprazole	20 mg Capsules (Gastro-Resistant)	N/A	2 CAPS DAILY	09-Jul-2012	03-Oct-2014		
In Practice	Sertraline Hydrochloride	50 mg Tablets	N/A	ONE TO BE TAKEN EACH DAY	01-Apr-2014	03-Oct-2014		
In Practice	Amitriptyline Hydrochloride	25 mg Tablets	N/A	ONE TO BE TAKEN IN THE EVENING DISP WEEKLY	03-Apr-2014	03-Oct-2014		
In Practice	Amitriptyline Hydrochloride	50 mg Tablets	N/A	ONE TO BE TAKEN IN THE EVENING	03-Apr-2014	03-Oct-2014		
In Practice	Simvastatin	40 mg Tablets	N/A	ONE TO BE TAKEN AT NIGHT	09-Jul-2012	03-Oct-2014		
In Practice	Asacol Mr	400 mg Gastro-resistant Tablets	N/A	3 TABS TWICE DAILY	19-May-2014	03-Oct-2014		
In Practice	Anusol	Cream	N/A	APPLY THINLY TWICE A DAY AS DIRECTED	19-May-2014	11-Aug-2014		
In Practice	Salofalk Foam	1 gram/application, 80g (14 dose) canister Rectal foam	N/A	ONE APPLICATION AT NIGHT	19-May-2014	11-Aug-2014		
In Practice	Peptac	(aniseed) Liquid	N/A	10 ML 3 TIMES DAILY	09-Jul-2012	11-Aug-2014		
In Practice	Salbutamol	100 micrograms/puff Cfc-free Inhaler	N/A	ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY	09-Jul-2012	11-Aug-2014		
In Practice	Capsaicin	0.025 % Cream	N/A	APPLY 3 TIMES DAILY	09-Jul-2012	11-Aug-2014		
In Practice	Atenolol	25 mg Tablets	N/A	ONE TO BE TAKEN EACH DAY	09-Jul-2012	11-Aug-2014		
In Practice	Loperamide Hydrochloride	2 mg Capsules	N/A	TWO TO BE TAKEN AT ONCE THEN ONE TO BE TAKEN AFTER EACH FURTHER LOOSE MOTION FOR UP TO 5 DAYS (MAX 8 CAPS PER 24 HOURS)	09-Jul-2012	11-Aug-2014		
In Practice	Buprenorphine	20 micrograms/hour Transdermal patches	N/A	APPLY ONE WEEKLY	10-Jul-2012	06-Aug-2014		
In Practice	Tramadol Hydrochloride	50 mg Capsules	N/A	1 OR 2 CAPS 4 TIMES DAILY	21-May-2014	06-Aug-2014		

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL

~~Do~~ Georgina Logan.
1908546042

Date & Time	Brownlee Clerk in from WIG	Signature, Print Name & Designation
27/10/14		
0100	(60) Admitted to WIG A+E on 26/10	
	♀ with abdominal pain and D+V.	
	HPC - often gets loose stools due to IBS	
	Doesnt usually get abdominal pain vomiting	
	3/7 ~~last few~~ days diarrhoea and crampy lower abdominal	
	pain. And vomiting	
	No fevers.	
	° blood in stool but confirms saw marks	
	Back from Turkey 2 days prior to initial admission	
	but doesn't recall eating anything unusual	
	D+V and pain started in Turkey on hr last day.	
	loose stools x 20 a day	
	Since admission x4 loose stools after having a cup of tea + sandwich	
	lower abd colicky lower abdominal pain similar to IBS pain but worse	
	Not been vomiting since this morning	
	had some I.V buscopan in A+E which helped pain	
	PMH / ° IBS	
	° Diverticular disease	
	° Asthma	
	° Anxiety	
	° Decompression of spinal cord	
	Drug history	
	Amitriptyline 75mg NOCTE — Symbicort 200/6 1 puff BD	
	Hydroxyzine 25mg NOCTE — Sertraline 50mg OD	
	Omeprazole 40mg BD	
	Pregabalin 300mg BD	
	Quinine sulphate 300mg NOCTE	

Date & Time		Signature, Print Name & Designation
	Social history -.	
	Non smoker	
	Does not drink alcohol	
	Lives at home with husband.	
	ℰ	
	O/E- RR - 16 SpO_2 - 97% on a/r	
	Temp - 37.5	
	HR - 90 BP 97/51	
	 chest clear.	
	HS I + II + 0 · JVP ↔.	
	No pitting oedema	
	 Some tenderness in (L) flank on deep palpation no guarding Abdomen soft Normal bowel sounds.	
	℞	
	Blood - Hb - 127 MCV - 95.0	
	WBC - 9.5	
	Na+ - 140 K+ - 4.1 urea 6.8 Creat - 79 eGFR >60	
	LFT - (N) Glucose - 4.8 Amylase 28	
	CRP - 41	
	Imp - ? Gastroenteritis	
	Plan - Buscopan	
	- PRN analgesia	
	- Urinalysis + MSU.	
	- anti-emetic	
	- Continue I.V fluids	
	- Repeat bloods mane	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL

GEORGINA LOGAN

Date & Time		Signature, Print Name & Designation
27/11/14	Seen on ward IBD on ward for 3/12 – long history of anxiety Allerx – 10/12 – 60 tablets – running out Today – progress with diet non-bloody – facial swelling Adm for under med unit – will take – (febrile 38.1°C on) Generalised tenderness → Ingrid Gastroenterology Referral for IBD → Dietitian/CN Review of dr 5/12 w/ under ECG for QT Seen	

Date & Time		Signature, Print Name & Designation
	WR CTI TEMPLETON	
	Pt missed on ward round - away from ward.	
	Ongoing diarrhoea (x 6 episodes in 24°).	
	→ Watery with some formed parts.	
	→ Occurs after eating.	
	→ Associated abdominal cramping	
	PUJ, no urinary Sx. No. other Sx reported.	
	Obs: SaO_2 96% (A) HR 76 Temp 36.7°C BP 108/70	
	O/E well, comfortable. Chest clear.	
	HS I + II +0, regular. Abdo soft. Non tender, non distended, tender in epigastrium, no guarding BS ✓	
	Impression: Vomiting now settled. Tolerating diet & fluids Ongoing diarrhoea.	
	Plan: Clost stool cultures. Continue abx (D2 azithromycin)	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL

1908546042
LOGAN F
Georgina 19/08/1954
17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire
G13 4NA

Date & Time		Signature, Print Name & Designation
29/10/14	WR Dr Seaton	
	Feeling better . Obs stable	CRP ↓
	Box3 yesterday	
	Eating small amounts but drinking ok	
	IVf stopped	
	Nil from cultures as yet - explained this not unusual	
	P/ Aim home tomorrow	
	to complete antibiotics	
30/10/14	WR METCALFE	
	feeling very tired & sleepy today	
	Bo yest - still loose - but no bowel movt yet today. abdo pain much improved but bloating after eating persists	CRP ↓ 27. WCC 4.5
	Eating & drinking small amounts	
	Obs stable	
	P/ allow (H) late today if feeling up to it, if not ⇒ tomorrow	MET CRP 65
31/10/14	WR Dr SEATON	
	? feeling better	
	c/o cough & spit but on Azithromycin	
	keen for (H)	
	P/ Home today	

Accident and Emergency Department
Medical Assessment Unit WIG

8B

50551545H

A&E No. 13000001720

2

Surname	LOGAN	**Forename**	GEORGINA	**Title:** MRS
Address:	17 SOLLAS PLACE GLASGOW LANARKSHIRE	**Postcode** **Telephone:**	G13 4NA 07774400790	**CHI No:**1908546042
Date of Birth:	19.08.54	**Sex:**	F	**Age:** 58 yrs

CHI Number: 1908546042

GP Name:	WEIR PHILLIP		
Address:	VICTORIA PARK MEDICA... 1398 DUMBARTON ROAD GLASGOW	**Postcode** **Telephone:**	G14 9DS 08444 773318

Next of Kin	GEORGE LOGAN		
Relationship:	HUSBAND		
Address:	17 SOLLAS PLACE GLASGOW	**Postcode** **Telephone:**	G13 4NA 9523728
Primary Carer:			

Date of Attendance: 03.05.13 13:26
Date of Incident:
Presenting Complaint: UNWELL ADULT

Triage	LEFT ARM PAIN AND NUMBNESS, ASSOC SOB AND SWEATING NOW PAIN FREE				**Tetanus Cover:** **Allergies:**
P= 51	**BP=** 114/72	**RR=** 15	**Sat=** 95	**BM=**	
PF=	**GCS=** E:	M:	V:	Total:	

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time

8B
-6B
18

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYAXIS)

Date given	Drug (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given by

PARENTERAL FLUID PRESCRIPTION SHEET

Date	FLUID	Volume	Time to run	Rate mls/hr	ADDED DRUGS	Quantity	Doctors Signature	Added by	Start time 24hr Clock	Put up by	Checked by	Serial/ Batch no

N.B. IF USING A SYRINGE DRIVER/INFUSION PUMP PLEASE USE THE "PRESRIPTION AND ADMINISTRATION SHEET FOR MEDICINES GIVEN BY SYRINGE DRIVER/INFUSION PUMP"

REFUSAL TO REMAIN UNDER HOSPITAL CARE

I wish to take my discharge. I appreciate that this is against the advice and wishes of the Consultant or his or her deputy looking after me. I acknowledge that I have been informed of the risks of doing so and I accept full responsibility for my actions and any consequences arising from them.

Name *(print)* _____ Signature _____

I confirm that I have explained to the patient the risks that might arise out of his / her decision to take his / her own discharge.

Date _____ Signature _____ *(Medical Practitioner)*

DISCHARGE DETAILS (NURSING)

Treatment _____

Signed *(Please put initials in box)*

Crutches ☐ Return appointment ☐ Advice Card ☐ Medication ☐

Escort to ward ☐ Relatives informed ☐ IRIS ☐ Transport ☐ Time booked _____

Discharged with _____ Admitted / transfered to _____

S 232946

Patient's name _____ Age _____ Date of Birth _____

NURSING DOCUMENTATION - ACCIDENT & EMERGENCY DEPARTMENT

Date _____ Time _____ Triage Nurse _____ PC _____

Triage category 1 2 3 4 5*

Relatives present: Relatives informed:

INITIAL VITAL SIGNS

at:(Time) _____
HR: _____
BP: _____
RR: _____
SaO_2: _____
Temp: _____
C.S: _____
Signed _____

INITIAL MANAGEMENT

Nurse _____

Oxygen started _____ %: Signed _____ ECG: Signed _____

Signed _____

Other _____

Treatment _____

NEUROLOGICAL OBSERVATIONS

RESPONSIVENESS

TIME hrs

EYES OPEN: spontaneously 4; to speech 3; to pain 2; none 1 — eye closed by swelling =C

BEST VERBAL RESPONSE: orientated 5; confused 4; inappropriate words 3; incomprehensible sounds 2; none 1 — Endotracheal tube or Tracheostomy = E; Dysphalsia=D

BEST MOTOR RESPONSE: obey commands 6; localises pain 5; normal flexion to pain 4; abnormal flexion to pain 3; extention to pain 2; none 1 — Record the best arm response; Paralysed =P

COMA SCORE 15

PUPILS: RIGHT size (mm) Reaction; LEFT size (mm) Reaction — += Reacts; -=No Reaction; C= Eye closed; SL= sluggish pupil

LIMB MOVEMENT

ARMS: Normal power; Mild weakness; Severe weakness; Extention; No response

LEGS: Normal power; Mild weakness; Severe weakness; Extention; No response

Record right (R) and left (L) seperatly if there is a difference between the two sides. Fractured limb = #

BLOOD PRESSURE mm Hg: 230, 220, 210, 200, 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40, 30

37 Temp C°: 40, 39, 38, 35, 34, 33, 32, 31, 30

PULSE RATE

PUPIL SCALE (mm): 1, 2, 3, 4, 5, 6, 8

RESPIRATORY RATE

SaO_2

INITIALS

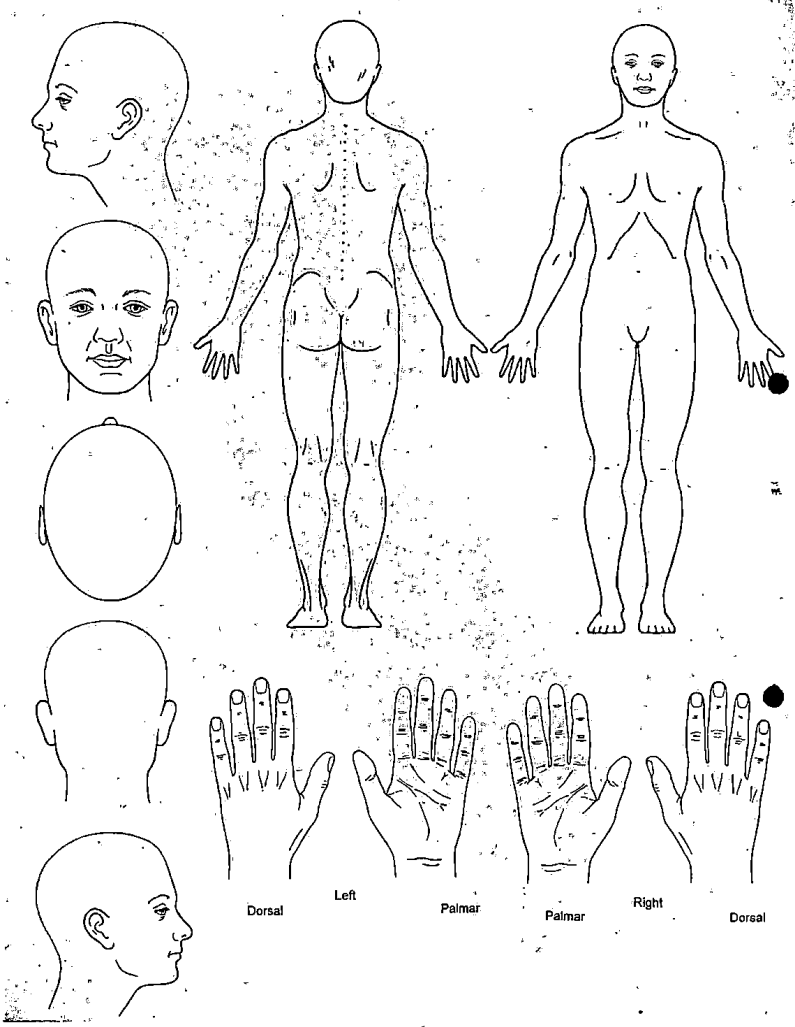
BLOOD GLUCOSE	Time	
BM STIX	BM	
PEAK FLOW	Time	
	PF	
VISUAL ACUITY	R. eye aided/unaided	
	L. eye aided/unaided	
	pH L. eye	R. eye

Signed: _____

URINALYSIS

Urobilinogen µmol/L	Normal 3	16	33	66	131		
Protein g/L	Neg	Trace	0.30 +	1 ++	3 +++	>20 ++++	
pH	5.0	6.0	6.5	7.0	7.5	8.0	8.5
Blood	Neg	Non Haem	Haem Trace	Small +	Mod ++	Large +++	
Specific Gravity	1.000	1.005	1.010	1.015	1.020	1.025	1.030
Ketones mmol/L	Neg	Trace 0.5	Small 1.5	Mod 4	Large 8	Large 16	
Bilirubin	Neg	Small +	Mod ++	Large +++			
Glucose mmol/L	Neg	5.5 Trace	14 +	28 ++	55 +++	111 ++++	
Nitrites	Neg	Positive					
Leucocytes	Neg	Trace	Small +	Mod ++	Large +++		
BHCG	+ ve	- ve					

Please annotate area of: Tenderness / Bruising / Swelling / Abrasions / Lacerations / Incised wounds



CLINICAL NOTES - EMERGENCY DEPA NT

Consultant _____ Seen by _____

Grade: FY1, FY2, ST1, ST2, ST3, ST4-6, FTSTA, Locum, ENP, Consultant, Other *(Please circle)* At (time) _____

Date

CLINICAL NOTES - EMERGENCY DEPARTMENT

Date

CLINICAL NOTES - EMERGENCY DEPAR IT

Date

CLINICAL NOTES - EMERGENCY DEPARTMENT

Date

UNITARY MEDICAL RECORD

Consultant: _____ Seen By: Bahaa ALBURSEEREE

Grade: FY1 FY2 (CMT1/2) ST3+ NP Other Time 15:40

Presenting Complaint

Left arm pain + numbness, started the night before admission

History Presenting Complaint

Sudden onset left leg + arm pain + numbness started 3 a.m., the pain in the arm radiate down to the hand and it is dull in character, no specific relieving or aggravating factor, didnt associated is nausea or vomiting. patient denied chest pain, but she mentioned feeling palpitation this is the 2nd episode of such pain, the 1st one was shorter + milder. (27/03/13) → see Gp notes please. Patient denied feeling dizzy or being fainted at home.

Past Medical History

Failed back Syndrom → Epidural steroids trial, Caudal Epidural block

Social History

- Home circumstances: live with husband
- Exercise tolerance: needs Crutchs most of the time
- Driving
- Smoking history: -ve
- Alcohol History: -ve
- Activites of Daily Living

Systemic Enquiry:

- CVS: palpitation, no chest pain
- Resp: no cough or sputum, mild SOB.
- GI: IBS
- Neuro: pain in left leg.
- GUS: Frequent UTI
- Other

MEDICINES RECONCILIATION

S0551545H
LOGAN F
GEORGINA 19/08/1954
17 SOLLAS PLACE
GLASGOW
LANARKSHIRE G13 4NA
CHI-1908546042

Source of Medical History (2 Sources)

Patient	☐	Relative/Carer	☐
GP Phone call	☐	ECS	☐
Patient own Drugs	☐	Com. Pharmacist	☐
GP Letter/Summary	☐	Repeat Script	☐

Other (please specify) .....

Admission Medicines (To Be Taken)			Plan for Medicines (Dr Complete)				Comments
Name	Dose	Freq	Continue	Amend	Withold	Stop	Reason for Alteration
Mibeverin HCL	135mg	TID.					
Gaviscon advance	10ml						
Clenil Modulite	100Mg	orbid					
Methocarbamol	750mg	2 tab QID					
pregabalin	300mg	BID					
Quinine Sulphate	300mg	o.d					
Salbutamol	100Mg	O/N					
Simvastatin	40mg	O.D.					
Atenolol	25mg	O.D.					
Buprenorphine	20Mg patch	once weekly					
Amitriptyline HCl	25mg	O.D.					
Omeprol cap	20mg	bid					
peptac	10ml	TID					
Hyoscine bromid	10mg	TID					
Tramadol HCl	50mg	QIS					
Amitriptyline Hcl	50mg	O.D.					
Capsaicin Cream	0.025%	T.I.D					
Loperamide HCl	2mg	PRN					

Allergies

None known ☑

LATEX

List any over the counter alternative medicines

Do medicines need further clarification Yes ☐ No ☐

Plan initiated by: Bahaa Albubsseree

List collected by: ; Date:

Designation: Date:

Compliance aid: Yes ☐ No ☐

Community pharmacist: Phone:

Reviewed by: Designation: Date:

8

NHS GG&C Adult Risk Assessment for Venous Thromboembolism (VTE)

NHS Greater Glasgow and Clyde

[excluding orthopaedics, obstetrics & ENT who have specialty-specific policies]

- Risk Assessment must be completed for all patients within 24 hours of admission to hospital
- Patients must be reassessed every 48 hours or sooner if condition changes
- Assessment must be documented in Kardex
- Provide patient information on VTE prevention

S0551545H
LOGAN F
GEORGINA 19/08/1954
17 SOLLAS PLACE
GLASGOW
LANARKSHIRE G13 4NA
CHI-1908546042

Surgical patients start here

Non-operative [mainly medical] patients start here

Is the patient bed-bound or expected to have reduced mobility relative to normal state for ≥ 2 days?

Yes

No

Does the patient have any risk factors for thrombosis? (tick √ all that apply)	
Age >60	Use of oestrogen-containing contraceptive therapy
Active cancer or cancer treatment	Use of hormone replacement therapy
Dehydration	Pregnancy or < 6 weeks post partum [seek specialist advice]
Known thrombophilias	Critical care admission eg HDU/ITU
Obesity (BMI>30)	Varicose veins with phlebitis
Current significant medical condition e.g. Serious infection, Heart failure, Respiratory disease, Inflammatory disease	Total anaesthetic + surgical time >90 minutes
	Surgery involving pelvis or lower limb with a total anaesthetic + surgical time >60 minutes
	Acute surgical admission with inflammatory or intra-abdominal condition
Personal history or first degree relative with a history of VTE	Hip fracture

- Risk assessment now complete
- No thromboprophylaxis required.
- Continue to review every 48 to 72 hours or sooner if condition changes.
- Document all assessments on kardex.

No ticks

Yes, 1 or more ticks

Does the patient have any bleeding risk factors? (tick √ all that apply)	
Active bleeding	Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrands)
Acquired bleeding disorders (e.g. acute liver failure)	Neurosurgery, spinal or posterior eye surgery
Concurrent use of anticoagulants (such as warfarin with INR>2)	Lumbar puncture, epidural/spinal anaesthesia expected within the next 12 hours
Acute stroke	Other procedure with high bleeding risk – discuss with senior if unsure
Uncontrolled hypertension (230/120 mmHg or higher)	Lumbar puncture, epidural/spinal analgesia within the previous 4 hours
Thrombocytopenia (<75 x 10⁹/l)	Thyroid surgery

Yes, 1 or more ticks

- Discuss with senior clinical staff before prescribing pharmacological prophylaxis
- Consider mechanical prophylaxis e.g. AES unless contra-indicated.
- Reassess patient every 48 to 72 hours or sooner if condition changes

No bleeding risk factor ticks

Surgical patients – Enoxaparin 40mg + AES
Medical patients – Enoxaparin 40mg

Prescribe Enoxaparin at 6pm [on day of surgery, at the later of 4h post-op or 6pm]
Reduce Enoxaparin to 20mg if < 50Kg or eGFR< 30
Discontinue at discharge or when returned to pre-morbid mobility

Contraindications to anti-embolism stockings (AES)

- ☐ Peripheral neuropathy
- ☐ Peripheral vascular disease
- ☐ Cellulitis or Gross oedema
- ☐ Leg deformity or Fragile skin
- ☐ Leg / foot ulcers

Risk assessment result – please circle all that apply

VTE risk factors: YES (NO) Bleeding risk factors: YES (NO) Prescribed: LMWH / AES / (NONE)

Assessors Name: Bahaa Albubsseree Date: 03/05/13

Patient Informed Yes / No Information leaflet provided Yes / No

EXAMINATION

Vital Signs: HR 62 BP 114/72 RR 15 T O2 sats 95% FIO2

MEWS:

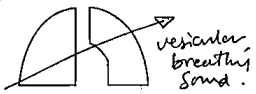
AMT: Age ✓ What year ✓ Date of birth ✓ Location ✓ AMT 4/4

General Appearance: Jaundice, anaemia, cyanosis, clubbing, oedema, Lymphadenopathy

Cardiovascular: Sinus Rythem. Regular pulse.
Normal S_1 & S_2, mild Ejection murmur, just Left to the edge of sternum 4 ICS.

Respiratory

Good bilateral air entry



Abdominal

SNT
no organomegally
BS +ve

Neurological

↓ power Left leg → Failed back Syndrome

PR

Other (if appropriate): e.g. musculoskeletal, skin

- Lumbar spine scar, Fall → Failed back Syndrome
- Lt lower edema., Superficial varicose veins ? ant phlebitis
- No calf pain or swelling.

INVESTIGATIONS

ECG Sinus bradycardia, Q-wave inferior leads I, II, III, aVF
T wave inversion, V1–V4., normal axis.

CXR

Other

ABG

Time					
FIO2					
H+					
PO2					
PCO2					
HCO3					
BE					
LAC					

DIFFERENTIAL DIAGNOSIS

- musculoskeletal pain (Cervical disc prolapse) ... ??
- ACS.

APPROPRIATE PROTOCOLS AND/OR CLINICAL SCORES (E.G. GRACE / MOD GENEVA)

Affix protocol sticker as required
i.e. Sepsis Six or ACS

MANAGEMENT AND FURTHER INVESTIGATIONS

- CXR. PA view
- x-ray Cervical spine Lat.
- D-Dimer & Coag.
- Kardex.
- Repeat troponin

- I discussed her ECG & Cardio team, they think the pain is not cardiac in origin, a copy of her cardiac angio report is added to this file.

Dr. Bahaa

SENIOR REVIEW / CONTINUATION

CONSULTANT REVIEW

Date/ time	03/05	05/05			03/05				
Na	131	140		HB	131		Paracetamol		
K	4.8	4.5		MCV	91.7		Salicylate		
Cl	106	107		WCC	5.92				
Ur	9.0	6.9		Neut	3.33				
Cr	78	73		Plts	251				
Gluc		5.0							
Ca	2.37	2.41							
Mg				INR					
Bil	11	9		APTT					
Ast	24	23		PT					
Alt	19	25		e GFR	>60				
GGT	68								
ALP	63	63		TROP	<0.04				
Alb	40	39		D-Dimers					
CRP	5	6.6		Amylase					

Destination/ Speciality

EDD

Name: Sign: Date: Time:

CONTINUATION

CONTINUATION

Am pain
Nodi chronic pain syndrome
No pain both
wants to go home

ECG - no change

troponin neg

(D)

CP f/u

Juvi Cano

3/5/13

Registration Details - Patient No: 7881

Personal details...		Address details...	
Sex	F	Post Code	G13 4NA
Surname	Logan	House Name Flat No	
Previous Surname	Logan	No and Street	17 Sollas Place
Forenames	Georgina	Village	
Calling Name	Georgina	Town	Glasgow
Date of birth	19/08/1954	County	
Title	Mrs		
Birth Surname			
Marital Status			
Ethnic Origin			

HA/HB Details...		Contact details...	
Trading partner	Greater Glasgow	Home Tel No	
Registered GP	Dr Philip Weir	Work Tel No	
Usual GP	Dr Philip Weir	Mobile Tel No	0777 4400 790
Residential Inst		E Mail Address	
Branch Surgery			
CHI Number	1908546042		
NHS Number			

Practice Information...		Distances	
Dispensing		Rural Mileage	
Hospital Number		Blocked Special	
Records At		Walking Quarters	

Further Information		Upload Consent	
Long/Short stay or Dead		SCI-DC Consent	Implied Consent (default)
Date of registration	02/10/2012		

AMS\CMS Details		ECS (GP Summary) Consent	
AMS Consent	Yes	Patient Consent	Implied Consent (default)
CMS Status	Not Registered		
Pharmacy Details			
Compliance Check	Yes		

Medical Record

Problems

Active Problems		Authorised By	Code
03/05/2013	Emergency hospital admission	Dr Singh	8H2

Past Problems		Authorised By	Code

Due Diary Entries		Authorised By	Code
19/08/2019	Influenza vaccination	Dr Weir	65E..
18/07/2015	Cervical smear due SCCRS Recall	Mrs Connell	685F.
18/07/2013	Medication review	Ms Dempsey	8B314

Overdue Diary Entries		Authorised By	Code
	None		

Alerts		Authorised By	Code
17/04/2013	Primary prevention of ischaemic heart disease KEEP WELL	Dr Transfer	6C0

Drug Allergies	Authorised By	Code
None		

Non Drug Allergies	Authorised By	Code
None		

Health Status

18/07/2012	Cervical smear result Cervical smear: negative
09/07/2012	Height 148 cm
09/07/2012	Weight 72 Kg
09/07/2012	Body Mass Index 32.87 kg/m2
03/05/2013	Blood pressure reading O/E - BP reading
03/05/2013	Blood pressure reading 118/70 mm Hg
03/05/2013	Smoking Status Never smoked tobacco
03/05/2013	FH: Ischaemic heart dis. <60
03/05/2013	FH: Ischaemic heart dis. >60

Consultations

03/05/2013 11:34	Dr Jasmeet Singh at Victoria Park Medical Practice
Problem (FIRST)	**Emergency hospital admission**
History	c/o L arm pain and numbness and tingling, also had palpitations, denies chest pain, assoc soba nd sweating though, now pain free
Examination	O/E - BP reading chest clear, HS-N, Blood pressure reading 118/70 mm Hg O/E - pulse rhythm regular O/E - pulse rate, 68 beats/minute sats-98% on air, looks well
Family History	FH: MI- myocardial infarct >60 (Sister) FH: MI- Myocardial infarct <60 (Father)
Social	Never smoked tobacco Non-drinker alcohol
Comment	imp/need to exclude cardiac cause, refer western infirmary, worsening statement, pt will get a taxi just now
03/05/2013 09:34	Dr Jasmeet Singh at Telephone Consultation
History	no chest pain but sx seem odd with palpitations and L arm pain, advised to come down now for an emergency appt
03/05/2013	Ms Ellen Dempsey at Data Entry
Comment	07774400790. sore left arm and leg all night and palpitaions
27/03/2013	Dr Anne Tumbull at Yoker
History	episode of severe low back pain yesterday associated with tingling L arm. Lasted 15 mins. Due to have epidural soon- attending pain clinic. Also having problems with patches coming off in bath. New prescription issued. Advised use only one at a time
27/03/2013	Mrs Jean Artru at Victoria Park Medical Practice
Comment	Bloods taken as per Dr Singh request.

Medication

Current Date Commenced	Drug Details	Date Last Issue	Authorised By	Type
18/04/2013	**Mebeverine Hydrochloride Tablets 135 mg** ONE TO BE TAKEN THREE TIMES A DAY 84 TABLET	18/04/2013P	Dr Andrew McCall	ACUTE
16/01/2013	**Tramadol Hydrochloride Capsules 50 mg** 1 OR 2 CAPS 4 TIMES DAILY 100 capsule	02/05/2013P	Dr Andrew McCall	REPEAT
21/08/2012	**Amitriptyline Hydrochloride Tablets 25 mg** ONE TO BE TAKEN IN THE EVENING DISP WEEKLY 28 TABLET	02/05/2013P	Dr Andrew McCall	REPEAT
10/07/2012	**Buprenorphine Transdermal patches 20 micrograms/hour** APPLY ONE WEEKLY 4 patch	02/05/2013P	Dr Andrew McCall	REPEAT
09/07/2012	**Clenil Modulite Cfc-free Inhaler 100 micrograms/actuation** TWO PUFFS TO BE INHALED TWICE A DAY 2 INHALER	02/05/2013P	Dr Andrew McCall	REPEAT
09/07/2012	**Methocarbamol Tablets 750 mg** 2 TABS 4 TIMES DAILY 224 TABLET	02/05/2013P	Dr Andrew McCall	REPEAT
09/07/2012	**Omeprazole Capsules (Gastro-Resistant) 20 mg** 2 CAPS DAILY 56 CAPSULE	02/05/2013P	Dr Andrew McCall	REPEAT
09/07/2012	**Peptac Liquid (aniseed)** 10 ML 3 TIMES DAILY 500 ML	02/05/2013P	Dr Andrew McCall	REPEAT
09/07/2012	**Pregabalin Capsules 300 mg** 1 CAP TWICE DAILY 56 capsule	02/05/2013P	Dr Andrew McCall	REPEAT
09/07/2012	**Quinine Sulphate Tablets 300 mg** ONE TO BE TAKEN AT NIGHT DISPENSE WEEKLY 28 tablet	02/05/2013P	Dr Andrew McCall	REPEAT
09/07/2012	**Salbutamol Cfc-free Inhaler 100 micrograms/puff** ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY 2 INHALER	02/05/2013P	Dr Andrew McCall	REPEAT
09/07/2012	**Simvastatin Tablets 40 mg** ONE TO BE TAKEN AT NIGHT 28 TABLET	02/05/2013P	Dr Andrew McCall	REPEAT
09/07/2012	**Hyoscine Butylbromide Tablets 10 mg** 1 TAB 3 TIMES DAILY 84 TABLET	02/05/2013P	Dr Andrew McCall	REPEAT
09/07/2012	**Capsaicin Cream 0.025 %** APPLY 3 TIMES DAILY 45 gram	02/05/2013P	Dr Andrew McCall	REPEAT
09/07/2012	**Amitriptyline Hydrochloride Tablets 50 mg** ONE TO BE TAKEN IN THE EVENING 28 TABLET	02/05/2013P	Dr Andrew McCall	REPEAT
09/07/2012	**Atenolol Tablets 25 mg** ONE TO BE TAKEN EACH DAY 28 TABLET	02/05/2013P	Dr Andrew McCall	REPEAT
09/07/2012	**Loperamide Hydrochloride Capsules 2 mg** TWO TO BE TAKEN AT ONCE THEN ONE TO BE TAKEN AFTER EACH FURTHER LOOSE MOTION FOR UP TO 5 DAYS (MAX 8 CAPS PER 24 HOURS) 30 CAPSULE	02/05/2013P	Dr Andrew McCall	REPEAT

Acute Services Division
Emergency Care and
Medical Services Directorate

DEPARTMENT OF CARDIOLOGY

Dr Piotr Sonecki Clinic of 29/03/2011

Western Infirmary
Dumbarton Road
Glasgow
G11 6NT
Direct Line: 0141 211 2803
Fax: 0141 211 1906

NHS
Greater Glasgow and Clyde

Our Ref: PS/LH//50551545H
Date: 06/04/2011

Dr Ann Morgan
Drumchapel Health Centre
80/90 Kinfauns Drive
G15 7TS

Dear Dr Morgan

Georgina Logan - 19/08/1954 - CHI: 1908546042
17 Sollas Place, Glasgow, Lanarkshire, G13 4NA

Please find a copy of this lady's myocardial perfusion scan. It shows some reperfusion defects and I will review her in the cardiac clinic to discuss the results and her symptoms.

Yours sincerely

Dr Piotr Sonecki
Consultant Cardiologist

ge 2.
tient ID : 7881
s Georgina Logan
Sollas Place Glasgow G13 4NA

enil Modulite Cfc-free inhaler 100 [ ]
crograms/actuation
O PUFFS TO BE INHALED TWICE A DAY
ant : 2 INHALER

---

oscine Butylbromide Tablets 10 mg [ ]
TAB 3 TIMES DAILY
ant : 84 TABLET

---

peramide Hydrochloride Capsules 2 mg [ ]
O TO BE TAKEN AT ONCE THEN ONE TO BE
KEN AFTER EACH FURTHER LOOSE MOTION
R UP TO 5 DAYS (MAX 8 CAPS PER 24
URS)
ant : 30 CAPSULE

---

thocarbamol Tablets 750 mg [ ]
TABS 4 TIMES DAILY
ant : 224 TABLET

---

prazole Capsules (Gastro-Resistant) [ ]
mg
CAPS DAILY
ant : 56 CAPSULE

---

ptac Liquid (aniseed) [ ]
ML 3 TIMES DAILY
ant : 500 ML

---

egabalin Capsules 300 mg [ ]
CAP TWICE DAILY
ant : 56 capsule

Page 1.
Patient ID : 7881
Mrs Georgina Logan
17 Sollas Place Glasgow G13 4NA

PLEASE TICK BOX FOR THE MEDICINE(S) YOU REQUIRE.
PLEASE ALLOW 48 HOURS BEFORE COLLECTION.
Usual Doctor : Dr Philip Weir
Date Printed : 03/05/2013
Date Printed :03.05.2013

Amitriptyline Hydrochloride Tablets 25 mg [ ]
ONE TO BE TAKEN IN THE EVENING DISP
WEEKLY
Quant : 28 TABLET

Amitriptyline Hydrochloride Tablets 50 mg [ ]
ONE TO BE TAKEN IN THE EVENING
Quant : 28 TABLET

Atenolol Tablets 25 mg [ ]
ONE TO BE TAKEN EACH DAY
Quant : 28 TABLET

Buprenorphine Transdermal patches 20 micrograms/hour [ ]
APPLY ONE WEEKLY
Quant : 4 patch

Capsaicin Cream 0.025 % [ ]
APPLY 3 TIMES DAILY
Quant : 45 gram

Page 3.
Patient ID : 7881
Mrs Georgina Logan
17 Sollas Place Glasgow G13 4NA

Quinine Sulphate Tablets 300 mg [ ]
ONE TO BE TAKEN AT NIGHT DISPENSE WEEKLY
Quant : 28 tablet

Salbutamol Cfc-free inhaler 100 micrograms/puff [ ]
ONE OR TWO PUFFS TO BE INHALED WHEN
REQUIRED UP TO FOUR TIMES A DAY
Quant : 2 INHALER

---

simvastatin Tablets 40 mg [ ]
ONE TO BE TAKEN AT NIGHT
Quant : 28 TABLET

-Tramadol Hydrochloride Capsules 50 mg [ ]
1 OR 2 CAPS 4 TIMES DAILY
Quant : 100 capsule

Review Date : 18.07.2013

Accident and Emergency Department
Medical Assessment Unit WIG

50551545H

A&E No. 11000003707

2

Surname	LOGAN	**Forename**	GEORGINA	**Title:**	MRS
Address:	17 SOLLAS PLACE GLASGOW LANARKSHIRE	**Postcode** **Telephone:**	G13 4NA 07500390352	**CHI No:**	1908546042
Date of Birth:	19.08.54	**Sex:**	F	**Age:**	56 yrs

CHI Number: 1908546042

GP Name:	MORGAN ANN		
Address:	DRUMCHAPEL HEALTH ... 80/90 KINFAUNS DRIVE GLASGOW	**Postcode** **Telephone:**	G15 7TS 0141 211 6120

Next of Kin	GEORGE LOGAN		
Relationship:			
Address:	17 SOLLAS PLACE GLASGOW	**Postcode** **Telephone:**	G13 4NA 9523728
Primary Carer:			

Date of Attendance: 10.08.11 22:33
Date of Incident:

Presenting Complaint: {Patient Expect: CHEST PAIN RECENT ANGIO}

Triage WOKE THIS MORNING AT 07:30 WITH (R) SIDED PLEURITIC CHEST PAIN HAS GRADUALLY GOT WORSE OVER THE COURSE OF THE DAY, PAIN WORSE ON INSPIRATION. TAMP 36.0

Tetanus Cover:

Allergies:

P= 70 **BP=** 110/75 **RR=** 19 **Sat=** 98 **BM=**

PF= **GCS=** E: M: V: Total:

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time

George.

Call No: 3198939	**CHI:**	**Date:** 10-08-2011	**NHS 24 No:**
Patients Name: Georgina Logan		**D.O.B.** 19/08/1954 **Age:** 56 years	**Callers Name:** **Relationship:**

Address Today: 17 Sollas Place
Knightswood
Glasgow

Post Code: G13 4NA

Phone Number: 0141 952 3728

Home Address if different 17 Sollas Place
Knightswood
Glasgow

Post Code: G13 4NA

Call Type: Walk In

Name of GP: Duffy,M(021)

Surgery: 021Drumchapel Health Centre

Practice Number:

Speed Dial: CONTACT DETAILS

(). FAX NUMBER()
(). SPEED DIAL(196)
(). PRACTICE(0141 211 6120)
(). MORNING FAX(0141 211 6128)

Time Call Received at NHS 24:

Time Details Received at GEMS:

Time Patient Arrived: 10/08/2011 21:07:46

Consultation Start time: 10/08/2011 21:14:25

Consultation End time: 10/08/2011 21:22:54

Dispatched To: Drumchapel

Clinical Information

Pain in lung area

Examination Results:

HEAD/NECK
Temperature C 36.4

HEART
Diastolic BP 70
Systolic BP mmHg 110
Pulse 74

LUNGS
Oxygen saturation % 97.0

Clinicians Notes

Right sided intercostal pain. Worse on inhalation.
obs noted. chest clear. posterior chest wall tenderness. looks well
likely musculoskeltal pain. but sudden onset pleurtic chest pain and sob. needs ecg and ddimer.
refer western a and e

Prescription Items:

Clinical Code/s: N145. Backache, unspecified

Informational Outcome: Hospital Referral

Referral: RECEIVING PHYSICIAN Consulting Clinician: Watson,Gary(CC)

RECEIVING PHYSICIAN

Date: Wednesday10-Aug-11 **Agency Phone No.**

Patient Name: Georgina Logan Sex: F **Date of Birth:** 19-Aug-1954 **Age:** 56 years
Address: 17 Sollas Place Knightswood **Own Doctor:** Duffy,M(021)
Glasgow **Surgery:** Provider Group

G13 4NA
Home Tel: 0141 952-3728

Case Origin: **Case Number:** 3198939
Caller Name: **Tel:** **Case Priority:**

Reported Condition: **Receive Time:** 8:07 PM **Operator:** LYNET
Pain in lung area

Latest Consultation Details **Consulted By:** Watson,Gary(CC) **Cons. Begin:** 9:14 PM
Right sided intercostal pain. Worse on inhalation. **Cons. Finished:** 9:22 PM

Examination Details:

obs noted. chest clear. posterior chest wall tenderness. looks well

HEAD/NECK
Temperature C 36.4

HEART
Diastolic BP 70
Systolic BP mmHg 110
Pulse 74

LUNGS
Oxygen saturation % 97.0

refer western a and e

Clinical Codes:
N145. Backache, unspecified

Prescription Items:

Diagnosis:
likely musculoskeltal pain. but sudden onset pleurtic chest pain and sob. needs ecg and ddimer.

Agency Questions and Answers

Agency Comments

MEDICINES RECONCILIATION

50551545H
LOGAN F
GEORGINA 19/08/1954
17 SOLLAS PLACE
GLASGOW
LANARKSHIRE G13 4NA
CHI-1908546042

Source Of Medication History (2 Sources)
Patient ☐ Relative/Carer ☐
GP Phone call ☐ ECS ☐
Patient Own Drugs ☐ Com. Pharmacist ☐
GP Letter/Summary ☐ Repeat Script ☐
Other (please specify) .....

Admission Medicines			Plan for Medicines (Dr Complete)				Comments
Name	Dose	Freq	Continue	Amend	Withold	Stop	Reason for Alteration
ASPIRIN	75mg	od					
BISOPROLOL	2.5mg	od					
CLENIL MODULITE	100mg INH	bd					
NICORANDIL	10mg	bd					
♡ MEPRAZOLE	20mg	od					
METHOCARBAMOL	1.5g	qds					
PREGABALIN	300mg	bd					
SIMVASTATIN	40mg	nocte					
QUININE	300mg	nocte					
SALBUTAMOL	2puffs	PRN					

Allergies	List any Over The Counter or Alternative Medicines
None known ☐	Do medicines need further clarification Yes ☐ No ☐
List collected by :	**Plan initiated by :**
Designation : Date :	Designation : Date :

Compliance aid : Yes ☐ No ☐	Community pharmacist Phone
Reviewed by : Designation : Date :	

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYAXIS)

Date given	Drug (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given by

PARENTERAL FLUID PRESCRIPTION SHEET

Date	FLUID	Volume	Time to run	Rate mls/hr	ADDED DRUGS	Quantity	Doctors Signature	Added by	Start time 24hr Clock	Put up by	Checked by	Serial/ Batch no

N.B. IF USING A SYRINGE DRIVER/INFUSION PUMP PLEASE USE THE "PRESRIPTION AND ADMINISTRATION SHEET FOR MEDICINES GIVEN BY SYRINGE DRIVER/INFUSION PUMP"

REFUSAL TO REMAIN UNDER HOSPITAL CARE

I wish to take my discharge. I appreciate that this is against the advice and wishes of the Consultant or his or her deputy looking after me. I acknowledge that I have been informed of the risks of doing so and I accept full responsibility for my actions and any consequences arising from them.

Name *(print)* _____ Signature _____

I confirm that I have explained to the patient the risks that might arise out of his / her decision to take his / her own discharge.

Date _____ Signature _____
(Medical Practitioner)

DISCHARGE DETAILS (NURSING)

Treatment _____

Signed *(Please put initials in box)*

Crutches ☐ Return appointment ☐ Advice Card ☐ Medication ☐

Escort to ward ☐ Relatives informed ☐ IRIS ☐ Transport ☐ Time booked _____

Discharged with _____ Admitted / transfered to _____

Time discharged _____ Signed _____

12

MIS 232646

Patient's name _____ Age _____ Date of Birth _____

NURSING DOCUMENTATION - ACCIDENT & EMERGENCY DEPARTMENT

Date _____ Time _____ Triage Nurse _____ PC _____

Triage category 1 2 3 4 5

Relatives present: Relatives informed:

INITIAL VITAL SIGNS

at:(Time) _____
HR: _____
BP: _____
RR: _____
SaO_2: _____
Temp: _____
G.C.S: _____
Signed _____

INITIAL MANAGEMENT

Nurse _____

Oxygen started _____ %: Signed _____ ECG: Signed _____

Signed _____

Other _____

Treatment _____

NEUROLOGICAL OBSERVATIONS

RESPONSIVENESS

TIME hrs

EYES OPEN: spontaneously 4; to speech 3; to pain 2; none 1

BEST VERBAL RESPONSE: orientated 5; confused 4; inappropriate words 3; incomprehensible sounds 2; none 1

BEST MOTOR RESPONSE: obey commands 6; localises pain 5; normal flexion to pain 4; abnormal flexion to pain 3; extention to pain 2; none 1

COMA SCORE 15

1 — eye closed by swelling =C

Endotracheal tube or Tracheostomy = E Dysphalsa=D

Record the best arm response

Paralysed =P.

PUPILS

RIGHT size (mm) Reaction

LEFT size (mm) Reaction

2 — += Reacts -=No Reaction C= Eye closed SL= sluggish pupil

LIMB MOVEMENT

ARMS: Normal power; Mild weakness; Severe weakness; Extention; No response

LEGS: Normal power; Mild weakness; Severe weakness; Extention; No response

3 — Record right (R) and left (L) seperatly if there is a difference between the two sides

Fractured limb = fl

4

BLOOD PRESSURE mm Hg: 230, 220, 210, 200, 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40

PULSE RATE

PUPIL SCALE (mm): 1, 2, 3, 4, 5, 6, 7

40, 39, 38, 37 Temp C°, 36, 35, 34, 33, 32, 31, 30

RESPIRATORY R

5

NURSE INITIALS

6

BLOOD GLUCOSE	Time									
BM STIX	BM									
PEAK FLOW	Time									
	PF									
VISUAL ACUITY	R. eye aided/unaided									
	L. eye aided/unaided									
	pH L. eye				R. eye					

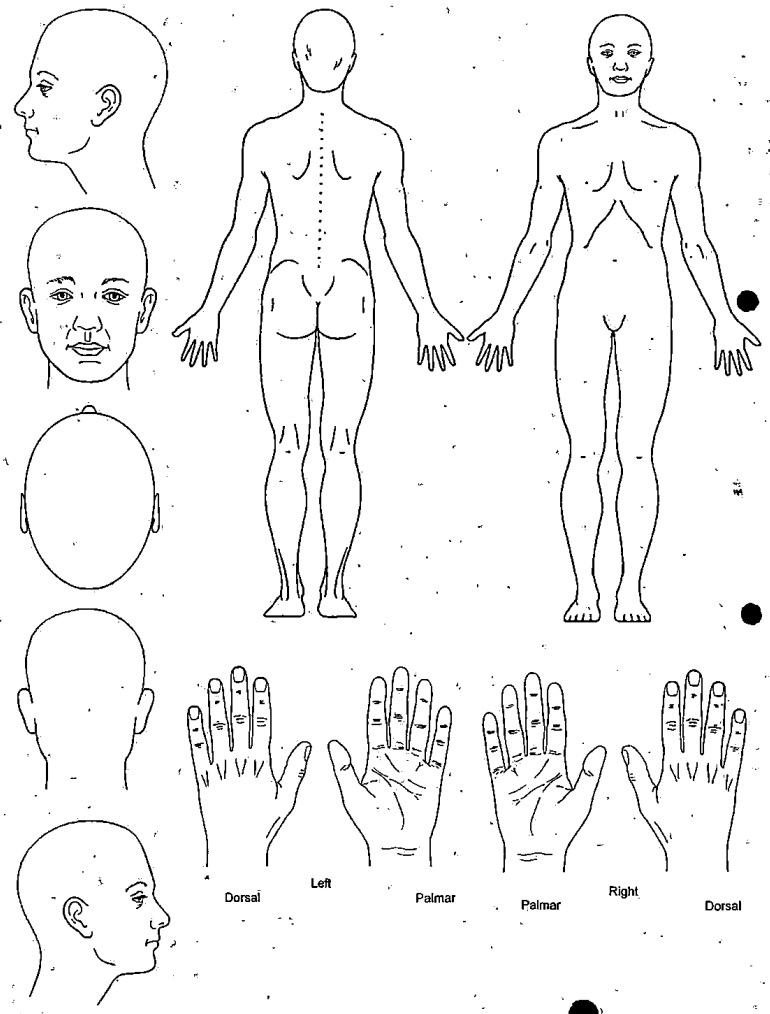
Signed: _____

URINALYSIS

Urobilinogen µmol/L	Normal 3	16	33	66	131		
Protein g/L	Neg	Trace	0.30	1	3	>20	
			+	++	+++	++++	
pH	5.0	6.0	6.5	7.0	7.5	8.0	8.5
Blood	Neg	Non Haem	Haem Trace	Small +	Mod ++	Large +++	
Specific Gravity	1.000	1.005	1.010	1.015	1.020	1.025	1.030
Ketones mmol/L	Neg	Trace 0.5	Small 1.5	Mod 4	Large 8	Large 16	
Bilirubin	Neg	Small +		Mod ++	Large +++		
Glucose mmol/L	Neg	5.5 Trace	14 +	28 ++	55 +++	111 ++++	
Nitrites	Neg	Positive					
Leucocytes	Neg	Trace	Small +		Mod ++	Large +++	
BHCG	+ ve				- ve		

Signed: _____

Please annotate area of: Tenderness / Bruising / Swelling / Abrasions / Lacerations / Incised wounds



CLINICAL NOTES - ACCIDENT and EMERGENCY

Consultant _____ Seen by _____

Grade: SpR SHO SHO3 JHO Clin Assist ENP *(Please circle)* At (time) _____

Date

CLINICAL NOTES - ACCIDENT and EMERGENCY

Date

CLINICAL NOTES - ACCIDENT and EMERGENCY

Date

Date

UNITARY MEDICAL RECORD and EXAMINATION

Consultant Winter Seen by [illegible] At (time) 0020

Grade: SpR (SHO) SHO3 JHO Clin Assist ENP *(Please circle)*

Date

HISTORY

Presenting Complaint:

GP referral → pleuritic chest pain

History of Presenting Complaint:

(SF) Background – Asthma
IHD – angina
– recent angio 2/52 ago. Normal
Chronic back pain

Developed (R) sided pleuritic chest pain this a-m
– mild SOB
– NO infective Sx
– nor coughing
– no injury

Has intermittent (R) leg swelling – not new.
No recent immobility / long journeys.

Past Medical History:

~~Nil. angio 2/52 ago.~~
No Hx DVT/PTE
(Separated from husband 2/52 ago)

- Diabetes
- Obesity
- Hypertension
- MI 2/52 ago
- CABG
- Rheumatic Fever
- TB

Allergies

NKDA

Drug History:

Nil reg.

Family and Social History:

Never smoking
Mum CHD?
Has 1 son
Sister – DVT.

MEDICAL NOTES - HISTORY and EXAMINATION *(cont)*

Date

Systemic Enquiry

- **General**
- **CVS**
- **RESP**
- **GI**
- **CNS**
- **GUS**
- **Other**

EXAMINATION

Vital Signs: BP 110/75 70 RR 19 T 36°C O2 Sat 98% air

General Appearance: Appears systemically well

Obesity

Cardiovascular

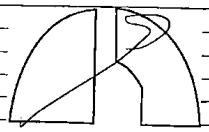
HR 70 Reg

HS 1 + II + 0

(II) Leg appears marginally swollen but pt states chronic

Respiratory

Tender under (R) axilla to palpation



8

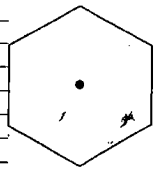
MEDICAL NOTES - HISTORY and EXAMINATION *(cont)*

Date

Abdominal NAD

Obese

SNT



Central / Peripheral Nervous System GCS (15)

EO MR

VR

Other

INVESTIGATIONS DONE TIME

U & E's		GLUC		LFT's		Para/Sal		Troponin		D - Dimer	
FBC		COAG		Blood Cultures		MSU		ABG			

ECG SR 63.

CXR requested

Other

DIFFERENTIAL DIAGNOSIS

Likely MSK pain

Date

PLAN

- Bloods/CXR inserted
- If above ok → (E) Tramadol 50

Name [illegible] Sign

Grade CT2

SHO / SPR REVIEW

CTn - ni ante

D-Dimer 69.

(PE) tonight.

A-[illegible]

CT2

Name Sign Grade Date Time

Date

Consultant Review

Name Sign Date Time

Results

Biochemistry			Haematology	Other
Na 140	Paracetamol		Hb 12.5	CXR
K 4.2	Salicylate		MCV	
CL			WCC 6.9	
Ur 4.2	D - Dimer 69		NEUT	
Cr 123			Platelets 257	
Gluc 4.5				
Ca 2+ 2.31	ABG		INR	
Troponin <0.04			APTT	
Amylase	O_2		PT	
Bil	CO_2			
AST	H+			
ALT	BI			
ALP	BE			
YGT				
ALB	COHb			
CRP 1.5				

NHS
Greater Glasgow and Clyde

Name	50551545H LOGAN F GEORGINA 19/08/1954 17 SOLLAS PLACE GLASGOW LANARKSHIRE G13 4NA CHI-1908546042
PHYS/ SURG	

l No.

OUT-PATIENT HISTORY

DATE	
22/5/9.	Wt 61.1 9st 9 Urine Neg
	Diabetes 10yrs, up to 10 u/day
	Very poor Hx:
	Retinopathy
	Known diabetic. Working, smoking.
	Currently for appetite for 4/7 T 11 N 34. for 7/7.
Plan:	Less high fat OB Drugs – unchanged.
	Advice: transfer to GP – for info
	Proc. done Fundoscopy
	retinal.
DA	For no access
	NAD no retinopathy
Dup.	Ophthalmic Medicine
	Glasgow.

NHS
Greater Glasgow and Clyde

Name

PHYS/
SURG

50551545H
LOGAN F
GEORGINA 19/08/1954
17 SOLLAS PLACE

GLASGOW G13 4NA
CHI-1908546042

OUT-PATIENT HISTORY

DATE

14/4/8 S/R S. Dover Clinic

main problem lower GI pain

mainly on

occ at night

BO 6-7x + accidents chest <

always soft 1x/w watery pasta <, bread <

malaena

constipation except for when on hydrocortisone

DH: immodium > (upto 6/d

+ currently on ~~Cipro~~ trimethprim for 2 UTI

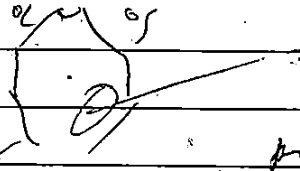
simvastatin

fluoxetine

amitryptiline

dihydrocodeine

H/x of ulcer

o/e:  no tenderness

flexi sig pr: not done

hx ~~OPA~~ c Prof. O'Dwyer

sp: IBS

2 Caelian

22 renal problems currently

plan: bloods + TTGc, F/S c Prof, 4XR

d/c if ND

DATE	HISTORY (Use other side first)
16/4/8	AXR: constipation ⇒ movicol stop loperamide & dihydrocodein

10

CHI: 1908546042

Western Infirmary

Total Att: **9**

12 Mth Att: **2**

Title: **MRS**

LOGAN

Georgina

DOB: **19/08/1954** Age: **59y**

Sex: **Female**

17 Sollas Place
Glasgow
Lanarkshire
G13 4NA
07774400790

Next of kin: **SAME?, GEORGE**
Relationship: **Husband**
952 3728

GP: **PJ Weir**
08444 773318

Attendance Date: **11/05/2014** Arrival Time: **20:51**

Registration Time: **20:51** Date of Incident: **11/05/2014**

Major Incident Desc:

Reason for Attendance: **med referral**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **Not Recorded** Pain Score:

Triage Category: **3** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **11/05/2014 21:07** Nurse name: **Nurse Lauren Gunn**

Temp	**34.8**	C
HR	**110**	bpm
BP	**131/75**	mmHg
MAP	**93.67**	mmHg
RR	**18**	bpm
SpO2	**99**	%
Oxygen		%

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils-Right		Pupils-Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: **gp ref for medics re abdo pain, d&v. hx diverticulitis, ibs**

1908546042
LOGAN
Georgina
17 Sollas Place
Glasgow, Lanarkshire
G13 4NA

F
19/08/1954

WESTERN INFIRMARY
RESUS

Patient Sample Report

Patient

ID:	1908546042
Last Name:	LOGAN
First Name:	GEORGINA
Gender/Age:	Female, 59 years
Birth Date:	19.08.1954
Status:	ACCEPTED
Analyzed:	11.05.2014 23:54:44
Sample Type:	Venous
Account Number:	
Clinician:	
Operator ID:	AMANDA PRINGLE0

Analyzer

Model:	GEM® *Premier 4000*
Area:	WIGRESUS
Name:	AERESUS
S/N:	06110216

Measured (37.0°C)

cH	42.1	nmol/L
pCO_2	5.7	kPa
pO_2	5.0	kPa
Na^+	139	mmol/L
K^+	3.9	mmol/L
Cl^-	105	mmol/L
Ca^{++}	1.21	mmol/L
Hct	42	%
Glu	5.6	mmol/L
Lac	1.5	mmol/L

CO-Oximetry

tHb	146	g/L
O_2Hb	76.3	%
COHb	1.7	%
MetHb	1.6	%
HHb	20.4	%
sO_2	78.9	%

Derived

BE(B)	0.0	mmol/L
HCO_3^-(c)	25.4	mmol/L
Hct(c)	44	%

Operator Entered

Temp	37.0	°C

O2 and Vent Settings

FIO_2		%

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYAXIS)

Date given	Drug (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given by

PARENTERAL FLUID PRESCRIPTION SHEET

Date	FLUID	Volume	Time to run	Rate ml/s/hr	ADDED DRUGS	Quantity	Doctors Signature	Added by	Start time 24hr Clock	Put up by	Checked by	Serial/ Batch no

N.B. IF USING A SYRINGE DRIVER/INFUSION PUMP PLEASE USE THE "PRESRIPTION AND ADMINISTRATION SHEET FOR MEDICINES GIVEN BY SYRINGE DRIVER/INFUSION PUMP"

REFUSAL TO REMAIN UNDER HOSPITAL CARE

I wish to take my discharge. I appreciate that this is against the advice and wishes of the Consultant or his or her deputy looking after me. I acknowledge that I have been informed of the risks of doing so and I accept full responsibility for my actions and any consequences arising from them.

Name *(print)* _____ Signature _____

I confirm that I have explained to the patient the risks that might arise out of his / her decision to take his / her own discharge.

Date _____ Signature _____
(Medical Practitioner)

DISCHARGE DETAILS (NURSING)

Treatment _____

_____

Signed *(Please put initials in box)*

Crutches ☐ Return appointment ☐ Advice Card ☐ Medication ☐

Escort to ward ☐ Relatives informed ☐ IRIS ☐ Transport ☐ Time booked _____

Discharged with _____ Admitted / transfered to _____

G46

Patient's name _____ Age _____ Date of Birth _____

NURSING DOCUMENTATION - ACCIDENT & EMERGENCY DEPARTMENT

Date _____ Time _____ Triage Nurse _____ PC _____

_____

_____

Triage category 1 2 3 4 5

Relatives present: Relatives informed:

1508546042
LOGAN
Georgina
17 Soltas Place
Glasgow, Lanarkshire
G13 4NA

F
19/08/1954

INITIAL VITAL SIGNS

at:(Time) _____
HR: _____
BP: _____
RR: _____

INITIAL MANAGEMENT

Nurse _____

Oxygen started _____ %: Signed _____ ECG: Signed _____

Signed _____

Other _____

Treatment _____

NEUROLOGICAL OBSERVATIONS

RESPONSIVENESS

TIME hrs

EYES OPEN: spontaneously 4; to speech 3; to pain 2; none 1 — eye closed by swelling =C

BEST VERBAL RESPONSE: orientated 5; confused 4; inappropriate words 3; incomprehensible sounds 2; none 1 — Endotracheal tube or Tracheostomy = E; Dysphasia=D

BEST MOTOR RESPONSE: obey commands 6; localises pain 5; normal flexion to pain 4; abnormal flexion to pain 3; extention to pain 2; none 1 — Record the best arm response; Paralysed =P

COMA SCORE 15

PUPILS: RIGHT size (mm) Reaction; LEFT size (mm) Reaction — = Reacts; - =No Reaction; C= Eye closed; SL= sluggish pupil

LIMB MOVEMENT

ARMS: Normal power; Mild weakness; Severe weakness; Extention; No response

LEGS: Normal power; Mild weakness; Severe weakness; Extention; No response — Record right (R) and left (L) seperatly if there is a difference between the two sides; Fractured limb = F

BLOOD PRESSURE mm Hg: 230, 220, 210, 200, 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40, 30

PULSE RATE: 1, 2, 3, 4, 5, 6, 7

PUPIL SCALE (mm)

40, 39, 38, 37 Temp C°, 36, 35, 34, 33, 32, 31, 30

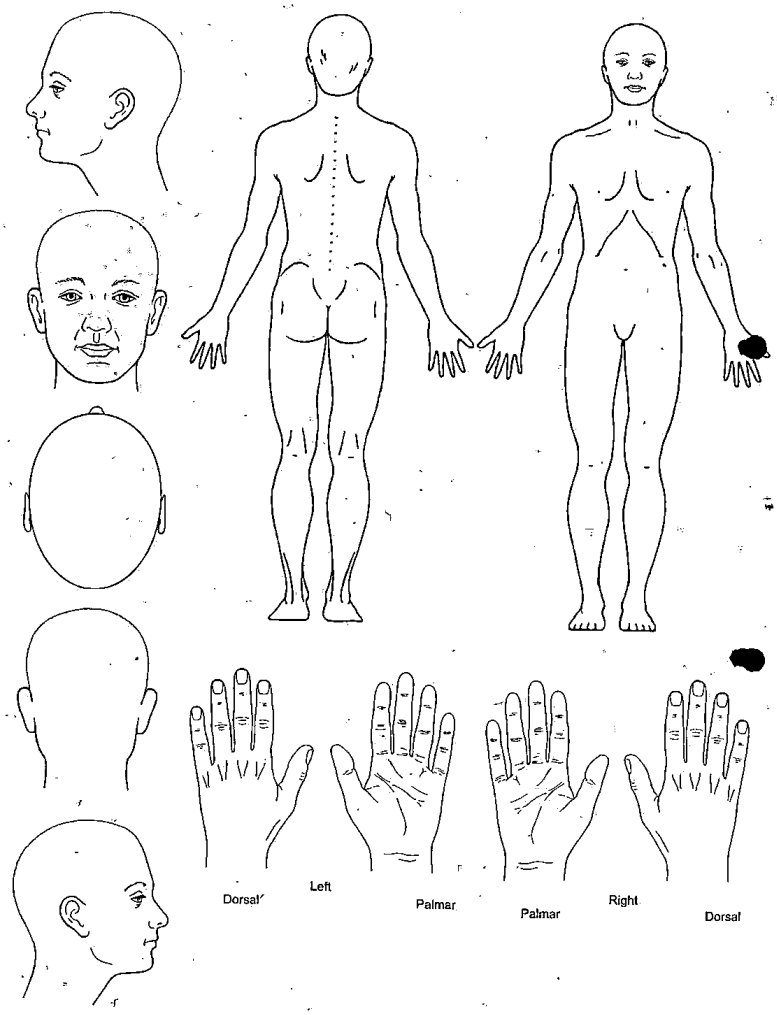
BLOOD GLUCOSE	Time
BM STIX	BM
PEAK FLOW	Time
	PF
VISUAL ACUITY	R. eye aided/unaided
	L. eye aided/unaided
	pH L. eye R. eye

Signed: _____

URINALYSIS

Urobilinogen µmol/L	Normal 3	16	33	66	131		
Protein g/mL	Neg	Trace	0.30 +	1 ++	3 +++	>20 ++++	
pH	5.0	6.0	6.5	7.0	7.5	8.0	8.5
Blood	Neg	Non Haem	Haem Trace	Small +	Mod ++	Large +++	
Specific Gravity	1.000	1.005	1.010	1.015	1.020	1.025	1.030
Ketones mmol/L	Neg	Trace 0.5	Small 1.5	Mod 4	Large 8	Large 16	
Bilirubin	Neg	Small +	Mod ++	Large +++			
Glucose mmol/L	Neg	5.5 Trace	14 +	28 ++	55 +++	111 ++++	
Nitrites	Neg	Positive					
Leucocytes	Neg	Trace	Small +	Mod ++	Large +++		
BHCG	+ ve	- ve					

Please annotate area of: Tenderness / Bruising / Swelling / Abrasions / Lacerations / Incised wo



Signed

CLINICAL NOTES - EMEI CY DEPARTMENT

Consultant _____ Seen by _____

Grade: FY1, FY2, ST1, ST2, ST3, ST4-6, FTSTA, Locum, ENP, Consultant, Other *(Please circle)* At (time) _____

Date	
12/5/19	WR Byrne
	Hx recorded (see admission note)
	Continued diarrhoea, started last Monday
	No offals
	Blood cultures + stool samples sent
	Possible gastroenteritis
	Mrs / Master Lloyd Lister
	To provide information; ? Abdo scan
	IV fluids

CLINICAL NOTES - EMERGENCY DEPARTMENT

Date

CLINICAL NOTES - EMERGENCY DEPARTMENT

Date

CLINICAL NOTES - EMERGENCY DEPARTMENT

Date

UNITARY MEDICAL RECORD

Consultant: _____ Seen By: A. Pringle PHL

Grade: FY1 (FY2) CMT1/2 ST3+ NP Other Time 00.10

Presenting Complaint

Diarrhoea + abdo pain.

History Presenting Complaint

59 o7.

7/7 Hx of ↑↑↑ freq stool. 10/day (normally 4/day IBS)

2/7 Vomiting ++, Abdo pain - lower abdo, constant, cramps, Diarrhoea becoming increasingly frequent, last night. countless, loose stools, watery. Streak of blood x 1 (fresh) More severe abdo pain. ↓ PO intake, lethargic ++. Feverish, Denies many symptoms (cough/spt.

Hx of diverticulitis + IBS.

Past Medical History

Asthma	GORD
IBS	HT
Appendicitis	IHD / Angina
Back Pain	cholecystectomy
↑cholesterol	
Depression	

Social History

- Home circumstances — lives alone, (I) ADLs
- Exercise tolerance
- Driving
- Smoking history — nil
- Alcohol History — nil
- Activites of Daily Living

Systemic Enquiry:

- CVS
- Resp
- GI
- Neuro
- GUS
- Other

MEDICINES RECONCILIATION

PATIENT LABEL

Source of Medical History (2 Sources)

- Patient ☐
- Relative/Carer ☐
- GP Phone call ☐
- ECS ☑
- Patient own Drugs ☐
- Com. Pharmacist ☑
- GP Letter/Summary ☐
- Repeat Script ☐

Other (please specify) .....

Admission Medicines			Plan for Medicines (Dr Complete)				Comments
Name	Dose	Freq.	Continue	Amend	Withold	Stop	Reason for Alteration
✓ BUPRENORPHINE	2mg/hr	weekly					Man change
✓ TRAMADOL	50mg	PRN	100mg BDS rep in box				
✓ AMITRIPTYLINE	75mg	OD night					
✓ Methocarbamol	1500mg	QID					
✓ OMEPERAZOLE	40mg	OD mane					
✓ PREGABALIN	300mg	BD. (✓--✓)					
✓ QUININE SULPHATE	300mg	OD night					
✓ SIMVASTATIN	40mg	OD night					
✓ HYOSCINE BUSCOPAN	10mg	TID	(✓--✓)				HYOSINE BUTYLBROMIDE
✓ ATENOLOL	25mg	OD mane					
CAPSAICIN CREAM 0.025%	1 app	TID.					
SALBUTAMOL	2 puffs	PRN					
PEPTAC	10ml	TID					
✓ SERTRALINE	50mg	OD mane					not in box
LOPERAMIDE		PRN					
Acute &							
TEMAZEPAM	10mg	nocte PRN					
Medication confirmed	by BENEFIELD	Pharmacist	13.5.14				

Allergies	List any over the counter alternative medicines
None known ☑	
	Do medicines need further clarification Yes ☐ No ☐
	Plan initiated by:
List collected by: Date:	Designation: Date:
Compliance aid: Yes ☑ No ☐	Community pharmacist: Phone:
THEY deliver - delivered a box	WILLIS PHARMACY 959 2551

13.5.14

NHS GG&C Adult ...sk Assessment for Venous Thromboembolism (VTE)

[excluding orthopaedics, obstetrics and gynaecology & ENT who have specialty-specific policies]

- Risk Assessment must be completed for all patients within 24 hours of admission to hospital
- Patients must be reassessed every 48-72 hours or sooner if condition changes
- Reassessment must be documented in Kardex
- Please complete risk assessment and then sign and date Risk Assessment Result box at bottom of page.

Pt Addressograph

Surgical patients start here

Non-operative [mainly medical] patients start here

Is the patient bed-bound or expected to have reduced mobility relative to normal state for ≥ 2 days?

Yes ☐ No ☐

Does the patient have any risk factors for thrombosis? (tick √ all that apply)

Age >60	☐	Use of oestrogen-containing contraceptive therapy	☐
Active cancer or cancer treatment	☐	Use of hormone replacement therapy	☐
Dehydration	☐	Pregnancy or < 6 weeks post partum [seek specialist advice]	☐
Known thrombophilias	☐	Critical care admission eg HDU/ITU	☐
Obesity (BMI>30)	☐	Total anaesthetic + surgical time >90 minutes	☐
Current significant medical condition e.g. Serious infection, Heart failure, Respiratory disease or inflammatory disease	☐	Surgery involving pelvis or lower limb with a total anaesthetic + surgical time >60 minutes	☐
Personal history or first degree relative with a history of VTE	☐	Acute surgical admission with inflammatory or intra-abdominal condition	☐
Varicose veins with phlebitis	☐	Hip fracture	☐

- No thromboprophylaxis required.
- Continue to reassess every 48-72 hours or sooner if condition changes.
- Document all reassessments in drug kardex.
- Risk assessment now complete
- Complete Risk Assessment Result Box

Yes, 1 or more risk factors identified ☐

No risk factors identified ☐

Does the patient have any contraindications to pharmacological prophylaxis? (tick √ all that apply)

Active bleeding	☐	Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrands)	☐
Acquired bleeding disorders (e.g. acute liver failure)	☐	Neurosurgery, spinal or posterior eye surgery	☐
Concurrent use of anticoagulants (such as warfarin with INR>2)	☐	Lumbar puncture, epidural/spinal anaesthesia expected within the next 12 hours	☐
Acute stroke	☐	Other procedure with high bleeding risk – discuss with senior if unsure	☐
Uncontrolled hypertension (230/120 mmHg or higher)	☐	Lumbar puncture, epidural/spinal analgesia within the previous 4 hours	☐
Thrombocytopenia (<75 x 10⁹/l)	☐	Thyroid surgery	☐

- Discuss with senior clinical staff before prescribing pharmacological prophylaxis
- Consider mechanical prophylaxis e.g. AES unless contra-indicated.
- Reassess patient every 48-72 hours or sooner if condition changes

No contraindications to pharmacological prophylaxis identified ☐

Contraindications to pharmacological prophylaxis identified ☐

Surgical patients – Enoxaparin 40mg + AES ☐*
*prior to application of AES, please check contraindications to AES

Medical patients – Enoxaparin 40mg ☐
Prescribe Enoxaparin at 6pm
[on day of surgery, at the later of either 4h post-op or 6pm]
Reduce Enoxaparin to 20mg if <50Kg or eGFR <30ml/minute/1.73m² ☐
Discontinue at discharge or when returned to pre-morbid mobility

Contraindications to anti-embolism stockings (AES) Y ☐ N ☐

Peripheral neuropathy	☐
Peripheral vascular disease	☐
Cellulitis or Gross oedema	☐
Leg deformity or Fragile skin	☐
Leg / foot ulcers	☐
Allergy	☐
Unusual leg size/shape	☐

Risk assessment result – please tick √ all that apply

VTE risk factors: YES ☑ NO ☐ Contraindications to pharmacological prophylaxis: YES ☐ NO ☑ Prescribed: LMWH ☐ AES ☐ NONE ☐

Patient informed of VTE risks and benefits of thromboprophylaxis YES ☐ NO ☐ N/A ☐ Information leaflet provided YES ☐ NO ☐

Print Assessor's Name: _____ Signature: _____ Date: _____

EXAMINATION

Vital Signs: HR 110 BP 131/75 RR 18 T 34.8 O2 sats 99% FIO2 A

MEWS:

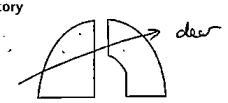
AMT: Age What year Date of birth Location AMT 4/4

General Appearance: Jaundice, anaemia, cyanosis, clubbing, oedema, Lymphadenopathy
Appears

Cardiovascular:

HS 1+11+0
nil

Respiratory



Abdominal

BS ✓
lower abdo - RLIF pain
voluntary guarding
+ percussion tender
soft

Neurological

Grossly intact

PR

Other (if appropriate): e.g. musculoskeletal, skin

INVESTIGATIONS

ECG Sinus tachy

CXR awaited

Other

ABG

Time					
FIO2	venous				
H+	42.1				
PO2					
PCO2					
HCO3					
BE					
LAC	1.5				

DIFFERENTIAL DIAGNOSIS

① likely gastroenteritis
but hx of diverticulitis

APPROPRIATE PROTOCOLS AND/OR CLINICAL SCORES (E.G. GRACE / MOD GENEVA)

SEPSIS 6 Time and date of NEWS >4 11/5/14 22:00
Early Treatment of Sepsis Saves Lives

Aim to complete Sepsis 6 Care Bundle within 1 hour in patients identified with NEWS > 4 and SEPSIS (suspected infection + 2 or more SIRS criteria)

SIRS Criteria: Tick all that apply

- Respiratory Rate > 20 ☐
- WCC < 4 or > 12 ☐
- Heart Rate > 90 bpm ☑
- Temperature <36 or >38°C ☑

If 2 or more SIRS criteria → ☑
Is there infection present? Yes ☑ No (stop here) ☐
Is there a decision not to escalate care? Yes ☐ No (stop here) ☐

Sepsis 6 Care Bundle (complete in 1 hour) — Time initiated

1. Oxygen titrated to achieve saturation 94-98% N/A
   If patient is known CO_2 retainer aim for 88-92%
2. IV Fluids, ≥ 500mls in first hour then reassess ✓ 22:00
3. Blood cultures prior to antibiotics 23:
4. Intravenous antibiotic as per local guideline
5. Measure serum lactate with Full Blood Count ✓
6. Measure urine output & consider catheter ✓

If features of Severe Sepsis or Septic Shock– arrange urgent Senior review.

MANAGEMENT AND FURTHER INVESTIGATIONS

P IV fluids Add on dose ☐
Stool culture ☑ BC ☑
Stool chart.
Analgesia / antiemetics
Sx RV in light of hx diverticulitis ☑ → referred - many thanks
CXR ☐ Chase bloods ☐
Single room please.

SENIOR REVIEW / CONTINUATION

CTZ Heidi

7/7 Hx lower spasmodic abdominal pain. Unable to tolerate despite buscopan & analgesia ++.
Diarrhoea +++
Decreased oral intake
weight loss (Gone over last 6 months

PMHx Diverticulitis – colonoscopy >3 yrs ago
IBS
Chronic back pain

O/E Obs improved T 35·7 HR 90 BP 110/71 SpO2 98% RA 13/05

RIF & LIF tenderness
Peritonism
BS +++

Date/ time									
Na				HB			Paracetamol		
K				MCV			Salicylate		
Cl				WCC					
Ur				Neut					
Cr				Plts					
Gluc									
Ca									
Mg				INR					
Bil				APTT					
Ast				PT					
Alt									
GGT									
ALP				TROP					
Alb				D-Dimers					
CRP				Amylase					

CONSULTANT REVIEW

U+E, LFT CRP (N)
PR Avoid
Stool + blood sent

mgt Likely gastroenteritis
? diverticulitis

P/ Admit
Fluids
No change to usual analgesia
Buscopan + 20mg BD
Not for Abx unless sepsis, ↑TRIPLE risk

Heidi CTZ

WR 87yrs
- feels safe at home
- had diarrhoea through the night
- gets dizziness after eating
Advised sips and less fatty than yesterday

(P) CT Abdo pelvis ? diverticulitis ? other cause

SHO GGH

Destination/ Speciality

EDD

Name: Sign: Date: Time:

CONTINUATION

1354 PHARMACIST
In addition to medication already prescribed, patient also usually on TRAMADOL 100mg OD & OMEPRAZOLE 40mg mane - ? to continue these - if so please prescribe when appropriate.
Thanks
Lindsay Beverly MURPHY # 1166

3/5/14 FUI SHANNON
1400 CT scan →
Diverticular change in sigmoid colon, no adjacent inflammation
Minor thickening of appendix, no adjacent inflammation
No free fluid. No significant lymphadenopathy
FUI

14/5/14 WR MR BYRNE
0830 Diarrhoea continues
No pos cultures
CT – no inflammation
PLAN/ Rigid sigmoidoscopy on ward today
? UC
If above OK → will need colonoscopy.
FUI SHANNON

CONTINUATION

14/5/14 J CONNOLLY
Rigid sigmoidoscopy on ward.
Poorly tolerated
(Mild) Proctitis - couldn't advance more than 10cm as patient unable to tolerate.
Biopsies taken. (x2)
Given stool cultures neg will d/w DB starting Predfoam enemas.
JC.

15/5/14 WR MR BYRNE
0845 Above noted
Biopsy results awaited
P/ Start pentasa.
Hold steroids until biopsy results available.
FUI

15/5/14 FUI SHANNON
1430 Phoned vascular reg Dr Sutherland #5511 for advice re. commencement of mesalazine
Unable to specify LT plan based on limited rigid sig results.
For initial therapy + based on current symptoms recommends both oral and topical
→ Asacol 2.4g daily (divided doses)
→ Asacol foam enema OD at night
→ Flexible sigmoidoscopy +/- colonoscopy.

12

Western Infirmary

CHI: 1908546042

Total Att: **10**

12 Mth Att: **2**

Title: **MRS**

LOGAN **Georgina**

DOB: **19/08/1954** Age: **59y** Sex: **Female**

17 Sollas Place
Glasgow
Lanarkshire
G13 4NA
07774400790

Next of kin: **LOGAN, GEORGE**
Relationship: **Husband**
07774400790

GP: **PJ Weir**
08444 773318

Attendance Date: **23/07/2014** Arrival Time: **18:48**

Registration Time: **18:48** Date of Incident: **23/07/2014**

Major Incident Desc:

Reason for Attendance: **gp ref to surgeons**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **Not Recorded** Pain Score:

Triage Category: **3** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **23/07/2014 19:15** Nurse name: **Nurse Karen Droy1**

Temp	**35.7**	C
HR	**88**	bpm
BP	**118/69**	mmHg
MAP	**85.33**	mmHg
RR	**18**	bpm
SpO2	**97**	%
Oxygen		%

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils-Right		Pupils-Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: **gp ref for surg. recent admission to I10 with diverticulitis- commenced on ascol which helped. 3days ago developed RIF pain relieved by bowel motion. has diarrhoea and nausea vomtiing.**

C. Marcetta FY1

23/07/14
20:30 59 y/o lady admitted via Mr. Byrne's clinic with D+V.

Background
Recent diagnosis (may) of sigmoid diverticulae
Anxiety + panic attacks
L2/3 lumbar micro-discectomy - 2009
Lap chole.

HPC
4 Day history of worsening diarrhoea 9-10 times a day - soft & loose not watery. Mucus, no blood. Associated with cramping lower abdominal pain. No radiation, no localising pain relieved by ~~diarrhoea~~ opening bowels.

24 hour history of vomiting. Is able to keep down solids & liquids but ↓ appetite Vomiting several times a day.

↑ lethargy over past four days and night sweats (related to heat). No fevers

No urinary symptoms.
No fever / viral symptoms.

Recent holiday to Spain (two weeks ago) Felt unwell and had diarrhoea on holiday. No family members unwell. Symptoms worsened by greasy foods.

Allergies - None known

Medication
As per Kardex

Mesalazine recently started.

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPH

Date given	Drug (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given by

PARENTERAL FLUID PRESCRIPTION SHEET

Date	FLUID	Volume	Time to run	Rate mls/hr	ADDED DRUGS	Quantity	Doctors Signature	Added by	Start time 24hr Clock	Put up by	Checked by	Serial/ Batch no

N.B. IF USING A SYRINGE DRIVER/INFUSION PUMP PLEASE USE THE "PRESRIPTION AND ADMINISTRATION SHEET FOR MEDICINES GIVEN BY SYRINGE DRIVER/INFUSION PUMP"

REFUSAL TO REMAIN UNDER HOSPITAL CARE

I wish to take my discharge. I appreciate that this is against the advice and wishes of the Consultant or his or her deputy looking after me. I acknowledge that I have been informed of the risks of doing so and I accept full responsibility for my actions and any consequences arising from them.

Name *(print)* _____ Signature _____

I confirm that I have explained to the patient the risks that might arise out of his / her decision to take his / her own discharge.

Date _____ Signature _____
(Medical Practitioner)

DISCHARGE DETAILS (NURSING)

Treatment _____

Signed *(Please put initials in box)*

Crutches ☐ Return appointment ☐ Advice Card ☐ Medication ☐

Escort to ward ☐ Relatives informed ☐ IRIS ☐ Transport ☐ Time booked _____

Discharged with _____ Admitted / transfered to _____

Time discharged _____ Signed _____

IS 232646

Patient's name _____ th _____

NURSING DOCUMENTATION - ACCIDENT & EMERGENCY

Date _____ Time _____ Triage Nurse _____

Triage category 1 2 3 4 5

Relatives present: Relatives informed:

INITIAL VITAL SIGNS

at:(Time) _____
HR: _____
BP: _____
RR: _____
SaO_2: _____
Temp: _____
G.C.S: _____

Signed _____

INITIAL MANAGEMENT

Nurse _____

Oxygen started _____ %: Signed _____ ECG: Signed _____

Signed _____

Other _____

Treatment _____

NEUROLOGICAL OBSERVATIONS

RISK OF WOUND DISHISCENCE

TIME hrs

EYES OPEN: spontaneously 4; to speech 3; to pain 2; none 1 — eye closed by swelling =C

BEST VERBAL RESPONSE: orientated 5; confused 4; inappropriate words 3; incomprehensible sounds 2; none 1 — Endotracheal tube or Tracheostomy = E; Dysphasia=D

BEST MOTOR RESPONSE: obey commands 6; localises pain 5; normal flexion to pain 4; abnormal flexion to pain 3; extention to pain 2; none 1 — Record the best arm response; Paralysed =P

COMA SCORE 15

PUPILS: RIGHT size (mm) Reaction; LEFT size (mm) Reaction — += Reacts; -=No Reaction; C= Eye closed; SL= sluggish pupil

LIMB MOVEMENT

ARMS: Normal power; Mild weakness; Severe weakness; Extention; No response

LEGS: Normal power; Mild weakness; Severe weakness; Extention; No response

Record right (R) and left (L) seperatly if there is a difference between the two sides; Fractured limb = #

PUPIL SCALE (mm): 1 2 3 4 5 6 7

BLOOD PRESSURE mm Hg: 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90

PULSE RATE: 80 70 60 50 40 30

37 Temp C°: 40 39 38 36 35 34 33 32 31 30

RESPIRATORY RATE

SaO_2

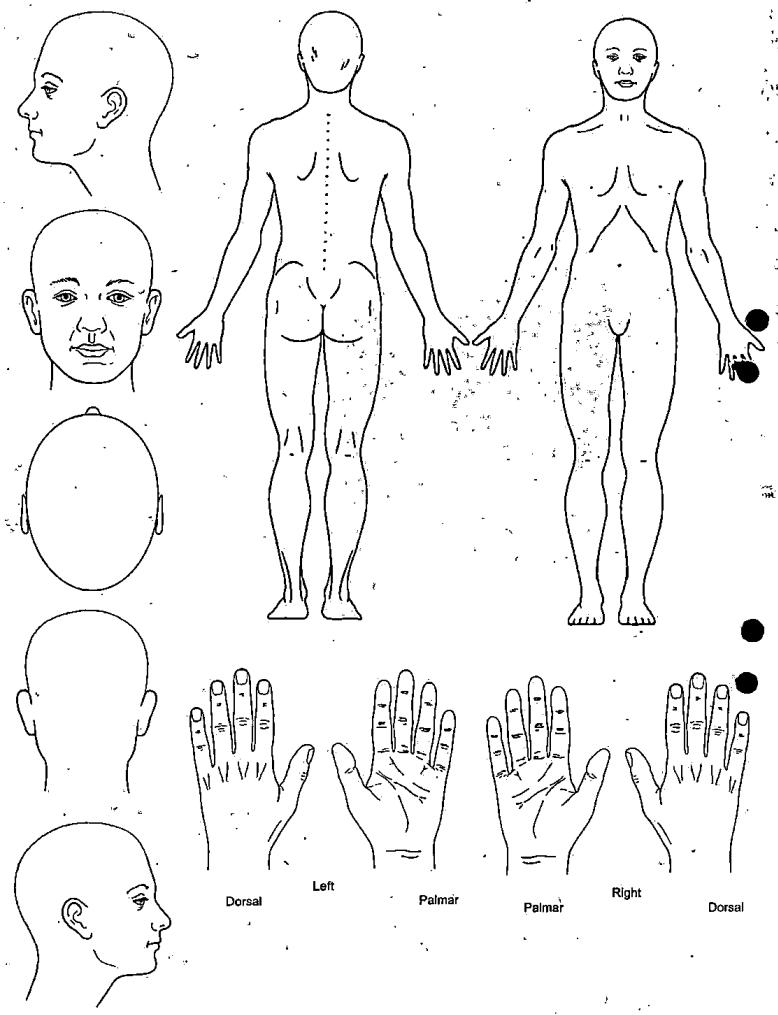
BLOOD GLUCOSE	Time
BM STIX	BM
PEAK FLOW	Time
	PF
VISUAL ACUITY	R. eye aided/unaided
	L. eye aided/unaided
	pH L. eye R. eye

Signed: _____

URINALYSIS

Urobilinogen µmol/L	Normal 3	16	33	66	131		
Protein gm/L	Neg	Trace	0.30 +	1 ++	3 +++	>20 ++++	
pH	5.0	6.0	6.5	7.0	7.5	8.0	8.5
Blood	Neg	Non Haem	Haem Trace	Small +	Mod ++	Large +++	
Specific Gravity	1.000	1.005	1.010	1.015	1.020	1.025	1.030
Ketones mmol/L	Neg	Trace 0.5	Small 1.5	Mod 4	Large 8	Large 16	
Bilirubin	Neg	Small +	Mod ++	Large +++			
Glucose mmol/L	Neg	5.5 Trace	14 +	28 ++	55 +++	111 ++++	
Nitrites	Neg	Positive					
Leucocytes	Neg	Trace	Small +	Mod ++	Large +++		
BHCG	+ ve	- ve					

Please annotate area of: Tenderness / Bruising / Swelling / Abrasions / Lacerations / Incised wou



CLINICAL NOTES - EMERG DEPARTMENT

Consultant Mr. Rogers Seen by C. Marlotte

Grade: FY1, FY2, ST1, ST2, ST3, ST4-6, FTSTA, Locum, ENP, Consultant, Other *(Please circle)* At (time) 20:30

Date

23/07/14

Systemic
Nil to note

Social
Lives with husband. Non-smoker. Non-drinker.
Social issues / stressors recently. Struggling to cope.

Recent Investigations -

Colonoscopy July - Diverticulosis + colonic polyp
Colonic biopsy - Acute inflammatory process - non-diagnostic
CT AP May - Bilat PUJ obstruction
Appendicolith.
Diverticular change in sigmoid colon
Post cholecystectomy

O/E Patient looks well
HR 88 Temp 35.7 BP 118/69
RR 18 Sp O2 97%.

SNT
Bowel sounds
No ascites.
No organomegaly.

NB In clinic RIF tender + guarding.

Impression
Non-infective diarrhoea secondary to diverticular disease.

IV fluids.
Stool culture.
Bloods - TTG + TFT.
Kardex.

Urinalysis
Leucocytes +++
no nitrates
no blood

FY1

CLINICAL NOTES - EMERGENCY DEPARTMENT

Date

24/7/14 · M · DUNWOODIE · CPST ·
General Surgery ·
0300 · Cons: Mr Rogers ·

59 yo D+V ·

Admitted from Mr Byrne's clinic ·

Background; Anxiety / Depression ·
Asthma ·
Cholecystectomy
Diverticulosis - colonoscopy July '14 ·
? Distal Proctitis - rigid sig May '14 ·
- biopsy non-diagnostic ·

3/7 hx of ↑ stool frequency · BO 6-7x / day ·
Chronic loose stools · Assoc cramping abdo pain ·
1x fresh blood PR 1x mucus PR ·
Assoc vomiting for 24hs - multiple episodes ·
Nil urinary ·
Seen in ADC today → ref MAU ·

GE · new · Undistressed · Dry ·

HR 60 BP 80/49 Temp 35.9 · ↘ Hypovolaemia 2° D+V

Well perfused ·
HR reg · HS 1+11 - 0
Abdo ^ Soft ·
1 x 1 Mild suprapubic tenderness ·
BS (+)

Bldss: WCC 8.4 CRP 2 Hb 126 ·
Urea 9.9 Creat 73

Urinalysis → leucocytes +++, nil else ·

IMP - ? 2° Diverticulitis ? gastroenteritis ·

Plan - Stool culture · · W/H Abx ·

CLINICAL NOTES - EMERGENCY DEPARTMENT

Date

MR Campbell
Feeling tired
29/7/14 Vomited
0800 Nausea, no vomit.
Obs ok, BP low side, Abdo soft

Plan rpt bloods
Continue IV F
Stool sample

Clerked
FVI

25/7/14 MR Campbell
0800 Well O/N E+D OR.
BM Constipated
Bloods - ↓ WCC, CRP (✓)
O/E Abdo soft
Up + about
E+D
Lactulose PRN
(H) later
Stop pred foams, stop PMARDs - steroids reduced.
Mr Byrne clinic 6wks
Note 10/12 - (✓) colonoscopy - no colitis

Clerked
FVI.

26/8/14 · MR Byrne
1830
Still no BO
(✓) AR → enema if loaded

CLINICAL NOTES - EMERGENCY DEPARTMENT

Date

26/7/14 16:15 FY1 Kohli-Lynch

PR performed:
- patient declined chaperone
- ? extent haemorrhoids / other lesions
- ? mass
- hard stool in rectum
- ? blood

- Rx For phosphate enemas

27/7/14 11:30 WR Quinn

Bowels opened yesterday.
Abdo soft ND ? tenderness.

(P) Neuro exam
Check electrolytes
(Note colonoscopy duly Rx
- Prednisolone)

28/7/14 13:05 FY1 Kohli-Lynch

Neuro exam performed:

Cranial nerves intact.

	RUL	RLL	LUL	LLL
Power	5/5	5/5	5/5	5/5
Tone	(N)	(N)	(N)	(N)
Reflexes	↔	↔	↔	↔

Bilateral downgoing plantar reflex.

Sensation (N) (N) (N) (N)

UNITARY MEDICAL RECORD

Consultant: _____ Seen By: _____

Grade: FY1 FY2 CMT1/2 ST3+ NP Other Time _____

Presenting Complaint

History Presenting Complaint

100 Vision / Speech / Hearing / Gait (N)
No uncoordination ?

Note No jerking of any limbs seen on observation.

Imp No neuro abnormality

(P) Check bloods tomorrow

Rou- way FY1

Past Medical History

28/7/14 AR completed

well, ongoing constipation
Laxative (P) ? (P) Lobe

Social History

- Home circumstances
- Exercise tolerance
- Driving
- Smoking history
- Alcohol History
- Activites of Daily Living

Systemic Enquiry:

- CVS
- Resp
- GI
- Neuro
- GUS
- Other

MEDICINES RECONCILIATION

PATIENT LABEL

Source of Medical History (2 Sources)

Patient ☐ Relative/Carer ☐
GP Phone call ☐ ECS ☐
Patient own Drugs ☐ Com. Pharmacist ☐
GP Letter/Summary ☐ Repeat Script ☐

Other (please specify) .....

Admission Medicines			Plan for Medicines (Dr Complete)				Comments
Name	Dose	Freq	Continue	Amend	Withhold	Stop	Reason for Alteration

Allergies	List any over the counter alternative medicines
None known ☐	
	Do medicines need further clarification Yes ☐ No ☐
	Plan initiated by:
List collected by: Date:	Designation: Date:
Compliance aid: Yes ☐ No ☐	Community pharmacist: Phone:

NHS GG&C Adult Risk Assessment for Venous Thromboembolism (VTE)

[excluding orthopaedics, obstetrics and gynaecology & ENT who have specialty-specific policies]

- **Risk Assessment must be completed for all patients within 24 hours of admission to hospital**
- **Patients must be reassessed every 48-72 hours or sooner if condition changes**
- **Reassessment must be documented in Kardex**
- **Please complete risk assessment and then sign and date Risk Assessment Result box at bottom of page.**

Pt Addressograph

Surgical patients start here

Non-operative [mainly medical] patients start here

Is the patient bed-bound or expected to have reduced mobility relative to normal state for ≥ 2 days?

Yes ☐ No ☐

Does the patient have any risk factors for thrombosis? (tick √ all that apply)

Age >60	☐	Use of oestrogen-containing contraceptive therapy	☐
Active cancer or cancer treatment	☐	Use of hormone replacement therapy	☐
Dehydration	☐	Pregnancy or < 6 weeks post partum [seek specialist advice]	☐
Known thrombophilias	☐	Critical care admission eg HDU/ITU	☐
Obesity (BMI>30)	☐	Total anaesthetic + surgical time >90 minutes	☐
Current significant medical condition e.g. Serious infection, Heart failure, Respiratory disease or inflammatory disease	☐	Surgery involving pelvis or lower limb with a total anaesthetic + surgical time >60 minutes	☐
Personal history or first degree relative with a history of VTE	☐	Acute surgical admission with inflammatory or intra-abdominal condition	☐
Varicose veins with phlebitis	☐	Hip fracture	☐

- No thromboprophylaxis required.
- Continue to reassess every 48-72 hours or sooner if condition changes.
- Document all reassessments in drug kardex.
- **Risk assessment now complete**
- **Complete Risk Assessment Result Box**

Yes, 1 or more risk factors identified ☐ **No risk factors identified ☐**

Does the patient have any contraindications to pharmacological prophylaxis? (tick √ all that apply)

Active bleeding	☐	Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrands)	☐
Acquired bleeding disorders (e.g. acute liver failure)	☐	Neurosurgery, spinal or posterior eye surgery	☐
Concurrent use of anticoagulants (such as warfarin with INR>2)	☐	Lumbar puncture, epidural/spinal anaesthesia expected within the next 12 hours	☐
Acute stroke	☐	Other procedure with high bleeding risk – discuss with senior if unsure	☐
Uncontrolled hypertension (230/120 mmHg or higher)	☐	Lumbar puncture, epidural/spinal analgesia within the previous 4 hours	☐
Thrombocytopenia (<75 x 10⁹/l)	☐	Thyroid surgery	☐

- **Discuss with senior clinical staff before prescribing pharmacological prophylaxis**
- Consider mechanical prophylaxis e.g. AES unless contra-indicated.
- Reassess patient every 48-72 hours or sooner if condition changes

No contraindications to pharmacological prophylaxis identified ☐ **Contraindications to pharmacological prophylaxis identified ☐**

Surgical patients – Enoxaparin 40mg + AES ☐*
*prior to application of AES, please check contraindications to AES
Medical patients – Enoxaparin 40mg ☐
Prescribe Enoxaparin at 6pm
[on day of surgery, at the later of either 4h post-op or 6pm]
Reduce Enoxaparin to 20mg if <50Kg or eGFR <30ml/minute/1.73m² ☐
Discontinue at discharge or when returned to pre-morbid mobility

Contraindications to anti-embolism stockings (AES) Y ☐ N ☐

Peripheral neuropathy	☐
Peripheral vascular disease	☐
Cellulitis or Gross oedema	☐
Leg deformity or Fragile skin	☐
Leg / foot ulcers	☐
Allergy	☐
Unusual leg size/shape	☐

Risk assessment result – please tick √ all that apply

VTE risk factors: YES ☐ NO ☐ Contraindications to pharmacological prophylaxis: YES ☐ NO ☐ Prescribed: LMWH ☐ AES ☐ NONE ☐
Patient informed of VTE risks and benefits of thromboprophylaxis YES ☐ NO ☐ N/A ☐ Information leaflet provided YES ☐ NO ☐
Print Assessor's Name: _____ Signature: _____ Date: _____

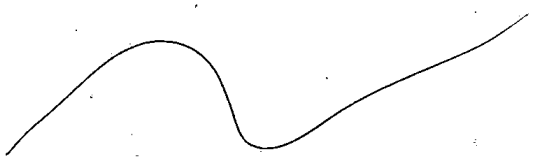
SENIOR REVIEW / CONTINUATION

29/4/14. NB - AMAN / STACCATO.

- Hx revisited. ?New Neuro symptoms.
- Co-ordination (N), but struggled more on (L) hand.
- No change in electrolytes.

(P) Ow Medical Team.

K - Seen



Date/ time									
Na				HB			Paracetamol		
K				MCV			Salicylate		
Cl				WCC					
Ur				Neut					
Cr				Plts					
Gluc									
Ca									
Mg				INR					
Bil				APTT					
Ast				PT					
Alt									
GGT									
ALP				TROP					
Alb				D-Dimers					
CRP				Amylase					

CONSULTANT REVIEW

29/4/14 FY2 - Medicine

- 64y old female : - Anxiety + panic attacks
  - Lap chole
  - Sigmoid diverticulitis
- ATSP regarding ↓ co-ordination in (L) hand + ↓ balance
- Very little Hx from pt + odd affect
- Status fairly light-headed (for day)

O/E

- BP = <100 systolic (for day)

	NAD	RUL	LUL	RLL	LLL
Tone	(N)				
Power	5/5				
Rhythm	(N)				
Co-ord	(N)				
Sensation	(N)				

CN's II-XII intact

Cerebellar signs: Dysdiadochokinesia X
Ataxia X
↳ Wash Hiding, but not ataxic
Nystagmus X
Intention tremor → Fluctuant
Slurred speech X
Hyperreflexia X

Destination/ Speciality

EDD

Name: Sign: Date: Time:

Imp peripheral light-headedness <91

CONTINUATION

30/7/14. Ward Consult

c/o

- New (R) sided weakness.
- o Normal power.
- Obs (N) —> No sig deterioration typing/bleeding gp.

(P) Neuro Exam + D/W Medics.

30/7/14. F41 - Gandhi.

- D/W Medics.
- (P) For CT head, Likely will be normal.

MiSys

MRN	null	Gender	Female
Name	LOGAN, GEORGINA	Date Of Birth	19-Aug-1954
Encounter Number			

COPY ONLY DO NOT FILE

SOPRANO

CT Head

Time Collected	30-Jul-2014 13:34	Time Received	30-Jul-2014 14:52
Time Reported	30-Jul-2014 14:50	Order Number	G516H29320392
Status	Final		

Results

CT Head Final

Georgina Logan

Clinical History :

59 years lady. Admitted under the surgeons with abdo pain related to diverticulitis. New onset ataxia, confusion and right arm weakness. ?Ischaemia

There is patchy white matter hypoattenuation consistent with small vessel ischaemic disease. No acute intracranial abnormality - specifically no haemorrhage, hydrocephalus or infarct. Skull vault, orbits and sinuses are within normal limits.

Reported by: Dr Oliver Cram
Verified by: Dr Oliver Cram

Prepared for Kevin Garrity (Kevin Garrity) on 30 July 2014 15:20:17

1908546042
LOGAN
Georgina F
17 Sollas Place 19/08/1954
Glasgow, Lanarkshire
G13 4NA

MR BYRNE
Clinic

Seen in clinic - D+V. D 9x/dy
V & N.
PR bleeding
c/o Abdo pn.

o/e looks miserable
abdo - RIF tender mild guarding
no rebound

Prev rigid sig - practically
CT - diverticular
colonoscopy - polyp not etc

P/ Admit on IVF copy
Bds nc TTG + TFT
Fluids

Ken

MISys

MRN	null	Gender	Female
Name	LOGAN, GEORGINA	Date Of Birth	19-Aug-1954
Encounter Number			

COPY ONLY DO NOT FILE

SOPRANO

CT Head

Time Collected	30-Jul-2014 13:34	Time Received	30-Jul-2014 14:52
Time Reported	30-Jul-2014 14:50	Order Number	G516H29320362
Status	Final		

Results
CT Head — Final

Georgina Logan
Clinical History :

59 years lady. Admitted under the surgeons with abdo pain related to diverticulitis. New onset ataxia, confusion and right arm weakness. ?Ischaemia

There is patchy white matter hypoattenuation consistent with small vessel ischaemic disease. No acute intracranial abnormality - specifically no haemorrhage, hydrocephalus or infarct. Skull vault, orbits and sinuses are within normal limits.

Reported by: Dr Oliver Cram
Verified by: Dr Oliver Cram

Prepared for Campbell MacLeod (Campbell MacLeod) on 30 July 2014 15:26:20

Western Infirmary **Not to be filed until discharge.**

Name Georgina Logan **CHI Number**

	Date:	23/7	24/7	25/7	27/7	28/7	28/7	29/7
	Time of result							
	WCC 4.0 - 11.0	5·4	5·9	6·2	6·1		5·0	4·3
	Hb M 13-18 / F 11.5-16.5	126	109	117	132		130	124
	MCV 80.0-100.0	90·8		94.3	93.8		91·7	91.0
	Plat 150-400	261	215	232	257		246	249
	Prothrombin Time 9-12							
	APTT 27-38							
	INR							
	Thrombin Clotting T 11-15							
	PT Ratio							
	Na+ 135-145	138	140	140	141	140	138	140
	K+ 3.5-5.0	Haem	4	4.2	4.3	3·5	4·0	4.1
	Cl 98-108	108	109	103	103	105	100	104
	Urea 2.5-7.5	9·9	6·5	5·3	5·6	7·5	7·0	8·8
	Creat 57-113	73	69	82	90	96	97	100
	eGFR <60	>60	>60	>60	56	50	51	49
	Bilirubin 3-22	5	7	5	7	14	6	6
	ALT <40	16	13	15	15	45	18	19
	AST < 50	Haem	16	15	18	47	17	19
	Alk. Phos 40-150	58	47	54	65	276	60	56
	Albumin 32-45	36	30	31	35	18	32	32
	GGT <55							
	Protein 60-80							
	Globulin 22-23							
	Ca 2.1-2.6							
	Adj Ca 2.1-2.6	2·3						
	PO4 0.7-1.4							
	Magnesium 0.7-1.0	Haem	0·87					
	Glucose 3.5-5.5							
	Amy <100							
	CRP <10	2	2	2	3		4	6
	FiO2							
	H+ 35-45							
	PO2 12-15							
	PCO2 4.4-5.6							
	HCO3 20-28							
	BE							
	Lactate 0.6-2.2							
	others:							

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - NURSING

Greenan Logan
190854 6042

Date & Time		Signature, Print Name & Designation
16/5/14	WR OSB	
	Can we catheter Path re Biopsies send	
	ask to assess	
	Will need full colonoscopy at appropriate	
	clinically unwell pt - Drain settled	
	-(H) tomorrow	
17/5/14	FARFAN F2 WR	
	Obs stable	
	Patient not at bedside on arrival	
	If no clinical change then for	
	(H) as per WIC team plan	
	If concerns please notify	FARFAN F2

193443

Call No: 4082906	**CHI:** 1908546042	**Date:** 11-05-2014	**NHS 24 No:** 14561077
Patients Name: Georgina Logan	**D.O.B.** 19/08/1954 **Age:** 59 years		**Callers Name:** **Relationship:**

Address Today: 17 Sollas Place
Knightswood
Glasgow
Post Code: G13 4NA

Phone Number: 07774 400790

Home Address if different: 17 Sollas Place
Knightswood
Glasgow
Post Code: G13 4NA

Call Type: Transport to PCEC within 4 Hrs

Priority: Pr 4 Within 4 hrs

Name of GP: Weir,Phillip(025)

Surgery: 025 Victoria Park Medical Practice /Dumbarton Road
Practice Number:

Time Call Received at NHS 24: 11/05/2014 18:14:28

Time Details Received at GEMS: 11/05/2014 18:34:40

Time Patient Arrived: 11/05/2014 19:34:14

Sl I Dial: CONTACT DETAILS
)
(). FAX()
(). SPEED DIAL(192)
(). MORNING FAX(0141 959 8463)
(). PRACTICE(0844 4773318)

Consultation Start time:
Consultation End time:

Dispatched To: Drumchapel

Clinical Information

Examination Results:

EVERYTHING PATIENT EATS IS GOING STRAIGHT THROUGH, SOMETIMES NOT MAKING IT TO THE TOILET. PATIENT HAS IBS AND DIVERTICULITIS. ((Non-Clinical User) (Edinburgh))

Clinical summary created by: (Nurse Advisor) (Glasgow) [11/05/2014 18:34:44]
DIARRHOEA , ABDOMINAL PAIN FOR 6 DAYS AND SEVERE PERSISTENT DIARRHOEA , PAST 24 HOURS BLACK IN COLOUR . LOWER ABDOMINAL PAIN . VOMITED FEW TIMES YESTERDAY . NOW FEELING VERY TIRED . SUFFERS FROM DIVERTICULITIS AND IBS , NO RELEIF WITH PRESCRIBED MEDICATION . DISTRESSED ON PHONE . TO ATTEND PCEC WITHIN 4 HOURS , TRANSPORT REQUIRED

D[illegible]RHOEA & ABDOMINAL PAIN, 7 DAYS, SEE A/V

[illegible]icians Notes

Severe abdominal cramps and diarrhoea for 48 hrs. Known to have diverticulitis and IBS.

Ongoing abdominal pain since last wk, gradually getting worse along with countless loose stools, small blood streak yesterday, vomited x3 yesterday but none today. Unable to keep anything down, comes straight diarrhoea. Sever abdominal cramps, unable to tolerate the pain. Today loose stools every 10-15mins, watery, no blood. Tried Imodium several times but not helping at all.
Lives alone
Past Med: Asthma, IBS, Diverticulitis, ch Back pain, Hypercholesterolaemia, Depression, GERD, HTN, IHD, Back surgery, cholecystectomy
Allergies: NKDA
Meds: simvastatin, tramadol, citalopram, amitriptyline 75mg, Atenolol 25mg, Hyoscine butylbromide, Methocarbamol, pregabalin, quine suflate

T 37.3 P98 BP 112/86.
Appears pale, dehydrated and anxious
Obs stable as noted above, except tachycardic
Abd: soft, no guarding or peritonism, subjectively discomfort lower abdomen, bowel sounds audible.
Chest: clear, no wheeze or crackles.
CVS: heart sounds audible, no murmur

Flare up of IBS & dehydration

Given Buscopan 20mgs/ml lot 227520A exp 6/17 given IM L buttock J Templeton.

Refer to oncall Medial team at Western Infirmary via A&E.

NAME [redacted] PITAL
50551545H F
LOGAN
GEORGINA 19/08/1954 AGE
17 SOLLAS PLACE
PH GLASGOW G13 4NA
SU CHI-1908546042 DEPT
WARD SC.

IN-PAT FORM 3

IN PATIENT
CONTINUATION HISTORY

DATE	
29/11/07	Seen at pre-assessment clinic, for hip Chole under care of W. Molloy. See anaesthetic form over ⇒.
O/E	Comfortable RC. Afebrile.
Resp	Chest clear no added sounds.
	H-K-N
	Thyroid Central.
CVS	HR reg
	H-S ↑↑↑ (Murmur not heard had resolved in childhood)
	JVP ⇒
	Rad pulse present
Abd	Abdo, tender RIF at epigastric region BK not done Bowel sounds present.

epigastric pain
left sternum

Mona Morrison
Clinical Admissions RC
13714

Plan:
Bloods + CTS ✓
Clear
Consent
Explain

00559

HISTORY
(Use other side first)

Date

29/1/07 Patient presented with epigastric + RUQ pain → Back.
Has FFI.
Pain onset usually at night → sometimes helped with Gaviscon.
Has been on PPI
U/S → calculi + tender GB.
No recent obstructive jaundice.
O/E = No jaundice.
Tender epigastrium.
Imp: ? Peptic ulcer
? Biliary Colic
Plan
① Spoken to patient that her symptoms could well be 2° to peptic ulcer disease as well as a degree of biliary colic. Advised to go for OGD (PPI, but patient declined. Patient insisted to go for lap. chole with the full knowledge this may not completely alleviate her symptoms.
② Please check FBC, Clotting, LFT.

(Consent Sgd)

1/2/07 Theatre. E. Leong/R. Molloy.
20
"Laparoscopic Cholecystectomy"
Findings: Inflamed GB.
Procedures: Pneumoperitoneum infraumbilical incision using Hassan's technique
- 1x 10mm + 2x 5mm ports.
- 2 clips to cystic artery + duct. They were divided leaving 2 clips on proximal stump.
- GB dissected off & retrieved via umbilical port

NAME Georgina Logan HOSPITAL No 50551548 AGE

PHYS/ SURG. DEPT WARD

IN-PAT FORM 3

IN PATIENT CONTINUATION HISTORY

DATE	
	using endocatch bag. Closure: Tissue glue + ethilon (3/0) to skin = PDS to umbilical fascia. Post-op: (1) Oral fluid + ~~light~~ light diet later (2) Observe. (Consultant)
31/7/01	(WR) Patient has some pain especially when coughing which has increased risk of Asthma & COPD / Smoking. Chest clear. Obs. Controlled if mobility fine = Home today.

00559

HISTORY

(Use other side first)

Date

NORTH GLASGOW UNIVERSITY HOSPITALS DIVISION

NHS Greater Glasgow

NAME
50551545H
LOGAN F
GEORGINA 19/08/1954
17 Sollas Place
PHYS/ GLASGOW G13 4NA
SURG. CHI-1908546042

OUT PATIENT
HISTORY

DATE

29/2/08 Toilet 6/ day

Loose Bm

Diarrhoea Bloating Pain

Blood occasionally

- Worried Fit

Pr : Haemorrhoid

Refer Surgeon

00597

DATE	HISTORY (Use other side first)
1/4/9	JS MORRISON PNR.

Pcen (cramp) @ night in (R) foot.
Sometimes (L) & (R) arm.

O/E: full complete ch pulses

Not vascular.

Plan: D/C:

JMorrison

NORTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST
ACCIDENT & EMERGENCY DEPT.
WESTERN INFIRMARY
GLASGOW
G11 6NT
Tel: 0141-211-2304/2409
Fax: 0141-339-3046

(4)

CONSULTANTS: Mr W M Tullett
Mr P T Grant
Dr S Perry
NURSE MANAGER: Mr G D Wright

NHS Greater Glasgow

CRN: 50551545H

TREATMENT COPY

PATIENT

Surname	Forename	Age	Date of Birth	Arr Date	Time	AE Number
LOGAN	GEORGINA	51	19/08/54	02/02/06	06:00	004573/06

Address	Sex	Religion	Date of Inc	Time
17 SOLLAS PLACE GLASGOW	Female		02/02/06	

Marital Status	Occupation/School	Type of Inc	Mode of Arrival
		OTHER	WALKING

PC G13 4NA Tel 211 6110

GP

Name: Dr GRIEVE
Address: DRUMCHAPEL HEALTH C
80/90 KINFAUNS DRIV
GLASGOW
G15 7TS
0141 211 6110

Referred by: GP

EXTENSION

Name JOHN LOGAN
Relat. HUSBAND
No. 211 6110
Address: 17 SOLLAS PLACE
GLASGOW
G13 4NA

Complaint:

ROAD TRAFFIC ACCIDENT PLACE

DETAILS

HOME ACCIDENT PROBABLE CAUSE

TO BE COMPLETED BY MEDICAL OFFICER AFTER SEEING PATIENT

Triage Time	Triage Category
21:40	Category 3

Initial Complaint: SURGICAL

Dear Doctor,

The above-named patient attended Accident & Emergency Department today.

Diagnosis: Biliary Colic

X-ray film/ECG shows

Treatment given: admit
analgesia

Drugs _____ days supply of _____ has been given.

Tetanus Prophylaxis has/has not been administered. TT Course _____ TT Booster _____ HATI _____ (Please Tick)

Would you please arrange

DISCHARGE CODES: *Please circle*

1. Admission
2. Discharge
3. Refer to G.P.
4. Transfer to other hospital *(see below)*
5. Died
6. Refer to O.P. Clinic *(see below)*
7. Irregular Discharge
8. D.O.A.

Ward No. *(if admitted)*	Transfer to Hospital	Consultant *(if admitted)*
10W		MALLAT

Follow-up	Not Arranged	Arranged	To be arranged	IRIS

Clinic Referred to	AE	Dressings	Hand	Fracture	Ortho	Medical	Surgical	Skin	ENT	Gyn	OHPAT	Others *(specify)*

Medical Officer's Name *(in BLOCK LETTERS)*: JOHNSTONE

Cons SpR SHO3 (SHO) JHO Clin Assist ENP *(please circle)*

Signature of Medical Officer

NURSING NOTES

TRIAGE DATE: TIME:

CHIEF COMPLAINT: RELEVANT HISTORY: PHYSICAL SIGNS

VITAL SIGNS:

HR:
BP:
RR:
GCS:
TEMP:

TREATMENT AT TRIAGE:

DISPOSITION:

1. RESUSCITATION
2. MEDICAL/SURGICAL
3. TRAUMA:
4. OTHER *(SPECIFY)*

TRIAGE NURSE ..... SIGN

..... PRINT

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYAXIS)

Date given	Drug (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given by
21216	Dihydrocodeine	60mg/50ml	PO TM	12am		

PARENTERAL FLUID PRESCRIPTION SHEET

Date	FLUID	Volume	Time to run	Rate mls/hr	ADDED DRUGS	Quantity	Doctors Signature	Added by	Start time 24hr Clock	Put up by	Checked by	Serial/ Batch no

N.B. IF USING A SYRINGE DRIVER/INFUSION PUMP PLEASE USE THE "PRESRIPTION AND ADMINISTRATION SHEET FOR MEDICINES GIVEN BY SYRINGE DRIVER/INFUSION PUMP"

REFUSAL TO REMAIN UNDER HOSPITAL CARE

I wish to take my discharge. I appreciate that this is against the advice and wishes of the Consultant or his or her deputy looking after me. I acknowledge that I have been informed of the risks of doing so and I accept full responsibility for my actions and any consequences arising from them.

Name *(print)* _____ Signature _____

I confirm that I have explained to the patient the risks that might arise out of his / her decision to take his / her own discharge.

Date _____ Signature _____
(Medical Practitioner)

DISCHARGE DETAILS (NURSING)

Treatment _____

_____ Signed _____

(Please put Initials in box)

Crutches ☐ Return appointment ☐ Advice Card ☐ Medication ☐

Escort to ward ☐ Relatives informed ☐ IRIS ☐ Transport ☐ Time booked ____

Discharged with _____ Admitted / transfered to _____

137

Patient's name [illegible] Age _____ Date of Birth 19·5·54

NURSING DOCUMENTATION - ACCIDENT & EMERGENCY DEPARTMENT

Date 2·7·06 Time 21:50 Triage Nurse DVS PC SOU

1. pancreatitis 2. cholecystitis

Triage category 1 2 (3) 4 5

Relatives present: Relatives informed: N/A

INITIAL VITAL SIGNS

at:(Time) 2200
HR: 72
BP: 119/81
RR: 14
SaO_2: 98%
Temp: 36.1
GCS:

Signed JS

INITIAL MANAGEMENT

Nurse _____

Oxygen started _____ %: Signed _____ ECG: Signed _____

Signed _____

Other _____

Treatment _____

NEUROLOGICAL OBSERVATIONS

RESPONSIVENESS	TIME	hrs	1
	EYES OPEN	spontaneously 4	eye closed by swelling =C
		to speech 3	
		to pain 2	
		none 1	
	BEST VERBAL RESPONSE	orientated 5	Endotracheal tube or Tracheostomy = E Dysphasia=D
		confused 4	
		inappropriate words 3	
		incomprehensible sounds 2	
		none 1	
	BEST MOTOR RESPONSE	obey commands 6	Record the best arm response Paralysed =P
		localises pain 5	
		normal flexion to pain 4	
		abnormal flexion to pain 3	
		extention to pain 2	
		none 1	
	COMA SCORE 15		
PUPILS	RIGHT	size (mm) Reaction	2 + = Reacts - =No Recaction C= Eye closed SL= sluggish pupil
	LEFT	size (mm) Reaction	
LIMB MOVEMENT	ARMS	Normal power	3 Record right (R) and left (L) seperally if there is a difference between the two sides Fractured limb = #
		Mild weakness	
		Severe weakness	
		Extention	
		No response	
	LEGS	Normal power	
		Mild weakness	
		Severe weakness	
		Extention	
		No response	
PUPIL SCALE (mm)	1 2 3 4 5 6 7	BLOOD PRESSURE mm Hg: 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30	4 40 39 38 37 Temp C° 36 35 34 33 32 31 30
		PULSE RATE	
		RESPIRATORY RATE	5

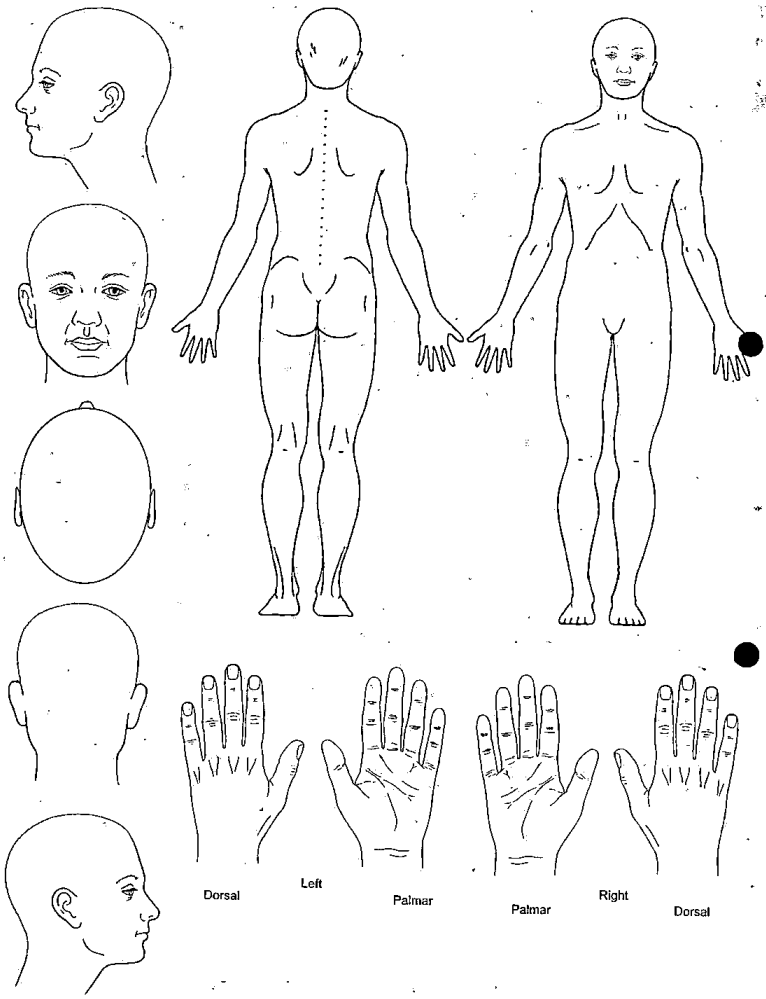
BLOOD GLUCOSE	Time								
BM STIX	BM								
PEAK FLOW	Time								
	PF								
VISUAL ACUITY	R. eye aided/unaided								
	L. eye aided/unaided								
	pH L. eye R. eye								

Signed: _____

URINALYSIS

Urobilinogen µmol/L	Normal 3 16	33	66	131	NAD.		
Protein gm/L	Neg	Trace	0.30 +	1 ++	3 +++	>20 ++++	
pH	5.0	6.0	6.5	7.0	7.5	8.0	8.5
Blood	Neg	Non Haem	Haem Trace	Small +	Mod ++	Large +++	
Specific Gravity	1.000	1.005	1.010	1.015	1.020	1.025	1.030
Ketones mmol/L	Neg	Trace 0.5	Small 1.5	Mod 4	Large 8	Large 16	
Bilirubin	Neg	Small +	Mod ++	Large +++			
Glucose mmol/L	Neg	5.5 Trace	14 +	28 ++	55 +++	111 ++++	
Nitrites	Neg	Positive					
Leucocytes	Neg	Trace	Small +	Mod ++	Large +++		
BHCG	+ ve	- ve					

Please annotate area of: Tenderness / Bruising / Swelling / Abrasions / Lacerations / Incised wounds



Signed _____

CLINICAL NOTES - ACCIDENT and RGENCY

Consultant _____ Seen by _____

Grade: SpR SHO SHO3 JHO Clin Assist ENP *(Please circle)* At (time) _____

Date

WR Evening - SpR.

Patient would like to be removed
Provisionally booked for theatre tomorrow.

Attended Newsham Path.

Date

UNITARY MEDICAL RECORD and E ...IATION

Consultant Molloy Seen by Mckeehan

Grade: SpR SHO SHO3 (JHO) Clin Assist ENP (Please circle) At (time) 1135pm

Date

HISTORY

Presenting Complaint: Abdominal Pain + vomiting.

History of Presenting Complaint:

51 ♀ - Peptic ulcer
- diagnosed gallstones in Beaumont Jan.
was due Aug/Sept for Beaumont cancelled.
On waiting list again.
- awaiting U/S for recurrent UTIs

presents with 1/52 hx of RUQ pain
radiating through to back.
Worse after food especially fatty food.
No relieving factors until today - sitting forward helps

completed antibiotics 2 days ago for UTI.
This is different from previous UTI symptoms.

No urinary/bowel symptoms. / weight loss.

Heartburn has been worse than usual in past month

MEDICAL NOTES - HISTORY and EXAMINATION *(cont)*

Date

Past Medical History:

as above

+ Strep sepsis

- Diabetes
- Obesity
- Hypertension
- MI
- CABG
- Rheumetic Fever
- TB

Allergies Sensitivity to morphine

Drug History: Omeprazole 20g mane
Diazepam 2mg PRN
Diclofenac 75 PRN SH (above)

Family and Social History: lives with husband + son + daughter
Daughter is mentally + physically handicap
One years up daughter.
2 aborted pregnancies

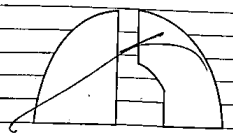
EXAMINATION:

Vital Signs: BP 119/61 P 72 RR 14 T 36.1°C General Appearance: Well
O_2 Sat 98% on air

Cardiovascular warm, well perfused.
72bpm regular
HS I+II+0
No ankle swelling

Respiratory Resp

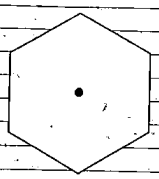
Good AE
N+ladder



MEDICAL NOTES - HISTORY and EXAMINATION *(cont)*

Date

Abdominal Soft
tender RUQ - tenderness
no rebound / guarding
bowel active



Central / Peripheral Nervous System GCS 15 orientated T/P/P.
EO MR VR

Other Urinalysis - NAD.

INVESTIGATIONS DONE Time

U & E's	/	GLUC	/	LFT's	/	Para/Sal		Troponin		D - Dimer	
FBC	/	COAG	/	Blood Cultures		MSU		ABG		any	

ECG

CXR

Other

DIFFERENTIAL DIAGNOSIS

① biliary pain

MEDICAL NOTES - HISTORY and EXAMINATION *(cont)*

Date

PLAN

Bloods c/s mane (Friedhaut).
Analgesia
IVF

Name Mckeehe Sign [signature] Grade Reg.

Date 2/2/16 Time 0000

SHO / SPR Review

3/2/16
0030 Surgical SHO.

51♀ epigastric + RUQ pain radiating to back nausea + anorexia
Known gallstones worse on eating
recurrent UTIs recently
worse on inspiration better sitting forward
PMH, PUD
Gallstones CNA for cholecystectomy due to bereavement

SE as ane/
DF as ane/ on PPI
CE, otherwise well
CE, warm, well perfused apyrexical

°LKKS BSV.

Imp Biliary colic
PUD

Plan, ① IV fluids ③ Omeprazole
② Analgesia ④ 2USS
⑤ U&E's
⑥ Urinalysis

Name Sign Grade Time

[signature] JOHNSTONE 3777

Date

Consultant Review

3/2/16 WR Mr Molloy
- remains uncomfortable + nausea
for U/S abdo today
-Lapcon commenced

[signature]
Registrar

3/2/16 PRHO. U/S
Note result: calculi in thin walled gall bladder
Biliary tree normal.
Mild hydronephrosis ⊕ kidney.

4/2 WR Mr Molloy
Is room for theatre today
If not FAD + closer

Name Sign [signature] Date 3/2/16 Time

Results

Biochemistry			Haematology	Other
Na	141	Paracetamol	Hb 12.6	CXR
K	4.1	Salicylate	MCV	
CL	109		WCC 7.44	
Ur	7.4	D - Dimer	NEUT	
Cr	82		Platelets	
Gluc	4.8		ESR 19	
Ca^{2+}		ABG	INR	
Troponin.			APTT	
Amylase	39	O_2	PT	
Bil	4	CO_2		
AST	16	H^+		
ALT	15	BI		
ALP	142	BE		
YGT	24			
ALB	40	COHb		
CRP	<6			

GREATER GLASGOW HEALTH BOARD

NAME	Hospital No.
	Age
	Sex
PHYS/ SURG.	Dept. Ward

OUT PATIENT HISTORY

DATE	
31/3	DNA Letter GP.

GREATER GLASGOW HEALTH BOARD – WESTERN DISTRICT

Patient

551545/
ROBERTS GEORGINA
13 SOLLAS PLACE F/M
KNIGHTSWOOD 19.8.50

Address

Dept DEPT WD MW

CONSENT FOR OPERATION

_____ Hospital

I ..... of .....

..... hereby consent to

*(undergo / the submission of my *(child / ward) ..... to undergo)

the operation of .....

the nature and purpose of which have been explained to me by

Dr./Mr.* .....

I also consent to such further or alternative operative measures as may be found necessary during the course of the above-mentioned operation and to the administration of general, local or other anaesthetics for any of these purposes.

No assurance has been given to me that the operation will be performed by any particular practitioner.

Date ..... Signed .....
(Patient/Parent/Guardian) *

I confirm that I have explained the nature and purpose of this operation to the patient/parent/guardian.*

Date ..... Signed .....
(Medical/Dental* Practitioner)

* DELETE AS APPROPRIATE

ANY DELETIONS, INSERTIONS OR AMENDMENTS TO THIS FORM MUST BE MADE BEFORE THE EXPLANATION IS GIVEN AND THE FORM SUBMITTED FOR SIGNATURE.

WESTERN
INFIRMARY
GLASGOW
G11

NAME 551545/
ROBERTS GEORGINA
13 SOLLAS PLACE F/M
KNIGHTSWOOD 19.8.54

PHYS DEPT WD MW
SURG. WARD

OUT PATIENT HISTORY

DATE 30/1/85

DEPARTMENT OF UROLOGY

Complaint and duration Episodic SP Pain intermittent 2-3 years / frequent

History lower abdl pain midline. Lasted 2/7's.
°Assisted dysuria. °Loin pain. °Freq. °Urgency.
Haematuria - redness in urine. °Clots. °
Pattern eventually settles with Septrin.
When not get pain °Urinary symptoms.
LMP 28/1/85. Abd pain slight. Irregular 5/28 not regular.

Previous illnesses Para 3 + 1 (3/7's old) DH, nil relative.
UTI during pregnancy.

Examination by Carter Build Tongue

Chest C.V.S. B.P.

Abdomen Nad.

Genitalia

Prostate

Ifx ? Recurrent Cystitis.

WP
MSU.

DATE

HISTORY

(Use other side first)

GG/FB
0.1.85

IVP. Preliminary film shows one or two small opacities on both sides of the bony pelvis, which look like phleoboliths. On the 5, 15 and 18 minute films, both kidneys excrete the dye promptly with good function, and the left pyelogram is distinct and normal. On the right side, there is some blunting of most of the calycew, and are rather full upper ureter, suggets a previous infection. There is no obstruction, however, and the bladder itself is smooth and regular with no trabeculation. Comment: apart from slight blunting of the calyces of the right kidney, this is a normal IVP. Patient reassured. Cystoscopy not required. Dr written.

ESTERN
IRMARY
ASGOW

NAME: 551545 ROBERTS GEORGINA F/M 13 SOLLAS PLACE KNIGHTSWOOD 19.8.59

PHYS/ SURG.: DEPT WD MW

OUT PATIENT HISTORY

DEPARTMENT OF DERMATOLOGY

DATE: 8.8.84 Prof Mackie

Duration — **Site of Initial Lesion**

History

Previous History

Family History

Occupational Details (when relevant)

Investigations

1

2.

3.

4.

Steroids

Photographs

Biopsy

M.N.I.

W/L. Date

Drugs and Medicaments used prior to attendance

Treatment (Initial)

ESTERN
IRMARY
ASGOW
W.1

NAME | HOSPITAL No. | AGE | PHYS/ SURG. D. McDonald | DEPT. WARD

OUT PATIENT HISTORY

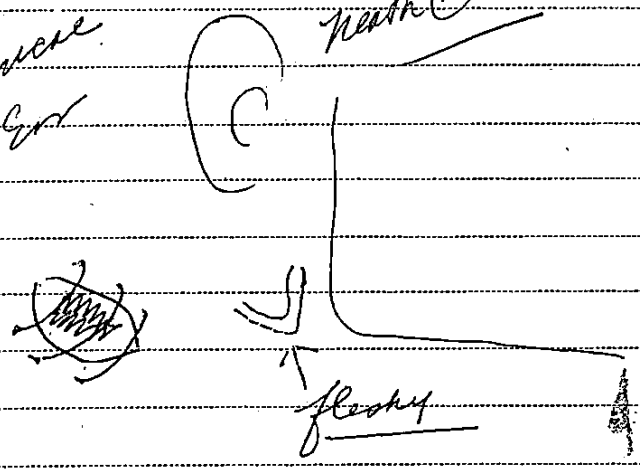
DEPARTMENT OF DERMATOLOGY

DATE 4-7-71

Duration Since Birth — **Site of Initial Lesion** Birthmark near ⓡ Ear

History

Pemoid Verrucae near ⓡ Ear



Previous History

Family History

Occupational Details (when relevant) Machinist. Sewing & works ē outs

	Investigations	Steroids
	1	Photographs
	2.	Biopsy
	3.	M.N.I.
	4.	W/L. Date

Drugs and Medicaments used prior to attendance No treatment Previously.

7.7.71 **Treatment (Initial)** for Exc on Friday 9th July. 2.30pm. Pemoid Verrucae / Exc. Biopsy

9.7.71. Brea Exc. & Biopsies today.

HISTORY
(Use other side first)

DATE	
.7.71	Biopsy shows junctional activity. Must be referred to Mr. Mac Gregor. Appt. for Wed PM. Clinic - linear nevus angle of (R) jaw. Lesion linear & angulated one portion (excised) is Pigmented & papillomatous - other portion not excised is flesh coloured & flat. Plastic Surgeon opinion req. ORGANOID NEVUS } — Prof Milne / R Day MD 30% Go malign. } Mr. MacGregor's opinion Please R Day
.9.71	Mr. MacGregor Would like to discuss the Pathology of Prof. Milne before committing himself. Patient to return to his clinic in (3/52) R Day
2.9.71	See ageu 9/12
6.72	D.N.A. Knew all 5.7.72.

NAME	HOSPITAL
GEORGINA ROBERTS	No.
	AGE
PHYS/ SURG.	DEPT. WARD

IN-PAT FORM 3

IN PATIENT
CONTINUATION HISTORY

DATE	
8/9/80	Arranged admission for lap. ster.
	PC "Could cope with any more children"
	3 living children 8 yrs, 5 yrs, 6 months.
	In 1976 the patient lost a son, 3 days old
	8 year old lives with mother.
	5 year old has "brain tumour"
	6 month & 8 year olds are well.
	All confinements resulted in "Labour shorter/more short" - 1 hr long. (??)
	Husband agrees with sterilisation
	Receiving Depo-provera 6 months.
	Previous illness.
	No RF. No asthma. Polio - no disability.
	Childhood murmur disappeared at 12yrs.
	Never jaundiced. Blood transfusions with no ill effects. No T.B. No diabetes.
	No previous operations
	Admitted for O.D. age 18yrs.
	Skin lesion excised ~1971, (R) neck - similar lesion reappeared close to original.
	~~22 stones~~
	Parity.
	4 + 0 F.M.P. 12yrs. L.M.P. 6/8/80
	cycle. 4/30 - Irregular since depo injection

HISTORY
(Use other side first)

Date

No dysmenorrhoea. No discharges

CVS. No dyspnoea. No chest discomfort.
No calf pain. No palpitations

RS. No cough. No ~~cough~~ sputum.
No haemoptysis. Occasional night sweats
No wheeze. Non smoker (previously
10/day for 6 yrs until 18 yo)

GIS. Appetite fair.
Weight 9 st. 4 lbs (8 st 6 months ago)
No indigestion No abdo. pain. No vomiting
Bowels regular. No constipation. No diarrhoea.
Motions normal.

GUS. No dysuria.
Kidney infection - with each pregnancy
→ back pain, treated with penicillin
No polyuria. No frequency
No loin pain

CNS. No headaches. No fits, faints.
No visual disturbances. No tinnitus
No vertigo No weakness. No paraesthesiae

O/E. Pale anxious 26 year old lady.
Not cyanosed Not icteric. No clubbing
No cervical lymphadenopathy.

NAME Georgina Roberts | HOSPITAL No. | AGE

PHYS/SURG. Dr. SHARP | DEPT. WARD

IN-PAT FORM 3

IN PATIENT CONTINUATION HISTORY

DATE

8/9/80 · CVS Pulse 60/min regular.
BP 110/65.
JVP not elevated.
Apex not located. HS I & II N
No murmurs

RS. Expansion fair
PN = PN & normal
BS vesicular nil added.

Abdo. V No scars
No masses
No LKKs
Striae.
PV not performed.

Imp. For Lap stat
FBC
G & R
Consent.

N.B. ? dermatologist about skin lesion on neck
+ ?? telangiectases on thighs.

8/9/80 for D-C. Cap/26

Date	HISTORY (Use other side first)
9/9/80	Theatre Dr Cerdines D. Akrebue GA Dr Nnamo.
	Normal vulva and vagina Cervix healthy SP 8cms. Curettings → path. Pneumoperitoneum induced with CO_2. Laparoscope inserted. Obese ++ Both tubes occluded with faldpe rings Normal pelvic organs. Clips to liver
	Post. D.C LAPAROSCOPY BILATERAL TUBAL occlusion

NAME GEORGINA ROBERTS

HOSPITAL No. 551545

AGE 26

PHYS/ SURG.

DEPT WARD C10

RESUSCITATION AND BLOOD PRESSURE CHART

IN-PAT FORM 7

DIAGNOSIS: LAP STER

SUGAR

URINE

ALB.

Drugs before admission

DATE 9.9.80

TIME 11-00AM

KEY B.P. PULSE RESP. XXX

BLOOD PRESSURE

PULSE RATE

RESPIRATION

INTAKE ml

URINE ml

IV LOSS

WOUND CHECK

THERAPY

Georgina Roberts 551545

DATE	DAY	TIME	CLINIC	HOSPITAL
29/1/86	9.15	Wed	Pre Conditional	Western

WHEN KEEPING A WESTERN INFIRMARY APPOINTMENT PLEASE USE THE ENTRANCE INDICATED (☑):
CHURCH STREET: TENNANT EYE INSTITUTE ENTRANCE ☐ or OUT-PATIENT ENTRANCE ☐
PHASE I NEW BUILDING: LEVEL 3 ENTRANCE ☐ or LEVEL 2 (FRONT ENTRANCE) ☐
PLEASE DO NOT ENTER THROUGH ACCIDENT & EMERGENCY DEPARTMENT

IMPORTANT PLEASE READ

1. Carry this card with you always, and bring it to the hospital which you attend.
2. Should you have any occasion to communicate with the hospital, you should quote your hospital number as shown opposite. **PLEASE WRITE. DO NOT PHONE EXCEPT IN AN EMERGENCY.**
3. All enquiries regarding appointments should be sent to the appointments office of the hospital you are attending. Patients will be seen by appointments only.
4. If the hospital doctor tells you to come again, be sure to let either the clerk or clinic receptionist know before leaving, and you will be given the date and time of your next appointment.
5. Your attendance time is shown opposite.

To avoid unnecessary waiting, please do not come before the time given.

Thank You

/ESTERN
IFIRMARY
iLASGOW

551545/
ROBERTS GEORGINA
13 SOLLAS PLACE F/
GLASGOW G13 19.8.54

DEPT WD MW
PHY/SURG McCandlish
DEPT. WARD

OUT-PATIENT HISTORY

Husband 30. John.

DATE 29/1/86

DEPARTMENT OF GYNAECOLOGY

Complaint and duration: Requests reversal of sterilyzation. Lonely during day - depressed.

Drugs - None off Aldrad.

Previous illnesses and operations: Sterilyzation - 1980. Legally adopted to mother.

Parity: 4 + 0 — 14 - well. — 11 - hydrocephalus. — 12 - died 3 days — 6 well.

Date of last delivery: 4/52 ago.

Menstrual history: F.M.P. L.M.P.

Cycle 5/28. Regular. Pain.

Discharge

NF

Bowels Reg. Urinary Symps. — DF SI

Urine Exam, Urgency

Examination by J

General

Breasts Pap. Smear

Abdominal

Pelvic Normal vulva & vagina. Cx hypertrophied. Normal A/V, mobile uterus. Adnexa NAD.

Treatment recommended

Write GP for background. Refer husb and → Uro. Review after this.

NB Husbands girlfriend ? pregnant at present J

Date	HISTORY *(Use other side first)*

WESTERN
INFIRMARY
GLASGOW

551545
ROBERTS GEORGINA
17 SOLLAS PL F/M
GLASGOW G13 19.8.54

DEPT WD NT79
SURG. WARD

OUT-PATIENT HISTORY

DATE 10/1/90

Dr Cardwell

DEPARTMENT OF GYNAECOLOGY

Complaint and duration

Previous illnesses and operations

Parity Date of last delivery

Menstrual history F.M.P. L.M.P.

Cycle Regular Pain

Discharge

NF

Bowels Urinary Symps. DF
SI

Urine Exam. Urgency

Examination by

General

Breasts Pap. Smear

Abdominal

Pelvic

Treatment recommended

Date	HISTORY *(Use other side first)*

N
551545
ROBERTS GEORGINA
17 SOLLAS PL., F
P GLASGOW 19/08/54
S G13 4NA
G.P.Prac. 40525

OUT-PATIENT HISTORY

DEPARTMENT OF GYNAECOLOGY

DATE 5/2/97

Prof Cameron

Complaint and duration

Previous illnesses and operations

Parity — Date of last delivery

Menstrual history — F.M.P. — L.M.P.

Cycle — Regular — Pain

Discharge — NF

Bowels — Urinary Symps. — DF / SI

Urine Exam. — Urgency

Examination by

General

Breasts — Pap. Smear

Abdominal

Pelvic

Treatment recommended

NORTH GLASGOW UNIVERSITY HOSPITALS DIVISION

NHS Greater Glasgow

NAME
50551545H
LOGAN F
GEORGINA 19/08/1954
17 Sollas Place

GLASGOW G13 4NA
CHI-1908546042

PHYS/
SURG.

OUT PATIENT
HISTORY

DATE	
27/6/05	DR CORDINER

00597

7/11/05

HYSTEROSCOPY RECORD

DATE

Patient details:

50551545H F
LOGAN
GEORGINA 19/08/1954
17 Sollas Place
GLASGOW G13 4NA
CHI-1908546042

Age: 51.

Par: 4+0 SNBS

Cycle:

LMP: June 2004.

Indication Bleed Jan, June, Sept, Oct } Mace period

Drugs: Tibolone ↘ 3/12 stopped June

Allergies: Morphine

Nurses +

Awaiting GB surg

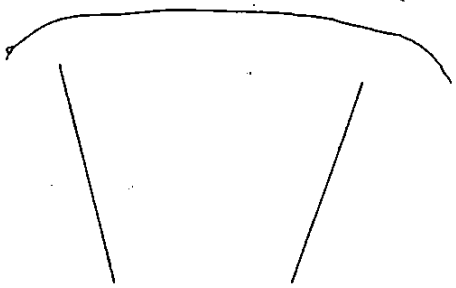
Recent smear -ve

TVNS NS AV uterus 69 x 44mm

Thin regular endometrium

Hysteroscope: NO

Anaesthetic:
- None
- Intra.
- PCB
- GA



Cavity Length:

Biopsy:

Pipelle: ✓

Tolerance:

Clinical findings: PV NAD. Cx (N).

Diagnosis:

Management:

Histology:

View:
- Poor
- Adequate
- Good

Follow-up:

Surgeon:

INSTRUMENT TRACKING INFORMATION

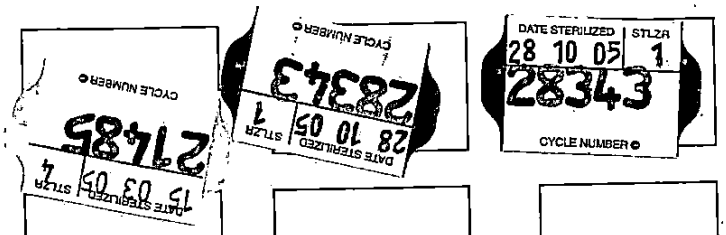
Patient's Name .....

H

50551545H F
LOGAN 19/08/1954
GEORGINA
17 Sollas Place
GLASGOW G13 4NA
CHI-1908546042

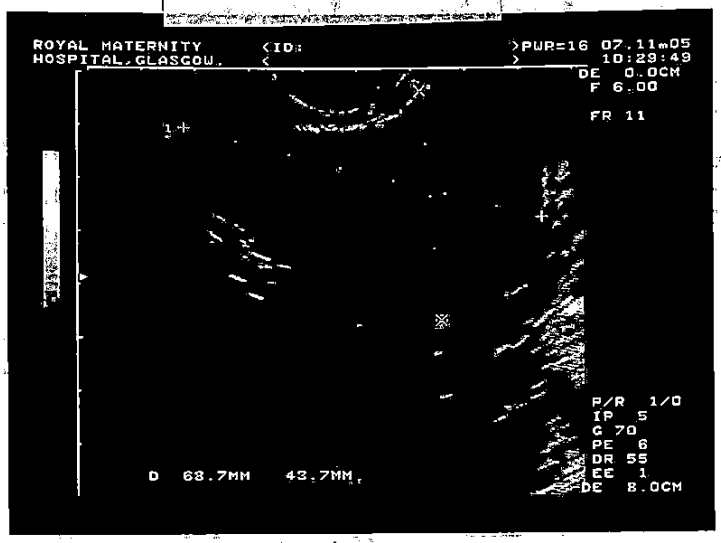
Pleas[illegible] tracebility labels from instrument sets + supplementary instruments and stick on form.

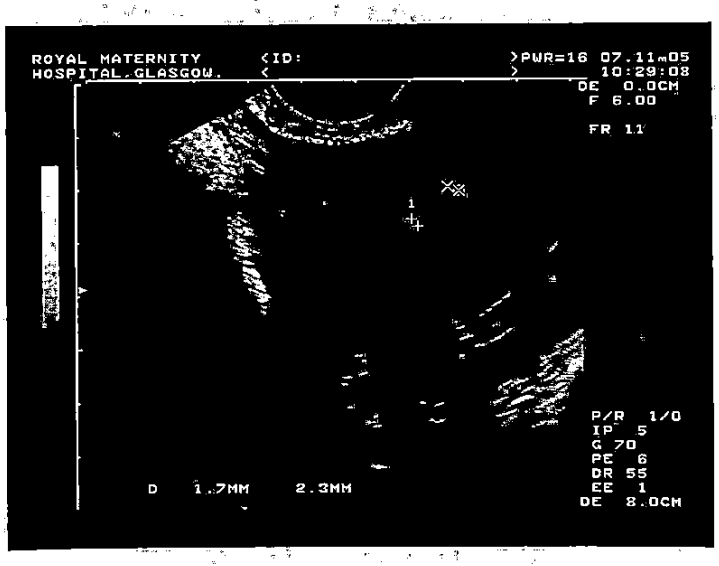
Place completed form in patient's notes.



50551545H
LOGAN F
GEORGINA 19/08/1954
17 Sollas Place

GLASGOW G13 4NA
CHI-1908546042





GREATER GLASGOW HEALTH BOARD – WESTERN DISTRICT

NAME	Hospital No.
	Age
	Sex
PHYS/ SURG.	Dept. Ward

OUT PATIENT-
HISTORY

DATE	
26-9-84	OP THEATRE MR SOUTAR – THEATRE CANCELLED
3-10-84	OP THEATRE MR SOUTAR DNA
24-10-84	OP THEATRE MR SOUTAR DNA
21-11-84	MR SOUTAR – PLASTICS. DNA N/A

Accident and Emergency Department
Medical Assessment Unit WIG

28

50551545H

A&E No. 11000002527

2

Surname	LOGAN	**Forename**	GEORGINA	**Title:**	MRS
Address:	17 SOLLAS PLACE GLASGOW LANARKSHIRE	**Postcode**	G13 4NA	**CHI No:**	1908546042
		Telephone:	07500390352		
Date of Birth:	19.08.54	**Sex:**	F	**Age:**	56 yrs

CHI Number: 1908546042

GP Name:	MORGAN ANN		
Address:	DRUMCHAPEL HEALTH ... 80/90 KINFAUNS DRIVE GLASGOW	**Postcode**	G15 7TS
		Telephone:	0141 211 6120

Next of Kin	GEORGE LOGAN		
Relationship:			
Address:	17 SOLLAS PLACE	**Postcode**	G13 4NA
	GLASGOW	**Telephone:**	9523728
Primary Carer:			

Time .....
MEWS ☐
ECG ☑
Bloods ☐
CXR ☐
Name Band ☑
Phoned Up ☐

Date of Attendance: 01.06.11 11:24
Date of Incident:
Presenting Complaint: NK

Triage RECENT ADMISSION TO F3, DISCHRGED FOR OP ANGIO. STOPPED TAKING MEDICATION ON DISCHARGE. C/O CHEST PAIN, DIFFICULT HISTORIAN, DESCRIBES AS SHARP. TEMP 36.1

Tetanus Cover:

Allergies:

P= 68 **BP=** 113/62 **RR=** 16 **Sat=** 99 **BM=**

PF= **GCS=** E: M: V: Total:

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time

MEDICINES RECONCILIATION

50551545H
LOGAN F
GEORGINA PATIENT LABEL 19/08/1954
17 SOLLAS PLACE
GLASGOW
LANARKSHIRE G13 4NA
CHI-1908546042

Source Of Medication History (2 Sources)
Patient ☐ Relative/Carer ☐
GP Phone call ☐ ECS ☑
Patient Own Drugs ☑ Com. Pharmacist ☐
GP Letter/Summary ☑ Repeat Script ☐
Other (please specify) .....

Admission Medicines			Plan for Medicines (Dr Complete)				Comments
Name	Dose	Freq	Continue	Amend	Withold	Stop	Reason for Alteration
TRAMADOL	50mg	bd	✓				
OMEPRAZOLE	40mg	od	✓				
QUININE SULPHATE	300mg	od	✓				
SIMVASTATIN	40mg	od	✓				
ASPIRIN	75mg	od	✓				
GABAPENTIN	600mg	tds	✓				
CLOPIDOGREL	75mg	od	✓				
METHOCARBAMOL	1.5g	qds	✓				
BISOPROLOL	2.5mg	od	✓				
NICORANDIL	10mg	bd	✓				
CLENIL MODULITE 100mcg	2 puffs	bd	✓				
SALBUTAMOL INH	2 puffs	prn	✓				
acute 26/5/11 DICYCLOVERINE	20mg	tds	) remain if required				
ALIMEMAZINE TARTRATE	10mg	nocte					
Medication confirmed. ATMai (Pharmacy)					2/6/11		

Allergies
None known ☑

List any Over The Counter or Alternative Medicines

Do medicines need further clarification Yes ☐ No ☐

List collected by : MARRAE
Designation : GPSTI Date : 1/6/11

Plan initiated by :
Designation : Date :

Compliance aid : Yes ☑ No ☐ Pluspak

Community pharmacist Sinclair Pharmacy, Spey Road Phone 9426626

Reviewed by :
Designation : Date :

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES

50551545H
LOGAN
GEORGINA F
17 SOLLAS PLACE 19/08/1954
GLASGOW
LANARKSHIRE G13 4NA
CHI-1908546642

Date & Time		Signature, Print Name & Designation
6/6/11	56 ♀ hx asthma.	
	Admitted 12/5/11 with chest pain - Troponin negative, but	
	refered for O/P Angiogram due Fri morning 3/6/11.	
	Has remained well until yesterday.	
	~2pm onset central chest pain.	
	Sharp in nature, assoc SOB, nausea, clammy.	
	Radiation of pain Through to back.	
	Pain helped with GTN.	
	On and off through yesterday + further episode today.	
	Pain free + settled now.	
	Also claims to have been having some epigastric pain	
	recently, prev. hx ulcer.	
	SH Non smoker.	
	Nil alcohol.	
	BP 113/62 Sats 99% air	
	Pulse 68 Temp 36.1°C	

Date & Time		Signature, Print Name & Designation
	Alert., settled.	
	Pain free. Chest well (each to palpation,	
	CRT < 2 secs. but different to symptoms.	
	HS I + II + 0 (quiet)	
	Chest clear.	
	Abdo soft, tender in epigastrium	
	ECG - low voltage, difficult to determine ? T-wave inversion.	
	Sinus 60/min. No ST changes	
	Imp. ? ACS	
	? Dyspepsia.	
	Plan. Bloods + Troponin.	
	· ~~Already~~ had 300mg aspirin	
	CXR.	
1/6/11	Blood results.	
	Trop < 0.04	
	Na 139 K 4.3 U 8.7 G 82	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES

505515451H
LOGAN P
GEORGINA 19/08/1954
17 SOLLAS PLACE
GLASGOW
LANARKSHIRE G13 4NA
CHI-1908546042

Date & Time		Signature, Print Name & Designation
	5 6 q	
	C.P.	
	Further episodes of C.P.	
	Remt admission - awaiting CA o-	3.6.11
	Now pain free.	
	N.I c/c.	
	ECG - n.i acute - CXR - ok.	
	Plan Monitor. TnI tomorrow.	
	SICU/HDU.	
	Minim meal.	

Date & Time		Signature, Print Name & Designation
02/06/11	WR CT1	
	States had a couple of episodes of pain overnight but did not alert nursing/medical staff	
	Nil new on ECG this a.m.	
	Note episode of vomiting this a.m.	
	GA 92/52 HR 60.	
	Plan Anti-emetics	
	Rpt. trop awaited from this a.m.	
	Awaits cardiology rv Cradle-dive angio tomorrow)	
	Withhold bisoprolol if BP low.	
		A. Dru CT1.

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES

Date & Time		Signature, Print Name & Designation

Dr Malachy Duffy

Dr Anne Morgan

Drumchapel Health Centre
80/90 Kinfauns Drive
Drumchapel
Glasgow G15 7TS

T. 0141 211 6120/1
F. 0141 211 6128

Miss Georgina Logan
17 Sollas Pl
GLASGOW
G134NA

1/5/11

~~Dear Miss Logan~~
Dear Doctor.

See enclosed recent discharge letter pulmonary clot
Cold had heart attack note letter trop -ve.

Last night states 7/24 episode of central chest pain
assoc nausea/dizzy. States similar to above admission

BP 105/71
HR 68
Sat 97%
Pain free currently.

Can you review? ACS.

Aspirin 300mg given

Declined ambulance.

iate Discharge and
ne Prescription Form - Confidential

Western Infirmary
Glasgow G11 6NT
Telephone: 0141 211 2000

PLUSPAK Ref. No: 034199

NHS Greater Glasgow and Clyde

of GP
/Health Centre

Fix ID label to all 4 copies

GEORGINA LOGAN
17 SOLLAS PLACE
GLASGOW
Post Code G13 4NA
19.08.54 Unit no: SO5515454H
it CHI no: 1908546042

Ward: F3 Tel:
Consultant: BZRG
Named Nurse:
Specialty: CARDIO
Admission date: 12/5/11
Mode of admission: Elective ☐ Emergency ☒ Transfer ☐
Source of Admission Home
Discharge date: 15/5/11

n for Admission, Diagnosis
^ - CP.
fue Thallium

Treatment, Investigations, Operations
For OP angiography

Complications
Enlargement of
Liver Nex recurrent

NURSE TO COMPLETE

Out Patient appointment date
Diagnosis informed (circle) Patient Relative
Circle support services set up:
District Nurse Home Help Health Visitor
Oncology referral Hospice: day care OR home care
Discharge address if not home:

WARD USE ONLY

Medication Rec. on Ward by: SM McKinney
Checked against kardex: SM McKinney
Issued by: SM McKinney Date: 15/05/11
Signature of Recipient:
All known drug sensitivities / adverse reactions:
Logan.

New Dose	MEDICINE	Form	Dose	TIMES FOR ADMINISTRATION am 8	md 12	pm 2	pm 6	pm 10	Other times	Course length
	TRAMADOL	tab	50mg	✓	✓			✓		1/7
	ORAMORPH	tab	40mg					✓		1/7
	CLEXANE	inj	40mg					✓		1/7
	SIMVASTATIN	tab	40mg	✓						1/7
	ASPIRIN	tab	75mg	✓		✓				1/7
	LABETALOL	tab	100mg	✓		✓		✓		1/7
	CLOPIDOGREL	tab	75mg	✓		✓		✓		1/7
	ISOSORBIDE MONONITRATE	tab	15mg	✓						1/7
	BISOPROLOL	tab	2.5mg	✓						1/7
	NICORANDIL	tab	10mg	✓		✓				1/7
	CLEXANE	inj	120mg					✓		1/7

Medicines Discontinued	Reason if known e.g. side effect

Other Information

PLUSPAK

PHARMACY USE ONLY

Clinical Pharmacy Check ☐ Professional Check ☒ RP 15/5

Quantity supplied	Dispensing Details
14	Mylan
7	Bristol
7	Ranbaxy
7	Wat V
42	Naproxide
7	Cansilient
	~~Not supplied~~ *
7	Sandoz
14	Clenus
PRN	

Dispensed by: RP Date: 15/5/11
Checked by: RP

Non-childproof containers required: Yes ☐ No ☐
Medicine compliance aids required: Yes ☐ No ☐
Specify:
Medication Collected by:

Prescribers name: CANNON Signature: Date 15/5/11
Designation: SR Pager number: mc5.6

White copy - G.P.; Pink copy - Case Notes; Blue copy - Pharmacy; Yellow copy - Patient

You must use a ballpoint pen and fully complete this form or the prescription will not be dispensed

ECS - Live - Patient Report

Patient

Patient Name	CHI	Date Of Birth	Age	GP	GP Practice	GP Practice Code
Georgina Logan	1908546042	19/08/1954	56	MORGAN, ANN	DRUMCHAPEL HEALTH CENTRE	40652

Name Changed

Clinical Data

Last Emergency Care Summary received 26 May 2011

Allergy

Description	Date Recorded	Comments

Acute Medication (within 30 days) Medicines Reconciliation Report

Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date
Dicycloverine Hydrochloride	TABS 20MG	1 Tab	tds		26 May 2011
Alimemazine Tartrate	TABS 10MG	1 Tab	At night		26 May 2011
Gaviscon Advance	Sf Chewable Peppermint TABS	1 or 2 Tabs	Take as required		18 May 2011
Co-Dydramol	10mg/500mg TABS	1 or 2 Tabs	3 times daily		06 May 2011
Alimemazine Tartrate	TABS 10MG	1 Tab	At night		06 May 2011
Transvasin	Heat RUB	Apply	4 times daily		06 May 2011
Methocarbamol	TABS 750MG	2 tabs 4 times daily	NOT RECORDED		06 May 2011

Repeat Medication Medicines Reconciliation Report

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Dispensed Date	Cancelled Date
	Nicorandil	TABS 10MG	1 Tab	Twice daily	01 Mar 2011	26 May 2011		
	GABAPENTIN	300MG CAPS	2 Caps	3 times daily	01 Mar 2011	26 May 2011		
	Aspirin	Ec TABS 75MG	1 Tab	In the morning	06 Apr 2009	26 May 2011		
	Clenil Modulite 100	200 Dose Cfc Free INHAL 100MCG/DOSE	2 Puffs	morning and night	27 Jan 2009	26 May 2011		
	Salbutamol	200 Dose Cfc Free INHAL 100MCG/DOSE	2 Puffs	Take as required	14 Mar 2008	26 May 2011		
	Simvastatin	TABS 40MG	1 Tab	In the morning	24 Oct 2007	26 May 2011		
	Clopidogrel	TABS 75MG	1 Tab	In the morning	18 May 2011	18 May 2011		
	Tramadol Hydrochloride	CAPS 50MG	1 Cap	Twice daily	18 May 2011	18 May 2011		
	Bisoprolol Fumarate	TABS 2.5MG	1 Tab	In the morning	18 May 2011	18 May 2011		
	Omeprazole	CAPS 20MG	2 Caps	In the morning	03 May 2011	18 May 2011		
	Methocarbamol	TABS 750MG	2 tabs 4 times daily	NOT RECORDED	19 Apr 2011	18 May 2011		
	Quinine Sulphate	TABS 300MG	1 Tab	At night	07 Apr 2011	18 May 2011		
	Peptac	Sf Aniseed LIQ	30	Take as	03 Apr	21 Mar 2011		

mls required 2006

☐ Patient does not want their GP to know about this access.

Show All Medication Information

Printed By: WIG.Anna Thain on 02/06/2011 10:07:01

E34GMFRI 21/4/06

MOPD Friday

NORTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST
ACCIDENT & EMERGENCY DEPT.
WESTERN INFIRMARY
GLASGOW
G11 6NT
Tel: 0141-211-2304/2409
Fax: 0141-339-3046

CONSULTANTS: Mr W M Tullett, Mr P T Grant, Dr S Perry
NURSE MANAGER: Mr G D Wright

NHS Greater Glasgow

* Any Please ref Mr Paonanthans MOPD

CRN: 50551545H

TREATMENT C

PATIENT

Surname	Forename	Age	Date of Birth	Arr Date	Time	AE Numbe
LOGAN	GEORGINA	51	19/08/54	24/03/06	01:55	011765/

Address	Sex	Religion	Date of Inc	Time
17 SOLLAS PLACE GLASGOW	Female		24/03/	

PC	Tel	Marital Status	Occupation/School	Type of Inc	Mode of Arrival
G13 4NA	211 6110			OTHER	AMUBLANC

GP

Name: Dr GRIEVE

Address: DRUMCHAPEL HEALTH C
80/90 KINFAUNS DRIV
GLASGOW
G15 7TS
0141 211 6110

Referred by: SELFREF

NEXT IF KIN

Name: GEORGE LOGAN

Relat: HUSBAND

Tel. No: 211 6110

Address: 17 SOLLAS PLACE
GLASGOW
G13 4NA

Complaint

ROAD TRAFFIC ACCIDENT PLACE

DETAILS

HOME ACCIDENT PROBABLE CAUSE

TO BE COMPLETED BY MEDICAL OFFICER AFTER SEEING PATIENT

Triage Time	Triage Category
01:56	Category 2

Initial Complaint: Chest Pain

Dear Doctor,

The above-named patient attended Accident & Emergency Department today.

Diagnosis _____

X-ray film/ECG shows _____

Treatment given _____

Drugs _____ days supply of _____ has been given.

Tetanus Prophylaxis has/has not been administered. TT Course _____ TT Booster _____ HAT! _____ (Please Tick)

Would you please arrange _____

DISCHARGE CODES: *Please circle*

1. Admission
2. Discharge
3. Refer to G.P.
4. Transfer to other hospital *(see below)*
5. Died
6. Refer to O.P. Clinic *(see below)*
7. Irregular Discharge
8. D.O.A.

Ward No. *(if admitted)*	Transfer to Hospital	Consultant *(if admitted)*

Follow-up: Not Arranged _____ Arranged _____ To be arranged _____ IRIS _____

Clinic Referred to	AE	Dressings	Hand	Fracture	Ortho	Medical	Surgical	Skin	ENT	Gyn	OHPAT	Others *(specify)*

Medical Officer's Name *(in BLOCK LETTERS)*

Signature of Medical Officer

Cons SpR SHO3 SHO JHO Clin Assist ENP *(please circle)*

Western Infirmary
Dept:
Room:
Oper:

BP:

Requested by:

PRE-DISCHARGE/PRE-INFIRMARY-MD MUST REVIEW

- OTHERWISE NORMAL ECG -

NORMAL SINUS RHYTHM, RATE 74
LEFT AXIS DEVIATION

normal P axis; PR, rate & rhythm
QRS axis(-31,-90)

SCOTTISH AMBULANCE SERVICE - PATIENT REPORT FORM

CCS INCIDENT No.

Last Name

First Name

Location

Age / Sex

D of B

Date

Time of Call

Time at Patient

Time Left

AMPDS Code

AMPDS Revised

Airway Clear | Suction | N/OPA | ET | LMA | Successful ? | C-spine

Breathing | Rate | BVM | Ventilation | Successful ? | Paralysis

Pulse | Rate | CPR | IV/IO | Fluids | Successful ? | ECG

Despite the above unable to
Clear airway | Detect breathing | Detect pulse

Injury Site	Wound	#	Pain	Splint	Dressed
Head					
Neck					
Chest			X		
Abdomen					
Back					
R/Arm					
R/Leg					
L/Arm					
L/Leg					

RTA
Trapped
Ejected
M / cyclist
Cyclist
Pedestrian
>20 min. Extricate

Temp. °C
PEFR % B. Sugar mmol

Allergies

Medication

Assisted by and Name -
Doctor | Nurse | Other

Time	Pulse	Resp	BP	C / Refill	SpO2 %	GCS	Lpupil

Time	Fluid/Drug/Gas	Dose	Unit	Route	Effect	Rhythm	No. Joules	Repeat	Result

Condition at hospital | Pulse | Breathing | Conscious | Time at Hospital

History and Additional Information

Working assessment | Diagn

Crew Name 1 | Grade

Crew Name 2 | Grade

PATIENT (9/2001) WS606183

NURSING NOTES

TRIAGE DATE: TIME:

CHIEF COMPLAINT: RELEVANT HISTORY: PHYSICAL SIGNS

VITAL SIGNS: TREATMENT AT TRIAGE: DISPOSITION:

HR:
BP:
RR:
GCS:
TEMP:

1: RESUSCITATION
2. MEDICAL/SURGICAL
3. TRAUMA:
4. OTHER *(SPECIFY)*

TRIAGE NURSE ..... SIGN

..... PRINT

Patient's name Geraldine Rogers Age 57 Date of Birth 19/8/54

NURSING DOCUMENTATION - ACCIDENT & EMERGENCY DEPARTMENT

Date 24/7/16 Time 0155 Triage Nurse CP PC CP

5/5 2/52 last pain

SOS - call

Hx gallstones

Triage category 1 (2) 3 4 5

Relatives present: Relatives informed:

INITIAL MANAGEMENT

Nurse

Oxygen started %: Signed ECG: Signed

Signed

Other

Treatment

INITIAL VITAL SIGNS

at:(Time) 02:05
HR: 69
BP: 103/53
RR: 18
SaO2: 99% AIR
Temp: 36.7°C
GCS:
Signed KB

NEUROLOGICAL OBSERVATIONS

TIME	hrs											[1]
EYES OPEN	spontaneously 4											eye closed by swelling =C
	to speech 3											
	to pain 2											
	none 1											
BEST VERBAL RESPONSE	orientated 5											Endotracheal tube or Tracheostomy = E
	confused 4											
	inappropriate words 3											Dysphasia=D
	incomprehensible sounds 2											
	none 1											
BEST MOTOR RESPONSE	obey commands 6											Record the best arm response
	localises pain 5											
	normal flexion to pain 4											
	abnormal flexion to pain 3											Paralysed =P
	extention to pain 2											
	none 1											
	COMA SCORE 15											
PUPILS	RIGHT size (mm) Reaction											[2] += Reacts -=No Recaction C= Eye closed SL= sluggish pupil
	LEFT size (mm) Reaction											
ARMS	Normal power											[3] Record right (R) and left (L) seperatly if there is a difference between the two sides
	Mild weakness											
	Severe weakness											
	Extention											
	No response											
LEGS	Normal power											Fractured limb =#
	Mild weakness											
	Severe weakness											
	Extention											
	No response											
1	230											[4] 40
2	220											39
	210											38
3	BLOOD PRESSURE 200											37 Temp C°
	mm Hg 190											36
	180											35
4	170											34
	160											33
	150											32
5	140											31
	130											30
6	120											
	110											
	100											
	90											
7	PULSE RATE 80											
	70											
	60											
	50											
PUPIL SCALE (mm)	40											
	30											
	RESPIRATORY RATE											[5]

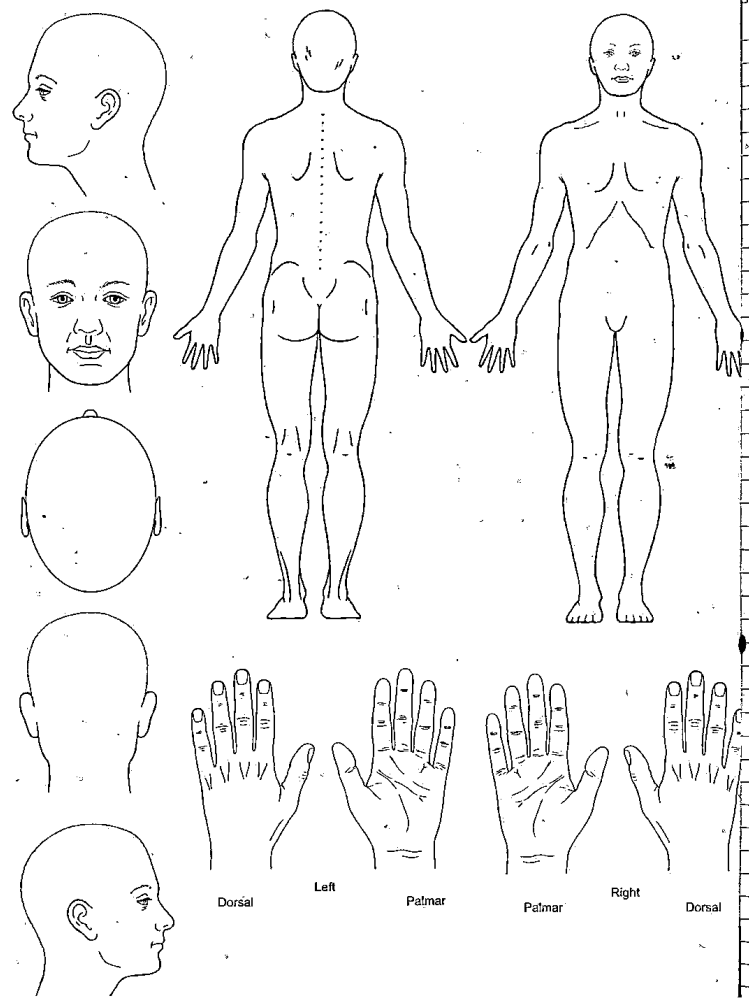
BLOOD GLUCOSE	Time						
BM STIX	BM						
PEAK FLOW	Time						
	PF						
VISUAL ACUITY	R. eye aided/unaided						
	L. eye aided/unaided						
	pH L. eye	R. eye					

Signed:

URINALYSIS

Urobilinogen µmol/L	Normal 3 16	33	66	131			
Protein gm/L	Neg	Trace	0.30 +	1 ++	3 +++	>20 ++++	
pH	5.0	6.0	6.5	7.0	7.5	8.0	8.5
Blood	Neg	Non Haem	Haem Trace	Small +	Mod ++	Large +++	
Specific Gravity	1.000	1.005	1.010	1.015	1.020	1.025	1.030
Ketones mmol/L	Neg	Trace 0.5	Small 1.5	Mod 4	Large 8	Large 16	
Bilirubin	Neg	Small +	Mod ++	Large +++			
Glucose mmol/L	Neg	5.5 Trace	14 +	28 ++	55 +++	111 ++++	
Nitrites	Neg	Positive					
Leucocytes	Neg	Trace	Small +	Mod ++	Large +++		
BHCG	+ ve	- ve					

Please annotate area of: Tenderness / Bruising / Swelling / Abrasions / Lacerations / Incised wounds



CLINICAL NOTES - ACCIDENT and EMERGENCY

Consultant _____ Seen by F. Farquharson

Grade: SpR SHO SHO3 JHO Clin Assist ENP *(Please circle)* At (time) 0330

Date 24/3/06

51 ♀ HIV gallstones awaiting ~~cholecystectomy~~ asthma

Attended 23/3/06 ē epig. pain

A - GORD

Was on diclofenac - told to stop on omeprazole

Reattended ē same epig. pain rad to back

N & V. ⇒ bilious. °blood

Some assoc. SOB °cough °palp

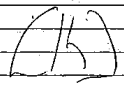
O/E P69 BP 103/53 RR18 Sats 97% ai T36.7

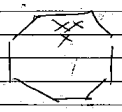
JVP ↔

HS 1+1+0

Murmurs

BS (+)





Epig tenderness

some RUQ pain °guarding/rebound

°organomegaly

BS (+)

ECG - SR no change from prev.

Imp/ gastritis / GORD

Plan/ (H)

cont. ē omeprazole

will need UGIE

- ~~procedural~~ a gaviscon for pain relief

OFF

FARQUHAR

SHO

MEDICAL NOTES - HISTORY and EXAMINATION *(cont)*

Date

Past Medical History:

- Diabetes
- Obesity
- Hypertension
- MI
- CABG
- Rheumetic Fever
- TB

Allergies

Drug History:

Family and Social History:

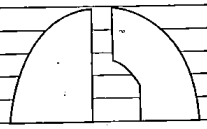
EXAMINATION:

Vital Signs: BP P RR T General Appearance:

0_2 Sat

Cardiovascular

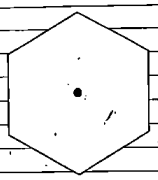
Respiratory



MEDICAL NOTES - HISTORY and EXAMINATION *(cont)*

Date

Abdominal



Central / Peripheral Nervous System GCS

EO MR VR

Other

INVESTIGATIONS DONE Time

U & E's		GLUC		LFT's		Para/Sal		Troponin		D - Dimer	
FBC		COAG		Blood Cultures		MSU		ABG			

ECG

CXR

Other

DIFFERENTIAL DIAGNOSIS

MEDICAL NOTES - HISTORY and EXAMINATION *(cont)*

Date

PLAN

Name Sign Grade

Date Time

SHO / SPR Review

Name Sign Grade Date Time

Date

Consultant Review

Name Sign Date Time

Results

Biochemistry		Haematology	Other
Na	Paracetamol	Hb	CXR
K	Salicylate	MCV	
CL		WCC	
Ur	D - Dimer	NEUT	
Cr		Platelets	
Gluc			
Ca^{2+}	ABG	INR	
Troponin		APTT	
Amylase	O_2	PT	
Bil	CO_2		
AST	H^+		
ALT	BI		
ALP	BE		
YGT			
ALB	$COHb$		
CRP			

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYA

Date given	Drug (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given by
24/3/6	Paracetamol	1g.	oral	0345		
24/3/6	Gaviscon	10ml	oral	0345		

PARENTERAL FLUID PRESCRIPTION SHEET

Date	FLUID	Volume	Time to run	Rate mls/hr	ADDED DRUGS	Quantity	Doctors Signature	Added by	Start time 24hr Clock	Put up by	Checked by	Serial/ Batch no

N.B. IF USING A SYRINGE DRIVER/INFUSION PUMP PLEASE USE THE "PRESRIPTION AND ADMINISTRATION SHEET FOR MEDICINES GIVEN BY SYRINGE DRIVER/INFUSION PUMP"

REFUSAL TO REMAIN UNDER HOSPITAL CARE

I wish to take my discharge. I appreciate that this is against the advice and wishes of the Consultant or his or her deputy looking after me. I acknowledge that I have been informed of the risks of doing so and I accept full responsibility for my actions and any consequences arising from them.

Name *(print)* _____ Signature _____

I confirm that I have explained to the patient the risks that might arise out of his / her decision to take his / her own discharge.

Date _____ Signature _____ *(Medical Practitioner)*

DISCHARGE DETAILS (NURSING)

Treatment _____

_____ Signed _____

(Please put initials in box)

Crutches ☐ Return appointment ☐ Advice Card ☐ Medication ☐

Escort to ward ☐ Relatives informed ☐ IRIS ☐ Transport ☐ Time booked _____

Discharged with _____ Admitted / transfered to _____

09437

34 BMFRI 21/4/06

H GLASGOW UNIVERSITY TALS NHS TRUST

ENT & EMERGENCY DEPT
RN INFIRMARY
OW
T
1-211-2304/2409
41-339-3046

CONSULTANTS: Mr W M Tullett, Mr P T Grant, Dr S Perry, Mr G D Wright

MO's Friday

NURSE MANAGER:

Ward Please let Mr Mammans know

CRN: 50551545H

NHS Greater Glasgow

TREATMENT COPY

Forename	Age	Date of Birth	Arr Date	Time	AE Number
GEORGINA	51	19/08/54	24/03/06	01:55	011765/06

LLAS PLACE

OW

4NA

Tel 211 6110

Sex	Religion	Date of Inc	Time
Female		24/03/06	

Marital Status	Occupation/School	Type of Inc	Mode of Arrival
		OTHER	AMBULANC

RIEVE

Address: DRUMCHAPEL HEALTH C, 80/90 KINFAUNS DRIV, GLASGOW, G15 7TS, 0141 211 6110

Referred by: SELFREF

Complaint

EORGE LOGAN

USBAND

211 6110

Address: 17 SOLLAS PLACE, GLASGOW, G13 4NA

TRAFFIC ACCIDENT PLACE

DETAILS

ACCIDENT PROBABLE CAUSE

E COMPLETED BY MEDICAL OFFICER AFTER SEEING PATIENT

Triage Time: 01:56

Triage Category: Category 2

Initial Complaint: Chest Pain

octor,

ove-named patient attended Accident & Emergency Department today.

osis _____

film/ECG shows _____

ent given _____

_____ days supply of _____ has been given.

s Prophylaxis has/has not been administered. TT Course _____ TT Booster _____ HATI _____ (Please Tick)

you please arrange _____

DISCHARGE CODES: *Please circle*

1. Admission 3. Refer to G.P. 5. Died 7. Irregular Discharge
2. Discharge 4. Transfer to other hospital *(see below)* 6. Refer to O.P. Clinic *(see below)* 8. D.O.A.

No. *(if admitted)* | Transfer to Hospital | Consultant *(if admitted)*

up: Not Arranged | Arranged | To be arranged | IRIS

AE	Dressings	Hand	Fracture	Ortho	Medical	Surgical	Skin	ENT	Gyn	OHPAT	Others *(specify)*

Officer's Name *(in BLOCK LETTERS)* | Signature of Medical Officer

SHO JHO Clin Assist. ENP *(please circle)*

SCOTTISH AMBULANCE SERVICE NHS TRUST - PATIENT REPORT FORM

INCIDENT No.

PATIENT NAME: GEORGINA LOGAN — SEX: F

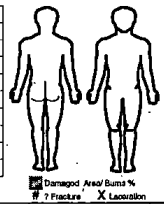
PATIENT ADDRESS: 17 SOLLAS PLACE G13 — D.O.B.: 19/08/54

TYPE OF INCIDENT: Trauma; Assault; Cardiac Arrest; Other Collapse [X]; DSH; IHT; Obstetric; Other

TRAUMA INCIDENTS

RTA: Cyclist; M/Cyclist; Pedestrian; Ejected; Trapped; >20 mins. Extricate; Helmet Worn; Seat Belt Worn

Home; Work; Leisure; Burns; Drowning; Fall < 2 mtr.; Fall > 2 mtr.; Head Injury; Poisoning; Other



Damaged Area; Point of Impact; X Position of Patient

Damaged Area/ Burns %; # ? Fracture; X Laceration

INJURY / ILLNESS: Acute Abdo.; Breathlessness; Chest Pain [X]; Other Cardiac; Convulsions; C.V.A.; DSH O/dose; Haemorrhage; Hypoglycaemia; Other

PRIMARY SURVEY

Treatment prior to arrival	Y	N
By whom		
Duration of treatment / CPR		
Airway — Clear [X] / Obstructed		
Breathing.	Y [X]	N
Circulation - Pulse	Y [X]	N
Disability- Alert	Y [X]	N
Vocal Stimuli	Y	N
Pain Stimuli	Y	N
Unresponsive	Y	N
Vomited	Y	N [X]
Fitting	Y	N [X]
Knocked Out	Y	N [X]

INITIAL ACTIONS

Airway
- Pharyngeal Airway Y N
- Tracheal Tube Y N
- Laryngeal Mask Y N
- Size
- Successful ? Y N

Breathing
- O2 Flow rate 6lpm % 93%
- Mask Type Duo
- IPPV

Circulation — Success
- Cannulation 1 — Size — Side — Site — full Y N
- 2 Y N

MOPHAMPLE

Allergies (See reverse for coding): 1 2 [3] 4 5 6 7 8 9

Medication: PARACETAMOL

Past Medical History

Last Eaten: 2130

Events Preceding Incident

OBSERVATIONS

Time	Breathing R.R.	Breathing SpO2 %	Circulation Pulse	Circulation Blood Pressure	Capillary Refill Norm	Capillary Refill Delay	Pupils Left Size (C N D)	Pupils Left React Y/N	Pupils Right Size (C N D)	Pupils Right React Y/N	Glasgow Coma Score E	M	V	Total
2135	22.		90 REG	118/92.			N	Y	N	Y	4	6	5	15

TREATMENTS

Time	Presenting Condition	Defib. (Joules)	Fluid / Drug	Batch / Box No.	Dose	Route	Result e.g. Pulse,Asys,VF,Other

COMMENTS / ADDITIONAL INFORMATION: 999 CALL FEMALE. 45 yrs. CHEST PAIN

PATIENT COMPLAINING OF PAIN IN THE STOMACH. WAS EATING A CURRY WHEN IT STARTED. NO HISTORY OF STOMACH COMPLAINTS. PATIENT VOMITED PAIN EASED SLIGHTLY.

E.C.G. ATTACHED.

CREW 1	ROBSON	R
CREW 2	TAYLOR	R
MEDICAL STAFF		
INCIDENT LOCATION		
DATE OF CALL	6 4 8 1 9 9	
TIME OF CALL	2 2 2	

SIGNATURE (Crew 1 or 2): N.

CONDITION ON ARRIVAL AT HOSPITAL: Conscious [X] Breathing; Pulse [Y]; No Vital Signs

DESTINATION HOSPITAL: GRIC

HOSPITAL USE ONLY

WEST GLASGOW HOSPITALS

505515451H F
LOGAN 19/08/1954
GEORGINA F
17 Sollas Place
GLASGOW G13 4NA
CHI-1908546042

OUT PATIENT HISTORY

DATE	
21/4/06	G3/4 CM DNA.

22
211

+19 d

Gb Lb d

ALLERGIES	
1	ANTIBIOTICS
2	ANIMAL SERUM
3	ANAESTHESIA
4	ASPIRIN
5	SHELLFISH
6	PEANUTS
7	DAIRY PRODUCE
8	VENOM
9	OTHER (Specify)

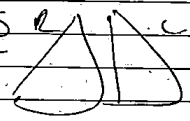
DATE	HISTORY *(Use other side first)*

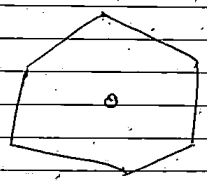
OPEN BEFORE WRITING

DATE | CLINICAL NOTES

GE General
alert, orientated, unstressed
? ACCOM

CVS P 64 BP 112/72
JVP ⇐
HS 1+II+0
0 mm

RS  RR 14
exp equal
PN resp at
AE good R=L

Abds  soft
non tender
no masses
no organs
BS active

CNS grossly intact

ECG: SR, lateral T wave ↓

Imp ? Prof Ischaemic sounding chest pain
spontaneous resolution
nausea, dyspnoea

Plan ⇒ IV access + bloods
⇒ Physicians

EST GLASGOW HOSPITALS UNIVERSITY NHS TRUST — TREATMENT CARD

ACCIDENT & EMERGENCY DEPT.
WESTERN INFIRMARY
GLASGOW
G11 6NT
TEL: 0141-211-2304/2409

ACCIDENT/EMERGENCY FORM

CRN: GG1645

Surname	Forename	Age	Date of Birth	Arr Date	Time	A/E Number
ROBERTS	GEORGINA	44	19/08/54	15/07/99	00:30	029763/99

Address	Sex	Religion	Date of Inc.	Time
17 SOLLAS PL., GLASGOW	Female		15/07/99	

	Marital Status	Occupation/School	Type of Inc	Mode of Arrival
G13 4NA Tel 951 4168	Married		Other	By Ambul

Name	Address	Referred by
Dr JORDAN	6 KELSO STREET YOKER GLASGOW	Selfref
Name JOHN Relat. HUSBAND Tel. No.	Address G14 0SJ	Complaint

ROAD TRAFFIC ACCIDENT PLACE | DETAILS

HOME ACCIDENT PROBABLE CAUSE

TO BE COMPLETED BY MEDICAL OFFICER AFTER SEEING PATIENT

TRIAGE
TRIAGE TIME 00:30 | TRIAGE CATEGORY Category 4

Dear Doctor,

The above-named patient attended Accident & Emergency Department today.

Diagnosis Chest pain — INITIAL COMPLAINT: Medical Other

X-Ray film/ECG shows lateral T wave ↓ — INITIAL TREATMENT

Treatment given IV access physicians — FILED BY - MRINCG

Drugs ____ days supply of ____ has been given.

Tetanus Prophylaxis has/has not been administered. TT Course ____ TT Booster ____ HATI ____ (Please Tick)

Would you please arrange ____

DISCHARGE CODES: Please Circle
1. Admission / Discharge 3. Refer to G.P. 4. Transfer to other hospital (see below) 5. Died 6. Refer to O.P. Clinic (see below) 7. Irregular Discharge 8. D.O.A.

Ward No. (if admitted) Medical 18M. | Transfer to Hospital | Consultant (if admitted) W Lit

Follow Up: Not arranged | Arranged ____ | To be arranged ____

Or to Referred to: AE | Hand Surg. | Fracture | Ortho | Medical | Surgical | Skin | ENT | Gyn. | Others Specify

Medical Officer's Name (in Block Letters) NELSON
Paed. Trn. Reg. SHO/JHO Clin. Assist. (please circle)

Signature of Medical Officer

NURSING NOTES

TRIAGE DATE: TIME:

CHIEF COMPLAINT: RELEVANT HISTORY: PHYSICAL SIGNS:

VITAL SIGNS: TREATMENT AT TRIAGE: DISPOSITION:

HR:
BP:
RR:
GCS:
TEMP:

1. RESUSCITATION:
2. MEDICAL/SURGICAL:
3. TRAUMA:
4. OTHER (SPECIFY):

TRIAGE NURSE ..... SIGN
..... PRINT

Na 140
K 3.6
Cl 106
B/C 22
Urea 6.3
Creat 75

WCC 8.66
Hb 131.9
Plts 292

Glucose 6.0

Anglase < 35

TO BE RECORDED ON /AL
T 36.1 P 64 R ____ BP 112/72 97%

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYLAXIS)

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION	SIGNATURE	GIVEN BY

CONSULTANT ____ REG/SHO ✓ JHO ____

SEEN BY NEILSON AT (TIME) 0045

CLINICAL NOTES

KEY TO CLINICAL NOTES
1 - HISTORY OF
2 - ON EXAMINATION
3 - X-RAY FINDINGS
4 - TREATMENT GIVEN
5 - DISPOSAL
6 - NAME OF MEDICAL OFFICER

DATE

15/7

44yo ♀
- chest pain
- central chest tightness.
- gripping pain
→ worst ever pain.
radiating to (L) shoulder
lasted for 1 hr.
settled spontaneously
- felt dizzy + lightheaded.
- nausea
vomited x2
no relief from pain.
dyspnoea.

PMHx fibroids
PV bleeding

NAME Georgina Roberts HOSPITAL No AGE PHYS/ SURG. DEPT WARD

IN-PAT FORM 3

IN PATIENT
CONTINUATION HISTORY

DATE	444EAE0DQ
15.7.99	
0130	No previous history of note
PC	CHEST PAIN.
	Sudden onset tonight of severe gripping central chest
	pain and ⓛ arm pain
	associated nausea ted
	came on whilst eating curry burdenier dyspepsia or
	dysphagia
	settled spontaneously after ~1 hour.
	Father c IHD. aged 60
	Smokes (but only for ~5 years)
	cholesterol not checked
OE	Overweight
	Pulse 80 SR
	BP 112/72
	JVP ~ 0
	HS I+II+0
	°oedema
	pedal pulses ✓✓
	Chest clear
	Abdo — nad of note
	BSV
ECG	Sinus rhythm.
	Widespread anterior T wave inversion / flattening

HISTORY
(Use other side first)

ate

IMP CHEST PAIN.

? CARDIAC note abnormal ECG..

? OESOPHAGEAL

→ admit.

Routine bloods.

CXR.

MI Screen.

→ Simple

IRVINE SHEET

15/2/89. Colonoscopy for ~~in~~ 44 y- ~~in~~ eng.

Polyp ~~in~~ rec. Tumour LUQ.

Now CEA & carcinoembryonic antigen. + ? U/S pancreas

[illegible]

5/2/89 CXR c39

-VE ETT

For OP ultrasound card sent ✓

Dr. Cox's clinic 6/52.

J. Hunter

(Surg)

GREATER GLASGOW HEALTH BOARD
WESTERN DISTRICT

TREATMENT CARD

C/ 485279 X

MEDICAL

ACCIDENT/EMERGENCY FORM

K

HOSPITAL CODE 601		CASE REFERENCE No.
PREVIOUS ATTENDANCE AT THIS HOSPITAL YES/NO NO	IN/OUT PATIENT	YEAR
SURNAME [illegible]		MAIDEN NAME [illegible]
FIRST FORENAME [illegible]	SECOND FORENAME	OTHER INITIALS
DATE OF BIRTH [illegible]	SEX F	MARITAL STATUS [illegible]
ADDRESS 13 [illegible]		
POSTCODE G13	TELEPHONE No.	
FAMILY DOCTOR: SURNAME [illegible]	INITIALS	
ADDRESS [illegible]		
POSTCODE [illegible]		
ACCIDENT/EMERGENCY: DATE OF ATTENDANCE [illegible]		TIME OF ATTENDANCE 1930
DATE OF INJURY OR ILLNESS [illegible]	SOURCE OF ATTENDANCE R	TYPE OF ATTENDANCE [illegible]
	PATIENTS RELIGION [illegible]	
PATIENT'S OWN OCCUPATION [illegible]		
HUSBAND'S OCCUPATION (MARRIED WOMAN)/ PARENT'S OCCUPATION (CHILD) [illegible]		
REASON FOR ATTENDANCE [illegible]		
IF ATTENDANCE IS CONSEQUENCE OF ROAD TRAFFIC ACCIDENT: PLACE		DATE OF INJURY
DETAILS		TIME OF INJURY
IF ATTENDANCE IS CONSEQUENCE OF HOME ACCIDENT: PROBABLE CAUSE		
NEXT OF KIN: NAME [illegible]	RELATIONSHIP husband	TELEPHONE No. [illegible]
ADDRESS [illegible]		POSTCODE

TO BE COMPLETED BY CASUALTY OFFICER AFTER SEEING PATIENT

DISCHARGE CODES: Please enter in the box the appropriate number from this list:–

1. Admission
2. Discharge
3. Refer to G.P.
4. Transfer to other hospital *(Please indicate which)*
5. Died
6. Refer to O.P. Clinic
7. Return to Casualty

DISCHARGE CODE 1	WARD No. (IF ADMITTED) SSJ	OUT-PATIENT CLINIC (IF REFERRED)
PROVISIONAL DIAGNOSIS [illegible]		CONSULTANT (IF ADMITTED) [illegible]
X-RAY TAKEN Yes/No	ANAESTHETIC Local/General/None	TOURNIQUET Yes/No
TETANUS PROPHYLAXIS		
ANTISERUM Yes/No	TOXOID Primary/Booster/None	ANTIBIOTIC Yes/No
		CASUALTY OFFICER'S SIGNATURE

T 36.8
P 104
BP 118/85

CLINICAL HISTORY

DATE

9-7-85 pc Overdose

HPC Took 24 ATNAM tabs + 20 TEGRETOL tabs 1 hr ago. Family made her vomit after this. Took tabs because daughter has a brain tumour and her husband has joined another woman.

PMH

Kidney infection.

°Polio as child. °RHF °TB °diabetes °fits °MI °CVA

DRUGS Water pills - for ankle swelling. No allergies.

SOCIAL Married. Husband works away from home. Non-smoker. Non-drinker.

SE CVS

Breathless on hills. No chest pain - Ankles swollen.

RESP No cough or spit.

ABDO Nil. GU Dysuria.

CNS Nil

O/E

Upset °Pallor °Cyanosis °Jaundice °Nodes °Clubbing

CVS Pulse 95/min, reg. JVP ⊘. HS I+II + ?systolic m. No oedema.

RESP Chest clear. ABDOM PAD.

CNS Alert, orientated. PERL. Moves 4 limbs. Reflexes R=L=N. Plantars ↓↓.

INV. OD. For stomach washout.

SHO

IF ADDITIONAL CLINICAL DETAIL IS REQUIRED, USE AN "OUT-PATIENT" SHEET AND PLEASE ENSURE THAT IT IS FASTENED TO THE CARD.

AFTER EXAMINING THE PATIENT, PLEASE COMPLETE THE SUMMARY ON THE FRONT OF THE FORMS.

PLEASE TICK [V] THE APPROPRIATE BOX IF THERE IS A SPECIAL CONTINUATION SHEET. IF POSSIBLE, PLEASE FASTEN THIS SHEET TO THE CARD.

EYE ☐ E.N.T. ☐ HEAD INJURY ☐ HAND INJURY ☐ SHOCK ☐ OTHER ☐

WESTERN INFIRMARY

Glasgow G11 6NT

Unit ..... SSW .....

Date ..... 10/7/85 .....

I, the undersigned, do hereby refuse further treatment and leave the above unit against the advice of the Medical Staff. Any consequences of this action can in no way reflect upon the Nursing or Medical staff of the above unit or the hospital concerned.

Signed ..... Roberts .....

Witness ..... David Brown .....

.....

NAME	HOSPITAL No.	IN-PAT FORM 3
	AGE	IN PATIENT CONTINUATION HISTORY
PHYS/ SURG.	DEPT. WARD	

DATE	
9/7/85	30 ♀
	one dose 24x Atwan (? strength) ? x tegretol. } v 1-2 hrs ago.
	vomited after taking
	Tablets belong to daughter
	Impulsive
	no alcohol.
	Considerable domestic strain – daughter has brain tumour, husband has paramour.
	↳ Alert, tearful. Otherwise well
	for lavage → no return
	→ SSU.

WESTERN INFIRMARY GLASGOW W.1

IN PATIENT CASE HISTORY SIR

IN-PAT. FORM 1

Admitted to the Wards of: DR T. N. FRASER | Ward: | Date Admitted: 29/5/72 | Time in: A.M. P.M. 8-5

Surname (Mr. Mrs. Miss): WATERSON | Other Names: GEORGINA | Sex: F | Age: 17 | Hospital No.:

Address: 58 AVENEL AVE VY3. | Tel. No.: | Occupation and Industry (If wife, give husband's; If child, give father's): MACHINIST/SEWING | Date of Birth: 19/8/54 | Civil Status: M. (S.) W. D. S. | Religion: PROT

Seen by: DR ROBERTSON | Admission Clerk: JG

SOURCE OF ADMISSION

1. Emergency – not accident ☑ | 5. Waiting List? If yes, state ☐
2. Accident – road ☐ | number of days on:
3. Home ☐ | 6. Transfer other hospital ☐
4. Other ☐ | 7. Other or not stated. ☐

MEANS OF ADMISSION

Own account ☑ AMB. | Arranged ☐ | Dr's Letter ☐ | Tick approp. box ☑

Reason for Attendance (or to indicate internal transfer): 999 CALL

If Road Traffic Accident, PLACE:

DATE:

TIME:

DETAILS: OVERDOSE

BROUGHT FROM 1 LADYLOAN PL W5

Relationship of Next of Kin: FATHER

Name: JOHN

Address: S/A

Tel. No.:

Other Relation or Friend (use only as required)

Name:

Address:

Tel. No.:

PENSIONS/ASSISTANCE

Retirement ☐ | Widow's ☐ | Widowed Mother's ☐ | Industrial Injury ☐ | National Assistance ☐ | Other ☐

Previous attendance: Out Patient ☑ | In Patient ☐ | Year

Family Dr: M^C GUAGER

Address: DUNKENNY RD W5

Tel. No.:

TO BE COMPLETED BY DOCTOR ON DISCHARGE OF PATIENT

Discharge Date: / /

WARD UNIT AND CONDITION ON DISCHARGE

1. Cured ☐ | Ward
2. Improved ☐ | Type of Unit
3. No change ☐
4. Worse ☐
5. Dead – Post Mortem ☐
6. Dead – No Post Mortem ☐

DISCHARGE OR TRANSFER TO

1. Home ☑
2. Home and O.P.D. supervision ☐
3. Convalescent Home N.H.S. ☐
4. Mental Hospital ☐
5. Other Hospital ☐
6. Local Authority or Voluntary Home ☐
7. Other or not stated. ☐

Tick approp. box

DIAGNOSIS

1.
2.
3.

OPERATIONS

1.
2.
3.

DATE	HISTORY
24/5/72	Emergency admission.
	PC. Self administered overdose of Reserpine (about 30 capsules) at 6pm. (45mg elemental Rx each.)
	HPC Unmarried & aged 7/52 ago gave birth to a child in QMH. She was cohabiting with the father - who is married to another woman but awaiting a divorce - but on Saturday (20/5/72) he left her and returned to his wife.
	PE. Fully conscious & orientated. Tearful. Mm's well injected. Well perfused. P. 96/min. Reg. BP 110/70 Apex normal. HS pure. Chest clear, Abdo. - no masses or organomegaly. CNS. intact. Breasts - similar.
	A - Overdose of Inderal.
	Se. R. Observe TPR & BP. hourly ? Desferrioxamine.

SOCIAL and NON MEDICAL REPORTS and DOCUMENTS

IN-PAT. FORM 10

STICK HERE

NAME WATERSON | HOSPITAL No. | AGE | SEX | PHYS/SURG. | DEPT. WARD

IN-PAT. FORM 3

IN PATIENT CONTINUATION HISTORY

DATE

Self-Referral. Overdose of Feaspan.

HPC: This girl took about 30 capsules of Feaspan at about 6pms. She has a 6 week old baby whose father says he will not marry her and has deserted her. She had anaemia during pregnancy and was in the Queen Mother's for 6/12. The birth was normal - SVD, labour 2 hours, male child 6 lbs plus. She also had a urinary tract infection in pregnancy, but this has now cleared up.

General. CVS/RS No dyspnoea, no chest pain, no cough or sputum, no haemoptysis. No ankle swelling.

GIT No nausea or vomiting, no abdominal pains, no diarrhoea, but has constipation with piles coming down and occasional frank blood PR. No melaena, no jaundice. Weight fell to 6 stones in pregnancy, but has since risen.

UGT No urinary symptoms now.
No vaginal bleeding since the pregnancy.

CNS No symptoms.

PMH: Nil of note.

Drugs: Feaspan only.

Social: Living with parents. She wants to keep the baby.

HISTORY
(Use other side first)

DATE

O/E Fully conscious.
No cyanosis, no jaundice, no oedema, no lymphadenopathy, no finger clubbing.
Conjunctivae fairly well injected.

CVS P 84/min, ~~regular~~ good volume, marked sinus arrhythmia. AB 5th ICS midclavicular line, JVP normal, no oedema. Heart sounds pure, no murmurs. B.P 110/70

RS Trachea central. Percussion note resonant. Breath sounds vesicular, no adventitiae, VR normal.

GIT Abdomen soft, no scars. No tenderness, no masses, no hepatosplenomegaly. Bowel sounds normal, no hernias.

CNS Pupils equal and react. Cranial nerves intact. Power, tone, and reflexes physiological

△ Overdose of Feospan
℞ Gastric lavage.
Admit for observation.

D. Robertson

6/5/72 Letter to follow.

Having as above. This girl has good support from her family and is not depressed at present. The overdose was a genuine attempt to have her boyfriend relent to his. Fit for discharge from a psychiatric standpoint.

Summary Adm. 24/5/72 Dis. 26/5/72.
17 yr. old patient admitted with an overdose of 30 capsules of Feospan. Treated with gastric lavage & desferroxamine. Seen by Dr. Wilkie who felt she was fit for ~~discharged~~ discharge.

WESTERN INFIRMARY GLASGOW W.1

NAME	HOSPITAL No.
	AGE
	SEX
PHY/ SURG.	DEPT. WARD

IN-PAT. FORM 4

INVESTIGATIONS RECORD

DATE	INVESTIGATIONS	RESULT
24/5/72	Serum iron ✓	
25/5/72	FBC ✓	
	ESR ✓	
	U+E ✓	
	Serum iron ✓	
	LFT's ✓	
	Psychiatric opinion ✓	